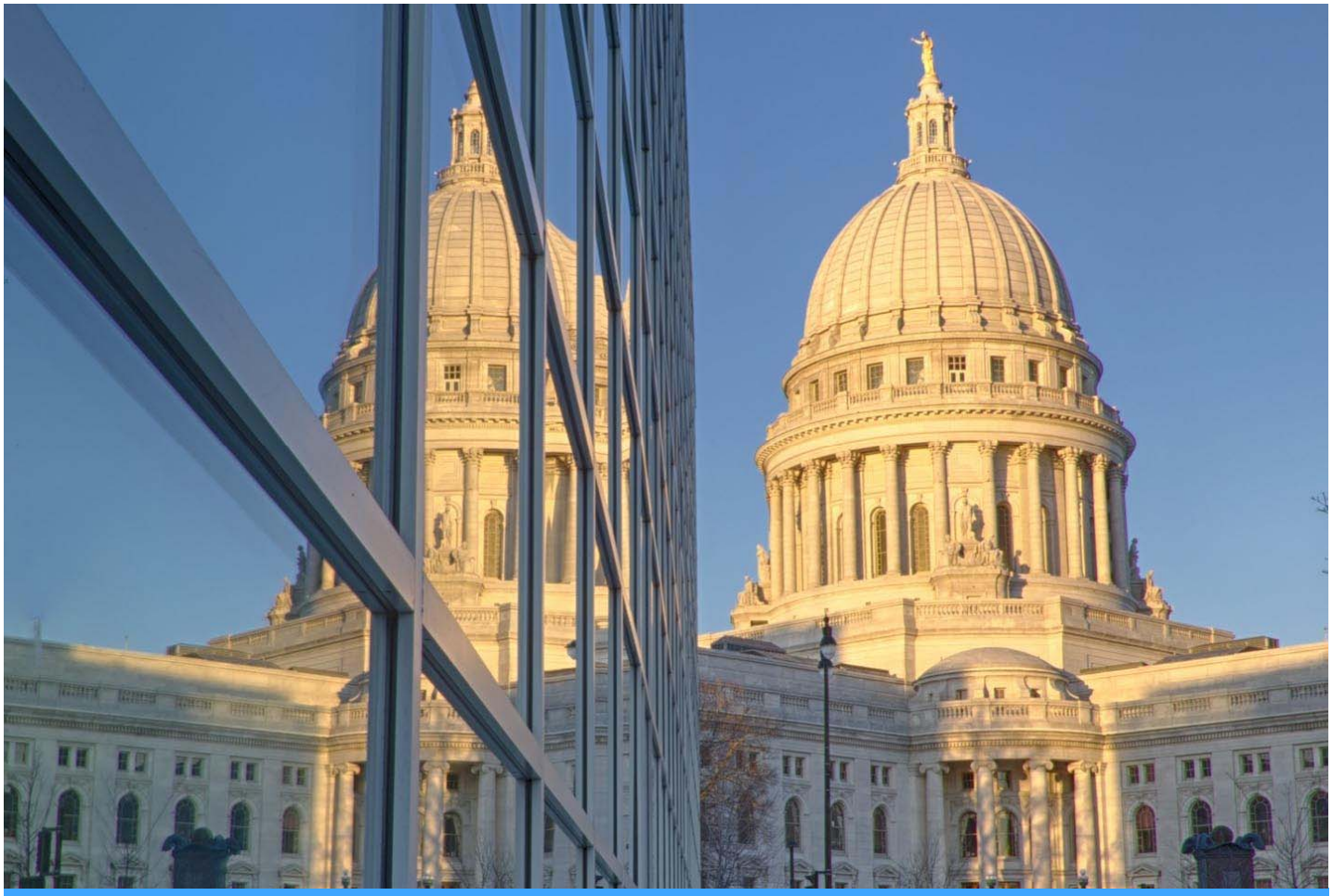

WISCONSIN GROUP INSURANCE BOARD
Department of Employee Trust Funds

Health Care Benefits Consultant

First Report –

Observations and 2016 Recommendations

March 25, 2015

THE SEGAL GROUP
Founded in 1939

Segal Consulting

GIB 3.25.15 Item 4C
Attachment A

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Health Care Benefits Consultant
March 25, 2015

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Executive Summary

Project Overview

The Wisconsin Group Insurance Board (GIB) was recently granted extended authority to retain an actuary and a consultant to support the programs the board oversees. In addition, the GIB now has power to make changes to existing health benefit plans, including self-insuring the benefits, provided the changes maintain or reduce premium costs for the state or its employees in the current or any future year.

Under this GIB authority, Segal Consulting was retained to perform a full range of services related to the analysis, design, management and communication of the State's health insurance program for employees and retirees.

The primary objective of the project is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

This report is the first of two deliverables anticipated by the contract and focuses on analysis and recommendations for consideration for calendar year 2016, as well as interim reports on larger analyses in process. The second report, to be issued later in 2015, will include findings, recommendations and strategies for consideration for 2017 and future years.

Segal has agreed to a high-level review of the following components for this report:

- Comprehensive Plan Benchmarking—plan costs, designs, access
- Health Management
- Pharmacy
- Consumer Driven Health Care Design
- ACA Review – Excise Tax
- Private and Public Exchanges
- Market Observations
- Self-Insurance Concepts
- WHIO Database

Segal has completed our review and recommendations for 2016 plan year. We have discussed each component in a separate section of this report. We have highlighted each section on the following pages.

Benchmarking Comparison

Segal compared the benefits and costs of the ETF program to state health plans nationally and regionally (IA, MN, IL, IN, MI), as well as to the Federal Employee Health Benefit Program. Overall, our findings were consistent between the groups.

Plan Designs

Compared to other state health plans in the region, the primary Wisconsin benefits structure, under the Uniform Benefit Design (UBD), provides the highest level of benefits (lowest member cost share). When compared nationally and with the FEHB, the Wisconsin design remains one of the highest. Benefits under the UBD are provided primarily through HMO based options. The Wisconsin Standard Plan is a PPO and is also a high-value plan.

Based on the comparisons and Segal's experience with state level health plans, we recommend that ETF consider introducing an annual deductible for the UBD and increasing the annual deductible for the Standard Plan and increasing the maximum out-of-pocket limits for both the UBD and the Standard Plan. We also recommend that ETF consider increasing the State's contribution to the Health Savings Account to increase the competitiveness of the HDHP option. Our plan design recommendations for consideration for 2016 include:

- **UBD:** Introduce $250 Annual Deductible and increase Annual Maximum Out-of-Pocket from $500 to $1,000. Family rates would be twice these figures.
- **Standard Plan:** Increase annual Deductible from $200 to $500 and increase Annual Maximum Out-of-Pocket from $500 to $1,000. Family rates would be twice these figures.
- **HDHP:** Increase the State's annual Health Saving Account (HSA) contribution from $170 to $750. Family rates would be twice these figures.

The overall projected savings from these changes is approximately three percent (3.0%) of total plan cost. Based on a preliminary projection for 2016 medical costs of $1.150 billion, this equates to $35 million in cost savings overall. We believe these changes could represent a solid initial step towards managing the State's exposure to the 40% Excise Tax, which begins in 2018.

Premiums, Employee Contributions and Premium Tier Structure

Premium costs for the UBD vary widely among the carriers, and provide an opportunity to adjust the annual negotiation strategy to drive rates and enrollment towards the more efficient and lower cost HMO/PPO plans in the UBD.

In aggregate, the levels are higher than the benchmark plans but some HMOs/PPOs fall at the lower end of the range. The employee contribution rates are similar to the benchmarks on a percentage basis, but with the higher total costs the absolute dollars are higher than the averages.

Premium rates and contributions are currently on a 2-tier system: single/family. The majority of plans are on either a 3-tier or 4-tier design. Since 39% of members in the current family tier do

not cover both a spouse and child, we recommend changing the tier structure to be more equitable. This could be designed to be budget neutral, having no financial impact to ETF.

Total Health Management

The report reviews disease management and wellness programs currently in place and compares the membership's current health risk and status against benchmarks and Evidence Based Medicine (EBM) guidelines and standards.

We reviewed the results by individual ETF health plan and found a significant variation in effectiveness of health management among the current health plans. Care gap levels and utilization patterns do not necessarily correspond to health risk levels between the health plans.

By incorporating enhanced quality and efficiency metrics, along with data reporting requirements, into the annual renewal and negotiation process for 2016, there is an opportunity to improve the overall performance and efficiency of the ETF program by improving member health vendor performance.

Wellness Program

We reviewed Well Wisconsin, the current wellness program, and believe that ETF has taken a number of steps in the right direction. The program currently provides a $150 incentive to adult members who complete a health risk assessment (HRA) and biometric screening. The program is administered by OptumHealth, in cooperation of the plans.

Segal has found that voluntary programs with an incentive will have very low participation. We note that the 2014 level of participation was only 13%. In order the get better participation and long-term engagement, there has been a movement to premium-based plans.

We recommend that ETF consider adopting a premium credit for participation. Those who do not participate would see their rates increase.

Pharmacy Benefits

Segal reviewed ETF's current pricing delivered under the pharmacy benefit manager (PBM) contract with Navitus and compared those results with recent PBM contract awards with other similarly situated states. We found that the overall pricing does not vary significantly with pricing obtained recently in the market. Overall discounts, rebates, administrative costs and dispensing fees are within 2% of the peer group's contracts we reviewed.

The Navitus contract does not include pricing guarantees, which is highly unusual in today's pharmacy benefit manager marketplace. While the current contract has produced reasonable results for ETF, we recommend that ETF help assure those results will continue by negotiating price guarantees into the Navitus contract.

Our review of ETF's current prescription drug benefit levels results in a recommendation for 2016 to convert the current copay cost sharing structure for brand drugs to a coinsurance structure. The coinsurance approach will provide better trend protection (as drug cost increases are also shared by the member rather than ETF picking up the entire cost over a fixed member

copay), additional incentives to utilize generic medications and result in a shift in utilization patterns towards lower cost brand drugs.

We recommend the following Rx benefit change, which we project will generate a cost savings of approximately 3.5% of Rx costs, or $7 million, in 2016.

Level	Current	Proposed
Level 1	$5	$5
Level 2	$15	20% ($50 max)
Level 3	$35[1]	40% ($150 max)[1]
Level 4 • Preferred • Non-preferred	 $15[2] $50	 $50[2] 40% ($200 max)
Out-of-Pocket Limits • Level 1 & 2 • Level 4	 $410 / $820 $1,000 / $2,000	 $410 / $820 $1,000 / $2,000
ACA MOOP (Medical & Rx)	$6,600 / $13,200	$6,600 / $13,200

[1] Level 3 copays do not apply toward OOPL.
[2] Reduced copay applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy.

Additional savings of $10 million could be achieved by doubling the out-of-pocket limits, moving them closer to the benchmarks. The current levels are extremely low, but this could be implemented in 2017, in conjunction with broader plan design changes.

In addition to the plan design and cost analyses above, Segal reviewed the pharmacy clinical programs in place for ETF through Navitus. We find that those clinical programs are generally sound and do not present any significant gaps to best practice among prescription drug programs.

Consumer Directed Health (CDH) Care Design

A CDHP is a combination of a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA). The recently implemented HDHP option has a benefit design that is both within the federal requirements for such plans and within industry norms for plans of this type. The premium level for the CDH program is also appropriate for the benefits. However, we do note that the State's annual Health Savings Account (HSA) contribution associated with HDHP program participation is well below competitive levels among other such plans. We believe this is a primary reason that participation in the CDH is low—only about 400 employees.

Increasing the State's HSA contribution to $750 annually per employee ($1,500 for family coverage), compared to the $1,500 Annual Deductible ($3,000 for family coverage), would result in a much more attractive design and likely generate a significant increase in enrollment in the lowest cost ETF option.

Additionally, we recommend that ETF consider streamlining and consolidating the number of carriers that provide the CDH option. A number of the current health plans are more aligned with providing managed care options and are not as focused on successful administration of a CDH

type product. It is our opinion that the ETF membership would be better served by vendors that have experience and operations geared towards supporting CDH. Such a change to consolidate CDH delivery is not likely feasible for 2016, but should be examined more closely in the coming months for possible implementation in 2017.

Affordable Care Act – 40% Excise Tax

Starting in 2018, the Affordable Care Act (ACA) will begin to impose a ceiling on the value of health benefits that can be provided to an employee or retiree on a pre-tax basis. This ceiling will be in the form of the 40% Excise Tax, sometimes referred to as the "Cadillac Tax", and will be assessed against health plans that provide a health benefit worth more than certain dollar amounts stated in the law.

The 40% Excise tax is assessed on the total value of any health benefit plans provided to an employee or retiree through an employer plan that exceeds a threshold of $10,200 for single coverage and $27,500 for all other coverage tiers. In certain cases, the threshold amounts can be increased to $11,850 (single) and $30,950 (other coverage tiers) for retirees and employees in hazardous duty employment. The Excise Tax dollar thresholds are indexed to the Consumer Price Index for Urban Consumers (CPI-U) for years after 2018.

Because medical inflation has persisted at significantly higher rates than general inflation, it is expected that, at some point, without changes that would reduce the total cost, nearly every employer health plan will reach and exceed the Excise Tax threshold.

The tax is based on the total cost for the health benefit programs, not on the value of the plans or the employer portion of the cost. For that reason, it is not possible for a plan to avoid the tax by shifting premium cost to the employee or retiree. Other changes must be made to stay under the tax thresholds.

Importantly, the Excise Tax applies to all health plans offered to employees and retirees, which will mean that other benefits that may or may not be administered by the Group Insurance Board will have to be included in the calculation of total cost. Those other plans include the State's Health Flexible Spending Accounts (FSAs), on-site health clinics, and potentially even the employee assistance program (EAP).

The IRS has not yet provided detailed guidance on how the 40% Excise Tax will work, but has begun to request comments on a number of key aspects of the tax. As the regulations are developed, the ways in which plans will need to adjust may change.

We project that under ETF's current benefit program with no changes, ETF's potential Excise Tax exposure is between $7 and $13 million in 2018 and could grow to as much as $193 million in 2027. These preliminary calculations, while likely to change as the IRS publishes specific guidance, do illustrate the need for ETF and the State to begin addressing the Excise Tax issue immediately. Any cost efficiencies and reductions that can be implemented between now and 2018 would, of course, have a positive impact on the State's exposure to the Tax.

Given the ongoing development of regulations by the IRS, Segal's principal recommendations at this time are to continue monitoring the potential Excise Tax exposure as the regulatory process moves ahead and initiate discussions with the appropriate State agencies with responsibility for

the other types of plans that may be included to prepare for plan and policy changes that may be required to help the State avoid assessment of this Excise Tax.

Private and Public Exchanges

A comparison of current ETF premiums and premiums for similar plans offered on the State's Healthcare Marketplace (Exchange) indicates that the plans on the Exchange may be more efficiently priced than the current ETF offerings.

In comparison to the State Exchange, the ETF's UBD and Standard Plan plan designs would be considered to be at the Platinum Plan level and the HDHP plan would be at the Gold Plan level. A Platinum Plan covers 90% of total costs, on average, and a Gold Plan covers 80%.

Plan options and premiums vary on the Exchange by age and location, but if State employees used the Exchange to purchase similar coverage to ETF (e.g., UBD and Standard Plan participants enrolled in an average Platinum level plan and HDHP participants enrolled in an average Gold level plan), the total plan costs would be 5% to 20% ($61 million to $240 million) lower in 2015. Note that ETF plans are 5%-6% richer than exchange plans, providing explanation for some of the difference. One should also recognize that the plans on the Exchange are fairly immature.

The population purchasing Platinum policies on the exchange should have higher health risk (and therefore higher costs) due to the exchange being a market of individual policies, which typically have higher premiums than otherwise similarly situated group policies. A well-designed state employee health plan like ETF should be able to provide benefits in a more cost efficient manner than those available in the same state's healthcare marketplace. We believe that ETF should continually be addressing the cost efficiency of its programs and the public exchanges now provide a more defined comparison point than has been available in the past.

Market Observations

Segal reviewed market data and surveyed the local Wisconsin healthcare market and has concluded/confirmed that:

- Healthcare costs vary across the State, and by carrier
- There is a wide range of capabilities and practices among the carriers and health plans within the State
  - Not all can support a self-funded ETF strategy
  - Different health plans are at different development points regarding tiered provider networks, care management practices, data mining and analytic capabilities, and innovative and value-based provider payment methodologies.
  - Some providers currently contract with multiple carriers and others are exclusive to a single carrier
  - Data provided to WHIO is not uniform
- Several national carriers report they are capable of supporting ETF on a statewide, even nationwide, basis

Self-Insurance Concepts

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and are primarily financial:

- **Elimination of most premium tax:** There is no premium tax on the self-insured claim expenditures.
- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced by ACA and applies to all fully insured medical and/or dental business.
- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a TPA are significantly lower than those included in the premium by an insurance carrier or health plan.
- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan (usually between 2% and 4%) are eliminated for the bulk of the plan.
- **Cash flow benefit:** The employer does not have to pre-pay for coverage, thereby providing for improved cash flow.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- **Control of plan design:** The employer has complete flexibility in determining the appropriate plan design to meet the needs of the employer and employees.
- **Data collection:** A key element of a self-insured program would be to receive detailed claims and encounter data, allowing ETF to better manage their financials.
- **National provider network:** The TPA should offer a national integrated program of networks for retirees and out-of-state workers.
- **Custom Provider Network:** The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees.
- **Mandatory benefits are optional:** State regulations mandating costly benefits for insured plans are usually optional because self-funding is regulated by federal legislation only.
- **Cost reporting:** The TPA should provide a monthly detailed reporting of costs, by department or location, and by type of medical service.

There are a number of possible drawbacks that need to be considered.

- **Health Plan Contracting:** although the results of the survey of ETF health plans conducted as part of this analysis indicate that the network providers are typically paid the same amount for services under either an insured arrangement or a self-insured plan using that network, we are not convinced that the overall levels of discounts would remain the same where the health plan is not taking the risk for the plan.
- **Care Management:** there are currently wide variations in practice patterns between the health plans. There may currently be advantage in the gatekeeper process initiated by some plans.

- **Current Program Design:** having 18 health plans under contract makes it virtually impossible to manage a self-insured design spread across all carriers. Additionally, the data is not available to accurately develop the rates.
- **Disruption:** if the plans are collapsed to fewer carriers to better allow more efficiency in self-insuring the program, there could be disruption to members in providers currently available under a particular health plan.

We believe there is an opportunity to lower administrative expenses and eliminate both the state premium tax and ACA "market share" fees. In an earlier study of self-insurance for ETF, Deloitte estimated this to be a 4.9% savings based on the RFI information received in 2013. We would expect slightly greater upside savings due to consolidation and administrative efficiencies. Our savings are expected to range from 5% to 7%. Based on estimated state employees' medical premiums, the savings would be $50 to $70 million.

We do believe that pricing will be impacted somewhat, but with the limited data available we are unable to estimate that impact. This may not necessarily reduce the savings as the prior report indicated, since more efficient plans, designed properly, could provide ETF additional savings potential. Further work on this will need to be performed for the second report later this year.

Initial Recommendations

For 2016, we recommend that ETF work on improving the health plan renewal process for fully-insured plans. Self-insuring is not practical in the current structure. Segal will recommend an alternative negotiation strategy and different application of the tiering approach, with a goal of a more accurate assessment of the costs and efficiencies of competing health plans. We believe the health plans will need to provide a more aggressive initial quote and ETF should consider not allowing a carrier to negotiate into Tier 1 if their initial submission is unreasonable or they have poor metrics on patient and operational quality. We are also evaluating the prospect of implementing a minimum loss ratio threshold.

Segal is in the process of revising the addenda and the health plan submissions will have additional exhibits to capture financial information. We recommend that the rates and submission be signed by their actuary and CFO. We are also going to suggest that detailed claims data is submitted and is reconciled to the summary information disclosed in the addendum. This would be claims data for fee-based claims and encounter data for capitation claims. Administrative costs also need to be itemized in greater detail.

For 2017, our subsequent report will have details on a recommended plan design structure, with early indication that a regional market component could benefit ETF. We do believe that the entire program could be self-insured in the appropriate structure. If that occurs, ETF will realize the savings from self-insurance discussed earlier, as well as any recommended overall programmatic changes.

WHIO Database

The WHIO database, as currently configured, does not provide ETF with access to the information and analytics tools needed to manage the program effectively.

We recommend further evaluation of the WHIO Database relative to the plan management needs of ETF staff and determine the most favorable course of action to close the gaps.

There are four likely courses of action:

1. ETF works with WHIO and Optum to expand the WHIO capabilities, reporting and data array for WHIO to become the data warehouse for ETF.
2. ETF continues to use WHIO for clinical and enrollment reports, but collects and develops plan financial information independently
3. ETF bids and contracts a new data warehouse system with a qualified contractor.
4. ETF builds its own data warehouse

We recommend ETF explore this options in this order, with the first being a preferred solution for ETF.

Next Steps

Going forward the major steps include:

- Group Insurance Board consideration and possible approval of recommended plan design changes for 2016
- Segal and ETF staff development of adjusted negotiation strategy and standards for 2016 health plan renewal and negotiations
- Segal and ETF staff work collaboratively to determine the best path forward regarding WHIO and ETF's data warehousing needs
- ETF negotiates pricing guarantees into the Navitus contract
- Segal continues to analyze the available data and investigate market options to develop and finalize recommendations for 2017, which will include:
    - Self-insurance options and the necessary program changes to support the recommended strategy
    - Improvements to health management and wellness program(s)
    - Additional benefit design and premium changes
    - Continue to monitor and evaluate the State's Excise Tax exposure and develop recommendations to mitigate this exposure

We will continue our analysis and working with ETF and their vendors to develop a go-forward strategy improves efficiency in the delivery of healthcare and introduces cost and pricing efficiencies that result in a long-term sustainable strategy.

Introduction

Segal Consulting was retained by the Group Insurance Board to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program. This report is the first of two and focuses on analysis and recommendations for consideration for calendar year 2016, as well as interim reports on larger analyses in process. The second report later in 2015 will include findings, recommendations and strategies for consideration for 2017 and future years.

Background

The State of Wisconsin Employee Trust Fund currently administers retirement, health, life, income continuation, disability, and other insurance programs for 570,000 state and local government employees and annuitants. ETF's Division of Insurance Services administers the state employee health insurance program.

The Group Insurance Board, consisting of 11 members, sets policy and oversees administration of the group health, life insurance, and income continuation insurance plans for state employees and retirees and the group health and life insurance plans for local employers who choose to offer them. The Board also can provide other insurance plans, if employees pay the entire premium.

Membership and Costs

The State and local health insurance programs cover over 240,000 lives. This includes 72,000 active state employees and 22,000 retired state employees and their dependents, and 12,000 active local employees and 2,000 retired local employees and their dependents. The program administers nearly $1.4 billion in annual insurance premiums.

Based on current premiums, member enrollment, administrative costs and recent claims experience, Segal projects the following costs and expenses for 2015 (amounts in $millions).

	Actives/ Non-Medicare Retirees	Medicare Retirees	Total
Total Medical Costs	$946	$86	$1,032
Total Pharmacy Costs	$137	$53	$190
Total Dental Costs	$48	$4	$52
Total Administrative Fees	$127	$12	$139
Total Annual Costs	**$1,258**	**$155**	**$1,413**
Member Premiums	($215)	($155)[1]	($370)
Net ETF Costs	**$1,043**	**$0**	**$1,043**

[1] Retiree premium contributions include sick leave funding from the State

Current Benefits

Most health insurance benefits (98%) are administered through 18 competing, fully insured health plans. Health insurance benefits follow a "uniform benefit" design, in that all participating health plans are required to offer the same benefits package. The pharmacy benefit has been administered separately from the insured health plans through a Pharmacy Benefits Manager (PBM) since 2004.

Also in 2004, the State implemented a three-tier rating system for the health plans that anticipates different levels of employee contribution for each tier. Most plans are offered in Tier 1.

- Tier 1: includes the top plans in efficiency and quality, and has the lowest employee contribution.
- Tier 2: includes lower ranking plans in efficiency and/or quality, and has a higher employee contribution.
- Tier 3: are the lowest ranking plans in efficiency and quality, and highest employee contribution.

The State also administers two self-insured plans—the "Standard Plan" and the "State Maintenance Plan". The Standard Plan is a PPO administered by Wisconsin Physician Services ("WPS") and provides comprehensive freedom of choice among hospitals and physicians across Wisconsin and nationwide. The Standard Plan is a Tier 3 health plan for employees.

The State Maintenance Plan ("SMP") is available only in counties that lack a qualified Tier 1 Alternate Plan HMO or PPO. It offers the same Coinsurance, Traditional and HDHP Uniform Benefits packages as the Alternate Health Plans. SMP does not offer Uniform Dental coverage.

Beginning January 1, 2015, the State is offering employees the option of a high deductible health plan (HDHP). In addition, those who enroll in the HDHP will be enrolled in a health savings account (HSA). The HDHP plan option has a minimum annual deductible and maximum out-of-pocket limit. Except as required by federal law, the health plan does not pay any medical, dental or prescription drug costs until the annual deductible has been met. Members must enroll in an HDHP in order to have the state-sponsored HSA. Amounts contributed to the HSA by the state belong to the member and can be used to pay for eligible medical expenses.

Health Management and Wellness

ETF requires the participating health plans to identify members with a moderate or high health risk and have in place a process to enroll them into appropriate health management programs.

Disease Management

ETF has identified five specific areas for disease management, which are covered by the following requirements in the health plan contract:

1. **Low Back Surgery:** Prior authorization for referrals to orthopedists and neurosurgeons for low back pain in members who have not completed an optimal regimen of conservative

care. This is not applicable to members who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

2. **High-Tech Radiology:** Prior authorization for high-tech radiology tests, including MRI, CT scan, and PET scans.

3. **Shared Decision Making (SDM) for Low Back Surgery:** Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS) for members considering low back surgery.

4. **Advance Care Planning (ACP):** Health plans and their contracting providers must provide an ACP program that meet one of the five options outlined in the ETF guidance. Those options include:

    a. health plan is actively participating in Honoring Choices of Wisconsin, Gundersen's Respecting Choices or the Institute for Healthcare Improvement's The Conversation Project;

    b. palliative care specialists are added to care teams that commonly care for ETF members with advanced or life-threatening disease;

    c. all ETF members over 60 are offered an opportunity for ACP with a trained facilitator;

    d. all ETF members with a serious disease and a likely survival of less than 1 year will be offered an ACP and/or palliative care consultation; OR,

    e. all ETF members with a likely survival of less than 90 days will be offered hospice services.

5. **Coordination of Care (COC)**: With the intent of reducing hospital admissions, health plans (or their contracted hospital/provider groups) must contact members who have been discharged from an in-patient hospital and have a diagnosis of heart failure, myocardial infarction, pneumonia, or any other high-risk health condition within 3 – 5 business days after the initial hospital discharge.

ETF also holds an annual Disease Management Symposium with the contracted health plans as well as meetings with the health plan chief medical officers. These meetings are an opportunity for health plans to share best practices for the areas targeted by ETF and to express challenges that may exist for ETF proposed program expansion.

Wellness

In 2013 the Group Insurance Board (GIB) approved a Uniform Wellness Incentive to begin in plan year 2014. The Uniform Wellness Incentive required all health plans to issue $150 to adult members who completed a biometric screening and a health plan administered health risk assessment (HRA).

Members have the option to complete the biometric screening with their physician or at a worksite biometric screening event. To improve the availability of worksite biometric screenings, the Department of Administration contracted with a single vendor, OptumHealth, in December 2013.

All employers participating in the State of Wisconsin Group Insurance program may access the OptumHealth contract to host worksite biometric screening events. The OptumHealth contract costs are covered by a wellness fee of $.80 per member per month added to the employer health insurance administrative fee paid to ETF. ETF assists with the transfer of screening results from OptumHealth to the health plans. Currently, approximately 13% of eligible members in 2014 have completed the requirements to earn the $150 incentive.

WHIO Data Mart

The Wisconsin Health Information Organization (WHIO) is a database resource for health claims information for the state employee health insurance program. WHIO's database is intended to improve health care transparency, quality and efficiency. Fifteen of the state employee health plans currently submit data to WHIO. For 2015, all ETF health plans are required to submit data to WHIO and the remaining three plans are being on-boarded.

The WHIO Health Analytics Data Mart functions as a data-driven marketplace that enables members to submit information and receive reports that analyze health system and physician performance based on hundreds of variables. The Data Mart is intended for use in identifying gaps in care for treatment of chronic conditions, costs per episode of care, population health, preventable hospital readmissions and variations in generic prescribing.

The Data Mart contains a volume and depth of data on medical services that spans multiple health care systems across the state and multiple service settings, including physician's offices, outpatient services, pharmacy claims, labs, radiology and hospitals.

The Data Mart maintains a rolling 27 months of claims data that comprises the experiences of more than 4 million people and 255 million treatment services. A total of 21.5 million episodes of care are currently in the database and its scope will grow as new members join and contribute to the cooperative effort. An episode of care is defined as the series of treatments and follow-up related to a single medical event, such as a broken leg or heart surgery or the year-long care of a diabetic patient.

Each successive version of the database, refreshed every six months, is intended to capture the most recent health care experiences of additional consumers. The current version of the database contains more than $70 billion of health care expenditures and allows comparisons of those expenditures by region, county, 3-digit ZIP code and medical system. The WHIO database is Health Insurance Portability and Accessibility Act (HIPAA) compliant.

Benefits Consultant Contract

In May, 2014, the State of Wisconsin issued a Request for Proposal (RFP) for a Health Care Benefits Consultant for the Employee Trust Fund (ETF). The RFP stated that the consultant's primary objective is to analyze data from a variety of sources to develop and recommend strategies to improve health outcomes and increase the efficient delivery of quality health care to participants in the state employee health insurance program.

Segal Consulting (Segal) was selected for this engagement, with the contract commencing in November 2014. The contract anticipates two main project deliverables:

- Within 6 months of the beginning of the contract, the vendor will provide a documented report ("Report 1") and a presentation to the Group Insurance Board (Board) outlining potential benefit design changes and strategies for the 2016 plan year.
- Within 12 months of the beginning of the contract, the vendor will provide a documented report ("Report 2") and a presentation to the Board outlining potential benefit design changes and strategies for the 2017 plan year.

The RFP also states that the Consultant would receive a large data set from the Wisconsin Health Information Organization (WHIO) immediately once under contract. WHIO provided data to Segal on January 16, 2015.

To fit the timing required for consideration, approval and implementation of changes for 2016, it was agreed that Report 1 would be presented to GIB at a meeting in March, 2015. Segal and ETF agreed upon a modified scope for the first report to reflect the delay in receiving usable data from WHIO.

In this Report 1, we present our comments and observations on the following topics:

- **Benchmarking Comparison:** This section provides a comparison of ETF benefits and costs with those of other selected states in the region, as well as nationally, where appropriate. The section also provides comparisons of the ETF benefits and costs to other comparable options available to employers in Wisconsin, to the options available on the state health insurance exchange, and to the Federal Employee Health Benefit Program (FEHB).
- **Total Health Management:** The report reviews disease management and wellness programs currently in place, including the membership's current health risk and status. In addition, the report notes best practice examples of disease management and wellness being offered by other states and large employers.
- **Pharmacy:** This report section reviews the ETF's current pricing, clinical programs and formulary for the current Pharmacy Benefit Manager (PBM), and includes a review of the current benefit design along with recommendations for possible changes for 2016 and beyond.
- **Consumer Directed Health (CDH) Care Design:** The report provides comments and observations on the recently implemented CDH options, including ideas for potential adjustments going forward to encourage broader enrollment in this plan.
- **Private and Public Exchanges:** This section includes an overview of private healthcare marketplaces and comparison of ETF benefits and costs to Platinum and Gold options available on the Wisconsin Healthcare Marketplace.
- **Affordable Care Act (ACA):** With the coming implementation of the 40% Excise Tax under the ACA in 2018, the report assesses ETFs potential Excise Tax exposure and offers commentary on the impact of other aspects of ACA on how ETF and the State may be affected.
- **Market Observations:** Separate from the more specific treatments in the sections above, this topic provides comments based on a preliminary review of the Wisconsin health insurance market, including current practices, emerging trends and opportunities available to ETF.
- **Self-Insurance Concepts:** In this section, the report discusses Segal's review of the feasibility of self-insuring the program, reviewing the advantages and disadvantages in such

an approach. We also make preliminary observations and comments on the current primarily fully-insured strategy, the annual renewal process and tiering structure.

- **WHIO Database:** This section analyzes the data capabilities provided through the current WHIO platform compared to ETF's needs in effectively managing a state employee health insurance program. The report identifies areas where WHIO might be enhanced for the state's purposes and discusses market available alternatives to that program.
- **Recommendations and Next Steps:** The report provides specific recommendations for ETF and the GIB to consider for 2016, along with rationale for making those changes as part of a longer term initiative to improve how the state offers coverage to its active employees and retirees. The report addresses necessary steps for the second report and to implement recommended changes for 2016 as well as to begin discussions and planning for changes for 2017.

Following the main narrative of the report, Segal also provides a number of Appendices that include detailed data tables not included in the main body of the report, as well as a listing of our data sources and methodology.

Benchmarking Comparison

In order to provide perspective on the current benefits provided to State employees, we compared ETF benefits with those provided by other state-level health plans, with plans offered by the Federal Employees Health Benefits Program (FEHB) in the State of Wisconsin, and with the benefits available to individuals on the state health insurance exchange. This section presents the comparisons to other state health plans and the Federal employee program. Comparisons to benefits available to individuals through the state health exchange are included in a later section of the report.

Methodology and States Compared

For the comparison of state benefits, we utilized the data collected annually for the *Segal Study of State Employee Health Benefits*. This data includes information for state health plans on costs, premiums, plan designs and related issues. The Segal state study data covers all states and the District of Columbia and reflects benefits offered to active, full-time employees of state jurisdictions.

The most recent complete data in our database is for plan years starting in 2014 (many states operate their health plans on a fiscal cycle different from the calendar year, so publication of information about the plans occurs across a number of months each year). We therefore based our analysis on the 2014 ETF medical and pharmacy benefits and costs to maintain comparability.

For the comparison to state health plan benefits and costs, we focused on the states in the immediate regional vicinity of Wisconsin. Segal and ETF staff identified the following five states for the regional peer group:

1. Illinois
2. Indiana
3. Iowa
4. Michigan
5. Minnesota

Additionally, there are thousands of Federal employees in Wisconsin. Our analysis also includes a comparison of ETF benefits and costs with FEHB plans offered to Federal employees in the State of Wisconsin. The Federal plan offers a variety of medical benefit options based on the employee's location.

The majority of the exhibits and commentary in this section of the report focus on how Wisconsin compares with other states on a regional basis. Detailed comparisons with states on a national level and with the FEHB are provided in **Appendix 1: Detailed Benchmarking Data Comparison.**

Medical Plan Types

Data was collected on the following medical plan type groupings:

- Health maintenance organizations (HMOs) and similar type plans
- Preferred provider organizations (PPOs) and point-of-service (POS) plans
- High-deductible health plans (HDHPs) and consumer-directed health plans (CDHPs)

While all three plan types are commonly offered by most states, the majority of states utilize PPO/POS plan(s) as the primary plan option(s) for their active employees in order to provide a uniform program for employees across their state and nationally. HMOs are generally utilized on a local targeted basis because of their more limited provider networks. HDHP/CDHPs have grown in popularity, typically offered to provide choice and promote increased member responsibility.

The following table shows the prevalence of each plan among the regional comparator states and nationally. All three plan types are offered by FEHB.

STATES OFFERING MEDICAL PLAN TYPES

	Wisconsin[1]	Regional States	National
HMO[2]	Offers Multiple Options	4	31
PPO/POS	Offers Multiple Options	4	47
HDHP/CDHP	Offers Multiple Options	2	30

Benefit Levels

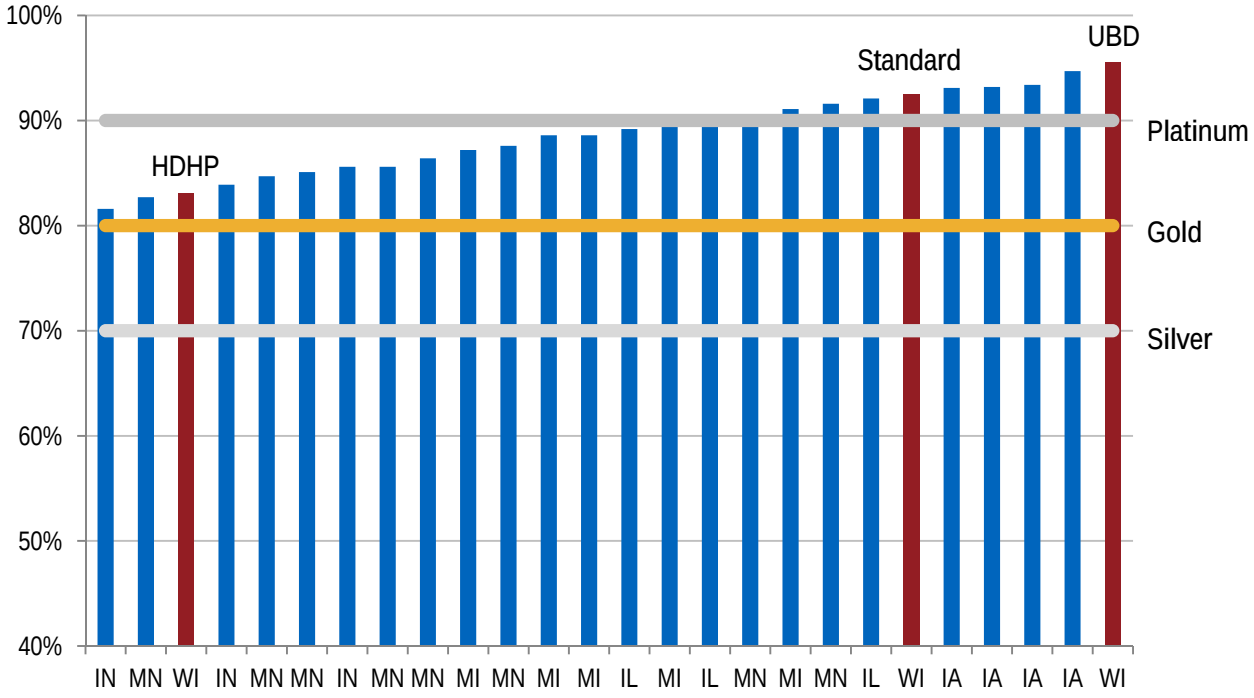
Actuarial Value is defined to be the portion of costs covered by the plan on average. The ACA defines plans on the state exchanges that provide a 90% Actuarial Value to be Platinum Plans. Gold Plans are 80%, Silver Plans are 70% and Bronze Plans are 60%.

For example, a Platinum Plan would expect the plan to cover 90% of expenses with the member picking up the remaining 10% through copays, coinsurance, deductibles, etc.

The benefits provided by the ETF Uniform Benefit Design meet or exceed the benefit levels provided by every other state. **Appendix 1: Detailed Benchmarking Data Comparison** includes a line-by-line comparison both regionally and nationally. The following graph illustrates the Actuarial Value for each plan offered by states within the identified region. The plans are arranged in order from lowest to highest value. The ETF UDB is the richest plan in the region at 96%, with benefits provided primarily via HMO options. The Standard Plan PPO is close behind at 93% actuarial value. Both exceed the highest Platinum level identified for state health insurance exchange policies.

1 The Wisconsin HDHP plan became effective January 1, 2015.
2 The HMO plan category also includes similar plans, such as EPO and POE plans.

ACTUARIAL VALUE COMPARISON



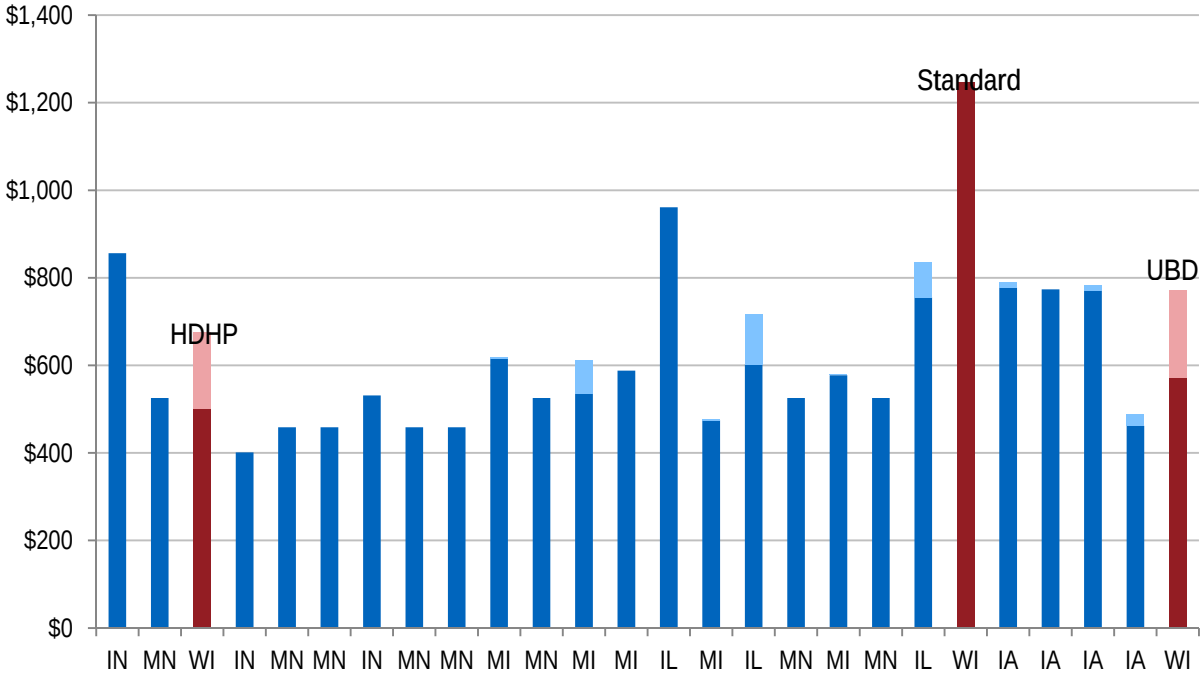
Cost Comparison

ETF full premiums are among the highest in the region as well. This is not unexpected given the high level of benefits. The following graphs reflect the premium cost for each of the plans included in the previous graph, arranged in the same order of Actuarial Value, from lowest to highest. Comparisons for single person coverage and family coverage are shown in separate charts. States with plans that have a range of premiums for multiple options providing the same benefits, similar to the Uniform Benefit Design in Wisconsin, are shown with premium range indicated by the lighter color at the top of the bar. Wisconsin UBD and HDHP premiums are shown without costs associated with dental.

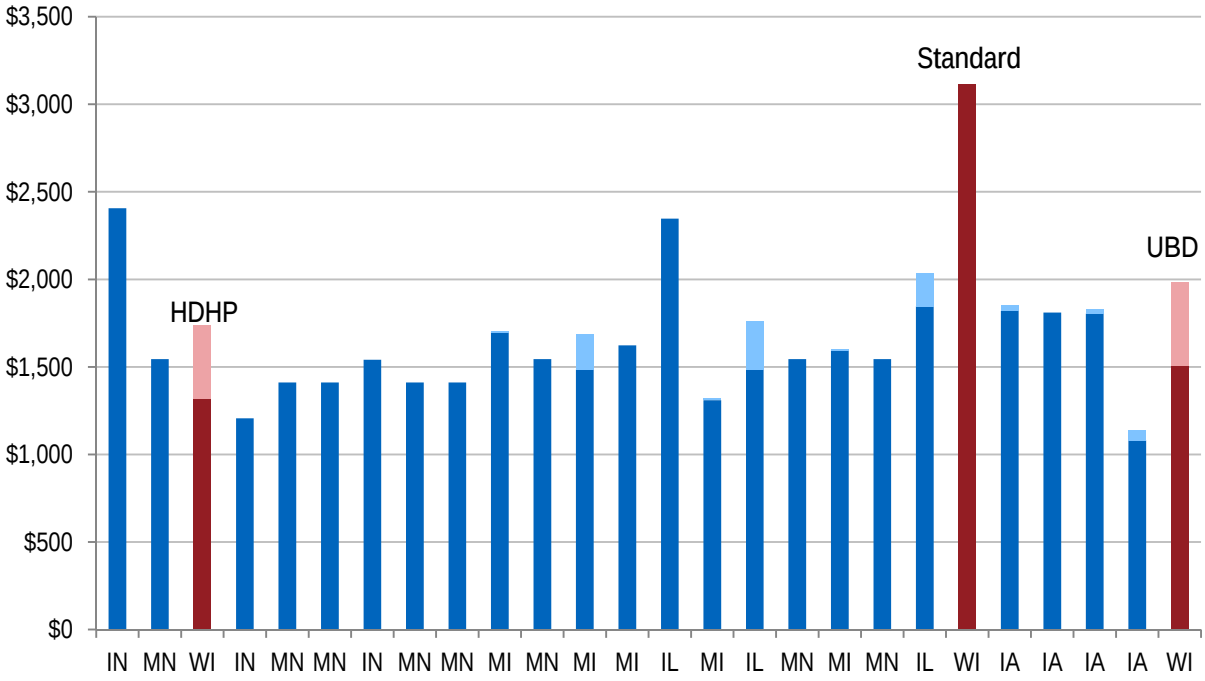
While plans for other states may include a slightly different member mix, due to differences in active employees, retirees, dependents, job classifications, local governments, educations (K-12 and higher education), collective bargaining, etc., we believe the comparisons are appropriate and provide informative high-level context.

It is immediately noticeable that the total premium cost for a plan is not directly proportional to the actuarial value of that plan. There are a number of factors that can influence the cost of a plan, such as demographics of group, adverse selection, geography, employment group, etc.

REGIONAL FULL MONTHLY PREMIUM RATE COMPARISON
Single Coverage



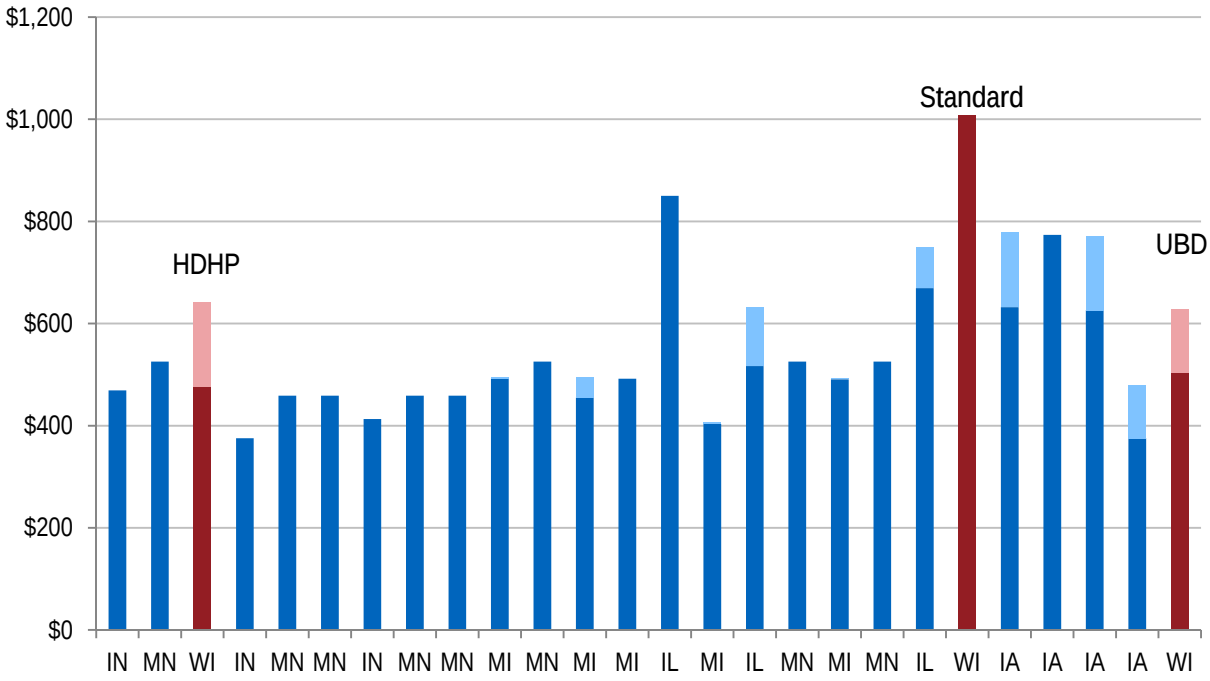
REGIONAL FULL MONTHLY PREMIUM RATE COMPARISON
Family Coverage



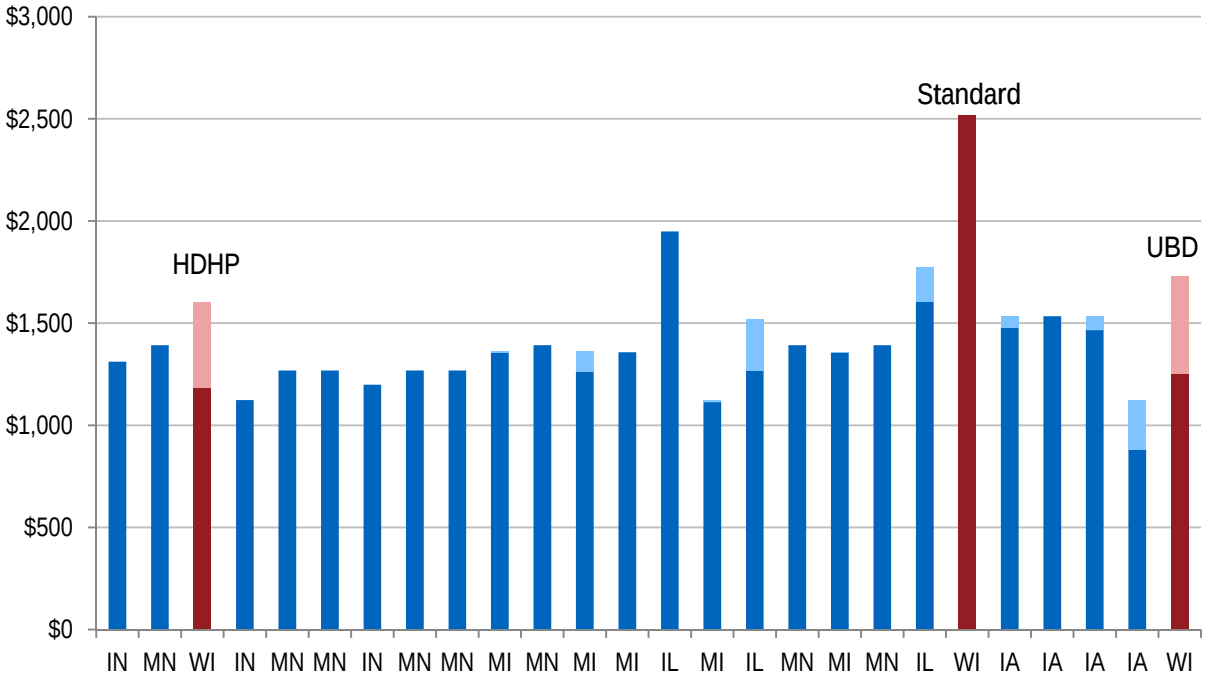
The Wisconsin employee premium contribution is in line with regional practices as a percentage of total premiums. Since Wisconsin premiums are generally higher, the contributions paid by employee are also higher.

Consistent with the charts above, the net costs for the State remain high overall within the region.

REGIONAL NET STATE MONTHLY PREMIUM RATE COMPARISON
Single Coverage



REGIONAL NET STATE MONTHLY PREMIUM RATE COMPARISON
Family Coverage



Geographical Cost Variance

Iowa and Illinois, along with Wisconsin, are the states with the highest cost plans in the region. Iowa and Illinois utilize an HMO-based managed competition model similar to ETF's. Indiana, with one of the lowest costs, utilizes a HDHP design.

The relatively high full premium rates will present a challenge to ETF when the Excise Tax goes into effect, which is currently scheduled for 2018. As shown in a later section of this report, the State's Excise Tax exposure could approach $200 million by 2027.

Employee Premium Structure

Our analysis includes a comparison of different structures and practices for employee premiums. We reviewed tier structure, surcharges and opt-out credits.

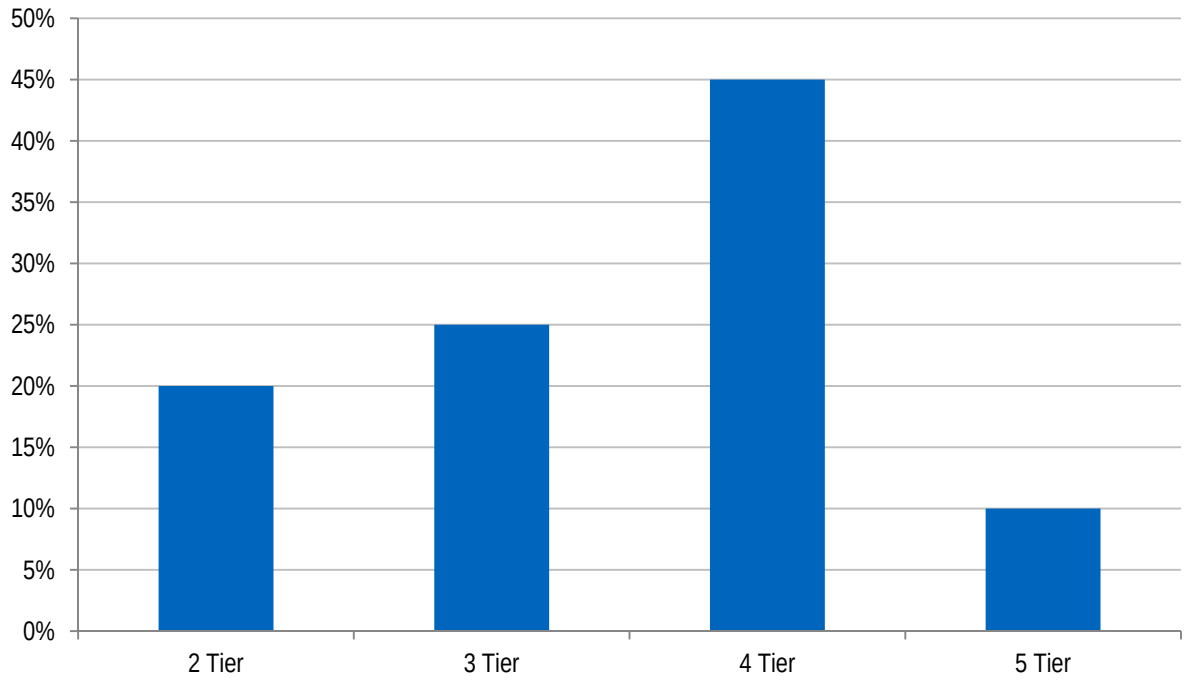
Premium Tiering Structure

ETF employs a two-tier structure, Single and Family, for employee premiums, as well as for full premium rates. Based on the current membership distribution, 61% of the ETF active family contracts cover both a spouse and child(ren). Below is a table summarizing the distribution:

ETF Contracts			
Tiers	Current	Split	% In Tier
Employee	20,096	20,096	
Child(ren)	41,637	4,293	10%
Spouse		11,813	29%
Family		25,531	61%
Total	61,733	61,733	

Most other states, including those in the regional group, utilize a 3- or 4-tier structure. The most common 3-tier structure is Single, Employee+1, Family and for 4-tier the most common array is Single, Employee+Spouse, Employee+Child(ren) and Family. The following graph reflects the number of rate tiers maintained by all states in the study.

NATIONAL PREMIUM TIERING STRUCTURES FOR STATE HEALTH PLANS



The 2-tier structure was more prevalent in the late 1990s. As States realized that the additional cost of spouses far exceeds those of children, tier structures were modified to be more financially equitable across all levels of coverage.

While the current single/family tier structure is workable, we recommend reviewing to determine whether that two-level structure provides equity in employee/retiree premium amounts for the demographics of the population. It would appear that a 4-tier structure is a better fit for ETF. Using only the current demographics and tier membership, we have calculated budget neutral premium ratios below:

Tiers	Average Age			Tier Ratios	
	Employee	Spouse	Child	2-Tier	4-Tier
Employee	44.0	-		1.00	1.00
Child(ren)	45.9	-	15.6	2.49	1.56
Spouse	52.5	53.4		2.49	2.39
Family	45.8	45.7	13.6	2.49	2.67
Overall	46.5	48.1	13.8	2.00	2.00

The tiering provides the most benefit to the single parents, who are currently subsidizing the remainder of the family tier. This structure would apply to both premiums and contributions. A similar approach could be used to develop factors for a 3-tier system, note the above Child(ren) tier would be the same.

A change to the tiering structure will not result in additional costs, or provide savings, to ETF, but does provide an opportunity to better align employee and retiree costs with family size and composition. Therefore, it may be more of a policy decision rather than a budget issue.

Salary Based Premiums

Salary based premiums are much more prevalent with private employers than they are in the public sector. This is due primarily to a greater degree of spread in private sector pay. For most public sector employers, pay does not vary greatly within the employee population, making it more difficult to structure and maintain pay-based premiums with a meaningful spread.

Nationally, seven states currently have salary based health care premiums, with employees paying, on average 13% of the total premium costs. Within the region, Illinois is the only state with an income based premium structure. Medicare retirees pay 1% of their pension check and pre-Medicare retirees pay 2%. Active employees' premiums are not based on income.

From the data provided for this study, we do not see a significant spread in salary among the Wisconsin employees. Therefore, it would be difficult to develop an income-based premium structure that results in meaningful differences in premiums. The administrative and communication effort required would not be justified by the outcome.

Premium Surcharges

The two most prevalent premium surcharges seen among state health plans are for tobacco use and for spouses that have coverage available from their employer(s).

Twelve states currently charge employees a higher premium if the employee, or a covered member of their family, uses tobacco. The average surcharge is $40 per month for employees and $60 per month for employees with family coverage. Compliance relies largely on the honor system, with employees typically required to sign an affidavit that they do not use tobacco in order to avoid the surcharge. None of the states in the regional peer group currently has a tobacco surcharge.

Surcharges for spouses that have coverage available from their own employer were once more prevalent, but are only currently used by two states, with an average surcharge of $50 per month. None of the states in the regional peer group currently has a spousal surcharge.

Opt-out Incentives

Incentives to waive coverage were also once more prevalent. Currently, a small number of states nationally provide an opt-out incentive to encourage employees to waive coverage. For these states, the average incentive is about $150 per month.

Within the regional peer group, Illinois provides an opt-out incentive for pre-Medicare retirees and Michigan provides a $50 monthly allowance for employees that opt-out of the State plan and provide evidence of other coverage.

Opt-out incentives work best when a plan has very low premiums and the election rate for coverage is otherwise near 100%. Otherwise, the incentive will be paid to a large number of employees that waive coverage without an incentive. Segal was informed that ETF currently has a 5% out-out rate, making them a potential candidate for this incentive.

Plans that have higher premium levels generally need to provide a more sizable incentive to generate any meaningful change in election rates, which also diminishes any potential savings. ETF premiums are nearly $90 per month for Tier 1 single coverage, which we believe presents a challenge in designing an incentive that would increase the opt-out rate significantly. We understand there is a proposal to have a $2,000 incentive. This is a sizable amount, which could be a challenge to achieve the desired savings.

We estimated that there are 3,249 (5%) opt-outs currently. We calculated a range of scenarios, from a low of 1% to high of 10% that decide to opt-out with the new incentive, 5% being the mid-point. With the provision we believe the total number of opt-outs will range from 3,500 to 6,500, with a maximum level peaking at 10% overall for the program.

		New Members Who Select Incentive (1/3 rate for Family)					
	Contracts	0.0%	1.0%	2.5%	5.0%	7.5%	10.0%
Employee	20,098	-	201	502	1,005	1,507	2,010
Family	41,637	-	139	347	694	1,041	1,388
Total	61,735	-	340	849	1,699	2,548	3,398
Total Cov	61,735	61,735	61,395	60,886	60,036	59,187	58,337
Opt-Out	3,249	3,249	3,589	4,099	4,948	5,797	6,647
Total Elig	64,984	64,984	64,984	64,984	64,984	64,984	64,984
Projected Opt-Out		**5.0%**	**5.5%**	**6.3%**	**7.6%**	**8.9%**	**10.2%**

Offsetting the net savings from the group (risk adjusted premium) with the incentive, we estimate that the impact could be a cost of $5 million to a savings of $7 million, with a break-even point of 7.6% (5% new election) total opt-out needed. The table below shows the savings estimated in $millions.

Opt-Outs	Opt-Out %	Incentive Cost	Plan Savings	Net Cost/(Savings)
3,249	5.0%	$6.5	$0	$6.5
3,589	5.5%	7.2	2.1	$5.1
4,099	6.3%	8.2	5.1	$ .1
4,948	7.6%	9.9	10.3	$(0.4)
5,797	8.9%	11.5	15.4	$(3.9)
6,647	10.2%	13.3	20.5	$(7.2)

If an opt-out option is made available to ETF employees, we believe there would be negligible financial impact overall on the program.

We discussed earlier, the ETF program provides benefits that are as rich or richer than those provided by any other state in the comparison, and have plan costs that are also at the higher end, particularly when differences in cost due to geography are included. Our analysis, shown in another section of the report, indicates that ETF will likely see a significant Excise Tax exposure under the current plan design and structure. The opt-out provision alone, does not address these issues and should be included as part of the overall program strategy decision if desired. This alternative may likely result in higher premiums for those remaining in the program, causing the Excise Tax to increase.

Benefit Design

The current ETF UBD and Standard Plan both have very high actuarial values. The UBD provides the lowest member cost share of any state-level plan not only in the regional peer group, but also nationally. The Standard Plan is not far behind. This is primarily due to the extremely limited cost sharing for medical benefits. Pharmacy benefits, while at the higher end, require some measure of member cost share.

Recently ETF received direction to reduce General Purpose Revenue needs by $25M for 2016. This directed reduction can be achieved without affecting the competitiveness of the benefits in the UBD and the Standard Plan. If these plans were reduced from actuarial values of 96% and 93%, to 93% and 90% respectively, both plans would remain at or above Platinum Plan levels and still enable ETF to provide benefits that are at the top of the class in the region, as well as nationally. Regionally, the highest actuarial value for an HMO (not in Wisconsin) is 95%. For PPOs, it is 93%.

The HDHP plan, on the other hand, is at the lower end of the range of actuarial values within the region, even for HDHPs. At 83% it is lower than the leanest HDHP in the region (not in Wisconsin). This is one of the reasons for the low take-up rate of State employees.

Based on the comparisons to other state plans, we recommend that ETF consider introducing an annual deductible for the UBD and increasing the annual deductible for the Standard Plan and increasing the maximum out-of-pocket limits for both the UBD and the Standard Plan. Also consider increasing the State's contribution to the Health Savings Account to increase the competitiveness of the HDHP option.

	2015	2016 Recommendation
Uniform Benefit Design		
Annual Deductible		
Single	None	$250
Family	None	$500
Annual Maximum Out-of-Pocket		
Single	$500	$1,000
Family	$1,000	$2,000
Standard Plan[1]		
Annual Deductible		
Single	$200	$500
Family	$400	$1,000
Annual Maximum Out-of-Pocket		
Single	$500	$1,000
Family	$1,000	$2,000
HDHP		
Annual State HSA Deposit		
Single	$170	$750
Family	$340	$1,500

This plan design will reduce costs in the UBD and Standard Plan by 3.5% and increase the overall value of the HDHP by about 8%**.** Increasing the member responsibility in the UBD and Standard Plan will introduce a measure of consumerism not currently present in the plan design, particularly in the UBD. The increased HSA contribution will result in a more attractive option to employees and families, and should increase enrollment significantly above the very modest 2015 initial enrollment of about 400 employees.

The overall projected savings is 3.0%. Based on a preliminary projection for 2016 medical costs of $1.150B, this equates to $35M in cost savings overall.

An additional measure for consideration is to modify the office visit benefit in the UBD to a copay structure. Currently, members pay 10% of the cost of an office visit. No other state-level HMO plans that we reviewed cover office visits on a coinsurance basis.

[1] For services provided outside the PPO network, deductible and maximum out-of-pocket is 2x network levels.

		Regional		National	
	Wisconsin	Range	Typical	Range	Typical
Primary	10%	$10 – $41	$20	$5 – $41	$15
Specialist	10%	$10 – $41	$35	$5 – $50	$25

Adjusting the benefits to a copay structure, in line with regional and national practices, would generate an additional 1% cost savings in the UBD, which translates to approximately $10M in 2016. We recommend considering implementing a $15 copay on Primary Care Physician Office Visits and a $25 copay on Specialist Office Visits.

Below is summary of the resulting actuarial values of the plans and comparisons within the region.

	Wisconsin	Recommended	Regional Average
UBD	96%	93%	87%
PPO	93%	90%	88%
HDHP	83%	90%	85%

If the benefits in all plans were adjusted such that the resulting actuarial values were then in line with the regional average, the expected savings would be approximately $90M in 2016. This could be accomplished with additional changes in deductibles, copays, and out-of-pocket maximums and, in our opinion, would not affect the overall competitiveness of the benefit design(s).

Premiums

The current employee premiums, when measured as a percentage of total premium costs are in line with regional and national practices for all three plan types, with the possible exception of the HDHP family premium.

Plan and Coverage Tier	Wisconsin	Regional Average	National Average
Uniform Benefit Design			
Single	12%	12%	14%
Family	12%	14%	17%
Standard Plan			
Single	19%	17%	16%
Family	19%	20%	19%
HDHP			
Single	5%	5%	8%
Family	5%	13%	13%

Our recommendation is to hold the employee premiums at the same percentages for 2016. The lower HDHP premiums, with the enhanced benefits recommended above, should result in increased enrollment in the lowest cost ETF option.

The current 2-tier (Single/Family) premium structure is not in-line with current practices. Other states prefer a 3- or 4-tier structure. With your population mix, we believe ETF should consider moving to a 4-tier structure that would be more equitable to your employees with only one or two dependents.

Incentives and Surcharges

With the ETF's current 5% opt-out rate and contribution levels, an incentive is not likely to have a significant financial impact on the program. Any incentive would need to be paid not only to the employees who actively opt out as a result of the program, but also to those that are currently waiving coverage without such an incentive.

A premium surcharge for tobacco use could make sense to incent a healthier lifestyle for many members. This is addressed in the Total Health Management section of the report.

A premium surcharge for spouses with coverage available from his/her employer is less prevalent than it once was. Even though the ETF benefits are likely to be the richest plans in a given area and, therefore, quite attractive options relative to the spouses' employer plans, the expected number of spouses to generate a surcharge is quite low. Typically, compliance rates are low and difficult to monitor and enforce. With a typical surcharge of $50 per month, the expected annual total would be negligible. The effort to administer and monitor this surcharge is not worth the benefit at this time in our option.

If ETF decides to not cover these spouses entirely, there would be significant savings to the program. Additional work would need to be performed to see which spouses would be denied coverage. Assuming 20%-30% of spouses, the savings would range from $40 million to $70 million annually.

Tiering and Negotiations

The current UBD premiums (as well as the HDHP premiums) vary greatly—Single monthly premiums in 2015 range from approximately $600 to $850 and family premiums range from approximately $1,500 to $2,100.

Adjusting the current annual tiering and negotiations to reserve the Tier 1 designation for only the most efficient plans will result in more plans in Tier 2 and Tier 3. Since employees pay higher premiums for Tier 2 and Tier 3 plans, the expectation is that enrollment would migrate to the lower cost, more efficient plans in Tier 1 and reduce overall program costs. We believe this could be accomplished for 2016 and reduce medical premium costs by 1% – 3%. Segal will work with ETF staff to explore adjustments to the current process for 2016.

Any reductions in cost, due either to changes in benefit levels or increased efficiencies in pricing and delivery of care will improve the State's exposure to the Excise Tax in 2018. Our current projections indicate that, without changes, the State will be subject to an Excise Tax in the first year, with the total tax due likely to grow substantially over time.

Total Health Management

Context

Like other states in the United States, Wisconsin is keenly aware of the unsustainable growth of healthcare costs, the growing lack of access to healthcare, and the increasing disparities in healthcare delivery. Two major pieces of federal legislation have attempted to take steps to address these issues.

1. The HITECH Act, part of the American recovery act and reinvestment act of 2009 authorizes up to 19 billion dollars in federal subsidies to doctors and hospitals for the meaningful use of electronic health records.

2. The Patient Protection and Affordability Care Act of 2010, includes provisions that encourage providers to begin taking responsibility for the costs and quality of care provided. The legislation has created a significant level of activity in the development of patient centered medical homes (PCMH) and accountable care organizations (ACO).

The overarching purpose of these legislative actions is to move away from the current fee-for-service system of reimbursing care to a system of a provider reimbursement that rewards patient outcomes and quality.

What is Total Health Management?

Total Health Management (THM) is a health care management model that seeks to improve the health outcomes of a given population through the aggregation of patient data across multiple health information resources; the analysis of that data into a single, actionable patient record; and the actions through which care providers can improve both clinical and financial outcomes.

THM is a health improvement model that highlights three components:

- The central care delivery and leadership roles of primary care physicians;
- The importance of patient activation (behavioral change), individual and personal responsibility; and
- The expansion of patient care coordination of wellness, chronic condition management and medical management programs.

For the THM model to function effectively, a plan sponsor like ETF, must supply proactive preventive and chronic care to all of its covered population, both during and between medical encounters with the healthcare system. This requires an effective and well-integrated system of care coordination to maintain patient contact and to support the patient's proactive efforts to manage their own health. At the same time, care managers must actively manage high-risk patients to prevent them from developing complications or becoming "unhealthier".

What are the Costs of Waste Related to Current Healthcare Delivery Model?

Due to the fragmented nature of the healthcare delivery system, most experts agree that there is significant waste in healthcare spending in the United States. Wasteful spending extends beyond one organization of a single health sector, and eliminating waste in one sector may actually increase waste in another. In a recent study of waste in the US healthcare system, Price Waterhouse Coopers Health Research Institute found that up to $1.3 trillion of healthcare expenditures of 2012 were unnecessary, avoidable or preventable. That represents 50% of the $2.6 trillion spent on healthcare that year.

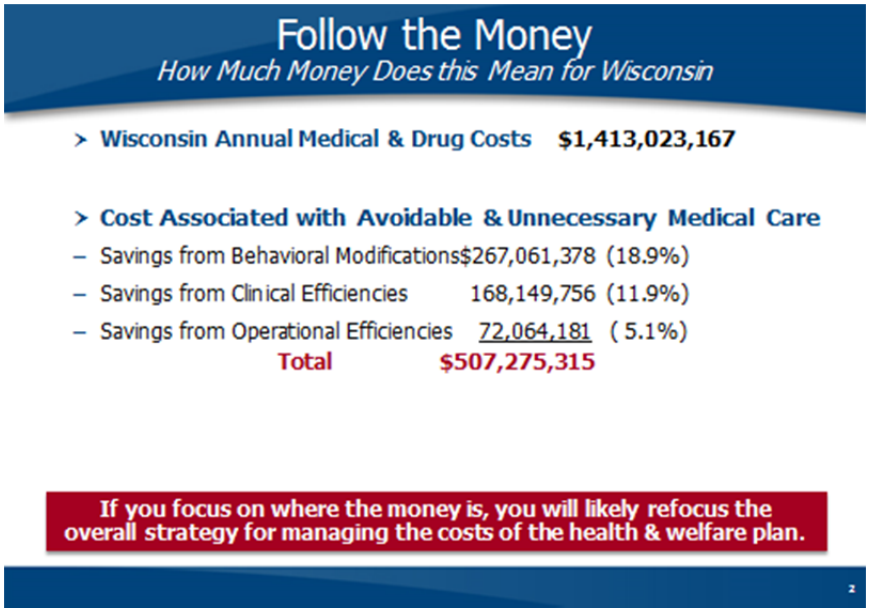
The Price Waterhouse Coopers study went on to categorize wasteful spending into three areas:

Behavior: Where individual behaviors are shown to lead to health problems, and have potential opportunities for earlier, non-medical interventions.

Operational: Where health care administration and other business processes appear to add costs without creating value.

Clinical: Where medical care itself is considered inappropriate entailing overuse, misuse or underuse of particular interventions, missed opportunities for earlier interventions, and overt errors leading to quality problems for the patient, plus cost and procedure rework.

The study concluded that 100% of waste cannot be eliminated, but significant amounts can and should be eliminated. Patients with preventable chronic conditions will always need to be treated, but that does not mean that unnecessary care will occur just because an individual has a chronic condition. Providers and payers must follow required processes for reimbursement. However, for a plan sponsor like ETF, understanding the three categories of waste provides ETF with some clear priorities.



We would suggest that the "low hanging fruit" for ETF would be to focus on the waste associated with individual behavior and what the health plans can do to improve its behavior. The associated behavior risk factors include—obesity, smoking, poor adherence to drug regimens, and alcohol abuse costs ETF $267 million annually in unnecessary or avoidable medical plan costs.

Health Risk Behaviors that Cause Chronic Disease

Health risk behaviors are unhealthy behaviors that can be prevented or changed, such as lack of exercise or physical activity, poor nutrition, stress, high blood pressure, high cholesterol, tobacco use and alcohol abuse. These modifiable risk factors cause much of the illness and medical care associated with chronic conditions. These chronic conditions- asthma, COPD, diabetes, coronary artery disease, hypertension and others account for 55% – 70% of healthcare plan costs.

The following statistics published by the Center for Disease Control and Prevention provide a clear picture of the opportunities (the low hanging fruit) that ETF can address. These lead to preventable, unnecessary and avoidable healthcare costs:

- As of 2012, about half of all adults—117 million people—have one or more chronic health care conditions. One of 4 adults has two or more chronic healthcare conditions.
- Seven of the top ten causes of death are chronic diseases. Two of these, heart disease and cancer, accounted for 48% of all deaths.
- Diabetes is the leading cause of kidney failure, lower limb amputations and new cases of blindness in adults.
- About half of adults (47%) have at least one of the following major risk factors for heart disease or stroke: Uncontrolled high blood pressure, uncontrolled high LDL cholesterol, or are current smokers.

Preventable health risk factors contribute nearly 19% of total US health expenditures in unnecessary or avoidable healthcare. We would estimate and expect this same level of avoidable and unnecessary healthcare costs to be occurring in the health plans provided through the ETF plans.

ETF Data and Observations

Segal has been provided with a full set of encounter and utilization data from the Wisconsin Health Information Organization (WHIO) and has reviewed key indicators of cost management and operational efficiencies. We did not audit the WHIO data; however, we did find a significant number of inconsistencies, both from internal and external comparisons.

ETF and WHIO are taking steps to improve the quality of the data. Later in this report we provide recommended strategies to improve the data and its ability to support ETF staff in plan management.

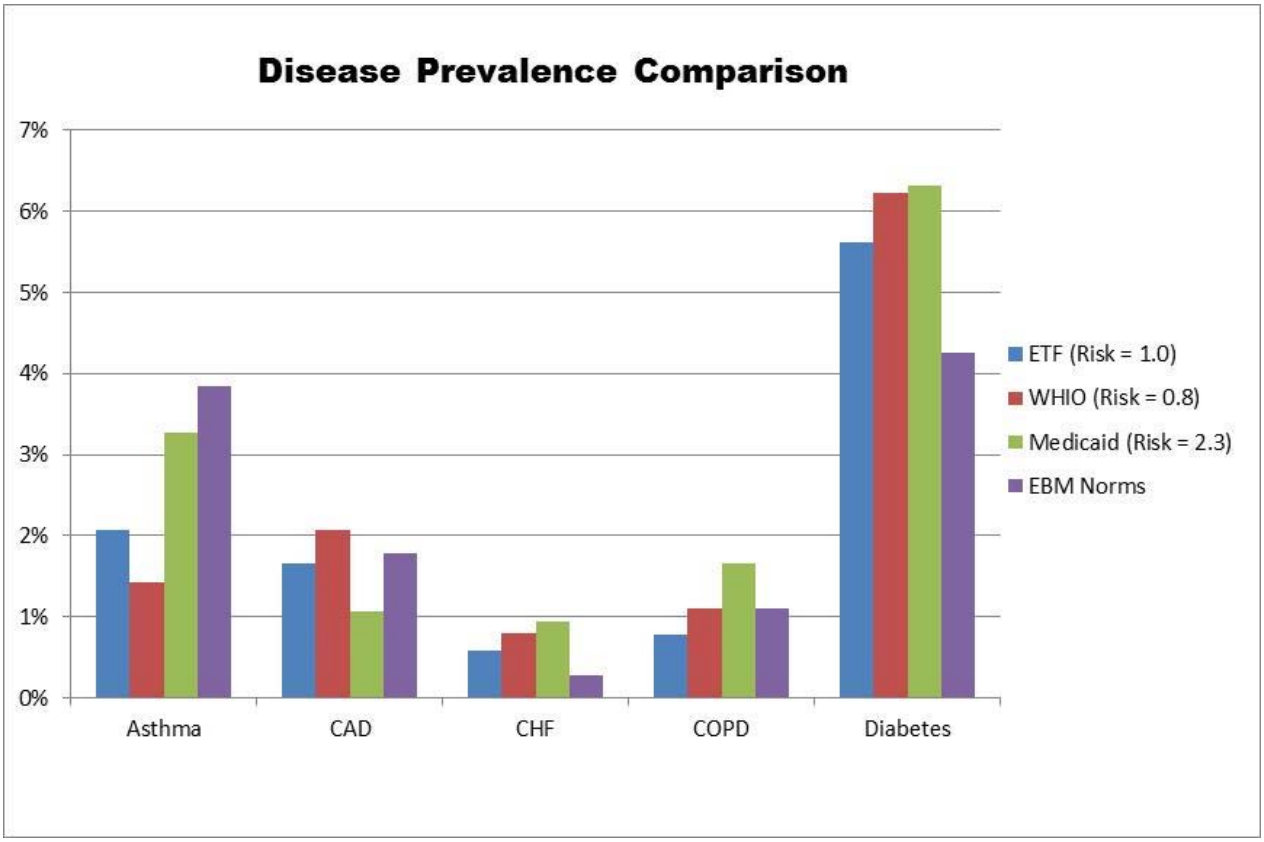
While quality appears to vary from health plan to health plan, our analysis indicates that there is a significant variance in the quality of health management programs among the health plans. This is an important observation and, while the degree of the variation may be unclear due to the quality of the data available, the analysis points towards a significant opportunity for ETF to improve overall efficiency.

Disease Prevalence and Care Gaps

With chronic illness being a primary driver of cost for the State, we have provided a series of charts and graphs that illustrate the prevalence of chronic illness in the ETF plans and compliance of recommended treatments for those diseases that are most prevalent in the ETF covered population.

The following chart presents a comparison of the most prevalent diseases reflected in the WHIO data. We have described the results for ETF, the overall WHIO database, Medicaid recipients and Evidence Based Medicine (EBM) standards[1].

[1] Evidence based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

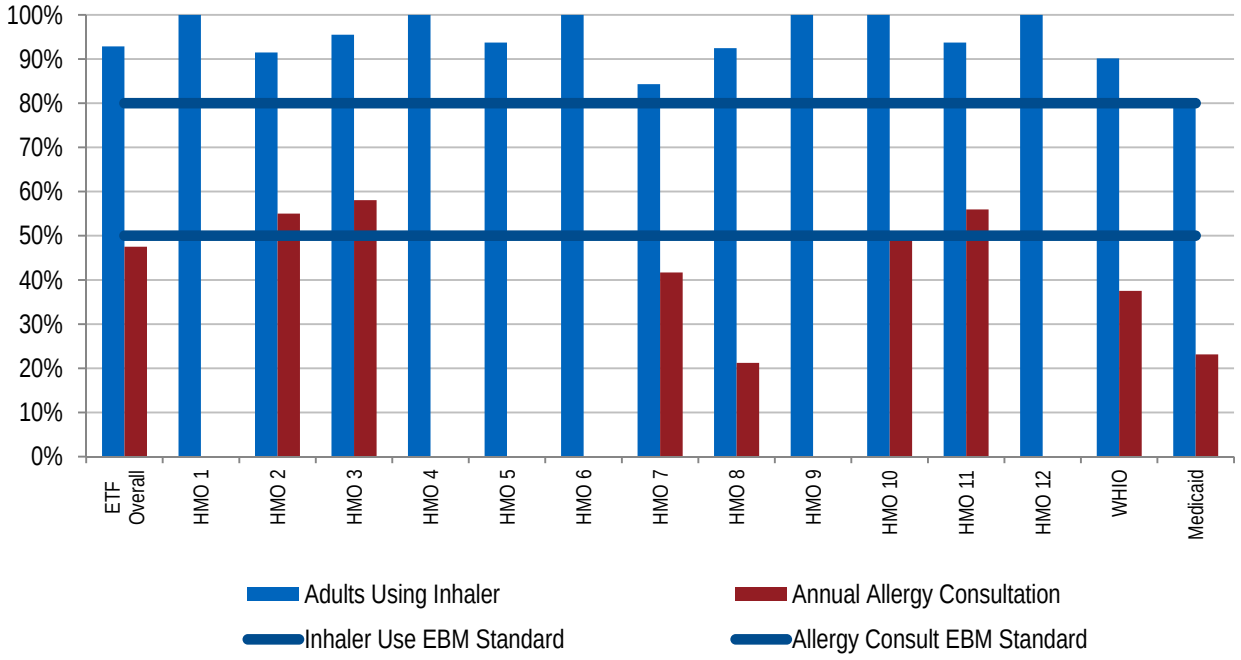


Given the prevalence of chronic conditions in the ETF population, we believe that there are significant cost saving opportunities for ETF. Of particular concern, is the higher than expected prevalence of diabetes. Savings can be achieved by implementing a focused wellness and medical management model to reduce health risk factors that contribute to avoidable and unnecessary costs. For the most part, savings will be generated from working directly with patients who have chronic conditions and supporting treatment compliance, medication adherence, and closing gaps in their medical care.

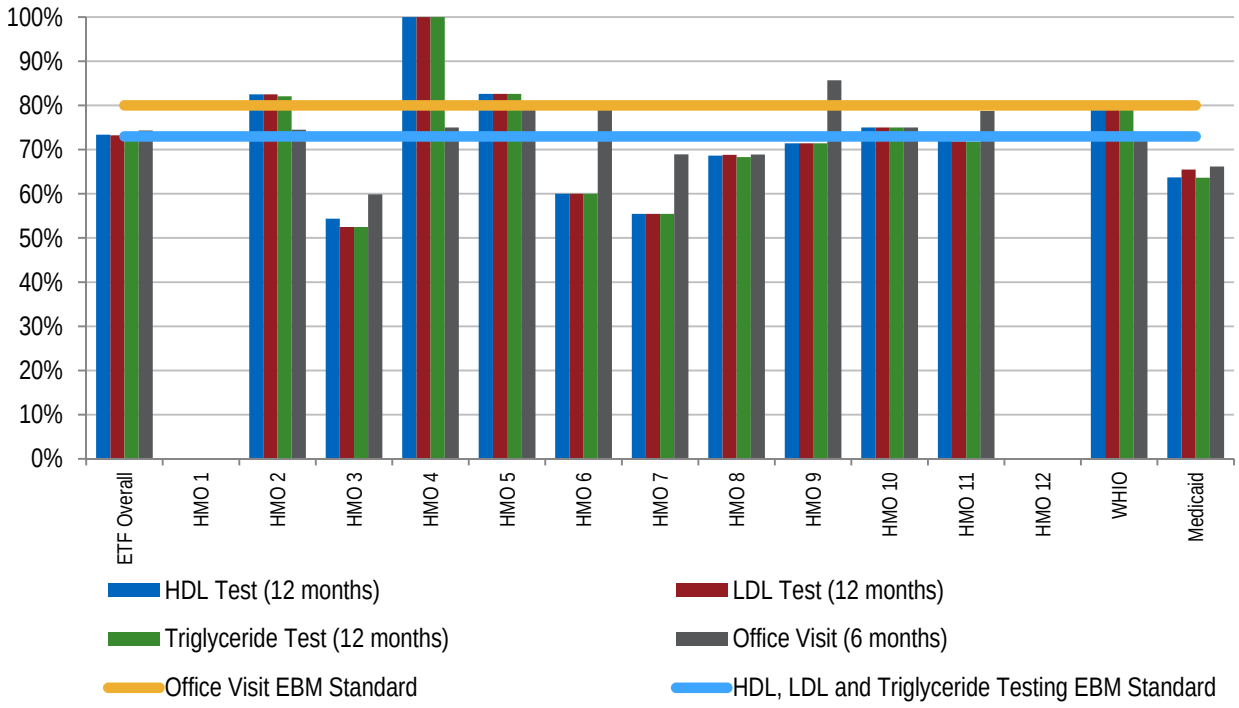
The next series of charts provides insights into why there are high levels of unnecessary and avoidable healthcare. Compliance patterns for asthma, coronary artery disease, congestive heart failure and diabetes show opportunities for improvement that will directly contribute to reducing unnecessary and avoidable health care costs. Any level of treatment compliance below 100% will result in some level avoidable hospital admissions, unnecessary emergency room visits and other avoidable medical service costs. These are medical costs that would not have occurred had the non-compliant person with a chronic illness been following medical guidelines for their condition.

Looking at the asthma care compliance chart below, there are obvious compliance problems related to patients receiving annual consultations. All of the ETF health plans show opportunities for improving care management for those with Asthma. Note those health plans with rates of compliance for an annual consultation below 50%. Asthmatics who are not using their inhaler or having at least an annual physician consultation are at risk for increased levels of emergency room visits, hospitalizations and other medical costs.

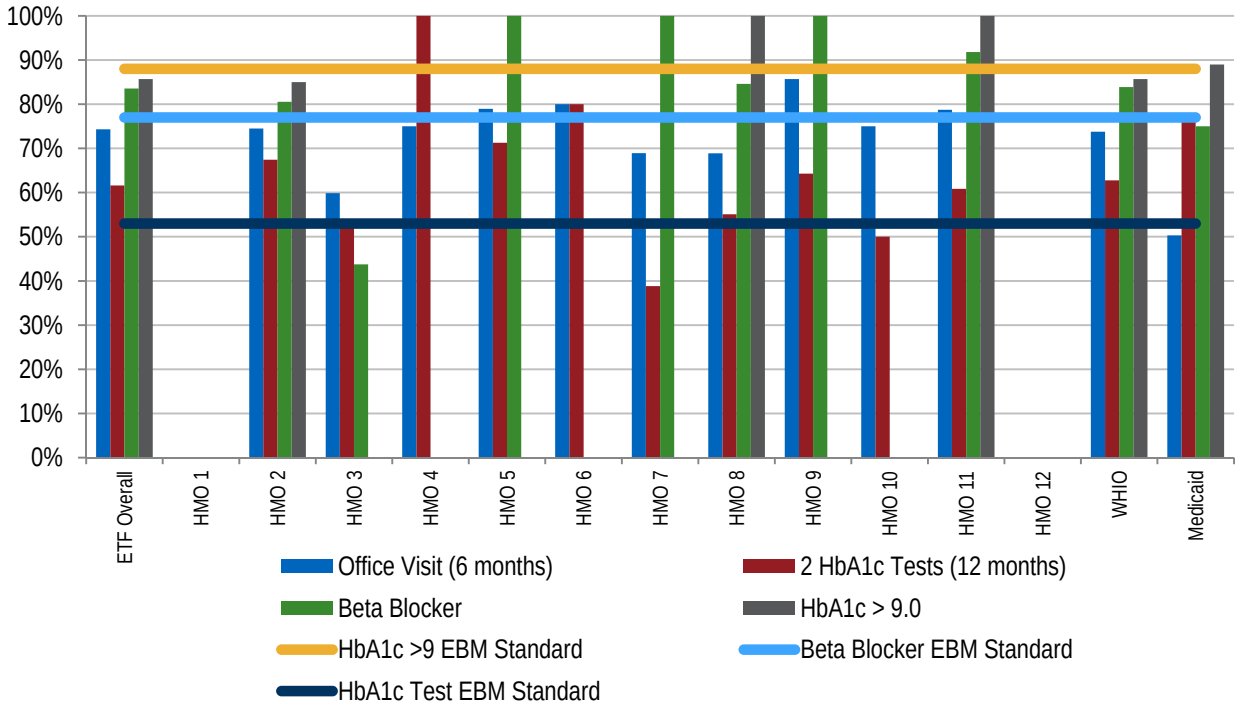
Asthma
CARE COMPLIANCE COMPARISON



The percentage of diabetics with HbA1c test scores greater than 9 is high. The goal for well-managed diabetes is a test score less than 7. The population shown in the chart with high HbA1c test scores is likely consuming unusually high levels of medical care, much of which is avoidable.

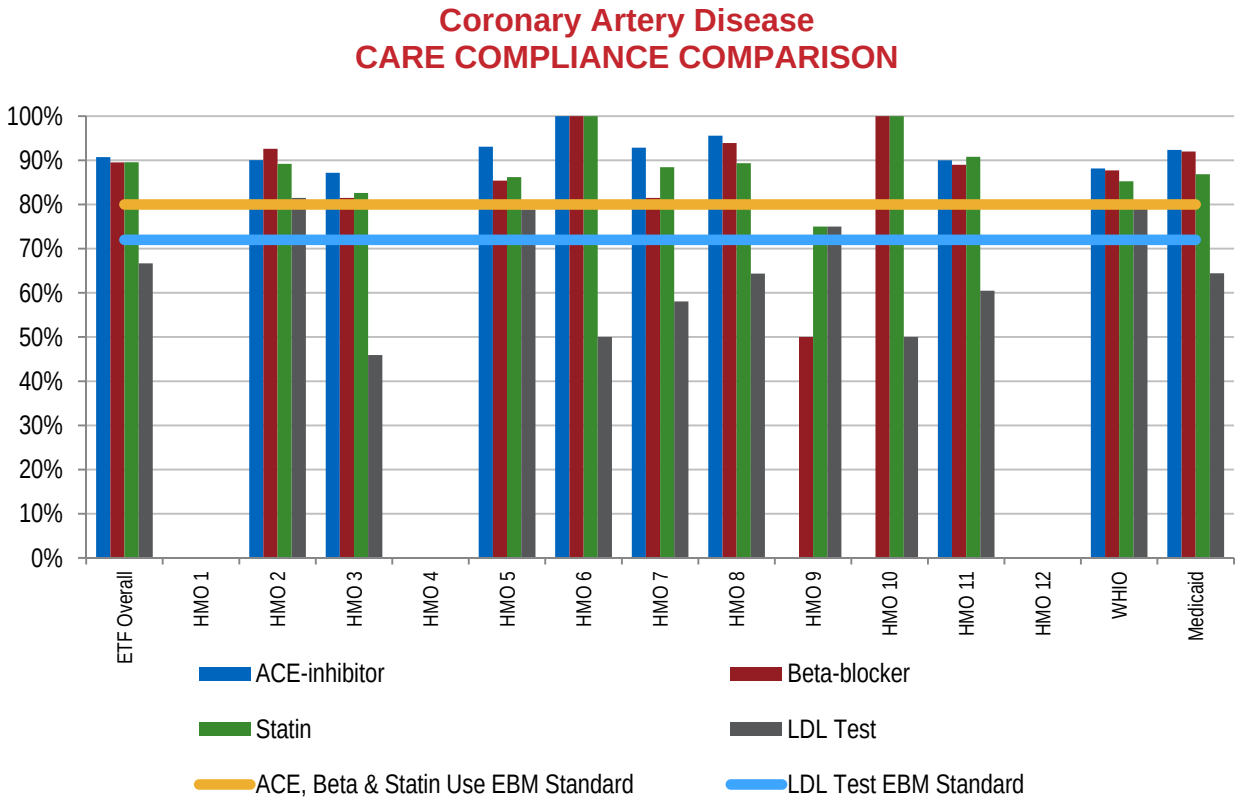


DIABETES CARE COMPLIANCE COMPARISON

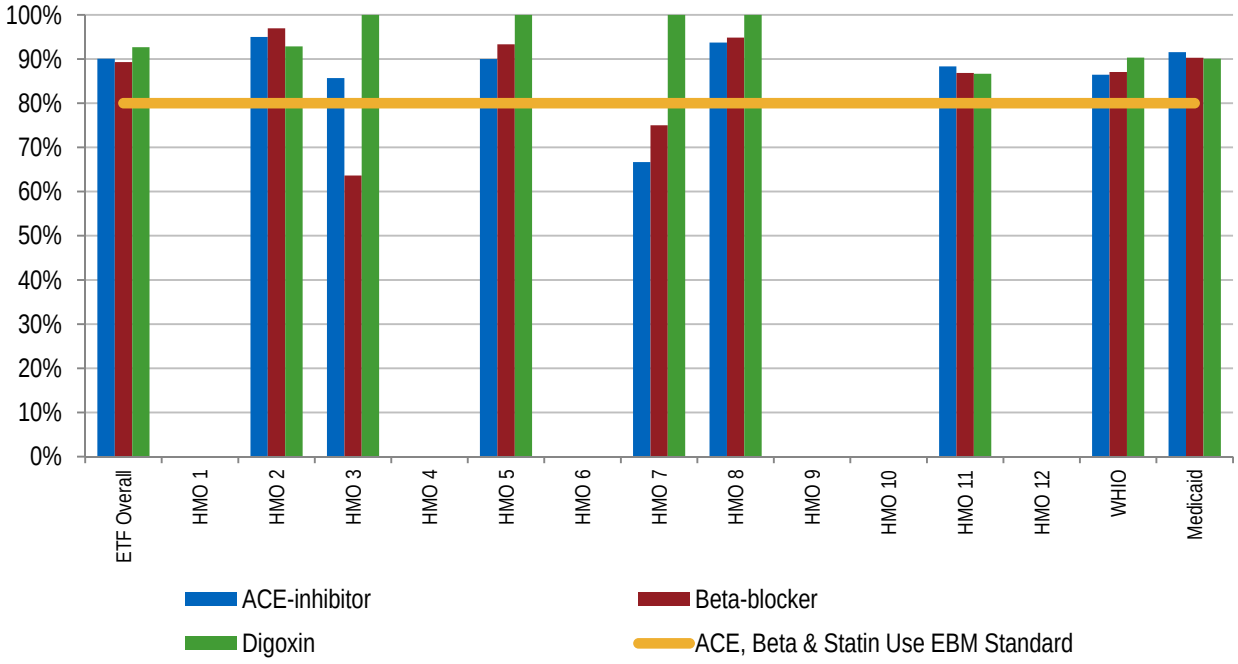


Analysis of the compliance patterns for other chronic conditions also presents opportunities for improving the care and treatment for many people with chronic conditions. ETF should establish clear targets for treatment compliance that each health plan should integrate into the performance requirements of providers in their networks.

The graphs below for heart disease (Coronary Artery Disease and Congestive Heart Failure) raise concerns in the compliance rates for LDL testing and beta-blocker usage. These gaps in care provide the ETF with more evidence that there are variations in the quality of care provided to patients by the providers in the health plan networks.



Congestive Heart Failure
CARE COMPLIANCE COMPARISON



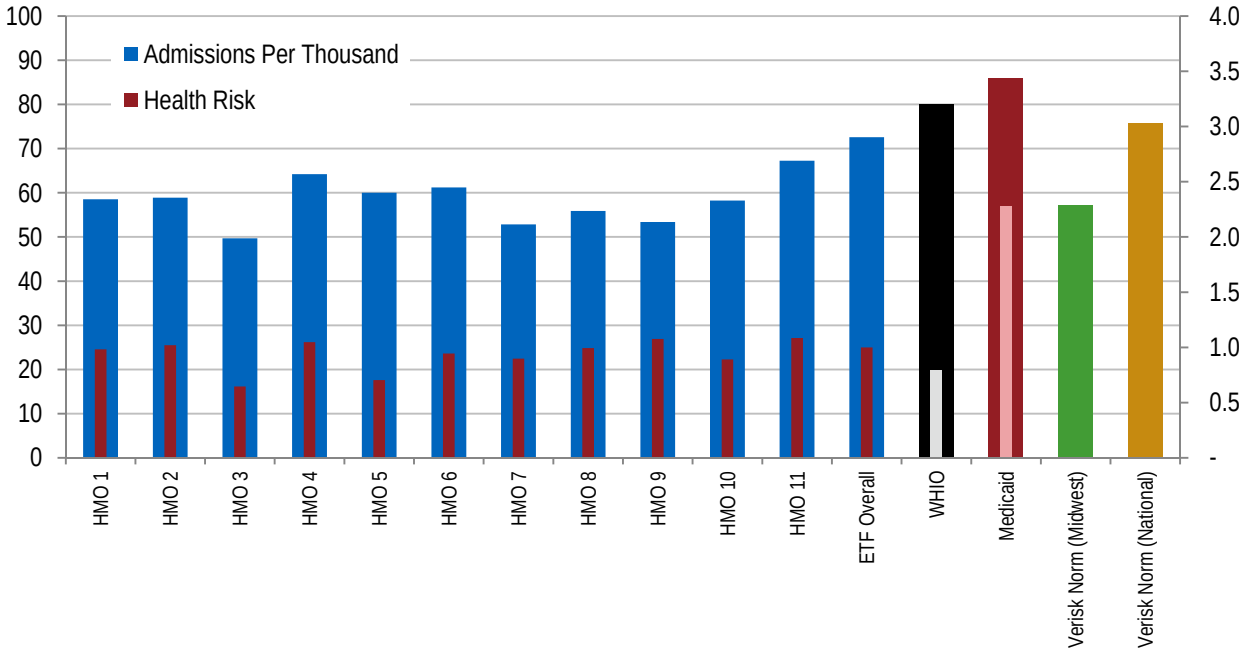
As you review the graphs, it is important to understand that the goal of treatment compliance for any one of these measures is 100%, not some norm or average. Given the current statistics, opportunities for improvement are clear. Note that some health plans are doing better at achieving treatment compliance for these indicators of health. The very fact that there are wide variations between the plans provides opportunities for ETF to hold each health plan accountable for treatment compliance outcomes.

The road map to developing a successful total health management program needs to focus on the following building blocks.

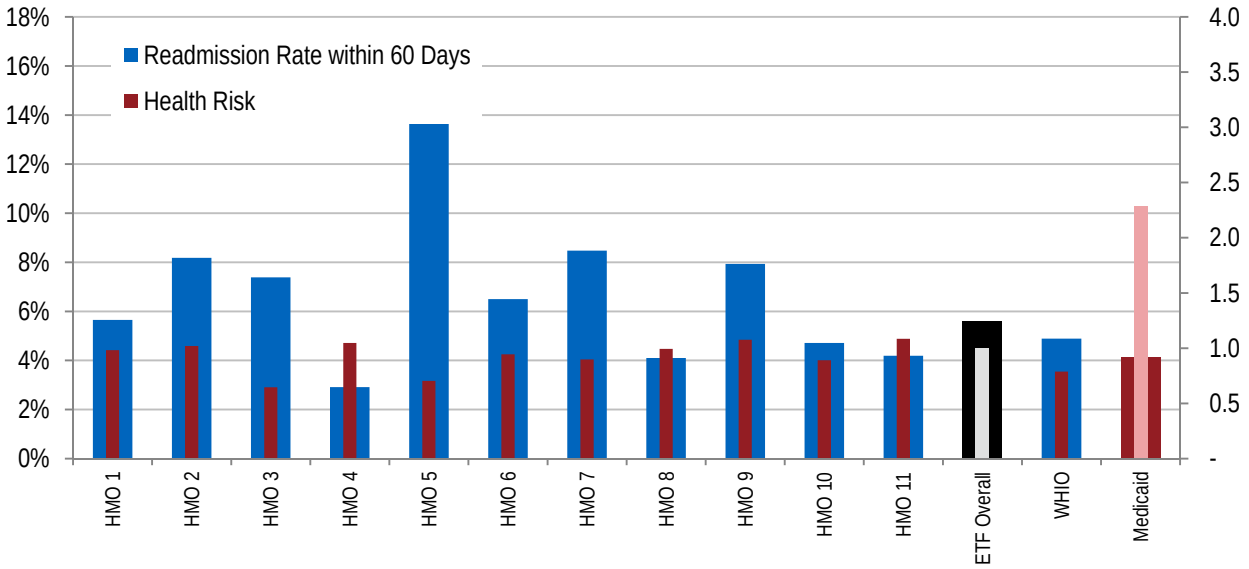
Utilization and Risk

The following charts and tables provide some insights into the effectiveness of the various health plans to utilize the hospitals and other care providers to manage the health of those employees in the health plans. As you review these charts on inpatient admissions and hospital readmissions, it is apparent that some of ETF's health plans are not doing as well as others in managing care.

INPATIENT ADMISSIONS PER 1,000 MEMBERS



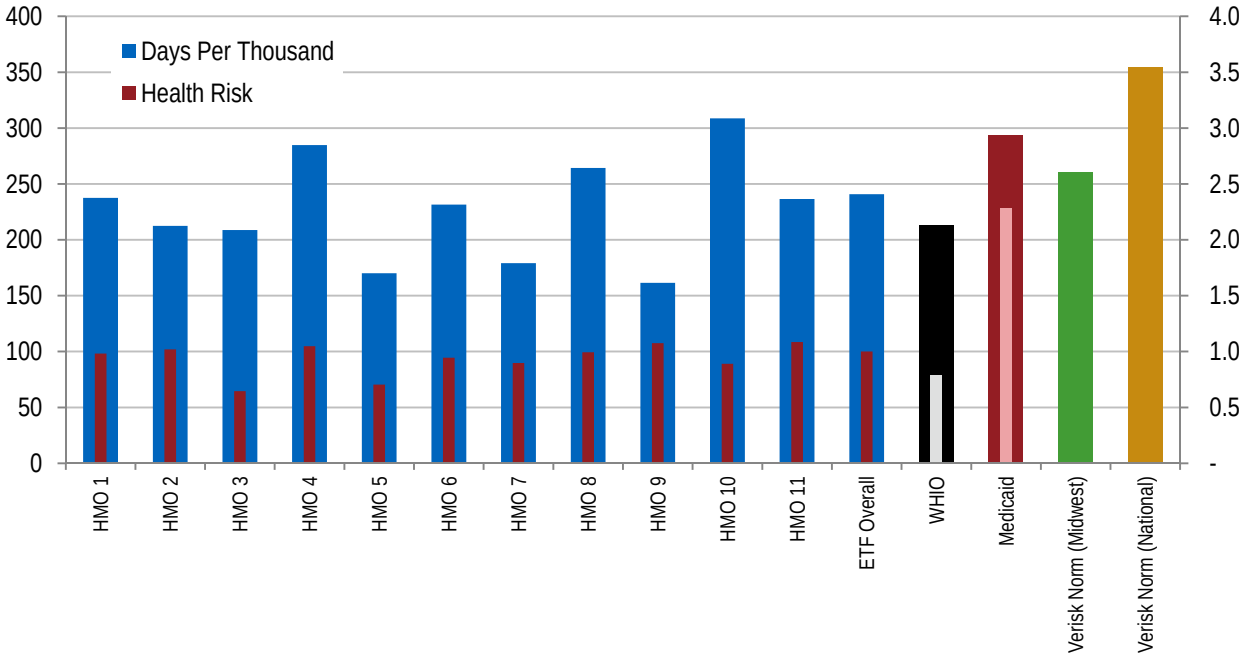
HOSPITAL READMISSIONS



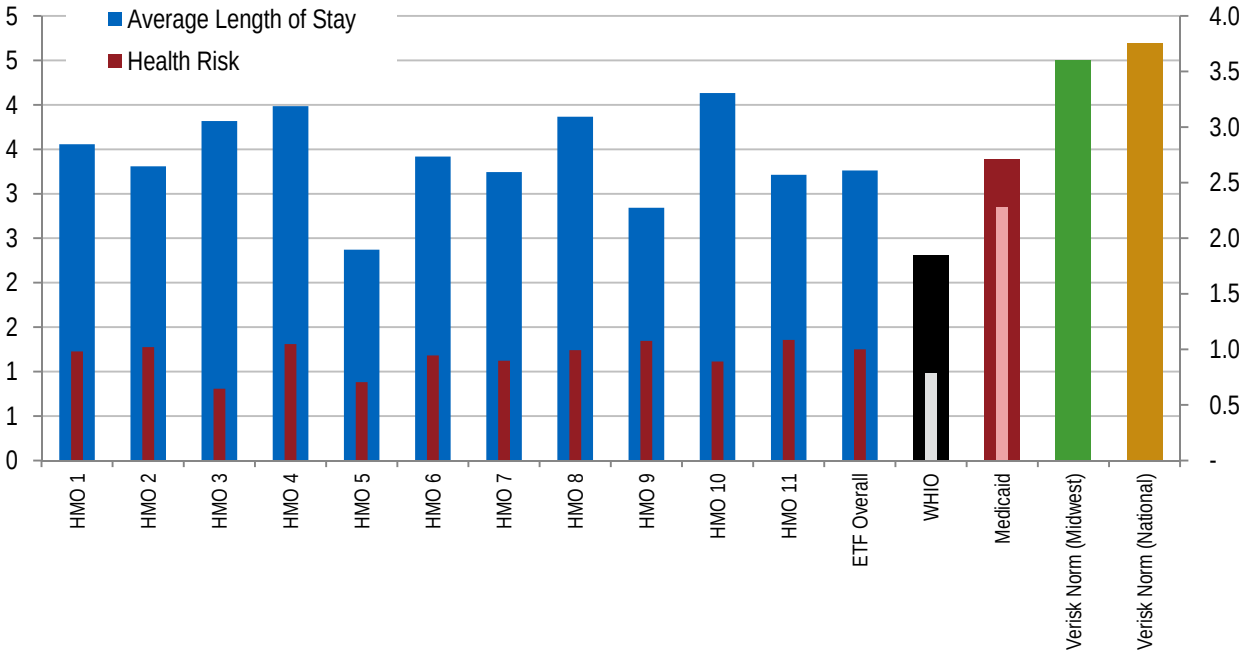
High readmission rates into hospitals is a measure of poor medical management and poor quality care. For example, HMO 5 would be expected to have a low readmission rate since its population is low risk. Note HMO 4 has a lower readmission rate than HMO 5, but its population is higher risk. It appears something is going on the hospitals in HMO 5's network that needs to be reviewed.

In the next two charts that review hospital utilization, please note that there are some wide variations in hospital days. These variations raise questions about how the health plans are managing the care of patients.

TOTAL ANNUAL HOSPITAL DAYS PER 1,000 MEMBERS

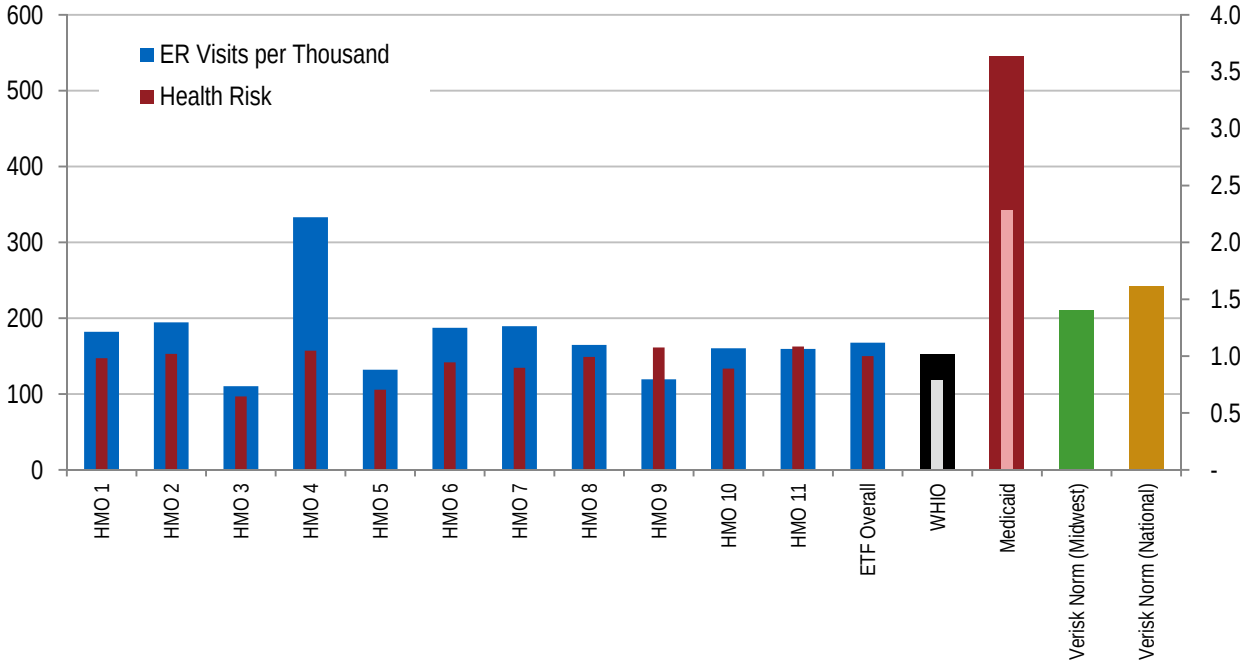


AVERAGE LENGTH OF HOSPITAL STAY



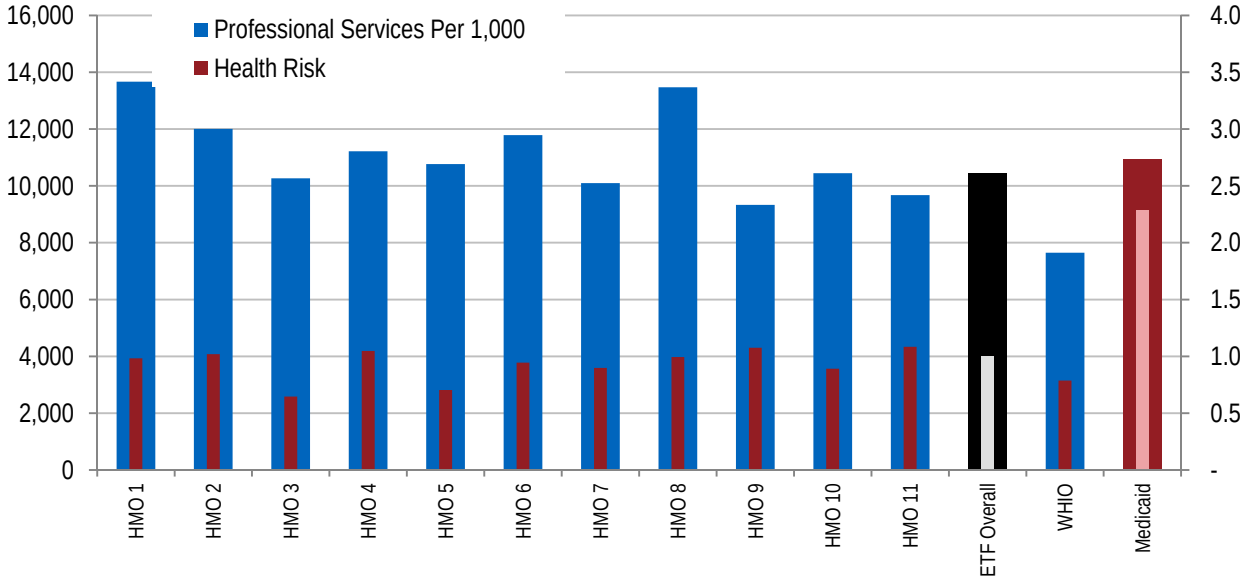
The chart below compares emergency room usage and clearly illustrates that HMO 4 experiences high E/R use, while other health plans with the same or lower risk scores have much lower E/R use. Going forward it will be useful to track three categories of E/R visits—emergent, non-emergent and emergent visits resulting from non-compliant patients with chronic conditions.

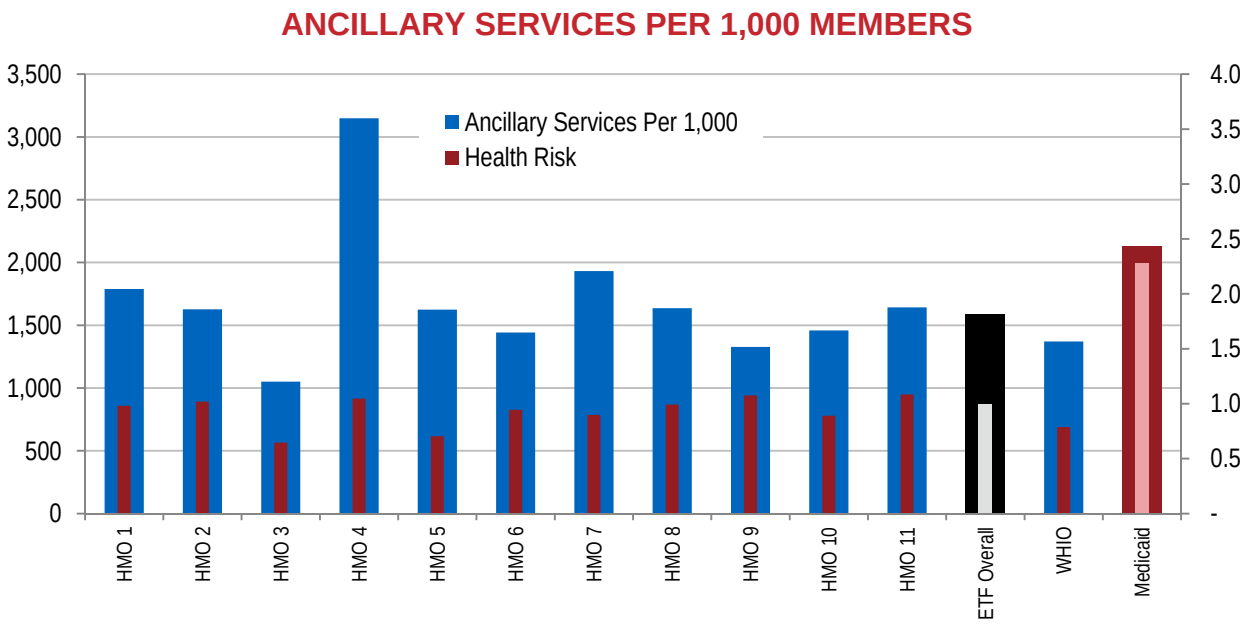
EMERGENCY ROOM VISITS PER 1,000 MEMBERS



The next two charts show wide variations in utilization of professional and ancillary services that are not easily explained. We also noticed that the quantity of visits and usage seemed high, so that should be monitored and tracked.

PROFESSIONAL SERVICES PER 1,000 MEMBERS





Going forward, the ETF should require the health plans to address these variations and develop reporting standards that will enable the ETF to monitor and manage the effectiveness of all the health plans. As the ETF is able to develop effective reporting standards for the health plan, it will be able to set standards of care management across all health plans. Standards of care that track evidence-based medical guidelines will result in improvements in care delivery, focus on gaps in care, and reduce patient health risk factors.

Additional Observations

Patient Engagement

Health plans must work with physicians to deliver appropriate, evidence based care during patient visits and they must ensure that care gaps are addressed even when patients do not come into the office.

Team Based Interventions

Effective primary care is the heart of total health management to ensure that patients receive appropriate preventive and chronic care. With the primary care physicians in short supply, other clinicians must be included in integrated teams to focus the level of needed care. These teams may include mid-level practitioners, nurses, medical assistants, dietitians, physical therapists, care managers, health coaches and others.

Measuring Outcomes

Data analysis is an integral part of total health management. Well-designed predictive modeling and data analytics are required to measure treatment compliance, health outcomes, health status, disease severity and patient engagement. Analysis of the health status of the ETF covered population can demonstrate the effectiveness of health plans.

As ETF looks to the future, utilizing the WHIO data will be important for automating a process of managing the health of the various population segments in the State. This will require a more standardized method for tracking data from the health plans so that each plan is providing care at the same high standard. The charts and tables above show that there are wide variations in care delivery and outcomes. Automation of data makes total health management feasible, scalable and sustainable.

What Are Other Public Sector Organizations Doing?

It is clear that plan sponsors in the public sector are beginning to address the issues of unsustainable healthcare costs using a variety of methods. The most effective are those that incorporate behavioral economics into their total health management models. The growing body of evidence shows that people need to be motivated by both extrinsic and intrinsic factors. This has led many public sector plan sponsors to implement incentive based plan design in their health benefit programs. These model designs include rewards and penalties to change unhealthy behaviors that lead to unnecessary and avoidable care. Some of the more prominent states that have adopted effective behavior changing plan designs include:

- Alabama
- Connecticut
- Georgia
- Indiana
- Kanas
- Maryland
- Missouri
- Nebraska
- North Carolina
- Tennessee
- West Virginia

Improving treatment compliance of people with chronic conditions should be a high focus area for ETF. In addition, the health plans and providers should be employing their own versions of total health management protocols to produce the needed improvements in the population health. Those states utilizing incentive-based models to motivate positive reductions in health risk factors are seeing progress in reducing waste in health care spending and improvements in the health of their covered populations.

Review of Well Wisconsin

In 2013 the Group Insurance Board (GIB) approved a Wellness Incentive to begin in plan year 2014. The Wellness Incentive required all health plans to issue $150 to adult members who completed a biometric screening and a health plan administered health risk assessment (HRA).

Members have the option to complete their biometric screening with their physician or at a worksite biometric screening event. To improve the availability of worksite biometric screenings, the Department of Administration contracted with a single vendor, OptumHealth, in December 2013. However, participation in the program in 2014 was only 13%, which is far below the desired level.

In order to have a measureable impact on changing the health risk profile of the covered population, the level of participation/engagement will need to be increased to at least 40% and preferably to 70%. Some of the most successful public sector medical management and wellness programs have participation/engagement rates of 75% – 95%.

As mentioned in the section, "What are Other Public Section Organizations Doing", those organizations that have been successful in gaining a high level of program engagement are using extrinsic incentives (rewards and penalties) to motivate wellness program engagement. Using a reward/penalty model is intended to "nudge" people into the program with the goal of exposing them to information about their health that will cause a positive intrinsic reaction that leads to necessary changes in their health.

All health and wellness incentives paid to ETF members by the health plans are considered taxable income to the adult members and are required to be reported as taxable income by the State. Most public employers have moved away from cash incentives and are providing premium credits or premium surcharges instead to avoid the tax reporting requirement.

Recommendations

Improvements in the health risk of the ETF membership can help to hold down program cost inflation. Reducing, or at least limiting, future costs should be a key consideration as the Excise Tax approaches in 2018.

Our review indicates there is a wide variation in health management performance and effectiveness among the ETF's current health plans. Data quality appears to vary as well. Strategies and initiatives should be developed and implemented to improve the performance of each health plan and incent employees to enroll in the higher performing plans. Based on best practices available in the market, ETF should implement more standardized measures across the health plans, including the following.

- Develop a vision statement that incorporates specific guiding principles for transitioning the health care plans to a total health management program.
- Make refinements to the WHIO database to assure that the data being collected is aligned with the total health management strategy. Areas of focus should include:
  - Defining the population segments,
  - Developing reporting to identify care gaps
  - Stratifying the risks with the population segments
  - Developing plan designs that will increase engagement of patients in care management and wellness programs
  - Setting guidelines for the health plans to manage care effectively
  - Caring for those with chronic conditions, and
  - Developing reporting standards for measuring the effectiveness of the health plans to improve the health of the covered populations and reduce health risk factors in those populations.
- Establish metrics to measure the ongoing heath risk profile of the population segments covered by each health plan with particular focus on treatment compliance and medication adherence for those with chronic illness; preventive screening and life-style improvement for all covered lives, high blood pressure and high cholesterol monitoring, and addressing stress and anxiety.

- Standardize the data reporting requirements for each health plan to support the key metrics ETF needs to measure improvements in the population health risk profile.
- Develop a common medical management and wellness methodology used by each health plan.
- For the Wellness Incentive program, the Board should consider converting the current $150 after tax cash reward to a credit against premium contributions, so that those participating in the program receive the tax benefits of pre-tax health plan premiums and the State does not have to report the incentive as taxable income.

Additionally, we recommend that the future tiering process for the plans should include measures like:

- Rates of treatment compliance
- Rates of medication adherence
- Rates of prevented screening for certain cancers
- Rates of improvement in key indicators of health like—blood pressure, cholesterol levels, weight, and nutrition.

With the above measures in place, ETF will be able to proactively set goals for a global health improvement in the State's population, and hold plans accountable for outcomes and results.

Pharmacy Benefits

As part of our review, we evaluated the competitiveness of the current ETF contract with Navitus, as well as the benefit design and overall management and efficiency of the pharmacy program.

Contract Pricing

The pharmacy benefit management (PBM) industry in the U.S. is highly concentrated and dominated by its two largest competitors: Express Scripts and CVS Health. Combined, these two companies possess a market share of approximately 60%. The next two largest PBMs are Catamaran (formed by the merger of CatalystRx and InformedRx in 2012) and OptumRx, a wholly owned subsidiary of United Healthcare. There are also dozens of mid-size and smaller PBMs that compete in the marketplace, often focusing on a particular market niche, such as union plans or public municipalities. In general, the largest PBMs have greater leverage with drug manufacturers and retailers which allow them to offer the deepest discounted pricing and highest manufacturer rebates to their customers. However, smaller PBMs often compete effectively in both customer service and price.

ETF has contracted with Navitus for PBM services since 2004. Navitus is a much smaller organization than the dominant industry leaders. Navitus touts its structure as more flexible to meet unique client needs and to be more aligned with client objectives. The contract between ETF and Navitus does not set out minimum discount, fee, and rebate guarantees, as is custom in the industry.

In order to help determine the competitiveness of the prescription drug pricing performance Navitus is delivering to ETF, we compared key discount, fee, and rebate measures to five other large State benefit plans. The comparison is summarized in the table below. The analysis includes the ETF discount performance as reported by Navitus compared to the contractually guaranteed terms of the comparative plans. Actual performance for the comparative plans likely exceeds the guaranteed terms.

We note that the ETF discount, rebate, and fee terms are self-reported by Navitus and are not verified or audited. The comparative State benefit plan terms are based on minimum contractual guarantees and actual performance can be better. The total membership (lives covered) of the comparative plans range from 175,000 to 500,000. The comparative pricing terms are shown as both an average as well as range of values. Note that this comparison includes the key financial components of PBM financial agreements but is not meant to be inclusive of all fees and costs.

COMPARISON OF PBM FINANCIAL TERMS

Pricing Component	Comparative Average	Comparative Range
Retail 30		
Brand	15.31%	14.0% – 16.5%
Generic	75.75%	73.0% – 79.0%
Dispensing Fee	$1.06	$0.80 – $1.50
Retail 90		
Brand	19.34%	17.0% – 24.0%
Generic	75.99%	73.0% – 79.0%
Dispensing Fee	$0.56	$0.00 – $2.00
Specialty Drug		
Discount	14.00%	13.0% – 15.0%
Rebates (per Brand Rx)		
Retail 30	$32.35	$22.00 – $43.00
Retail 90	$97.00	$62.00 – $130.00
Mail Order	$97.00	$62.00 – $130.00
Administration Fee	**$1.74**	**$0.75 – $3.50**

Overall, we find that the Navitus contract is providing access to competitive pricing terms to ETF. The recent pricing delivered by Navitus is, by our estimates, within 2% of the aggregate pricing that would be provided by the average pricing in the comparator group.

We note that the comparability of financial terms from different PBMs across different plan sponsors is challenging and effected by a number of variables including differences in: contractual definitions, included and excluded services, demographics, and other factors. Therefore, we recommend using the comparative information as a high level guide as to the competitiveness of financial terms rather than a focus on variations at the detail level.

PBM Pricing Competitiveness—Considerations:

- Since the current PBM contract does not contain discount and rebate guarantees, performance should be reported by Navitus and reviewed with ETF periodically. These guarantees will need to coordinate with the current incentives for overall trend performance.
- ETF may wish to work with Navitus to establish discount and rebate targets and measure subsequent performance on a regular basis, which may help identify future opportunities or challenges

Plan Design

The current pharmacy benefit cost share is consistent with designs with low member cost-share that were implemented in the public sector market over the past two decades to ensure that participants had access to drugs treatment with minimal cost burden. Fixed copays and consistent increases in drug costs have resulted in erosion of the cost share. Segal worked with Navitus to model plan design options that will continue to provide participants access to drug treatment at a minimal cost but will bring the overall member cost share percentage in-line with industry benchmarks.

SCENARIO 1: FIXED GENERIC COPAY, COINSURANCE FOR BRANDS, MAXIMUMS & NO MINIMUMS

Level	Current	Proposed
Level 1	$5	$5
Level 2	$15	20% ($50 max)
Level 3	$35[1]	40% ($150 max)[1]
Level 4 • Preferred • Non-preferred	 $15[2] $50	 $50[2] 40% ($200 max)
Out-of-Pocket Limits • Level 1 & 2 • Level 4	 $410 / $820 $1,000 / $2,000	 $410 / $820 $1,000 / $2,000
ACA MOOP (Medical & Rx)	$6,600 / $13,200	$6,600 / $13,200

This design is projected to generate a cost savings of approximately 3.5%, or $7M, for 2016. The member cost share would increase by this same differential, from approximately 8% to 11%, which represents an 89% Actuarial Value in 2016 (Platinum Level). In addition, for every 1% increase in generic dispensing rate, ETF will save an additional 2% – 2.5% off total drug cost.

Benefits	Concerns
• Fixed generic copay coupled with coinsurance for brand drugs can result in higher generic dispensing rates • Coinsurance for brands and specialty drugs allows for cost transparency and encourages consumerism • Maximums per prescription limits the out-of-pocket exposure per prescription for participants which limits the potential for non-adherence from the cost burden	• Member cost share percentage can erode over time with fixed generic copay • Coinsurance for brands and specialty drugs can result in point-of-sale price uncertainty and more price variability month-to-month for maintenance drugs • Out-of-pocket limits can be hit early in the year for participants on brand or specialty maintenance drugs which can lead to over-utilization, wastage and/or non-adherence

[1] Level 3 copays do not apply toward OOPL

[2] Reduced copay applies when Preferred Specialty Medications are obtained from a Preferred Specialty PharmacyUU

SCENARIO 2: FIXED GENERIC COPAY, COINSURANCE FOR BRANDS, MAXIMUMS & MINIMUMS

Level	Current	Proposed
Level 1	$5	$5
Level 2	$15	20% ($15 min / $50 max)
Level 3	$35[1]	40% ($35 min / $150 max)[1]
Level 4 • Preferred • Non-preferred	 $15[2] $50	 $50[2] 40% ($50 min / $200 max)
Out-of-Pocket Limits • Level 1 & 2 • Level 4	 $410 / $820 $1000 / $2000	 $410 / $820 $1000 / $2000
ACA MOOP (Medical & Rx)	$6,600 / $13,200	$6,600 / $13,200

This scenario is projected to generate a cost savings of approximately 4.0%, or $8M, for 2016. The member cost share would increase by this same differential, from approximately 8% to 12%, which represents an 88% Actuarial Value in 2016 (Platinum Level).

The addition to the same Benefits and Concerns from Scenario 1, the addition of a minimum out-of-pocket cost for the coinsurance tiers limits the downside exposure for ETF, but adds more complexity to the plan. Further, the combination of a minimum with a maximum will require adjustments more often to combat cost share erosion.

The current pharmacy-only, tier-specific out-of-pocket limits coupled with the combined ACA maximum out of pocket (MOOP) should be reevaluated. If ETF considers a plan change which results in a higher member cost share percentage, the out of pocket limits combined with the MOOP will result in more participants hitting their annual caps earlier in the year. This could result in over-utilization, wastage and/or non-adherence due to the lack of cost share. Segal modeled each of the above scenarios with higher out of pocket limits and without out of pocket limits and the results are shown below.

SCENARIOS WITH HIGHER OOPLS AND REMOVAL OF OOPLS

	Doubling of OOPLs		Removal of OOPLs	
	Member Cost Share	Annual Savings	Member Cost Share	Annual Savings
Scenario 1	13.1%	$10.4M	14.3%	$13.2M
Scenario 2	14.0%	$12.4M	15.3%	$15.5M

[1] Level 3 copays do not apply toward OOPL.
[2] Reduced copay applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy.

Value Based Designs and Clinical Programs

The implementation of value-based benefit designs (VBBD) for pharmacy benefits started to gain momentum in 2008 but the success of these plans has been continuously debated. Many studies have found that a copay waiver for maintenance drugs will result in short-term increases in adherence, as measured by medication possession ratio (MPR), but the long-term adherence rates are not typically maintained. The most effective VBBDs are coupled with a mandate for participants to enroll and actively participate in disease management programs in order to qualify for ongoing maintenance drug copay waivers. With ETF's current high drug adherence in most of the key maintenance drug classes (as reported by Navitus) and a high generic dispensing rate, Segal does not currently recommend that ETF implement a value-based benefit design with full copay waivers.

ETF should consider partnering with Navitus to customize and implement their Pharmacoadherence Program for the commercial plan as a first step towards the evaluation of whether or not implementing a VBBD would be an effective solution.

Segal reviewed Navitus' clinical programs and it appears that ETF is taking advantage of most of Navitus' available clinical management programs. The Split-Fill program and Retrospective Drug Utilization Review (RDUR) are two programs that are very effective in both managing drug cost and encouraging safe prescribing. ETF should consider expanding their RDUR efforts to include the "Cost" RDUR. Also, ETF should work with Navitus to ensure that the current suite of programs includes ongoing review of compound prescriptions. The newest trends in compound drug dispensing is that compounding pharmacies are crushing expensive tablets into compounds for topical agents and are formulating patches that cannot be clinically supported.

ETF should immediately start discussions with Navitus about how they plan to manage a new class of expensive cholesterol-lowering medications called the PCSK9 Inhibitors. The first of these new drugs is scheduled to be released on July 24, 2015 and the cost of these medications will be anywhere from $5,000-$9,000 more expensive per year than existing medications. While the increase in cost doesn't appear to be significant, with hyperlipidemic medications being ETF's 6th highest therapeutic category for the commercial plan and 2nd highest class for the EGWP, if only 20% of ETF's current utilizers transition to these new drug then ETF will see an increase in cost of $12M+ per year.

Segal will continue to review ETF's detailed claims data and perform further analysis on the effectiveness of the other already implemented clinical programs and will recommend additional clinical programs that may be necessary to control drug costs.

Recommendations

Our analysis indicates that the current contract with Navitus is providing competitive pricing. However, it is best practice for a state-level plan's PBM contract to include minimum pricing guarantees to help assure continued competitive pricing over the contract term. We recommend that ETF negotiate similar guarantees in the Navitus contract. These guarantees will provide an additional measure of protection should the trend target not be met.

For plan design, we recommend Scenario 1 described above, which will help to introduce inflation and trend protection by implementing a coinsurance design for brand medications. This

design should also improve the already strong Generic Dispensing Rate (the generic copay remains at $5) and will incent members to see lower cost brand medications.

For additional savings, Scenario 2 is presented for consideration, which builds on Scenario 1 by adding a minimum copay for brand drugs. The same savings could easily be achieved by simply increasing copays across the board. However, this approach does not provide automatic trend sharing with the members and would need to be updated every few years.

Once the impact of the new coinsurance is evaluated, then the OOPLs can be evaluated. We recommend a multi-year approach to benefit changes to ensure that medication compliance and affordability is not compromised.

Consumer Directed Health Care Design

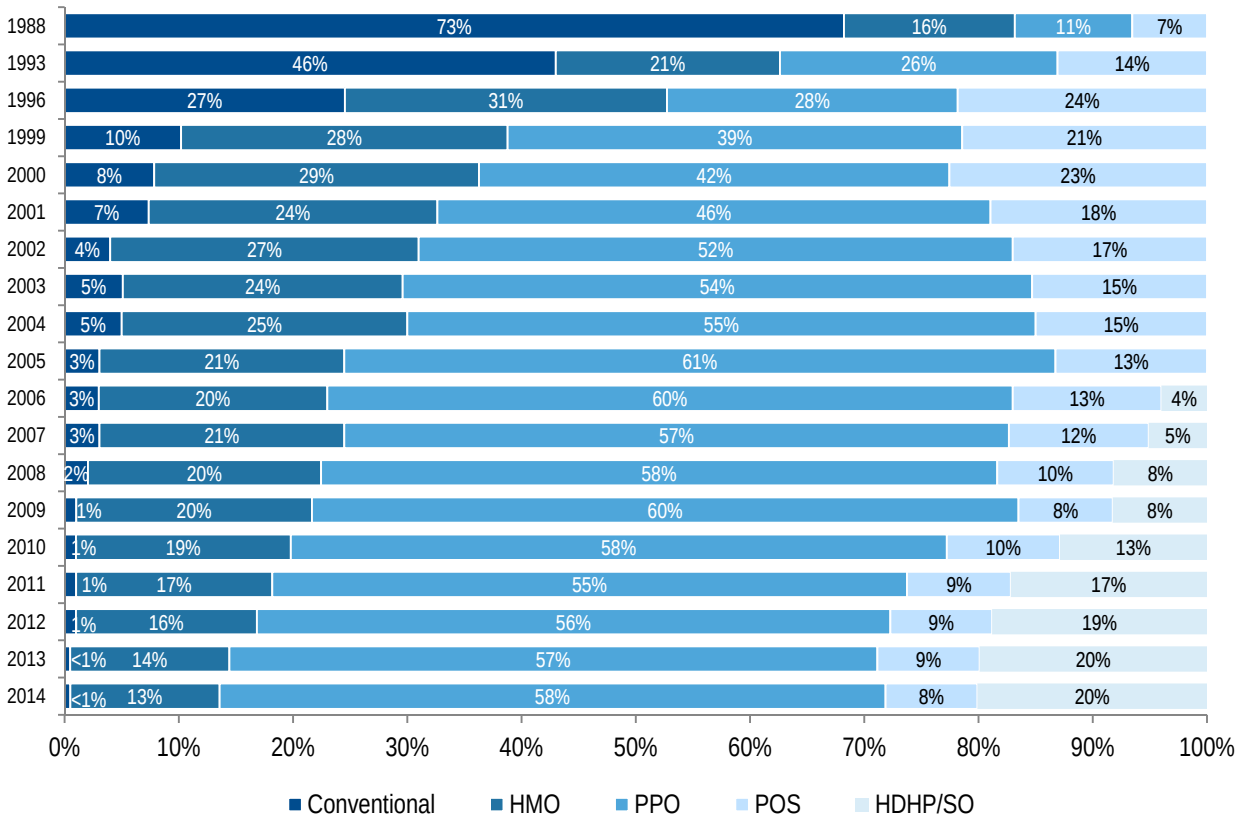
During the past decade, employers have turned their attention to consumer-directed health plans (CDHPs)—a combination of health benefit coverage with high deductibles and tax-preferred savings or spending accounts that workers and their families can use to pay their out-of-pocket health care expenses. A handful of employers first started offering CDHPs in 2001 with health reimbursement arrangements (HRAs). In 2004, employers were authorized to start offering health plans with health savings accounts (HSAs), causing a steady growth in enrollment.

For an HSA, the benefits are subject to IRS regulations. The two main components include limitations on:

- **High deductible health plan:** For calendar year 2015, a "high deductible health plan" is defined under IRC § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,300 for self-only coverage or $2,600 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,450 for self-only coverage or $12,900 for family coverage.
- **Annual contribution limitation:** For calendar year 2015, the annual limitation on deductions under IRC § 223(b)(2)(A) for an individual with self-only coverage under a high deductible health plan is $3,350. For calendar year 2015, the annual limitation on deductions under § 223(b)(2)(B) for an individual with family coverage under a high deductible health plan is $6,650.

The number of workers enrolled in CHDPs has grown from 4% in 2006 to 20% in 2014.

DISTRIBUTION OF HEALTH PLAN ENROLLMENT FOR COVERED WORKERS BY PLAN TYPE 1988 – 2104[1]



Consumer directed health plans are now more than 10 years old and there is a growing body of data that supports the cost effectiveness of a well-designed consumer focused health care strategy. There are a number of published articles, surveys, and research briefs on consumer directed health care for the past ten years. Based on our experience, we have developed the following key CDHP Success Factors.

- Make the plan design attractive. If the CDHP plan competes with an HMO, the CDHP should be perceived by eligible employees as a better plan than the HMO or at least on a par with the HMO, in order to attract significant enrollment.
- Make the CDHP employee contributions attractive. Employee contributions for the CDHP should compare favorably to the other plans.
- Eliminate or change existing plans. This will disrupt the "status quo" and encourage employees to consider the new CDHP where they would otherwise tend to stay with the traditional PPO or POS plan options.

[1] Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999 – 2014; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of American (HIAA), 1988.

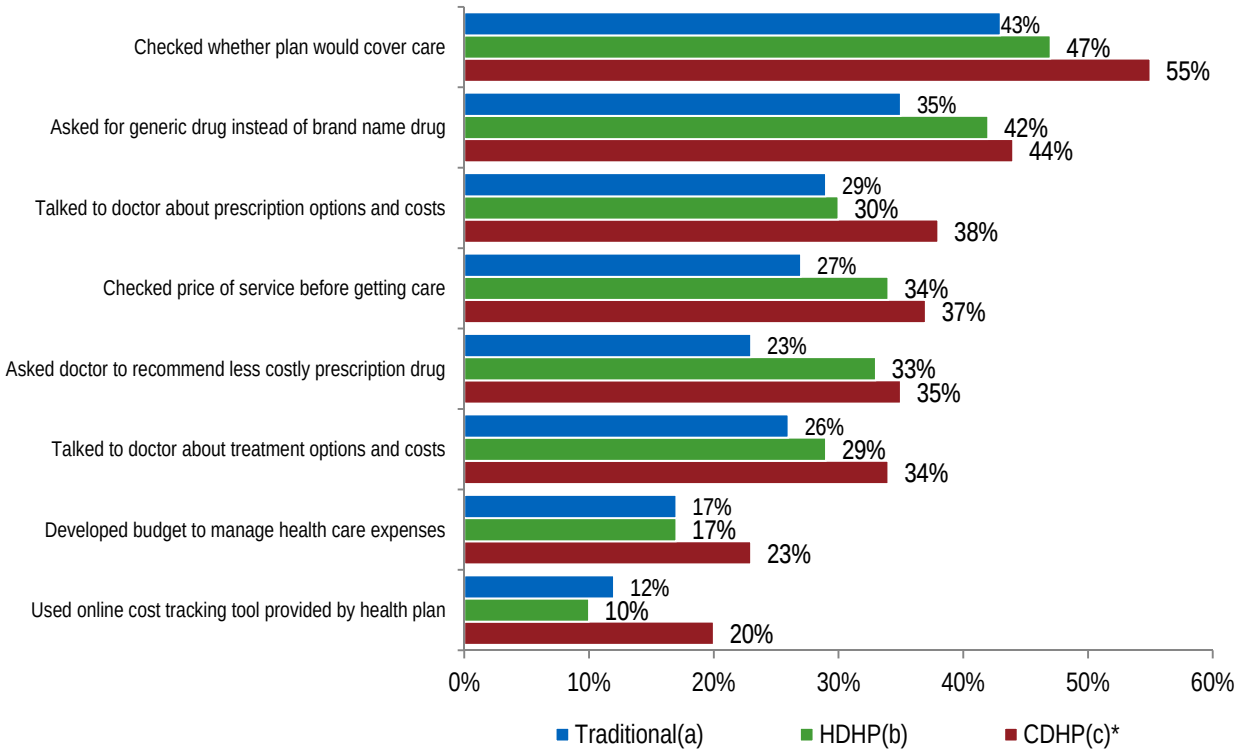
- Pick a good CDHP vendor. CDHP vendor capabilities vary considerably. Pick a vendor with a good network, good CDHP administrative system, good customer support, good medical management and good consumerism tools.
- Include wellness and disease management programs. These programs will help control costs for the chronically ill and improve member's health.
- Add healthy behavior financial incentives and make the financial incentive meaningful in order to encourage high participation.
- Have leadership promote CDHP. The leadership of the organization should endorse and help promote the new program to employees.
- Set a CDHP plan enrollment goal of at least 30% in the first year. A 30% enrollment level is necessary in order to avoid adverse selection and generate reasonable consumer engagement savings.
- Provide an online plan selector tool. This will show employees that the CDHP plan out-of-pocket costs compare favorably to the other plans.

In 2015, ETF added a High Deductible Health Plan with an HSA. ETF administers the HSA for all plan options, with the health plans providing medical coverage and Navitus administering the pharmacy benefits. Some of the key factors above were included in the plan design, but many were absent, leading to less than 1% initial enrollment.

Creating a Better Consumer

Numerous studies indicate that members who have elected a CDHP are better and more conscientious consumers of health care. A recent study by the Employee Benefits Research Institute (EBRI) showed that in nearly every consumer related question posed, members of a CDHP scored higher than the traditional plans. That included checking their plan features, looking for lower cost medications, checking the pricing of services, budgets, etc. The following table summarizes the EBRI results.

COST-CONSCIOUS DECISION MAKING
By Type Of Health Plan 2014[1]
(Percentage of privately insured adults 21 – 64
who received health care in the last 12 months)



(a) Traditional = Health plan with no deductible or <$1,250 (individual), <$2,500 (family) in 2014.

(b) HDHP = High-deductible health plan with deductible $1,250+ (individual), $2,500+ (family), not HSA-eligible in 2014.

(c) CDHP = Consumer=driven health plan with deductible $1,250+ (individual), $2,500+ (family), with HRS, HAS, or HSA-eligible in 2014.

* Difference between HDHP/CDHP and Traditional is statistically significant at the p ≤0.05 or better.

There are also a number of similar studies from large national insurance companies. Below are just a few excerpts from recent studies.

The 9th Annual NYSE Aetna HealthFund® Study

The study looked at nearly 2.2 million members. Approximately 760,000 of these members had Aetna HealthFund plans. More than 1.4 million of these members had an employer that offered an Aetna HealthFund plan but who chose another product.

The survey shows that employers that replace their traditional health benefits plans with Aetna HealthFund consumer-directed plans saved nearly $350 per member per year. The lower health

[1] Source: EBRI/Greenwald & Associates Consumer Engagement in Health Care Survey, 2014.

care costs result in savings of $20.8 million over a six-year period for every 10,000 members. The Aetna HealthFund study is the longest running review of consumer-directed plans in the industry, drawing experience from a decade of claims data.

Members with Aetna HealthFund plans spent less on most types of health care services, including specialist doctor's visits, emergency room visits and total pharmacy costs. Despite lower overall health care costs, members with Aetna HealthFund plans received routine preventive care from their primary care doctors 11% more than members with traditional Preferred Provider Organization (PPO) plans. Aetna HealthFund members also had higher rates of screenings for cervical cancer (nearly 7% higher), colorectal cancer (8%), and prostate cancer (10%), as well as mammograms (6%) and immunizations (3%).

The 8th Annual Cigna Choice Fund Experience Study

The Cigna Choice Fund Experience Study is a multiyear comparative analysis of utilization, claim and cost trend data for two groups of customers: Those in Traditional PPO/HMO plans (the control group) and those in Cigna Choice Fund CDHPs. There were 602,000 customers continuously enrolled in a Cigna Choice Fund plan, and 2,856,000 traditional HMO and PPO customers from the same employer groups served as the control group.

The study examined the total cost of claims for both employers and individuals to isolate behavior changes associated with enrollment in CDHPs. Observed differences were carefully analyzed to determine whether they were the result of changes in coverage or of increases in customer cost-sharing.

When compared to customers in Traditional plan designs, the study demonstrates that Cigna Choice Fund customers achieve better outcomes. Members in its consumer directed health plans were nearly 50% more likely to complete a health risk assessment, while those with chronic illnesses were up to 41% more likely to participate in a disease management program than those participants in a traditional plan. Members of a CDHP are more likely to choose generic drugs and less likely to get care at a hospital emergency room

An analysis by Cigna of its consumer-directed health plans, where members take more responsibility for their own medical costs and are encouraged to engage actively with the health care system, found a 12% reduction in medical spending compared to traditional plans.

Third Year Health Care Service Corporation (HCSC) Study

Individuals enrolled in consumer-directed health plans (CDHPs) continue to utilize health care services more efficiently, long after switching from their traditional insurance plans, according to a comprehensive data analysis by Health Care Service Corporation (HCSC), operator of the Blue Cross and Blue Shield Plans in Illinois, Montana, New Mexico, Oklahoma and Texas.

The study tracked more than 316,000 individual Blue Cross and Blue Shield members and found those migrating to a CDHP plan not only saw cost savings in the first year but continued to experience even lower health costs years later. This study measured and tracked the claims experience of members previously enrolled in traditional plans who switched to a CDHP, not just those members who selected a CDHP over those who did not.

The study found that after switching from a traditional plan to HCSC's BlueEdge CDHP, members saw a 3-year average reduction in:

- **Medical expenses:** decreased by 11.8%
- **Overall spending, combined medical and pharmacy costs:** decreased by 10.5%
- **Inpatient care costs:** decreased by 23.5%
- **Outpatient care costs:** decreased by 5.1%
- **Professional services costs:** decreased by 14.0%

All of these reports are self-reported and have not been audited by Segal. We believe the directional nature of the results are reasonable and support a consumer directed plan focus.

ETF HDHP Plan Design

As mentioned earlier in the benefits benchmarking section, Segal collected information to compare the HSA plan design on a regional and national basis. Below is a high-level summary of key HDHP plan provisions:

	HDHP/CDHP				
	Wisconsin	Regional		National	
		Range	Typical	Range	Typical
Medical Benefits—In-Network					
Type					
HSA	Yes	2		18	
HRA	No	0		6	
HSA – ER Contribution					
Single	$170	$500 – $1,002	$600	$0 – $1,821	$500
Family	$340	$1,000 – $2,003	$1,200	$0 – $3,643	$1,000
HRA – ER Contribution					
Single	N/A	N/A	N/A	$100 – $1,250	$600
Family	N/A	N/A	N/A	$200 – $2,500	$1,200
Deductible					
Single	$1,500	$1,500 – $2,500	$1,750	$1,250 – $4,000	$1,800
Family	$3,000	$3,000 – $5,000	$3,500	$2,500 – $8,000	$3,600
Coinsurance					
After Deductible	10%	5% – 25%	15%	0% – 30%	20%
Out of Pocket Maximum					
Single	$2,500	$3,000 – $4,000	$3,250	$1,500 – $6,350	$3,750
Family	$5,000	$6,000 – $8,000	$6,500	$3,000 – $12,100	$7,500

	HDHP/CDHP				
	Wisconsin	Regional		National	
		Range	Typical	Range	Typical
Prescription Drug					
Retail—Copay					
Generic	$5 after Deductible	$10 – $12	$10	$5 – $20	$10
Formulary/Preferred Brand	$15 after Deductible	$18	$20	$15 – $50	$30
Non-Formulary/Non-Preferred Brand	$35 after Deductible	$38	$40	$30 – $80	$50
Retail—Coinsurance					
Generic	N/A	N/A	N/A	10% – 30%	20%
Formulary/Preferred Brand	N/A	20%	20%	15% – 30%	20%
Non-Formulary/Non-Preferred Brand	N/A	40%	40%	15% – 75%	30%

ETF plan design has a deductible of $1,500 (greater than the $1,300 required minimum) and out-of-pocket max of $2,500 (less than the $6,450 max). Both of these are more generous than the regional and national norms.

The most obvious concern we see with the HDHP plan design is that the HSA Employer Contribution is only $170 per year. That amount is well under the regional average of $600 and national average of $500. We believe this creates too much exposure for your plan members when compared to the UBD plans and discourages migration to the HDHP platform. The deductible gap is $1,330 ($1,500 less $170) where the regional is only $1,150 ($1,750 – $600).

The monthly contribution rates for the HDHP appear to be at a reasonable level and comparable to the market, although the total employer monthly cost is high. Figures for ETF are shown without dental costs.

	HDHP/CDHP							
	Wisconsin[1]		Regional			National		
		Percentage	Range	Typical	Percentage	Range	Typical	Percentage
Total Monthly Costs[2]								
Single	$588		$375 – $577	$461		$193 – $1,026	$477	
Family	$1,478		$1,191 – $1,541	$1,292		$356 – $1,900	$1,110	
Monthly Employer Contributions[3]								
Single	$559	95%	$375 – $459	$437	95%	$193 $860	$439	92%
Family	$1,404	95%	$1,108 – $1,199	$1,126	87%	$356 – $1,441	$965	87%
Monthly Employee Contributions[4]								
Single	$29	5%	$0 – $119	$24	5%	$0 – $166	$38	8%
Family	$74	5%	$83 – $342	$166	13%	$0 – $459	$145	13%

ETF has set the premium rate HDHP factor to be 87.5% of the UBD rate. From a pure relative benefit value perspective, we believe that relationship is accurate, but only if the membership characteristics, health risk and utilization patterns are identical for each plan. What is not considered is the impact participant behavior plays on the total cost of the program. Typically, an additional 5% – 7% reduction can be anticipated due to changes in participant utilization behavior. We believe that factor should be revised and subject to further review during the upcoming health plan renewals.

1 The Wisconsin HDHP plan became effective 1/1/15.

2 Cost sharing information reflects rates for non-smokers and those who have not participated in a wellness activity/program. If cost sharing varies by salary level, the rates reflect those applicable to someone with a salary level of $40,000/

3 Wisconsin monthly premiums vary by plan, ranging from $501 to $675 for single coverage and from $1,247 to $1,685 for family coverage.

4 The Wisconsin employee contributions shown represent Tier 1 plans. Rates shown are retro-adjusted to 2014 level, to be consistent with comparator data.

Recommendations

Developing appropriate pricing and introducing additional efficiencies into the HDHP option will provide ETF with an effective lower cost plan option to utilize in managing the upcoming Excise Tax. In order for the HSA plans to be successful and be a benefit to ETF:

- The State contribution to the HSA should be increased
- The HSA/HDHP plan premiums should reflect a more accurate assessment of the total plan cost under the HDHP program. That should include benefit relativity, behavior change and selection bias. With relatively low enrollment in 2015, as well as this being the first year for these options, it may not be prudent to use claims experience to date in the renewal for 2016, as the experience is likely not credible and is preliminary. However, for subsequent years, actual claims experience for the HDHP option(s) should be incorporated into the renewal and negotiation process.
- It was noted in Segal's survey of the ETF health plans that some current health plans cannot support a self-insurance approach. Segal does not understand how these plans could process claims and operate an HSA plan design. It is unclear how these plans could provide claims to ETF for HSA administration, but not be able to support and self-insured approach From our perspective, having the ability to administer an HSA/HDHP option should enable a plan to support a self-insured approach.
- Given the low number of members it could make more sense to consolidate the HSA plan designs into one Statewide offering. This is not feasible for 2016. We will work with ETF to evaluate consolidation options for 2017 and develop a recommendation in our second report.

Affordable Care Act—40% Excise Tax

The Patient Protection and Affordable Care Act (ACA) of 2010 has significantly changed the landscape of healthcare, for employers, patients, plans and governments/regulators. Through the imposition of individual and employer health insurance coverage mandates and penalties, the definition of minimum essential coverage and of full-time employees at 30-hours per week, and the addition of employer and plan reporting of coverage for each individual employee or dependent, the ACA has established a floor for minimum health benefit.

Starting in 2018, the ACA will begin to impose a ceiling on the value of health benefits that can be provided to an employee or retiree on a pre-tax basis. This ceiling will be in the form of the 40% Excise Tax, sometimes referred to as the "Cadillac Tax", and will be assessed against health plans that provide a plan worth more than established and indexed threshold amounts.

This section of the report examines the 40% Excise Tax and how it is likely to affect the ETF's current benefit programs.

How the 40% Excise Tax Works

The 40% Excise tax is assessed on the total value of any health benefit plans provided to an employee or retiree through an employer plan that exceeds a threshold of $10,200 for single coverage and $27,500 for all other coverage tiers. In certain cases, the threshold amounts can be increased to $11,850 and $30,950, respectively, for retirees and certain employees in hazardous duty employment.

The dollar thresholds are indexed to the Consumer Price Index for Urban Consumers (CPI-U) for years after 2018. Because medical inflation has persisted at significantly higher rates than general inflation, it is expected that, at some point, nearly every employer health plan will reach the Excise Tax thresholds.

The tax is based on the total cost for the health benefit programs, not on the value of the plans or the employer portion of the cost. For that reason, it is not possible for a plan to avoid the tax by shifting premium cost to the employee or retiree. Other changes must be made to stay under the tax thresholds.

In addition, there is no regional adjustment in the tax threshold to reflect the varying cost of medical care in different regions or cities. For a plan with statewide participation like ETF, the cost for medical services varies by location and health plan so the tax may be triggered at different total service levels in different locations.

The IRS has not yet provided detailed guidance on how the 40% Excise Tax will work. In late February 2015, the agency provided some preliminary information and requested comments from the benefits community about a number of key aspects of the tax. As the regulations are developed, the ways in which plans will need to adjust may change.

Who Pays the Tax?

The tax is payable by the plan administrator. The ACA generally follows ERISA on the definition of plan administrator (insurer for insured plan, plan administrator for self-insured group health plan, health FSA or HRA, employer where the employer acts as plan administrator for self-insured group plan, health FSA or HRA; employer where employer contributes to an HSA or Archer MSA).

Plans Included for 40% Excise Tax Purposes

The following plans must be included in the calculation of the 40% Excise Tax. We have also included relevant notes under each plan type reflecting points of interest to ETF and the GIB:

- Medical/hospitalization/prescription drug
  - These would include ETF's health plans and pharmacy benefit program
- Dental and vision (if not voluntary standalone)
  - ETF is already bidding its dental benefit coverage to a separate voluntary plan
- Health Flexible Spending Accounts (FSAs)
  - The State's Health FSA is not under the control of ETF or the Group Insurance Board
  - ETF does not exercise any control over Health FSA programs maintained by other employers participating in the health benefit program
- Health Reimbursement Arrangements (HRAs)
- Health Savings Accounts (HSAs) and Archer Medicare Savings Accounts (MSAs)
  - ETF's Consumer Directed Health Plan (CDHP) is paired with an HSA for certain employer contributions toward out of pocket medical costs
- Onsite medical clinic value
- Executive physical programs
- Coverage for a specific disease or illness and hospital indemnity, unless coverage is paid for with after-tax dollars
- Employee Assistance Programs (if not excepted)
  - To the extent the State maintains an EAP that provides actual medical services, it will need to be included in the calculation

Additional details about the plans included for 40% Excise Tax analysis are shown in **Appendix 2: Detailed Information on the ACA 40% Excise Tax.**

The most immediate issue with the 40% Excise Tax would result from the combination of the medical and prescription drug benefits and the FSA or HSA accounts that are added on top of the health plan value. In general, an employer with a health plan well under the 40% Excise Tax threshold is still likely to have potential issues when the Health Flexible Spending Account is considered. In a state government environment, where different agencies administer different benefit programs, there is a growing need for close coordination among agencies to minimize the impact of the tax.

Projected Fiscal Impact

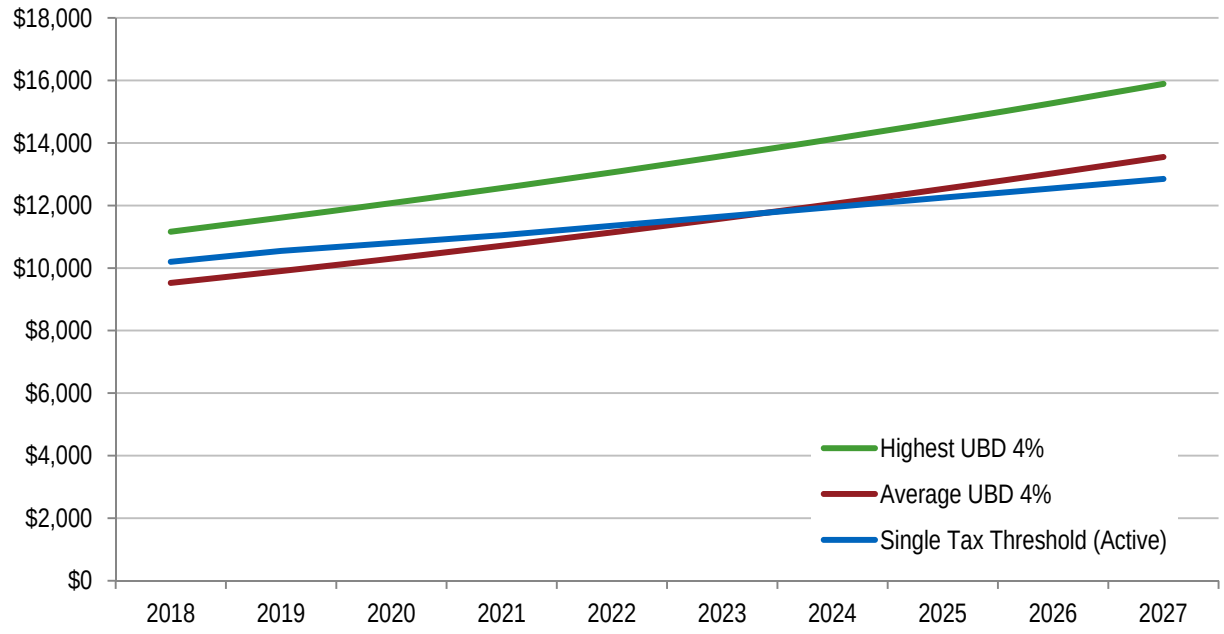
The following presents a comparison of likely, and possible, scenarios and Excise Tax costs for ETF from 2018 through 2027.

Current health cost trends are at about 4% annually and, while that may be a likely and reasonable assumption in the near term, it is important to consider other less favorable possibilities. Therefore, we also evaluated the potential Excise Tax exposure with a 6% annual trend.

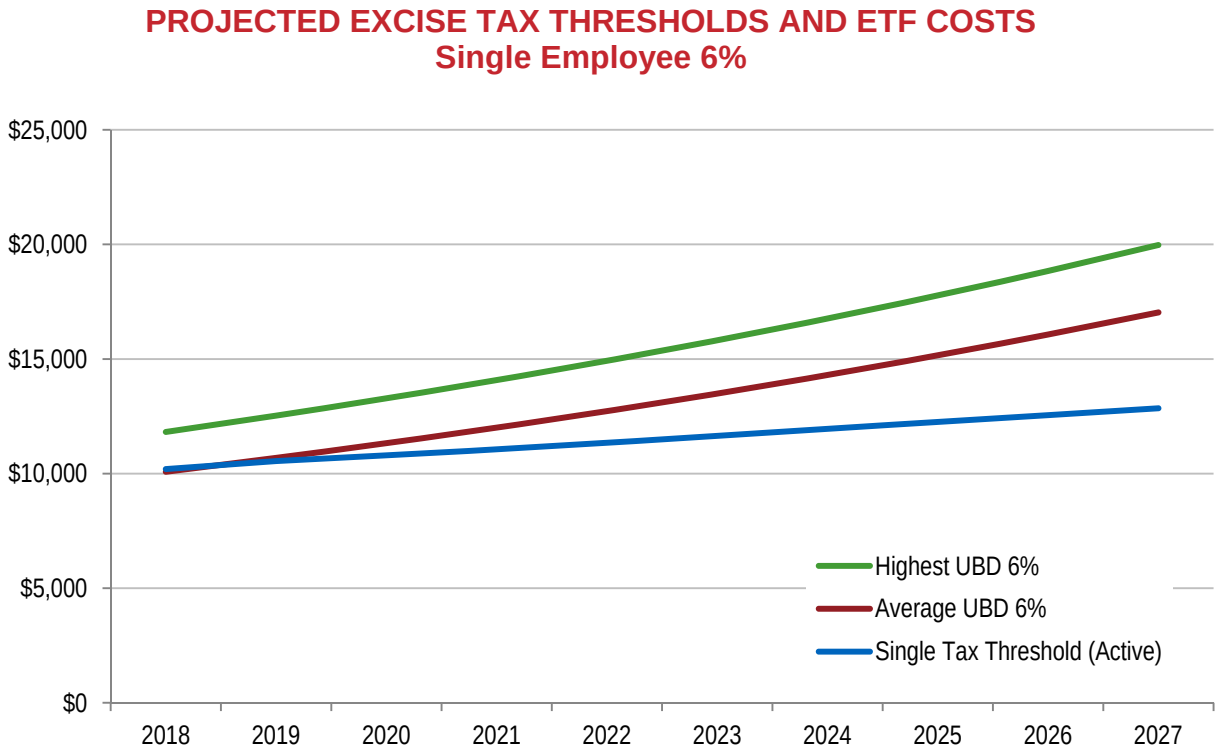
Segal calculated the total cost for the current ETF program health plans. For the Health FSA, we assumed the current statutory maximum of $2,550 in salary reductions allowed per year.

As illustrated in the following graph, at 4% annual trend, the current average UBD single premium cost is projected to be just below the Excise Tax threshold in 2018, but will catch up to the threshold in 2024. However, we expect that the single premium cost for many of the higher cost UBD plans will already exceed the threshold in 2018 when the Excise Tax is first implemented. Since the tax may have to be calculated on an individual employee level, employees in those higher cost UBD plans will generate a tax for ETF in 2018.

PROJECTED EXCISE TAX THRESHOLDS AND ETF COSTS
Single Employee 4%

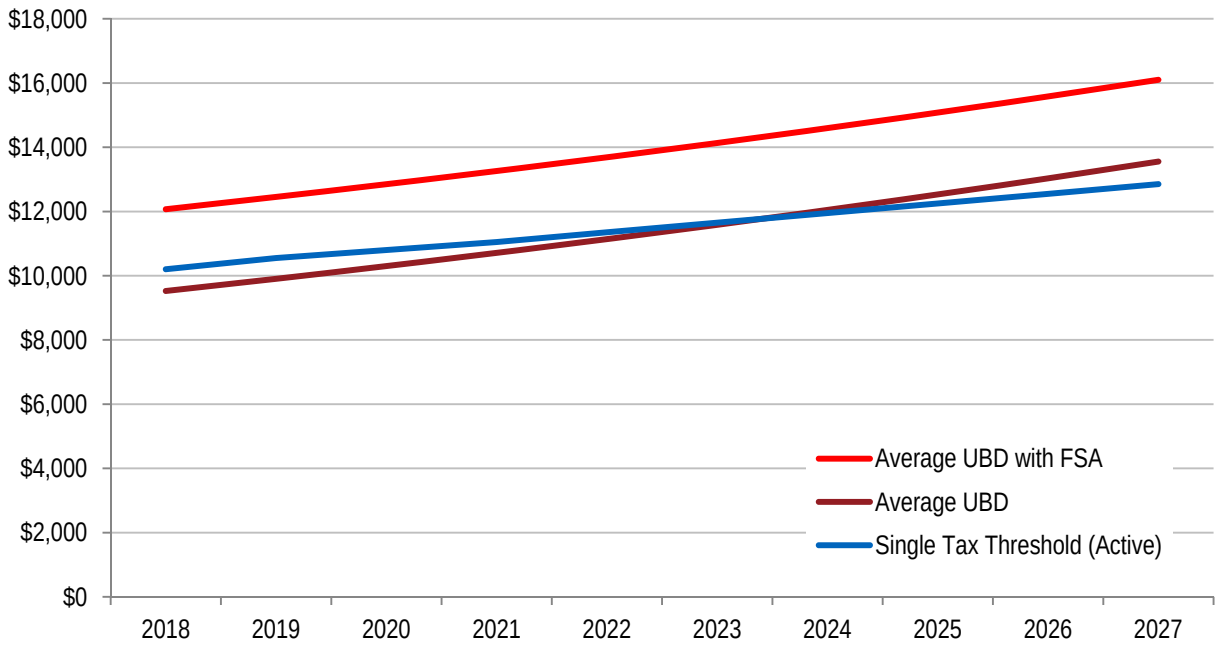


Under less favorable trend experience (6% annually), the average UBD single premium is expected to exceed the threshold at the inception of the 40% Excise Tax in 2018. This will create an immediate tax issue for the ETF program. The following graph illustrates that progression.



Employees contributing the maximum amount to their Flexible Spending Accounts ($2,550 for 2015) are anticipated to generate a tax even under the lower 4% trend assumption. The graph below reflects both the average UBD cost and the higher cost of the UBD plus the FSA contribution.

PROJECTED EXCISE TAX THRESHOLDS AND ETF COSTS
Single Employee 4% Trend



Calculation methodology for the Excise Tax is still in the process of regulation by the Internal Revenue Services (IRS), which has just issued a call for comments on how the program should be administered. Under a cafeteria benefit program (IRC Section 125), each participant has the option to voluntarily reduce his or her pay for a year by up to the maximum amount allowed by the employer for that year, but not more than $2,550 (for 2015, indexed). Typically, between 10% and 15% of eligible participants in an employer health plan actually make the salary reduction election for the medical FSA.

To estimate the potential impact of the 40% Excise Tax on ETF's benefit programs, Segal projected the amount of benefit value that would exceed the dollar thresholds for single coverage and for all other coverage over the next several years using the 4% and 6% trend assumptions described above. We accounted for the different thresholds of single coverage and "not single" coverage for actives and non-Medicare retirees and included modest assumptions for employee salary reductions to the State's Health Flexible Spending Account (FSA) as well as the employer contributions to an employee's Health Savings Account (HSA) attached to the Consumer Directed Health Plan.

We project that, under the current benefit program with no changes, ETF's potential Excise Tax exposure is between $7 and $13 million in 2018 and could grow to as much as $193 million in 2027. The following table summarizes the results of this analysis:

ETF PROJECTED EXCISE TAX
($ Millions)

Year	Tax with 4% Trend	Tax with 6% Trend
2018	$7	$13
2019	$7	$20
2020	$8	$31
2021	$11	$43
2022	$14	$58
2023	$17	$76
2024	$21	$99
2025	$26	$127
2026	$32	$158
2027	$39	$193

These calculations and estimates are acknowledged to be preliminary and may vary from the actual calculations according to processes yet to be adopted by the IRS. They do, however, illustrate the need for ETF and the State to begin addressing the Excise Tax issue immediately.

We believe it would be difficult for ETF or the GIB to justify requests for state budget funding of any Excise Tax amount. Typically, states do not desire for their budget dollars to be applied toward penalties being paid to the Federal government, particularly penalties being assess because the state is providing benefits for its employees and retirees that exceed the legislated pre-tax maximums. The excise tax cannot be offset by simply charging employees a higher premium share, because the additional contribution costs would simply push the overall cost of the program higher and create even larger Excise Tax penalties.

ETF should begin work immediately with the state agencies responsible for the Section 125 cafeteria plan and Medical Flexible Spending Account and the Employee Assistance Program to assess the potential impact of the 40% Excise Tax and to agree upon policies and precedents as to which benefit program will cut back benefit levels and how that will be accomplished.

Strategies to Avoid the 40% Excise Tax

Segal suggests three different strategies public employers and plans can explore to help avoid the 40% excise tax—calculation strategies, retiree strategies, and cost control strategies.

Calculation Strategies

With such complex employer health benefit programs and the wide variation in plan types available to various groups of employees or retirees, the IRS is already considering how to allow employers to aggregate or disaggregate groups for purposes of the Excise Tax calculation. For example, it has been traditional for the IRS to allow separation of collectively bargained employees for other benefits testing and qualification purposes. Now, with the ACA's definition of full-time employee as one who works at least 30 hours per week or equivalent, the IRS is already considering comments on how individuals might be groups or ungrouped for calculation of the 40% Excise Tax.

Segal suggests that ETF actively analyze its various groups of employees and retirees who participate in the plans to determine whether aggregation or disaggregation might help delay the impact of the Excise Tax. This exercise would likely need to be in collaboration with the State Human Resources or other departments, to better understand the current covered workforce and the possibilities for grouping.

In addition, the Excise Tax is not adjusted for regional variations in health benefit cost. Additional work may be needed to understand fully the participant population's underlying medical cost variations across the state.

Retiree Strategies

Most state government health plans include both active employees and non-Medicare and Medicare eligible retirees in the primary rating pool. For self-insured plans, this typically takes the form of a single rating pool for all participant experience, where everyone in the plan pays the same rate for their respective coverage level (single, family, etc.) and there is no differential in premium made for age or other factors. The same rating approach is used for most fully-insured plans, where a single rate structure applies to all participants, except for Medicare eligible employees still employed where a reduced rate may apply to reflect the fact that Medicare is a secondary insurance while those eligible persons are still working.

This "one for all" traditional rating approach contributes to the stability of the health benefit program, and helps to build confidence among older employees that when they retire, they will not be charged any different premium base than what they paid during their employment.

However, there is a direct relationship between age and illness. The older a person is, the more likely he or she is to have one or more serious conditions. More conditions means greater medical cost, and increased medical cost means higher premiums required to fund those medical costs. In effect, the older and sicker persons covered in the plan will drive up the required premium cost for younger and healthier members, so with a broad based employer health plan covering active employees, non-Medicare and Medicare retirees, premium cost will be higher per person than in a plan that does not cover the non-Medicare and Medicare retirees.

A number of large governmental employers have begun to address this issue and have looked at how their cost and premium contributions would be affected if retirees were to be carved out of the active employee health plan and provided their own health benefit programs specifically designed for retiree needs. Removing retirees to their own health benefit programs would generally have the effect of lowering the per member per month cost for the actives only plan and could help delay the onset of the 40% Excise Tax for the employee plan without requiring as drastic reductions in the benefit program.

If retirees are carved out to their own separate health plan, the per member per month cost for the remaining active population would go down, but without the low-cost actives in the mix, the retiree-only plan would have a much higher cost for the same benefits. This increased per member per month cost may be workable because of the higher Excise Tax thresholds for retirees in their own plan. Careful analysis would be needed to adjust the employer subsidy amount or percentage for the retiree population in the separated plan, to maintain consistency in overall funding and retiree cost share.

Additional advantages of having all retirees in a separate health benefit program include the ability to design the health plans specifically for the needs of retirees and to take maximum advantage of any Federal subsidies that might be available. Also, if the retiree plan is administered in a completely separate trust from the active employees, many of the ACA benefits mandates and penalties simply do not apply, which provides even more flexibility for program design.

Cost Control Strategies

Health plan sponsors can exercise cost control strategies through careful management in three primary areas: vendor management, health management and plan design management

Vendor Management

One strategy to control plan costs is strive for cost efficiency in the administration of the plan. Vendor contracts can be reviewed, restructured and re-bid as necessary to capture current market pricing for services relating to the health benefit plans.

Health Management

Overall plan costs are heavily dependent on the utilization of the promised services by members of the plan. Where possible, plan sponsors should encourage participants to take ownership for improving their own health. Health improvement can result in lower long-term trends thereby reducing the longer term cost for the program and reducing the impact of the Excise tax.

Plan Design Management

The employer's most potent tool in managing plan cost to avoid the Excise Tax is the plan design. Where control of administrative costs can provide an immediate solution and encouragement of healthier lifestyles and choices among participants can improve the plan's cost efficiency gradually, the adjustment of plan benefits to reduce program cost is the most

immediate and effective way to avoid the tax. Reduction of benefits in effect shifts medical cost to the participant outside of plan coverage.

Recommended Next Steps on the Excise Tax

While the regulatory details of the Excise Tax calculation are not yet fully completed, ETF should immediately begin to analyze its current health plan situation to determine which plans must be counted for Excise Tax purposes. ETF should work closely with the State agency that administers the Employee Assistance Plans to jointly understand how each of this plan affects the potential for being taxed.

ETF administers the HSA and FSA and therefore can, and should, evaluate and manage the contribution limits to minimize the State's Excise Tax exposure.

In addition, ETF should hold discussions with each of its fully insured health plans to understand how they are addressing the Excise Tax question and what steps they plan to take with their customers to mitigate the impact of the tax.

As soon as the IRS publishes actionable regulation or guidance on the Excise Tax, ETF should also perform a full assessment of its likely tax situation, including a plan by plan analysis and test calculations of the tax impact. Also, ETF should review potential plan design changes for implementation to avoid the Excise Tax.

ETF should also initiate communications with its non-state participating employers regarding the coming Excise Tax and discuss how they might be affected with regard to their own medical FSA programs, particularly as ETF considers adjustments to its own plans. ETF should also establish and update clear policies and expectations with participating employers as how the cost of any Excise Tax imposed on the plan because of their programs will be handled.

Longer-term, ETF and the State will need to work together to coordinate plan changes across all health plans to stay under the Excise Tax thresholds. Program objectives should be restated to include a provision describing protocols for the continual adjustment of plan design that will likely be required to avoid the tax as long as medical inflation exceeds general inflation.

Public and Private Exchanges

The healthcare benefits market has changed significantly over the last few years. In particular, the advent of the Health Insurance Exchanges – or "marketplaces" – have provided a new element to the competitive dynamics in the health insurance market. At the most basic level, an insurance exchange is an online portal where individuals can compare and shop for individual health insurance policies.

The ACA requires states to either establish and operate their own exchange or, absent that, the Federal government will operate one in its place. A collaborative approach is also an option. To date the State of Wisconsin has elected to allow the Federal government to operate the exchange in Wisconsin. The state exchanges currently provide coverage only to individuals and some smaller employers. Large employers may first utilize public exchanges in 2017 to provide their employees coverage.

In the interim, large employers that wish to utilize an exchange type environment must use a private health insurance exchange, operated by a commercial enterprise. There are multiple competitors that can provide a large group with an exchange option. The most prominent are operated by benefits consulting firms such as AonHewitt, Buck Consultants, Mercer Consulting and Towers Watson. Private exchanges have up to now focused primarily on servicing an employer's Medicare eligible retirees, but are beginning to broaden out to include non-Medicare eligible retirees and active employees.

This section reviews both the state health exchange and private exchanges and compares the ETF benefit program to the plans and policies available through those exchange alternatives.

Public Exchanges

Individuals who are not Medicare-eligible may purchase coverage through their local state exchange on a guaranteed issue basis, with plans generally providing benefits at the following levels:

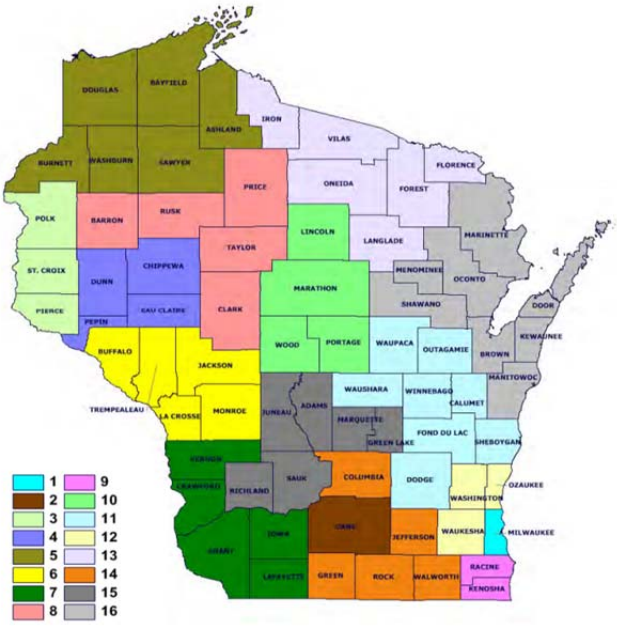
- **Platinum** plans have a 90% Actuarial Value, which means they cover 90% of covered expenses on average;
- **Gold** plans have an 80% Actuarial Value;
- **Silver** plans have a 70% Actuarial Value;
- **Bronze** plans have a 60% Actuarial Value;
- **Catastrophic** coverage is available to some people under 30 and those with hardship exemptions. Catastrophic plans only cover the bare minimum health benefits and have a very limited network and can result in high out-of-pocket costs.

All plans offered through the state exchange must provide minimum essential coverage, with premium subsidies and enhanced benefits provided on a sliding-scale basis to individuals with income below 400% of the Federal Poverty Level ($46,800 in 2015 for an individual and $97,000 for a family of four).

While any citizen can apply for coverage on a state exchange, an employee of an organization with 50 or more employees is generally not eligible to receive any federal subsidies for coverage purchased through the state exchange, unless the employer's lowest cost plan is 9.5% or more of that employee's household income. That employee would have to be offered health insurance through his or her employer under the Affordable Care Act. If the employee in this situation chooses to enroll in the exchange instead of the employer's health benefit plan, and if he or she does so and qualifies for a federal subsidy, then the employer may be charged a $3,000 shared responsibility penalty for that employee.

Options and Choice

Benefits for plans in the same metal level can, and often do, vary. One plan may have a lower deductible and higher copays while another plan has a higher deductible and lower copays, but both balance out to the same actuarial value.



Each state is divided into multiple regions, called rating areas. Carriers must offer the same plans at the same premium levels uniformly across a rating area. Wisconsin's state exchange has 16 rating areas, offering over 5,000 plans and providing coverage to approximately 175,000 individuals across the State.

Fifteen of the sixteen rating areas in Wisconsin have at least one option for each metal level. One rating area, in the western part of the State, does not have a Platinum plan option.

The following table summarizes the number of plans at each metal level for each of the 16 rating areas:

Rating Area	Location	Platinum	Gold	Silver	Bronze	Catastrophic	Carrier
Rating Area 1	Milwaukee	5	21	53	32	5	Ambetter MHS, Anthem BCBS, Arise, Common, Molina, UHC
Rating Area 2	Madison/Dean County	14	18	35	18	6	Dean, GHC-SCW, Physicians Plus, Unity
Rating Area 3	St. Croix/West	0	9	6	6	3	Medica
Rating Area 4	Eau Claire/West	1	22	53	46	12	Health Tradition, Security, UHC
Rating Area 5	Far Northwest	0	25	40	33	13	Medica, Security
Rating Area 6	La Crosse	15	48	110	100	19	Anthem BCBS, Gundersen, Health Tradition, Security, UHC
Rating Area 7	Southwest	45	73	169	115	23	Anthem BCBS, Dean, GHC-SCW, Gundersen, Health Tradition, UHC, Unity
Rating Area 8	NW Interior	8	31	86	58	14	Anthem BCBS, Arise, Health Tradition, Security, UHC
Rating Area 9	Racine/SE	10	36	91	52	10	Ambetter MHS, Anthem BCBS, Arise, Common, Molina, UHC
Rating Area 10	Wausau/Central	20	50	136	82	18	Anthem BCBS, Arise, Molina, Security, UHC
Rating Area 11	Oshkosh/East	62	157	404	233	46	Ambetter MHS, Anthem BCBS, Arise, Common, Dean, GHC-SCW, Molina, Security, UHC, Unity
Rating Area 12	Waukesha/SE	15	58	149	87	16	Ambetter MHS, Anthem BCBS, Arise, Common, Dean, Molina, UHC
Rating Area 13	Green Bay/NE	10	31	81	49	9	Anthem BCBS, Arise, Molina, Security, UHC
Rating Area 14	South/Central (NOT Dane)	65	109	226	128	28	Anthem BCBS, Arise, Common, Dean, GHC-SCW, MercyCare, Molina, UHC, Unity
Rating Area 15	Castle Rock Lake Area	60	101	251	160	32	Anthem BCBS, Arise, Dean, GHC-SCW, Gundersen, Health Tradition, Security, UHC, Unity
Rating Area 16	Rhinelander/North	36	116	314	169	44	Anthem BCBS, Arise, Common, Dean, Molina, Security, UHC
Total Plans Offered (5141)		366	905	2,204	1,368	298	

Premium Comparison

Premiums for plans in the State exchange vary by age, with premiums for the oldest individuals capped at 300% of premiums for the youngest adult individuals. Premiums for children are lower than for adults. Premiums for a given plan in the individual market are generally expected to be higher than premiums for the same plan in the employer group insurance market due to carrier costs for marketing, underwriting, additional administrative needs and risk margin for selection. The selection load for higher value plans is generally higher than for lower value plans—people tend to opt for higher value plans in order to use the benefits, generally speaking.

Segal compared the 2015 premiums for the current ETF plans with similar plans on the exchange. We excluded Medicare-eligible retirees since the state exchange does not provide coverage for those retirees.

We first established the actuarial values of the ETF plans as follows:

Plan Type	Actuarial Value
Uniform Benefit Design	96%
Standard Plan	93%
High Deductible Health Plan	83%

We then mapped ETF members to the appropriate State exchange premium for their age for a comparable metal-level plan in their rating area. Members in UBD and Standard Plan were mapped to Platinum level plans and members in the HDHP were mapped to Gold level plans. Note that in every case, the exchange plan options were slightly less generous in actuarial value than the ETF designs.

We conducted the analysis under three scenarios:

1. Each member would choose the plan with the highest premium available;
2. Members would choose plans resulting in an average premium in aggregate
3. Each member would choose the plan with the lowest premium available;

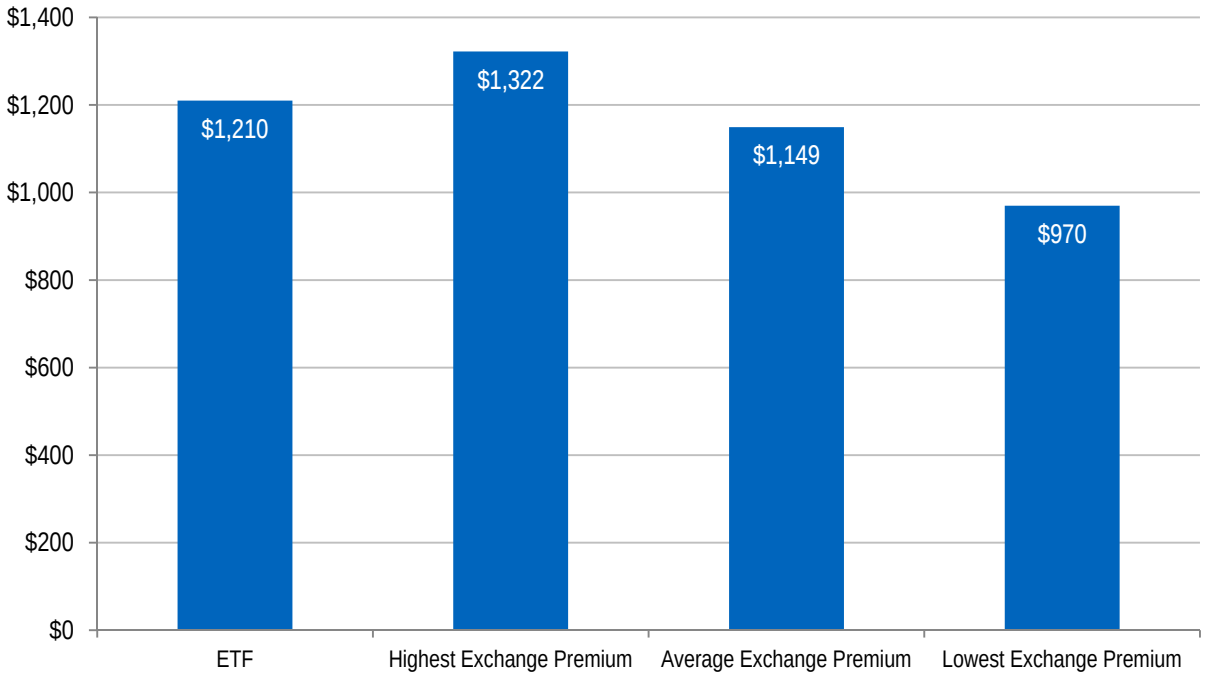
In all three scenarios, we compared the ETF premiums, without dental costs, against the premiums available on the exchange. Some of the plans on the Exchange include dental coverage, and no adjustment for dental was made to the Exchange plans' premiums.

Based on projected 2015 total ETF costs of $1.210 Billion (medical, pharmacy and administration costs only – no dental) for covering the non-Medicare ETF members, these scenarios produce the following results:

Scenario	2015 Projected Costs	Difference
Baseline/ETF	$1.210 B	
Choose Highest Premium Plans	$1.322 B	+ $112 M (+ 9.3%)
Choose Average Premiums	$1.149 B	- $61M (- 5.0%)
Choose Lowest Premium Plans	$0.970 B	- $240 M (- 19.9%)

The following graph displays these same results (in $ millions):

PROJECTED 2015 COSTS FOR NON-MEDICARE MEMBERSHIP CURRENT ETF PLANS COMPARED WITH EXCHANGE ELECTION SCENARIOS



A small number of ETF members (approximately 2,000 in Rating Area 3, near St. Croix) do not have a Platinum Plan option on the state exchange. For these members, we assumed no cost or savings from the current ETF plans. By contrast, every member in the HDHP has a Gold Plan option in his or her geographic rating area.

The ETF Uniform Benefit Design is richer than the Platinum Plan value on the state exchange, and the 5–6% difference in Actuarial Value explains the 5.0% differential in costs for the average premium election scenario. However, it does not explain the 19.9% difference for the most competitive plans. The population purchasing Platinum policies on the exchange should have higher health risk (and therefore higher costs) due to the exchange being a market of individual policies, which typically have higher premiums than otherwise similarly situated group policies. A well-designed state employee health plan like ETF should be able to provide benefits in a more cost efficient manner than those available in the same state's healthcare marketplace.

Some might suspect that the Exchange premiums are artificially low and therefore insufficient to cover the carriers' costs. However, PricewaterhouseCoopers' Health Research Institute reports that, from 2014 to 2015, the average premium increase for exchange plans in Wisconsin was

only 3.2%[1]. With 19 carriers competing in the market across the State, and with reasonably flat rates for the second policy year, the results suggest that the market is strong and attractive and the premiums are a good indication of the carriers' underlying costs. However, it should be noted that 2015 premiums were filed by the carriers with limited 2014 experience. Once the carriers have a full year of experience, renewal trends may differ for 2017.

Further, the ETF managed competition model employs a tiering structure to reward carriers with lower costs that deliver higher quality care with lower employee contributions. That model is intended to drive costs to a more efficient level than would be seen without the process. However, our analysis of the WHIO data indicates that there is a wide variation among ETF carriers in the apparent effectiveness in care and health management and the overall cost for non-Medicare members in ETF is still higher than most Platinum level individual policies on the State exchange.

The following graphs compare ETF HMO/PPO premiums (without dental costs) with the Platinum Plans available on the Exchange for Madison and Milwaukee, the cities with the most State employees. Exchange plans shown are those offered locally in Madison and Milwaukee, respectively. Some of the plans on the Exchange include dental coverage. The premiums shown are at age 44, which is the State employee average age.

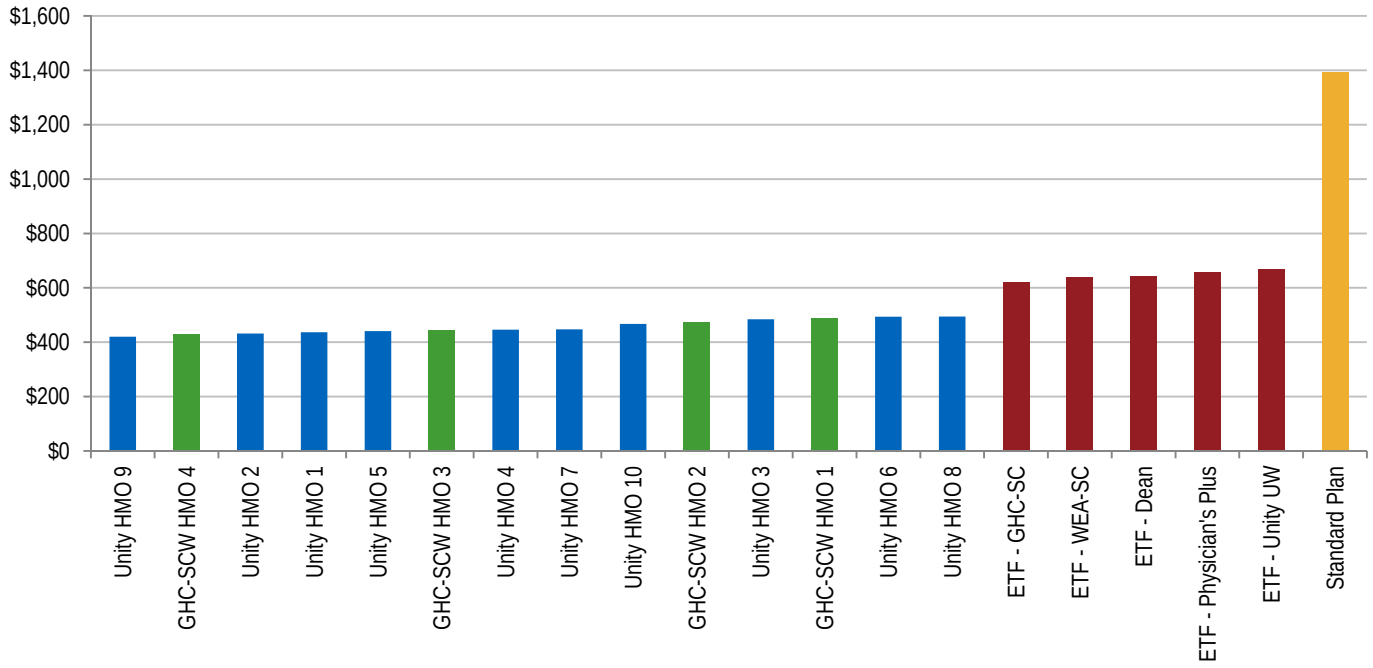
In Madison, all of the ETF plans are higher cost than the highest cost option on the Exchange. The ETF plans in Milwaukee are more competitive with the Exchange, but the Exchange provides more lower cost options than ETF.

[1] PwC's Health Research Institute compiles information in each state's exchange and provides the information to the public at the following website. The most recent data at the time of this writing was as of February 25, 2015 http://www.pwc.com/us/en/health-industries/health-research-institute/aca-state-exchanges.jhtml

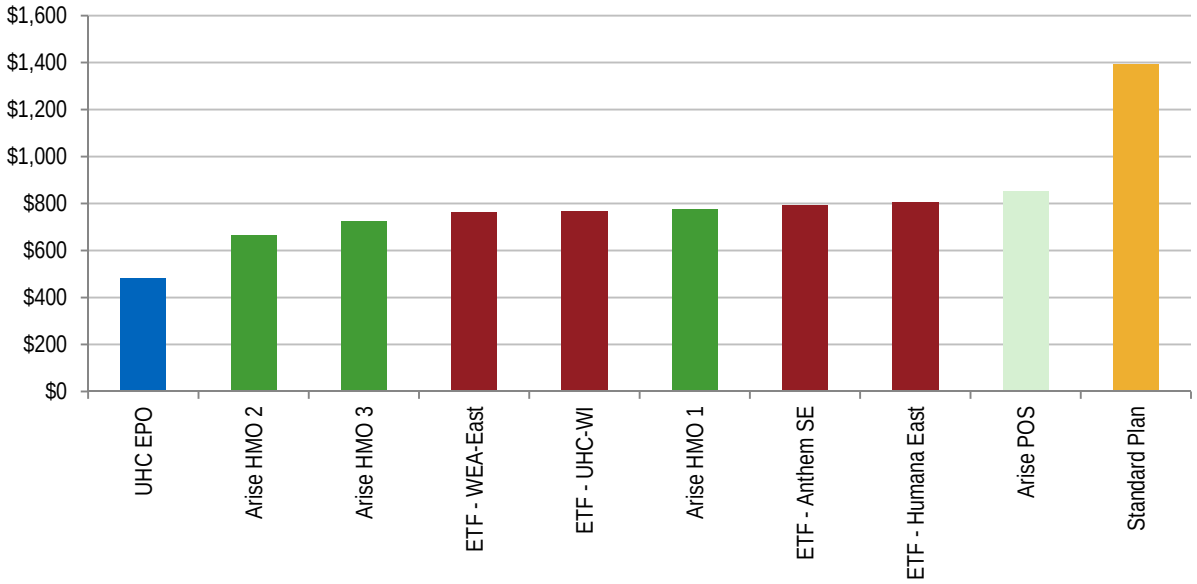
CURRENT ETF PLAN COMPARED TO PUBLIC EXCHANGE OPTIONS

Madison

Single Premiums for Active Employees—Age 44 Exchange Premiums



CURRENT ETF PLAN COMPARED TO PUBLIC EXCHANGE OPTIONS
Milwaukee
Single Premiums For Active Employees—Age 44 Exchange Premiums



In each of these situations, the case can be made that most employees/retirees over age 44 would have a higher than average cost on the state exchange while having the same marginal cost in ETF because the overall costs are spread across all ages in the population. While that is indeed the case, the converse is also true, that the price for Platinum coverage on the state exchange for a younger person would be less than under ETF and therefore potentially more attractive.

All of these comparisons against the State exchange options suggest that there is room for improvement in ETF's cost efficiency in delivering benefits to be reasonably comparable to rates now available for traditionally expensive individual policies in the state exchange marketplace. In short, the exchanges are delivering a comparably rich benefit plan design for a lower cost for an average age individual.

Private Exchanges

The private health exchange market has developed over the last several years, predating the implementation of the state exchanges in 2014. A private health exchange offers an array of individual and/or group based health insurance options along with the customer service and account service functions for administering the program. In short, an employer implementing a private exchange hands over its retirees or employees to the exchange for health benefit purposes and the exchange maintains primary contact with those retirees or employees going forward.

Private exchanges developed initially to serve Medicare eligible retirees, where there are many individual Medicare supplement and Medicare Advantage individual products already on the market. Customer service representatives for the private exchange will spend the lengthy time needed to help each retiree understand the options available and make a choice based on

expressed needs. Then, the exchange administers the policy and stays in contact with the retiree each time the retiree needs questions answered or options reviewed.

From their initial focus on Medicare retirees, private exchanges have expanded to provide similar outreach and administration for non-Medicare retirees and for a growing number of employers, administration of health benefit programs for all active employees as well.

As an alternative to traditional employer sponsored group health benefit plans, a private exchange can provide an employer and its employees and retirees added plan choice through a variety of carriers, as well as flexibility and customization to fit the plan options to the employer's needs, not into predetermined metal levels. As an alternative to the state exchange, a private exchange can provide the opportunity for external administration of the plan while still maintaining group insurance based employer coverage.

The private exchange market continues to evolve rapidly as more employers in the private sector adopt a private exchange strategy and as more private exchange companies enter the competition. Private exchanges are now offered by a number of companies, including a number of benefit consulting firms, as well as many insurance carriers. Those exchanges offered by consulting firms and other organizations typically offer a variety of policies and plans from a number of different insurance carriers, while the insurance company exchanges tend to be single-carrier product lines.

For additional details about how private exchanges operate and a summary of the key differentiators among private exchanges that should be considered in comparing program options, please see **Appendix 3: Private Exchange Details**.

Because of the wide variability of plans and policies that can be offered through a private exchange, it is not possible to make direct comparisons of ETF's benefits and costs to those offered through a private exchange. It is, however, important for the GIB to become and remain aware of the development of this alternative delivery model for health insurance benefits and to monitor the success of private exchanges in delivering health benefits that are both high quality and affordable in comparison to employer sponsored group insurance plans.

Market Observations

We are currently conducting a thorough review of the Wisconsin healthcare market and this report includes some initial observations.

Provider Access and Disruption

The WHIO data includes information on providers and health plans by claim and eligible member. Information submitted by the health plans as part of the annual renewal negotiation includes information on their provider network(s). However, there is significant inconsistency among the health plans' Addendum 2 submissions, and it is not feasible to incorporate the 2014 information into this analysis.

We reviewed the WHIO data to begin assessing how much network overlap there may be among the current health plans and what impact on provider access there could be if a there is a change in the current mix of ETF health plans. Unfortunately, utilizing the WHIO data presents some challenges as well, as claims for emergency room visits and some other services provided on an out-of-network basis are included.

Typically, these non-network claims comprise a small fraction of the overall claims. Therefore, our analysis filtered out claims for providers with low utilization below a certain threshold so that our analysis is not impacted by this "noise". Without this step, an analysis would likely overstate the degree the health plans' networks overlap one another. The analysis is further complicated by the large number of health plans and significant geographic variation in their respective service areas.

Ideally, the results of an access and disruption analysis would result in an indication of the networks that include each specific provider. Unfortunately, the quality and limited detail in the data does not support reporting this information in a credible manner. However, we are able to review and report at a high level the amount of overlap that may exist between the health plans' networks.

We utilized the existing regions for the State's Medicaid program to evaluate relative access and network overlap on a geographic basis. Using the WHIO claims, we were able estimate the number of claims in 2014 for providers that participate in one ETF health plan, two ETF health plans, three ETF health plans, etc. (after filtering out the low-volume providers, or "noise" claims as described above).

The following table shows the number of hospital claims groups by how many health plans a hospital has contracted with. For example, in the Northeastern region, 13% of all hospital claims for the entire region were provided by hospitals contracting with a single ETF health plan. Hospitals contracting with two ETF health plans provided 7% of claims for the entire region.

	Number of Health Plans Contracted With by Hospitals				
Region	**1**	**2**	**3**	**4**	**5**
Northeastern	13%	7%	38%	11%	31%
Northern	91%	9%			
Southeastern	12%	14%	68%	2%	4%
Southern	63%	14%	12%	4%	7%
Western	87%	5%	8%		
Overall	**56%**	**12%**	**20%**	**4%**	**8%**

These initial results provide the impression that there is not significant overlap in the current ETF health plan networks where hospitals are concerned. In the Northeastern, Southern and Western regions the majority of claims are provided by hospitals that contract with a single health plan. Since many of the health plans have grown out of provider group origins, this should not be a surprising conclusion. It is interesting though, that in the Northeastern and Southeastern regions, there appears to be a greater number of hospitals that contract with multiple health plans.

For professional services, the analysis is further complicated by the larger number of providers, and also by the fact that individual physicians are more geographically dispersed than facilities. The WHIO data contains information on the provider group for a physician. For many of these provider groups, a single address is provided for all providers in that group. While that may provide the location for that group's facility, it does not necessarily provide a good indication of the actual location for a physician. Therefore, the data does not support a region-based analysis for physicians. However, we were able to group physicians by specialty.

	Number of Health Plans Contracted With by Physicians					
	1	**2**	**3**	**4**	**5**	**6**
Medical Specialties	45%	34%	18%	2%	1%	0%
Other Professional Providers	51%	34%	12%	2%	0%	0%
Other Providers	15%	11%	45%	0%	29%	0%
Other Specialties	52%	27%	20%	2%	0%	
Primary Care Specialties	49%	34%	12%	4%	1%	
Surgical Specialties	35%	38%	22%	4%	0%	0%

For many specialties, it appears that most physicians contract with one or two health plans, providing potentially slightly more over overlap between health plan networks than is evident for hospitals.

Going forward, it is recommended that the data collected in Addendum 2 during the annual renewal negotiations become more standardized. Additionally, for our second report, we will

survey the health plans directly to collect the specific data necessary to fully measure the access provided by each health plan and the potential disruption that could occur if the current mix of health plans changed.

Provider Discounts

Segal participates in the Uniform Data System (UDS), which collects and tracks provider discounts for the major national health plans. Due to its national focus, many of the current ETF health plans do not provide data to the UDS. However, we are able to evaluate how competitive the national carriers are relative to each other, which provides an indication of whether a single carrier could provide the most competitive discounts across the State, or if a regional approach would be required in order to maximize provider discounts.

The following table shows aggregate provider discounts as reported by each carrier.

	Carrier A	Carrier B	Carrier C	Carrier D
Eau Claire	22%	22%	24%	16%
Green Bay	38%	27%	34%	43%
LaCrosse	18%	10%	13%	20%
Madison	38%	21%	29%	40%
Milwaukee-Racine	45%	38%	35%	50%
Oshkosh-Neenah	32%	24%	25%	41%
St. Paul, MN-WI	32%	24%	39%	39%
Wausau	25%	15%	16%	23%
Overall	**36%**	**24%**	**28%**	**39%**

This preliminary review indicates that one carrier has the best discounts in the majority of State. Of particular note is how competitive this carrier is in Madison and Milwaukee, where the majority of State employees reside. However, other carriers are more competitive in other areas of the State. The UDS data does not account for ETF-specific utilization patterns and health risk. This would need to be considered in order to arrive at a more conclusive outcome. Additionally, a complete analysis requires pricing information from local health plans in the State.

For our second report, we plan to survey the current ETF health plans to better understand their overall provider contracting and discount competitiveness and how that compares with this preliminary assessment on basis that accounts for ETF utilization patterns and health risk.

Survey of Current Health Plans

In the winter/early spring of 2015, Segal surveyed the current ETF health plans on their current practices, capabilities and upcoming initiatives. We received responses from:

- Anthem Blue Cross and Blue Shield
- Dean Health Plan
- Group Health Cooperative of Eau Claire
- Group Health Cooperative of South Central Wisconsin
- Gundersen Health Plan
- Health Tradition Health Plan
- HealthPartners
- Humana, Inc.
- Medical Associates Health Plans
- MercyCare Health Plans
- Network Health
- Physicians Plus
- Security Health Plan of WI Inc.
- UnitedHealthCare
- Unity Health Plans Insurance Corporation
- WEA Trust
- WPS and Arise Health Plans

With a group this size, it should come as no surprise that there is a wide range of responses for some topics.

Capitation Practices

Most health plans have capitation arrangements with a select number of providers, or for targeted services. However, a few health plans widely utilize capitated arrangements. The following table shows the number of health plans that capitate various types of services.

	<0% – 20%	21% – 40%	41% – 60%	61% – 80%	81% – 100%
Primary Care Providers	9	0	2	2	4
Specialists	10	0	1	4	2
Facilities	9	3	1	3	1

Book of Business

Several health plans report a large component of their book of business (BOB) is with ETF and all but the more national health plans report near 100% of their membership resides within Wisconsin. All plans report strong renewal rates.

2014 BOB represented by ETF	0 – 10%: 8 10 – 30%: 7 30 – 38%: 2
2014 BOB from members located in Wisconsin	0 – 10%: 2 90 – 100%: 15
2014 to 2015 renewal rate	One at 75%, with the rest 90%+

Rate Tiers

Most of the health plans report that their customers utilize a 2 (Single/Family) or 4 (Single/EE+Spouse/EE+Child(ren)/Family) tier rating structure. With ETF being a significant piece of their business, we would expect a non-ETF membership would show a much higher 4-tier percentage.

2 or less	46.7%
3	13.3%
4	40.0%

Self-Insurance Support

We asked the plans if they could provide administrative services only (ASO) if ETF opted to self-insure the program and 15 indicated they could, but only 13 reported having experience in providing ASO services.

The larger national carriers, as well as some of the local plans, report significant experience in providing ASO services, having large self-insured memberships and several very large group customers. The smaller local health plans reported less experience, especially in serving large public sector groups.

Provider Networks

Eleven (11) of the plans report that they manage their own networks, while six report utilizing leased networks to some degree.

Only two plans report that their providers are exclusive to their network. Providers that participate in other plans may contract with multiple plans. Our analysis of the WHIO data indicates that physician contracting with multiple plans is not widespread. However, it does not appear to be contractually prohibited (to any great degree) and should ETF decide to implement a strategy that results in vendor consolidation, market forces could very well result in a change in contracting practices.

Most of the current ETF health plans employ some measure of risk sharing, but there is a significant portion that do not.

Shared Risk only	23.5%
Full Risk only	5.9%
Both Shared & Full Risk	41.2%
No Risk Sharing	29.4%

Tiered Provider Networks

There is movement towards developing tiered networks of preferred high quality providers. However, most of the plans are not currently able to support a tiered network strategy. Those considering a tiered network expect to be able to implement it by 2017.

Providing currently	29.4%
Considering	35.3%
Not Planning to Provide	35.3%

Those that currently provide tiered provider networks utilize a range of approaches, from withholding a portion of provider payments to fund a bonus payment pool, to leveraging provider payments based on performance against outcome-based metrics, to simply designating certain providers as high-quality without providing enhanced payments to those providers. All health plans currently providing a tiered network option indicated that they can provide a customized tiered network.

Centers of Excellence

All of the health plans report utilizing centers of excellence (COE) for certain high cost highly specialized procedures. Transplants are the most common procedure utilizing the COE approach, with 13 health plans reporting. Other procedures include:

- Bariatric surgery
- Cancer
- Cardiovascular
- Transplants
- End Stage Renal Disease
- Knee replacement
- Hip replacement
- Back surgeries
- Heart bypass

All health plans report they are continuing to expand the list of procedures provided utilizing the COE approach.

Members are generally incented to utilize the higher performing providers and COEs with lower cost sharing and enhanced benefits in the preferred network.

PBM Coordination

All of the health plans report that they accept and utilize pharmacy claims from Navitus. Daily data updates are sufficient for care coordination and health management. However, for purposes of administering the Health Savings Accounts with the High Deductible Health Plan, real time integration is the industry standard.

It is of particular concern that some of the health plans update less frequently than once-per-day. One indicates daily updates, Monday through Friday, but another reports performing weekly updates.

Real time	11.8%
Multiple times per day	0.0%
Once per day	70.6%
Less than daily	17.6%

The health plans report a wide variation in practices and initiatives. Some are near the head of the pack with industry leading programs and operations, while others lag behind even basic practices. We recommend that ETF tighten the requirements on health plans to assure more frequent updates of PBM utilization.

Additional Discussions

Our review to date consists of meetings and discussions with many of the current ETF vendors, including each health plan providing an option under the Uniform Benefit Design and Navitus. We have had discussions with the major national carriers, focusing on their ability to provide a statewide (and national) network and to assess the opportunities for introducing more uniformity in care management across the membership. Based on this carrier feedback, we have begun to evaluate how the State should expand the degree of self-insurance in the ETF program.

While the discussions were high-level in nature and the topics discussed are more relevant for our second report, which will include recommendations for 2017 and beyond, we are in a position to provide a few comments and observations:

- Four national carriers report they can provide a comprehensive statewide (and national) network of providers, although some expressed some difficulty in the Madison market in negotiating competitive contracts with more than one major provider group
- Five national carriers provide comprehensive care management programs that utilize data-intensive risk profiling, predictive modeling and risk stratification methodologies
- Five national carriers have significant membership enrolled in consumer directed health plans
- Five national carriers have implemented, and continue to develop, value-based provider payment programs to reward quality and the delivery of efficient care, although the strategies utilized vary

- Five national carriers report significant membership enrolled in programs with value-based benefits designs and features
- Five national carriers report robust member services departments that can support the ETF membership
- Five national carriers have experience in providing medical benefits on a self-insured basis to large state health plans, like ETF

We will continue to canvas the market to best determine how the ETF program can take advantage of opportunities in the market and develop its own initiatives to drive positive change in the market.

Self-Insurance Concepts

Segal has reviewed a wealth of information related to the current financing of the ETF program. Two medical plans are currently self-insured, the Standard Plan and State Maintenance Plan, but enrollment is less than 5% of the total membership, with many of the members in these being out-of-state retirees. With retirees comprising a much larger portion of the membership for these plans that for the plans supporting the Uniform Benefit Design, the experience and performance of these self-funded plans is not very relevant in projecting the impact of self-insurance on the broader plan population.

ETF moved to a self-insured approach with the pharmacy program in 2004. Results appear to have been successful. With Navitus contracted as the Pharmacy Benefit Manager, ETF has a transparent program providing full access to claims data, a partner that is both flexible and proactive in managing costs on behalf of ETF, and a uniform plan experience for all members wherever their location. This same migration to self-insurance is currently under way for the dental benefits, with an RFP to be released this year. Thus, ETF does have self-funding experience.

With the above in mind, our review concentrates on the fully-insured managed competition health plan model ETF has had in place since 2004. The model was designed to encourage competition among the health plans and, in theory, to reduce the corresponding premium rates charged to ETF. There are primarily four steps in the annual rate setting process for these fully insured health plans. Below is a brief summary:

- **Estimated Rate Bids:** Health plans submit estimated rates in early May. This submission is not binding and simply a high-level expectation of what the plans believe their renewal will look like. In our opinion, these submissions are obviously at a very high level and add only minimal value to the process, except to indicate that the health plan intends to participate for the next year.
- **Health Plans Submit Experience Reports (Addendum):** This is the only data submitted to ETF from the plans to support their rate submissions. The submission includes experience reports, enrollment summaries, trends, administrative load and profit margins. Note that no claims or encounter data is submitted and none of this information is reconciled or audited.
- **Preliminary Rate Bids:** Due in early July, the plans present their first rate submissions. This is the starting point for the renewal process. From these bids and the Addendum, the plans are risk adjusted and placed in pricing tiers, 1, 2 or 3. Plans in tier 1 will have the lowest employee contribution rates, incenting employees to choose that option.
- **Best & Final Rate Bids:** Plans are notified of their current tier placement and told what rate movement is required to move them into Tier 1. With this information, health plans are to submit a final rate submission. No further negotiations occur after this point.

For 2015, every plan was placed in Tier 1. We understand that the original intent of the tiering process was to merge quality and cost metrics, highlighting plans and carriers with superior performance by placing them in the lowest tiers that reward participants with lower rates to select those plan options. It appears instead that the tiering process is now being utilized primarily as a rate negotiation tool.

In 2013, Deloitte Consulting, LLP conducted a review of the process and estimated "that the current managed competition and tiering program saves the State a minimum of 4-5% of premium". It appears that this result was calculated by comparing the Preliminary Rate Bid to the Best & Final Rate Bid. Although submitted rates drop 4-5% on average during this process, in our opinion the Preliminary Rate Bids are at risk of being artificially high. Under this process, health plans have limited incentive to submit a fully competitive rate on this first pass, since ETF later informs them of where they need to be to get to Tier 1. In addition, the tier breakpoints are built off these original submissions, so there is additional incentive for the plans to come in high, pushing the breakpoints higher.

The true savings that result from the managed competition model are difficult to calculate at this point in time. Over the past few years, the plan has experienced rate increases under the industry norms, but at that same time, benchmarking has shown the cost of program to be on the high end of the range. As we discuss the opportunities to self-insure the program there are number of elements to consider.

What Are the Benefits of Self-Insuring?

There are several reasons why employers choose the self-insurance option. The following are the most common reasons and primarily financial:

- **Elimination of most premium tax:** There is no premium tax on the self-insured claim expenditures. Premium tax is applied only to the stop loss premium, which would not be applicable for ETF. This is approximately 2% in the State of Wisconsin.
- **Elimination of Affordable Care Act (ACA) Market Share Fees:** This fee was introduced by ACA and will apply to all fully insured medical and/or dental business. The fee is to be divided between all health insurance issuers and expected to increase beyond 2018. This fee is not applicable to self-funded health plans. This is approximately 2% of health premiums.
- **Lower cost of administration:** Employers find that administrative costs for a self-insured program administered through a TPA are significantly lower than those included in the premium by an insurance carrier or health plan.
- **Carrier profit margin and risk charge eliminated:** The profit margin and risk charge of an insurance carrier/health plan are eliminated for the bulk of the plan. Normally these represent 2-4% but upon our review of various Health Plan Market Reports, it appears to be lower in Wisconsin.
- **Cash flow benefit:** The employer does not have to pre-pay for coverage, thereby providing for improved cash flow. The employer also maintains control over the health plan reserves, enabling maximization of interest income that would be otherwise generated by an insurance carrier through the investment of premium dollars.

There are also other non-financial reasons plans choose to self-insure their programs. These include:

- **Control of plan design:** The employer has complete flexibility in determining the appropriate plan design to meet the needs of the employer and employees. The employer can redesign the plan at any time.

- **Data collection:** A key element of a self-insured program would be to receive detailed claims and encounter data, allowing ETF to more effectively manage their financials. This is a major problem of the program right now and the plans currently claim confidentiality issues prevent them from providing full data about ETF's plan.
- **National provider network:** The third party administrator for a self-insured plan should be able to offer a national integrated program of networks for retirees and out-of-state workers. While some out-of-area coverage is available now, the self-insured program essentially has no arbitrary plan boundaries.
- **Custom Provider Network:** The employer is free to contract with the providers or provider network best suited to meet the health care needs of its employees. It also allows the plan to initiate pilot program or value based initiatives.
- **Mandatory benefits are optional:** State regulations mandating costly benefits are optional because self-funding is regulated by federal legislation only. *(Note: mandated benefits would typically not apply to ETF, although ETF may be included in the scope of state legislation.)*
- **Cost reporting:** The TPA should provide a monthly detailed reporting of costs, by department or location, and by type of medical service. Utilization and lag reports should also be available.

What Are Some of the Issues?

By reviewing the advantages listed above it would seem like a fairly straightforward decision to self-insure the program. Within your current environment it is not that simple. There are a number of factors that need to be considered.

- **Health Plan Contracting:** although the health plan survey reports indicate that the providers are paid the same under either an insured or self-insured arrangement, we are not convinced that the overall levels of discounts would be maintained.
- **Care Management:** there is currently wide variation in practice patterns among the plans. There may currently be advantage in the gatekeeper process initiated by some plans.
- **Current Program Design:** the current large number of health plan vendors makes it virtually impossible to manage a self-insured design. Additionally, the data is not available to accurately develop the rates.
- **Disruption:** if the plans were to be collapsed to fewer carriers to better allow self-insuring the program under its current separate health plan configuration, there would likely be disruption to members in providers they currently have under contract.

None of the above issues appears to be insurmountable for the long-term. Under the current structure, simply self-insuring all of the existing health plans would be difficult to achieve and a likely setup for overall program failure. With that said, program changes could result in our recommendation to self-insure the entire program long-term, either through a combination of health plans or through a single network provider and third party administrator. That topic will be reviewed and be a significant element of our next report.

Which States Self-Insure Their State Employee Health Program

Segal reviewed a report from the National Conference of State Legislators (www.ncls.org). It reported that 46 (92%) of the 50 states now self-insure and/or self-fund at least one of their employee health care plans (including Wisconsin). At least 20 states (40%) self-fund all of their health plan offerings, indicated below as [♦].

As of the 2010 NCSL report, the self-funding states are:

Alabama ♦	Illinois	Nebraska	South Dakota ♦
Alaska ♦	Indiana	Nevada	Tennessee ♦
Arizona	Kansas	New Hampshire ♦	Texas
Arkansas ♦	Kentucky ♦	New Jersey	Utah
California	Louisiana	New Mexico ♦	Vermont ♦
Colorado	Maryland	North Carolina ♦	Virginia
Connecticut	Massachusetts	Ohio	Washington
Delaware ♦	Michigan	Oklahoma ♦	West Virginia ♦
Florida	Minnesota ♦	Oregon	Wisconsin
Georgia	Mississippi ♦	Pennsylvania ♦	Wyoming♦
Hawaii	Missouri	Rhode Island ♦	
Idaho ♦	Montana ♦	South Carolina	

All states with self-funded plans contract with outside vendors to provide some type of administrative service. Services include claims payment, utilization review, disease management and pharmacy benefit management.

What the Health Plans Say

Segal reviewed the RFI from 2013 and supplemented that by a survey this year of the current health plans. The RFI suggested that most of the plans could operate in a self-insured environment and currently have groups in that arrangement. The RFI also suggested that the provider reimbursements would be similar under either insured arrangement.

In order to validate the RFI, Segal has participated in calls with many of the health plans and has since issued a survey to the health plans to gather key information and responses. As part of that survey we asked the following questions:

Can you operate under a self-insured arrangement?

Answer Options	Response Percent	Response Count
Yes	88.2%	15
No	11.8%	2
Answered question	**17**	**17**

Have you had experience operating in a self-insured environment?

Answer Options	Response Percent	Response Count
Yes	81.3%	13
No	18.8%	3
Answered question	**16**	**16**
Skipped question	**1**	**1**

From this response it appears that 16 of the 18 plans currently operate in a self-insured environment. We then wanted to find out about their providers and contracting strategy.

Are your providers exclusive to your organization only?

Answer Options	Response Percent	Response Count
Yes	11.8%	2
No	88.2%	15
	Answered question	**17**

The vast majority of providers are not exclusive to the Plan and currently contract with other organizations. In the event ETF were to self-insure the benefit program, we would expect the two organizations that indicated they have dedicated network providers to negotiate on behalf of their providers if the structure changes.

We also asked questions to determine if the plans are handling high quality tiered networks, where provider quality becomes a factor in the financial contracts and participation in the network.

Are you providing or planning to provide any tiered provider networks?

Answer Options	Response Percent	Response Count
Providing currently	29.4%	5
Considering	35.3%	6
Not Planning to Provide	35.3%	6
	Answered question	**17**

What is the expected time frame for implementation of a narrow network?

Answer Options	Response Percent	Response Count
2015	53.8%	7
2016	23.1%	3
2017	15.4%	2
Later than 2017	7.7%	1
	Answered question	**13**

Currently more than 50% provide a tiered network option and are looking to further expand these networks.

If ETF desired a program that tiers providers, 13 of the plans report that they could administer that design.

Do you have the capability to administer a customized narrow network of physicians, ancillary providers, and/or facilities determined by the ETF?

Answer Options	Response Percent	Response Count
Yes	100.0%	13
No	0.0%	0
	Answered question	**13**
	Skipped question	**4**

The health plan responses validate their responses to the RFI. It appears that there would be little or no obstruction to operating a program in a self-insured environment and that the health plans have the capability to design a tiered network with ETF.

In Summary

We have reviewed the performance of the plans and note what they have built into their recent rates. Based on the 2014 addendum, we estimate that the plans in aggregate are running at approximately a 90% loss ratio for ETF. The ratios vary considerably by plan, from a low of 70% to a high of over 100%. This is likely due to the Best & Final Rate negotiations that drive the revenue component.

As discussed earlier, there is an opportunity to lower administrative expenses and eliminate both the state premium tax and ACA "market share" fees. Deloitte estimated this to be a 4.9% savings based on the RFI information received in 2013. We would expect slightly greater upside savings due to consolidation and administrative efficiencies. At this preliminary point in the analysis, our savings are expected to range from 5% to 7%. Based on estimated state employee medical premiums, the savings would be $50 to $70 million.

We do believe that pricing will be impacted somewhat, but with the limited data available we are unable to estimate that impact. Further work on this will need to be performed for Report 2 later this year.

Recommendations

For 2016, we will be working with ETF on improving the UBD fully-insured renewal process. We will recommend an alternative negotiation strategy and different application of the tiering approach, with a goal of a more accurate assessment of the costs and efficiencies of competing health plans. We believe the health plans will need to provide a more aggressive initial quote and consideration should be given to prohibiting a health plan from negotiating into Tier 1 status if their initial submission is unreasonable or they have poor quality metrics. We are also evaluating the prospect of implementing a minimum loss ratio threshold.

Segal is in the process of revising the addenda and the health plan submissions will have additional exhibits to capture financial information. We recommend that the rates and submission be signed by their actuary and Chief Financial Officer. We also will suggest that detailed claims data be submitted with the rate submissions and be reconciled to the summary information disclosed in the addendum. This would be claims data for fee-based claims and encounter data for capitation claims. Administrative costs also will need to be identified at a greater level of detail than in the past. All of these adjustments are, we believe, imperative so ETF can better understand their cost structure and prepare for potential self-insurance.

We anticipate that the renewal strategy and approach could save as much as 1% to 3% of total cost. We do not recommend self-insuring for 2016, noting that the current program structure makes a self-insured option virtually unmanageable and that significant time will be required to determine and set up the mechanisms for data reporting and contracting.

For 2017, our subsequent report will provide details on a recommended plan design structure, with early indication that a regional market approach could benefit ETF. We do believe that the entire program could be self-insured in the appropriate structure. If that occurs, ETF will realize the savings from self-insurance discussed earlier, as well as any recommended overall programmatic changes.

WHIO Database

As part of its initial report, Segal has begun reviewing the Wisconsin Health Insurance Organization (WHIO) database to identify how that extensive collection of medical and pharmacy data for patients across Wisconsin can best be utilized for efficient management of ETF's health plan.

There are numerous broadly marketed and proprietary data warehouse tools available to employer health plans in the marketplace. WHIO utilizes one of those data warehouse platforms—Optum (previously known as Ingenix) – for its primary functions.

We believe the first step in understanding how WHIO might be applied to manage the ETF health benefit plans is to understand what a data warehouse tool should do and what functions it should have.

Features of an Ideal Claims Data Warehouse Tool

An ideal data warehouse tool should be able to turn medical, dental, prescription drug and other related claims data for employer sponsored plans into actionable insights that help plan sponsors improve population health while maintaining or controlling costs.

Ideally the tool should be able to accept a broad array of claims related data from medical, drug, behavioral health and dental plans, including coverage/enrollment, laboratory results (biometrics), health risk appraisals, EAP, nurseline usage, employee opinion/satisfaction surveys, disease management, laboratory, illness/absence, FMLA, disability and workers' compensation data, to name the most common.

It should also be capable of customizing output and reporting from across all plans such that reports will include both common variables and client-defined variables. Common variables include attributes such as gender, age, relationship, type of service, place of service, provider type, and provider specialty. Client-defined fields can include attributes such as employee status, work location, product, union/non-union status, business unit, job function, etc.

Other features of an ideal data warehouse tool include:

- Fully web-based platform with a secure delivery model that makes the data warehouse accessible to the end user at any time (24x7)
- Extensive drill-down and drill-across capabilities to support the highest level of analysts and "power users" researching detailed utilization and connection of claims into episodes of care
- Continual benchmarking against national, state and local norms where available. The data warehouse should also provide normative reports using book of business data, adjusted for risk when necessary.
- Executive/Operational level dashboard reports designed to provide quarterly or more frequent summaries and cost mitigation opportunity identification, including identification of trends based on selected key indicators, cost and utilization norms, and episodes of care – with both cost and prevalence based standard reports

- Strong longitudinal tracking at the patient level over multiple years to allow analysis of developing trends and program response to plan sponsor initiatives.
- Forecast and modeling of likely claims experience, based on captured experience in the data warehouse
- Incurred and paid claim options on all reports.
- Demographic splits to allow analysis based on selected member characteristics, such as age, gender, location, family status, etc., for all plans and plan types.
- Ability to identify total paid claims costs for each type of plan being tracked.
- Ability to identify costs by major clinical categories and drug therapeutic classes
- Reporting on clinical gaps in care compared to established national or regional practice norms
- Ability to analyze burden of illness
- Ability to analyze provider level costs vs provider quality reporting
- Surgical and pharmaceutical treatment comparisons
- Capability to provide cost and utilization reports rated on both a per-member and per-month basis.

Additional Details

The following sections provide additional description of specific aspects of a fully functional data warehouse for an employer sponsored health benefits program.

Medical and Inpatient Claims

These program areas include medical, mental health, vision, dental, inpatient and substance abuse claims. The data comprise individual service records, where every line item from each claim is broken out into its own individual record. This structure enables the ability to drill down on a specific service provided by a specific physician for a specific patient on a specific day.

Inpatient reporting should allow the customer to:

- Provide a comprehensive view of the types and durations of acute care inpatient hospital stays
- Link facility, ancillary and physician claims together to create a complete inpatient confinement
- Categorize admissions into a diagnosis related group (DRG) as a foundation for case mix adjustment
- Compare admission rates and average length of stay (ALOS) among networks, providers, or vendors and against regional and plan-specific norms

Eligibility

Enrollment data can be used in conjunction with other tables within the data warehouse to produce information such as admission rates, services per covered life, and average benefits costs per member. Eligibility reporting addresses multiple demographic information needs that go beyond the simple need for population counts, to include important information about enrollment patterns, the effect of age and gender on a plan's experience, and the potential costs for changes in benefits that affect certain populations.

Prescription Drug Claims

Data collected for prescription drug claims should include claimant and expense information, prescription number, physician DEA number, pharmacy number and type, an indicator to identify how the drug was dispensed, and the National Drug Classification (NDC) code. In addition to the PBM data, the vendor should also use clinical and average cost data from Wolters Kluwer Clinical Drug Information, Medi-Span or First Databank's National Drug Data File (NDDF).

With pharmacy reporting, the plan sponsor should be able to:

- Monitor overall costs and utilization of prescription drug plans (mail order and retail)
- Determine effective discount amounts by using the Average Wholesale Price (AWP)
- Evaluate the opportunity or success of formularies, if data is provided
- Provide detailed claimant information on prescription drug use, which can then be used to cross reference medical experience
- Evaluate refill experience of mail and retail programs
- Review top drugs (volume or benefit paid) by retail versus mail programs
- Evaluate pharmacy network adequacy and cost-sharing
- Allow identification of type of disease and correlate to prescription drug information to determine whether clinical, demographic and provider characteristics influence prescribing patterns
- Understand drug use under inpatient and outpatient settings, including hospital use patterns, switching behavior, combination therapy and patient characteristics. This can be used to determine if therapies would improve clinical and overall cost outcomes.

Clinical Conditions and Population Risk

The data warehouse platform should offer a clinical risk grouper as a standard part of the analytical package. A clinical risk grouper allows the warehouse to analyze claims for each individual to assign a risk level based on the severity of the illness and whether the person has diagnoses for a single or multiple illnesses. The risk assignment provides a foundation for all episode-based reporting and analysis, risk stratification for individuals and groups, assigning risk on both a concurrent or prospective basis (enabled by Predictive Modeling), and evidence-based medicine guidelines to identify areas of care where intervention will lead to improved physician compliance with treatment guidelines and member compliance with prescribed treatment. This

measurement and risk assignment capability enables clients to reduce health care costs while improving the health of their members.

Every vendor in the data warehouse space should offer clinical groupers. Below are examples of commercially available risk groupers along with the acronyms that are often used to identify their particular approach.

Company	Risk Grouper
CMS	Diagnostic Risk Groups (DRG) (There are a number of subsequent "refinements" to the original DRG model)
CMS	Hierarchical Condition Categories (HCC)
3M	Clinical Risk Groups (CRG)
UC San Diego	Chronic disability payment system (CDPS) Medicaid Rx
Verisk Sightlines	DCG RxGroup
Optum Insight	Episode Risk Groups (ERG) Pharmacy Risk Groups (PRG)
Optum Insight	Episode Treatment Groups (ETG)
Johns Hopkins	Adjusted Clinical Groups (ACG)
Wakely Consulting Group	Wakely Risk Assessment (WRA)
Healthcare Cost and Utilization Project (HCUP)	The Clinical Classifications Software (CCS)

Episode grouping and predictive modeling capabilities should be fully integrated within the solution and facilitate the clinical evaluation of care by linking together medical and drug experience related to a single condition. Grouping methodology is invaluable in understanding the effect of major diseases and care management programs, and risk stratification for individuals and groups.

In addition, there should be a standard integrated "Gaps in Care" methodology that is a quality of care assessment tool, connecting evidence-based medicine with claims data to evaluate compliance with established clinical guidelines in patient care. This kind of report presents opportunities to both reduce health care costs and improve the quality of medical care that patients receive.

In a nutshell, the data warehouse tool should be able to assist the plan sponsor in making decisions on a new or existing clinical programs (e.g. wellness, disease management, onsite clinics, etc.), as well as in evaluating the impact or return on investment (ROI) of these programs after they have been implemented.

Provider Level Reporting

Using the clinical risk groupers and risk adjustment methodology mentioned above, the data warehouse tool should be able to provide provider level reporting to allow the plan sponsor to:

- Determine providers with highest patient volume and costs
- Measure efficient use of costly healthcare resources against expected levels using risk models to adjust for population differences
- Drill down to population, provider group, individual provider and patient-level detail
- Benchmark cost, quality, and efficiency against national norms
- Create and evaluate narrow networks with a more limited number of providers

Financial Reporting and Budgeting

The data warehouse tool should be able to support the various aspects of plan financial management, including:

- Development of accrual rates (premium equivalents)
- Cost allocation
- Budgeting
- Development of contribution rates
- GASB OPEB reporting
- Evaluation of plan caps

Claims paid data, when coupled through a data warehouse with other financial data such as administrative fees, fully insured premiums, self-insured premium equivalents, and employee contributions, will allow segmented analyses (e.g., by plan, by business unit, by employee type) to assist benefit managers and financial analysts in all aspects of plan financial management.

Total Health and Productivity

The data warehouse analytical tool should ideally have the capability to access non-occupational disability, workers' compensation, and time and attendance cost and utilization information in a useful, informative, and comprehensive format. Standard and customized reports from the warehouse should allow the client to assess the entire range of direct and indirect costs. This should be supported by the ability to analyze the most costly and disruptive diagnoses across all types of coverage, incidence of lost work time and duration associated with specific job titles, and track usage of vacation or holiday time. The ideal data warehouse system should enable the plan sponsor's ability to:

- Measure the impact of diseases on absenteeism, long- and short-term disability, and workers' compensation
- Track total healthcare costs across both medical and workers' compensation systems
- Estimate the potential return on investments in wellness or disease management programs

- Assess the impact of a child's or spouse's illness on employee absence
- Determine the relative costs of alternative pharmaceutical and medical device interventions, considering both group medical costs and absenteeism costs
- Develop predictive models that help define relationships between demographic factors and health and productivity outcomes

Lab Data

The warehouse should include the ability to capture lab testing. This will help the plan sponsor understand treatment patterns between patients whose disease is under control and those that are not. It will also help the sponsor understand the effectiveness of a drug therapy through the ability to compare diagnostic test results prior to the initiation of drug therapy and those after the therapy has been implemented.

Health Risk Assessment Data

An ideal health data warehouse should allow analysis of the contribution of patient behavior on health outcomes, as well as the analysis of the health and productivity of various patient cohorts. The system should provide means to reconcile the information gathered about members through a health risk assessment (HRA) with other data sources.

Supplemental Medicare and Medicaid Analyses

The ideal system should include supplemental data on large-scale populations with Medicare coverage and eligible for Medicaid benefits. This broad data set will allow the plan sponsor to profile its plan experience with the healthcare experience of Medicare retirees with supplemental insurance. The Medicare supplemental data should include detailed cost, use, and outcomes data for healthcare services (inpatient and outpatient settings and prescription drug claims).

The system should also contain broad based medical and prescription drug experience of Medicaid enrollees. Because of the volume of reported data nationally, as well as within Wisconsin, this component of the warehouse allows the plan to compare itself to standard demographic variables, such as patient age and gender as well as factors of particular value to researchers investigating Medicaid populations, such as aid category (e.g., blind or disabled, Medicare eligible). This will enable the ability to assess trends in healthcare cost, utilization, and outcomes for diseases that strike broadly across all populations, such as asthma, cancer, and cardiovascular conditions. It will also enable the analysis of disease conditions that are especially prevalent among Medicaid populations.

Benchmarking and Normative Comparisons

The tool's normative dataset should be large, multi-year and comprehensive with respect to important characteristics such as geographic dispersion, industry representation and diversity of health plan design (indemnity, PPO, POS, HMO), claim administrators and PBMs.

Norms can be a combination of purchased industry norms and the vendor's proprietary normative data, such as book of business. All standard reporting should have a column on normative benchmark, with the ability to adjust norms by geography, age and gender.

Data Quality Management

Meaningful data analysis is contingent upon the availability of clean, quality data, the right reports, the appropriate methodology and knowledge to draw the correct conclusions.

Quality assurance in the data warehouse should include:

- Validation of raw data upon receipt from each carrier
- Quality assessment of data after being imported into the tool
- Acceptance testing to verify loaded data history, trend, and populations
- Spot testing of report outputs to assure proper consolidation and comparison of data fields.

Fully Compliant with HIPAA

Because the health data warehouse deals with detailed claims and enrollment information containing protected health information (PHI) and its variants , the system must meet strict criteria for limited-use data sets. Reports and output should contain none of the data elements prohibited by HIPAA for such data sets. The overall system should support privacy and security to protect patient-level, provider-level and data contributor-level data in accordance with all regulatory requirements.

How WHIO Compares with Best Practice Data Warehouse

Given the short time from our receipt of actual WHIO data to the date of this report, we have made a first level review of the WHIO data and offer the following observations:

- WHIO has contracted with Optum (previously known as Ingenix) to provide the platform for its data warehouse. Optum is a recognized and respected purveyor of such products.
- The WHIO datamart was useful to us in developing preliminary high-level analyses of disease prevalence, assessment of clinical compliance care gaps and analysis of health risk among the Wisconsin populations covered in the database.
- Not all of ETF's contracted health plans provide data to WHIO, so some portions of the ETF population are not represented in the reporting.

- The WHIO database does not include full financial information. Most of the health plans report only encounter data without specific fees or costs for the services, provider discounts or administrative cost loads. Once the data is received, WHIO assigns a price per service that does not reflect the carrier's actual reported cost. This makes the system of limited value for financial management of ETF's health plans, a key requirement in any health plan data warehouse.
- There are apparent inconsistencies within the WHIO database. Utilization, disease prevalence and care compliance metrics vary widely among the current ETF vendors, more that would be expected among health plans administering the same uniform plan design for a reasonable broad distribution of state and local government employees and retirees. At this point it is not clear to what extent WHIO is engaged in conversations with the contributors to ensure data consistency throughout the entire database.
- The Datamart standard report sets are designed for reporting primarily to health plans submitting data to the database, not for managing an employer health benefit program.

These gaps place limitations on ETF's ability to use WHIO to analyze opportunities for population health improvement while maintaining or controlling costs. Being able to reliably link plan and member costs to utilization and quality metrics would greatly improve ETF's ability to manage the health care plan.

Based on the initial analysis, we suggest the following approaches as possibilities for ETF to consider with regard to WHIO as a health plan management data warehouse:

<table>
<tr><th colspan="2">Option 1:</th></tr>
<tr><td colspan="2">ETF works with WHIO and Optum to expand the WHIO capabilities, reporting and data array for WHIO to become the data warehouse for ETF.
This would require expansion of the data sets being reported by each carrier, addition of a requirement that to be approved as an ETF health plan, a carrier must submit full data to WHIO, addition of financial claims and discount data to the current WHIO data set, and expansion of standard and ad hoc reporting capability for ETF use of the data.</td></tr>
<tr><th>Benefits</th><th>Concerns</th></tr>
<tr><td>• This approach utilizes an existing system with a recognized data vendor that provides similar employer data services to other large public entities.
• Data will be integrated for all Wisconsin health systems, including those not currently participating
• ETF will not need to bid, contract, learn or support a separate system
• The state already funds part of the WHIO costs, so the additional costs should be incremental
• ETF already has representation on the WHIO board
• Standard and ad hoc reporting developed for ETF could be made available to other WHIO users (without providing access to the financial data)</td><td>• Sensitive financial data will need to be appropriately firewalled from other WHIO users so that only ETF staff and their approved consultants and actuaries have access
• Health plans may not be willing to provide full financial details to a composite data warehouse
• Additional work and cost by Optum as system host would be required to reconcile and test the additional data being submitted; that cost would need to be borne by ETF or by a combination of users</td></tr>
</table>

Option 2:	
ETF continues to use WHIO for clinical and enrollment reports, but collects and develops plan financial information independently ETF would make use of available data, but not attempt to integrate the financial information into the data warehouse	
Benefits	**Concerns**
• This approach will provide an ability for WHIO to address the gaps in financial data without having to implement a separate system or substantially augment the WHIO system • ETF can perform some of this analysis starting at any time.	• Integration of ETF-developed financial data with WHIO Datamart would be a challenge, involving a full data dump and analysis of WHIO data in a separate environment. • Norms and best practice results from Optum's WHIO product would be lost. • ETF may have limited ways to tie its specific financial information back to member specific claims and encounter information from WHIO
Option 3:	
ETF bids and contracts a new data warehouse system with a qualified contractor. ETF would develop its own contract and warehouse specifications and bid the contract.	
Benefits	**Concerns**
• ETF can specify data warehouse requirements to meet best practices including integration of other data sources (such as lab, absence management) • An experienced data warehouse vendor may have more success in ensuring uniform data submission and therefore consistency in the database between plans • ETF could determine the level of analytical capabilities it desires from its warehouse and focus on aspects that make the most business sense. • Data warehouse services have become more efficient over the years and bidding a new contract may net ETF a better market price than the existing WHIO pricing • Using a commercial vendor with a strong public sector client commitment may allow a broader array of benchmarks relevant to ETF's particular situation.	• This will be a more costly option for ETF and the State because ETF is bearing the full cost of the warehouse for its own benefit • The norms and benchmarks may not be as Wisconsin-specific as those in WHIO • Bidding, contracting and implementation will take time • In the current multiple health plan environment, ETF may find some of its plans unwilling or unable to provide the level of data reporting required in the specifications.

Option 4:	
ETF builds its own data warehouse ETF would identify the data needed and construct the platform, programming, reporting and quality processes to operate the system.	
Benefits	**Concerns**
• The data warehouse can be custom designed to meet ETF's exact needs and to eliminate data elements not directly germane to employer health plan operation and analysis • Dedicated staff may have more success in ensuring uniform data submission and therefore consistency in the database between plans. • ETF would own its own plan data.	• A significant amount of time and effort would be required to design and develop the specifications and processes, even before any programming occurs. • ETF would require dedicated staff with highly specialized experience to design, build, operate, maintain and fix the system. • ETF would also need to staff for turnover and succession to keep the system running when personnel changes do occur. • The cost for building a system from scratch would likely far exceed that of purchasing a marketed system from a qualified vendor in that business, particularly with the wide range of very capable and flexible systems in the market today. • ETF would not have access to norms for Wisconsin, Medicare, Medicaid or other national measures without additional cost to purchase sets of those norms. • ETF would not have book of business comparators • This approach would require a long-term commitment by ETF and the state to funding the data warehouse. If funding is reduced or lost, the system would become unusable very quickly, where with a commercial vendor, there would at least be the possibility of moving to a lower level data product without losing the value of the analyses already developed.

Segal suggests that establishing a secure and comprehensive data warehouse is essential for long-term financial success of a state level health benefit program, as well as for the improvement of participant health to drive lower health cost trends. We recommend that ETF actively discuss these possible approaches and determine a supportable course of action. Further, we believe the process should move ahead to either augment WHIO or contract an ETF data warehouse to be implemented for 2017. Further analysis of this topic will be included in the second Segal report for 2017.

Appendix 1: Detailed Benchmarking Data Comparison

This section presents the comparisons to other state health plans and the Federal employee program.

Methodology and States Compared

For the comparison of state benefits, we utilized the data collected annually for the *Segal Study of State Employee Health Benefits*. This data includes information for state health plans on costs, premiums, plan designs and related issues. The Segal state study data covers all states and the District of Columbia and reflects benefits offered to active, full-time employees of state jurisdictions.

The most recent complete data in our database is for plan years starting in 2014 (many states operate their health plans on a fiscal cycle different from the calendar year, so publication of information about the plans occurs across a number of months each year). We therefore based our analysis on the 2014 ETF medical and pharmacy benefits and costs to maintain comparability.

For the comparison to state health plan benefits and costs, we focused on the states in the immediate regional vicinity of Wisconsin. Segal and ETF staff identified the following five states for the regional peer group:

- Illinois
- Indiana
- Iowa
- Michigan
- Minnesota

The following tables show how 2014 ETF benefits and premium costs compare with those for other states, both regionally and nationally, as well as with FEHB options available to Federal employees in Wisconsin.

Actuarial values are provided, as are each plan's value relative to the ETF UBD. In other words, the ETF UBD, with an Actuarial Value of 96% has a relative value of 1.00 and the ETF Standard Plan PPO, with an Actuarial Value of 93%, has a relative value of 0.97. Some figures may not fully reconcile due to rounded values being shown.

UNIFORM BENEFIT DESIGN/HMO[1]

		Regional		National	
In Network	Wisconsin	Range	Typical	Range	Typical
Medical					
Deductible					
Single	$0	$0 – $1,000	$200	$0 – $1,000	$200
Family	$0	$0 – $2,000	$400	$0 – $2,000	$400
Office Visits copay/coinsurance					
Primary	10%	$10 – $41	$20	$5 – $41	$15
Specialist	10%	$10 – $41	$35	$5 – $50	$25
Inpatient Hospital copay/coinsurance					
Copay	N/A	$100 – $500	$300	$0 – $750	$300
Coinsurance	10%	0% – 25%	10%	0% – 25%	10%
Out of Pocket Maximum[2]					
Single	$500	$750 – $3,000	$2,000	$350 – $6,350	$3,000
Family	$1,000	$1,500 – $6,000	$4,000	$1,200 – $12,700	$6,000
Prescription Drug					
Retail—Copay					
Generic	$5	$5 – $12	$10	$3 – $20	$10
Formulary/Preferred Brand	$15	$15 – $30	$25	$10 – $50	$25
Non-Formulary/Non-Preferred Brand	$35	$30 – $60	$50	$15 – $95	$45
Retail—Coinsurance					
Generic	N/A	N/A	N/A	50% – 100%	85%
Formulary/Preferred Brand	N/A	N/A	N/A	50%	50%
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A	50%	50%
Mail—Copay					
Generic	$10	$10 – $24	$20	$5 – $50	$15
Formulary/Preferred Brand	$30	$30 – $65	$50	$10 – $135	$50
Non-Formulary/Non-Preferred Brand	$105	$60 – $135	$100	$15 – $285	$90
Mail—Coinsurance					
Generic	N/A	N/A	N/A	50% – 100%	90%
Formulary/Preferred Brand	N/A	N/A	N/A	30% – 50%	40%
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A	40% – 50%	45%
Actuarial Value	0.96	0.83 – 0.95	0.88	0.77 – 0.93	0.86
Relative Value[3]	1.00	0.86 – 0.99	0.92	0.80 – 0.97	0.90

1 The HMO plan category also includes similar plans categorized as EPO and POE plans.
2 In 2014, the Affordable Care Act's Out-of-Pocket Limit was $6,350 for individual coverage and $12,700 for family coverage.
3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

PPO/POS

		Regional		National	
In Network	Wisconsin[1]	Regional	Regional	National	National
Medical					
Deductible					
Single	$200	$0 – $750	$300	$0 – $1,000	$350
Family	$400	$0 – $1,500	$600	$0 – $2,100	$700
Office Visits Copay					
Primary	N/A	$15 – $20	$20	$0 – $35	$20
Specialist	N/A	$15 – $25	$20	$5 – $70	$30
Office Visits Coinsurance					
Primary	10%	10% – 30%	15%	10% – 30%	15%
Specialist	10%	10% – 30%	15%	10% – 30%	15%
Inpatient Hospital copay/coinsurance					
Copay	N/A	$75 – $325	$250	$0 – $1,000	$300
Coinsurance	10%	0% – 30%	10%	0% – 35%	15%
Out of Pocket Maximum[2]					
Single	$800	$600 – $2,500	$1,500	$250 – $6,250	$2,250
Family	$1,600	$800 – $5,000	$3,000	$500 – $12,700	$4,500
Prescription Drug					
Retail – Copay					
Generic	$5	$5 – $10	$10	$3 – $15	$10
Formulary/Preferred Brand	$15	$15 – $30	$25	$10 – $45	$25
Non-Formulary/Non-Preferred Brand	$35	$30 – $60	$55	$25 – $100	$50
Retail – Coinsurance					
Generic	N/A	N/A	N/A	0% – 50%	20%
Formulary/Preferred Brand	N/A	20%	20%	20% – 50%	30%
Non-Formulary/Non-Preferred Brand	N/A	40%	40%	20% – 75%	55%
Mail – Copay					
Generic	$10	$10 – $25	$20	$5 – $45	$15
Formulary/Preferred Brand	$30	$30 – $75	$55	$10 – $120	$50
Non-Formulary/Non-Preferred Brand	$105	$60 – $150	$115	$25 – $250	$100
Mail – Coinsurance					
Generic	N/A	N/A	N/A	0% – 100%	25%
Formulary/Preferred Brand	N/A	20%	20%	20% – 50%	30%
Non-Formulary/Non-Preferred Brand	N/A	20%	20%	20% – 75%	50%
Actuarial Value	0.93	0.82 – 0.93	0.90	0.76 – 0.94	0.86
Relative Value[3]	0.97	0.85 – 0.97	0.94	0.79 – 0.98	0.90

HDHP/CDHP

1 For the PPO, the plan design for the Standard Plan was used.
2 In 2014, the Affordable Care Act's Out-of-Pocket Limit was $6,350 for individual coverage and $12,700 for family coverage.
3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

		Regional		National	
In Network	Wisconsin[1]	Range	Typical	Range	Typical
Medical					
HSA – ER Contribution					
Single	$170	$500 – $1,002	$600	$0 – $1,821	$500
Family	$340	$1,000 – $2,003	$1,200	$0 – $3,643	$1,000
HRA – ER Contribution					
Single	N/A	N/A	N/A	$100 – $1,250	$600
Family	N/A	N/A	N/A	$200 – $2,500	$1,200
Deductible					
Single	$1,500	$1,500 – $2,500	$1,750	$1,250 – $4,000	$1,800
Family	$3,000	$3,000 – $5,000	$3,500	$2,500 – $8,000	$3,600
Office Visits Coinsurance					
Primary	10%	5% – 25%	15%	0% – 30%	20%
Specialist	10%	5% – 25%	15%	0% – 30%	20%
Inpatient Hospital Coinsurance					
Coinsurance	10%	5% – 25%	15%	5% – 30%	20%
Out of Pocket Maximum[2]					
Single	$2,500	$3,000 – $4,000	$3,250	$1,500 – $6,350	$3,750
Family	$5,000	$6,000 – $8,000	$6,500	$3,000 – $12,100	$7,500
Prescription Drug					
Retail—Copay					
Generic	$5	$10 – $12	$10	$5 – $20	$10
Formulary/Preferred Brand	$15	$18	$20	$15 – $50	$30
Non-Formulary/Non-Preferred Brand	$35	$38	$40	$30 – $80	$50
Retail—Coinsurance					
Generic	N/A	N/A	N/A	10% – 30%	20%
Formulary/Preferred Brand	N/A	20%	20%	15% – 30%	20%
Non-Formulary/Non-Preferred Brand	N/A	40%	40%	15% – 75%	30%
Mail—Copay					
Generic	$10	$20 – $24	$25	$15 – $50	$25
Formulary/Preferred Brand	$30	$36	$35	$27 – $125	$65
Non-Formulary/Non-Preferred Brand	$105	$76	$75	$54 – $200	$115
Mail—Coinsurance					
Generic	N/A	N/A	N/A	10% – 30%	20%
Formulary/Preferred Brand	N/A	20%	20%	15% – 30%	20%
Non-Formulary/Non-Preferred Brand	N/A	20%	20%	15% – 50%	30%
Actuarial Value	0.83	0.83 – 0.86	0.85	0.74 – 0.90	0.86
Relative Value[3]	0.86	0.86 – 0.90	0.89	0.77 – 0.94	0.90

1 The Wisconsin HDHP plan became effective 1/1/15.

2 In 2015, the Affordable Care Act's Out-of-Pocket Limit is $6,600 for individual coverage and $13,200 for family coverage.

3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

Comparison to Federal Employees Health Benefits (FEHB) Program Benefits Offered to Federal Employees in the State of Wisconsin

UNIFORM BENEFIT DESIGN/HMO[1]

		FEHB	
In Network	Wisconsin	Range	Typical
Medical			
Deductible			
Single	$0	$0 – $1,000	$200
Family	$0	$0 – $2,000	$400
Office Visits Copay			
Primary	N/A	$5 – $25	$15
Specialist	N/A	$10 – $45	$30
Office Visits Coinsurance			
Primary	0%	N/A	N/A
Specialist	0%	N/A	N/A
Inpatient Hospital copay/coinsurance			
Copay	N/A	N/A	N/A
Coinsurance	10%	0% – 20%	10%
Out of Pocket Maximum[2]			
Single	$500	$3,000 – $6,600	$5,000
Family	$1,000	$6,000 – $13,200	$10,000
Prescription Drug			
Retail – Copay			
Generic	$5	$5 – $25	$10
Formulary/Preferred Brand	$15	$20 – $45	$30
Non-Formulary/Non-Preferred Brand	$35	$20 – $90	$60
Retail – Coinsurance			
Generic	N/A	N/A	N/A
Formulary/Preferred Brand	N/A	N/A	N/A
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A
Mail – Copay			
Generic	$10	$10 – $50	$20
Formulary/Preferred Brand	$30	$70 – $90	$70
Non-Formulary/Non-Preferred Brand	$105	$120 – $180	$150
Mail – Coinsurance			
Generic	N/A	N/A	N/A
Formulary/Preferred Brand	N/A	N/A	N/A
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A
Actuarial Value	0.96	0.81 – 0.92	0.85
Relative Value[3]	1.00	0.84 – 0.96	0.89

1 The HMO plan category also includes similar plans, such as EPO and POE plans.
2 In 2014, the Affordable Care Act's Out-of-Pocket Limit was $6,350 for individual coverage and $12,700 for family coverage.
3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

PPO/POS

		FEHB	
In Network	Wisconsin[1]	BCBS Standard Plan	BCBS Basic Plan
Medical			
Deductible			
Single	$200	$350	$0
Family	$400	$700	$0
Office Visits Copay			
Primary	N/A	Tier 1: $20	Tier 1: $25
Specialist	N/A	Tier 1: $30	Tier 1: $35
Office Visits Coinsurance			
Primary	10%	Tier 2: 35%	Tier 2: Not covered
Specialist	10%	Tier 2: 35%	Tier 2: Not covered
Inpatient Hospital copay/coinsurance			
Copay	N/A	Tier 1: $250/admit Tier 2: $350/admit	Tier 1: $175/day up to max of $875/admit Tier 2: Not covered
Coinsurance	10%	Tier 2: 35%	N/A
Out of Pocket Maximum[2]			
Single	$800	Tier 1: $5,000	Tier 1: $5,500
Family	$1,600	Tier 1: $6,000	Tier 1: $7,000
Prescription Drug			
Retail – Copay			
Generic	$5	N/A	Tier 1: $10 Copay
Formulary/Preferred Brand	$15	N/A	Tier 2: $45 Copay
Non-Formulary/Non-Preferred Brand	$35	N/A	N/A
Retail – Coinsurance			
Generic	N/A	Tier 1: 20%	N/A
Formulary/Preferred Brand	N/A	Tier 1: 30%	N/A
Non-Formulary/Non-Preferred Brand	N/A	Tier 1: 45%	Tier 2: 50%
Mail – Copay			
Generic	$10	$15	N/A
Formulary/Preferred Brand	$30	$80	N/A
Non-Formulary/Non-Preferred Brand	$105	$105	N/A
Mail – Coinsurance			
Generic	N/A	N/A	N/A
Formulary/Preferred Brand	N/A	N/A	N/A
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A
Actuarial Value	0.93	0.80	0.70
Relative Value[3]	0.97	0.83	0.73

1 For the PPO, the plan design for the Standard Plan was used.
2 In 2014, the Affordable Care Act's Out-of-Pocket Limit was $6,350 for individual coverage and $12,700 for family coverage.
3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

HDHP/CDHP

		FEHB	
In Network	Wisconsin[1]	Range	Typical
Medical			
HSA – ER Contribution			
Single	$170	$750 – $750	$750
Family	$340	$1,500 – $1,500	$1,500
HRA – ER Contribution			
Single	N/A	$750 – $1,000	$875
Family	N/A	$1,500 – $2,000	$1,750
Deductible			
Single	$1,500	$1,000 -$1,500	$1,250
Family	$3,000	$2,000 – $3,000	$3,000
Office Visits Coinsurance			
Primary	10%	10% – 20%	15%
Specialist	10%	10% – 20%	15%
Inpatient Hospital Coinsurance			
Coinsurance	10%	10% – 20%	15%
Out of Pocket Maximum[2]			
Single	$2,500	$4,000 – $5,000	$4,500
Family	$5,000	$8,000 – $10,000	$9,000
Prescription Drug			
Retail – Copay			
Generic	$5	$5 – $10	$10
Formulary/Preferred Brand	$15	$35	$35
Non-Formulary/Non-Preferred Brand	$35	$60	$60
Retail – Coinsurance			
Generic	N/A	N/A	N/A
Formulary/Preferred Brand	N/A	N/A	N/A
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A
Mail – Copay			
Generic	$10	$10 – $20	$20
Formulary/Preferred Brand	$30	$70	$70
Non-Formulary/Non-Preferred Brand	105	$120	$120
Mail – Coinsurance			
Generic	N/A	N/A	N/A
Formulary/Preferred Brand	N/A	N/A	N/A
Non-Formulary/Non-Preferred Brand	N/A	N/A	N/A
Actuarial Value	0.83	0.83 – 0.90	0.87
Relative Value[3]	0.86	0.86 – 0.94	0.91

1 The Wisconsin HDHP plan became effective 1/1/15.

2 In 2014, the Affordable Care Act's Out-of-Pocket Limit was $6,350 for individual coverage and $12,700 for family coverage.

3 This is the value of the medical and pharmacy benefits relative to the 2014 Wisconsin Uniform Benefits Design.

UNIFORM BENEFIT DESIGN/HMO[1]

	Wisconsin[2]		Regional			National[3]		
		Percentage	Range	Typical	Percentage	Range	Typical	Percentage
Total Monthly Costs[4][5]								
Single	$671		$376 – $748	$562		$267 – $1,052	$604	
Family	$1,688		$879 – $1,657	$1,336		$670 – $1,889	$1,403	
Monthly Employer Contributions								
Single	$590	88%	$376 – $631	$497	88%	$267 – $999	$519	86%
Family	$1,485	88%	$879 – $1,380	$1,150	86%	$670 – $1,752	$1,165	83%
Monthly Employee Contributions[6]								
Single	$81	12%	$0 – $117	$65	12%	$0 – $345	$85	14%
Family	$203	12%	$0 – $277	$186	14%	$0 – $1,130	$237	17%

PPO/POS

	Wisconsin[7]		Regional			National		
		Percentage	Range	Typical	Percentage	Range	Typical	Percentage
Total Monthly Costs[8]								
Single	$1,247		$403 – $1,237	$692		$260 – $1,394	$631	
Family	$3,113		$1,125 – $2,940	$1,645		$356 – $3,160	$1,434	
Monthly Employer Contributions								
Single	$1,008	81%	$403 – $850	$576	83%	$260 – $1,007	$531	84%
Family	$2,517	81%	$956 – $1,846	$1,318	80%	$356 – $2,065	$1,157	81%
Monthly Employee Contributions								
Single	$239	19%	$0 – $387	$116	17%	$0 – $387	$100	16%
Family	$596	19%	$169 – $1,095	$327	20%	$0 – $1,095	$277	19%

1 The HMO plan category also includes similar plans categorized as EPO and POE plans.
2 For the Wisconsin UBD, the monthly costs and contributions reflect a weighted average of the plans with the 2014 Wisconsin Uniform Benefits Design.
3 Several plans were identified as outliers, highly collectively bargained plans, and eliminated because they were not representative of the data findings.
4 Cost sharing information reflects rates for non-smokers and those who have not participated in a wellness activity/program. If cost sharing varies by salary level, the rates reflect those applicable to someone with a salary level of $40,000. Wisconsin figures do not include dental.
5 Wisconsin UBD monthly premiums vary by plan, ranging from $572 to $772 for single coverage and from $1,424 to $1,925 for family coverage.
6 The Wisconsin employee contributions shown represent Tier 1 plans.
7 For the Wisconsin PPO, the monthly costs and contributions reflect those of the Standard Plan.
8 Cost sharing information reflects rates for non-smokers and those who have not participated in a wellness activity/program. If cost sharing varies by salary level, the rates reflect those applicable to someone with a salary level of $40,000

HDHP/CDHP

	Wisconsin[1]		Regional			National		
		Percentage	Range	Typical	Percentage	Range	Typical	Percentage
Total Monthly Costs[2][3]								
Single	$588		$375 – $577	$461		$193 – $1,026	$477	
Family	$1,478		$1,191 – $1,541	$1,292		$356 – $1,900	$1,110	
Monthly Employer Contributions								
Single	$559	95%	$375 – $459	$437	95%	$193 – $860	$439	92%
Family	$1,404	95%	$1,108 – $1,199	$1,126	87%	$356 – $1,441	$965	87%
Monthly Employee Contributions[4]								
Single	$29	5%	$0 – $119	$24	5%	$0 – $166	$38	8%
Family	$74	5%	$83 – $342	$166	13%	$0 – $459	$145	13%

Comparison to Federal Employees Health Benefits (FEHB) Program Costs Offered to Federal Employees in the State of Wisconsin

UNIFORM BENEFIT DESIGN/HMO[5]

	Wisconsin[6]		FEHB		
		Percentage	Range	Typical	Percentage
Total Monthly Costs[7]					
Single	$671		$367 – $776	$592	
Family	$1,688		$843 – $1,940	$1,460	
Monthly Employer Contributions					
Single	$590	88%	$275 – $438	$407	69%
Family	$1,485	88%	$632 – $972	$934	64%
Monthly Employee Contributions[8]					
Single	$81	12%	$92 – $338	$184	31%
Family	$203	12%	$211 – $652	$526	36%

1 The Wisconsin HDHP plan became effective January 1, 2015.

2 Cost sharing information reflects rates for non-smokers and those who have not participated in a wellness activity/program. If cost sharing varies by salary level, the rates reflect those applicable to someone with a salary level of $40,000.

3 Wisconsin HDHP monthly premiums vary by plan, ranging from $501 to $675 for single coverage and from $1,247 to $1,685 for family coverage.

4 The Wisconsin employee contributions shown represent Tier 1 plans. Rates shown are retro-adjusted to 2014 level, to be consistent with comparator data.

5 The HMO plan category also includes similar plans categorized as EPO and POE plans.

6 For the Wisconsin UBD, the monthly costs and contributions reflect a weighted average of the plans with the 2014 Wisconsin Uniform Benefits Design.

7 Wisconsin UBD monthly premiums vary by plan, ranging from $572 to $772 for single coverage and from $1,424 to $1,925 for family coverage.

8 The Wisconsin employee contributions shown represent Tier 1 plans.

PPO/POS

	Wisconsin[1]		FEHB			
		Percentage	BCBS Standard Plan	Percentage	BCBS Basic Plan	Percentage
Total Monthly Costs						
Single	$1,247		$635		$550	
Family	$3,113		$1,434		$1,287	
Monthly Employer Contributions						
Single	$1,008	81%	$438	69%	$412	75%
Family	$2,517	81%	$972	68%	$965	75%
Monthly Employee Contributions						
Single	$239	19%	$197	31%	$137	25%
Family	$596	19%	$462	32%	$322	25%

HDHP/CDHP

	Wisconsin[2]		FEHB		
		Percentage	Range	Typical	Percentage
Total Monthly Costs					
Single	$588		$456 – $738	$561	
Family	$1,478		$1,027 – $1,675	$1,260	
Monthly Employer Contributions[3]					
Single	$559	95%	$341 – $438	$383	68%
Family	$1,404	95%	$771 – $972	$850	67%
Monthly Employee Contributions[4]					
Single	$29	5%	$114 – $300	$179	32%
Family	$74	5%	$257 – $704	$410	33%

1 For the Wisconsin PPO, the monthly costs and contributions reflect those of the Standard Plan.
2 The Wisconsin HDHP plan became effective January 1, 2015.
3 Wisconsin monthly premiums vary by plan, ranging from $501 to $675 for single coverage and from $1,247 to $1,685 for family coverage.
4 The Wisconsin employee contributions shown represent Tier 1 plans. Rates shown are retro-adjusted to 2014 level, to be consistent with comparator data.

Appendix 2: Detailed Information on the ACA 40% Excise Tax

This appendix presents additional detail about the coming 40% Excise Tax, including descriptions of the actual law provisions, what is known currently about the administration of the tax by IRS, and methods that appear to be under consideration in how to count the value of benefits for purposes of the tax.

Introduction

One of the revenue provisions under the Affordable Care Act (ACA) is the excise tax on high-cost health plans effective in 2018. This provision, often referred to as the "Cadillac" tax, imposes a 40% excise tax on the cost of high-cost health plans above a certain threshold amount. This tax is imposed on insurers and entities that administer benefits under a health plan. The potential tax liability on plans that sponsor health care coverage can be significant.

Beginning in 2018, the base threshold amounts are $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. In other words, the tax will be assessed on the excess value of health coverage per employee, if the value exceeds $10,200 for self-only coverage and $27,500 for other-than-self-only coverage. When valuing the tax, there are a number of adjustments to threshold amounts that will be considered when accounting for the fiscal impact of the tax.

The Treasury Department (Treasury) and Internal Revenue Service (IRS) have not proposed regulations implementing the excise tax as of this writing, so our analysis is based on: (i) the statutory language in the ACA; (ii) the March 21, 2010 "Technical Explanation of the Revenue Provisions of the Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable Care Act" report prepared by the Joint Committee on Taxation; and (iii) Notice 2015-16 released by the Treasury Department and the IRS on February 23, 2015.

Notice 2015-16 seeks comments on a range of issues related to implementation of the excise tax. This is a preliminary step in the rule-making process. The Treasury Department and IRS will address additional issues in a second notice. Comments received in response to both notices will form the basis of a proposed rule. Comments are due by May 15, 2015.

Health Cost Adjustment Percentage and Inflation Adjustments

The health cost adjustment percentage is designed to increase the thresholds if actual growth in the cost of health care between 2010 and 2018 is greater than the projected growth for that period. In addition, in 2019, the threshold amounts, after applying the health cost adjustment percentage, are indexed to the CPI-U plus one percentage point, rounded to the nearest $50. After 2019, threshold amounts are indexed to the CPI-U, rounded to the nearest $50. Factoring in the CPI-U allows the excise tax calculation to account for inflation, but the amount does not take into consideration the impact of medical cost inflation.

Employer-Specific Age and Gender Adjustment

The dollar limit thresholds for any tax period for each employee may be adjusted upwards if the age and gender characteristics of an employer's workforce are different from those of the national workforce. This adjustment is made each tax period to the threshold amount so that an employer that is more expensive to insure due to the age and gender of its workforce is not put at a disadvantage.

Additions to Thresholds for Coverage of High Risk Professionals

Threshold amounts are also increased for individuals covered by a plan sponsored by an employer, the majority of whose employees covered by the plan are engaged in a high-risk profession or employed to repair or install electrical and telecommunications lines. The statute includes a list of these professions, as follows:

- Law enforcement officers.
- Employees who engage in fire protection activities.
- Individuals who provide out-of-hospital emergency medical care (including emergency medical technicians, paramedics, and first-responders).
- Individuals whose primary work is longshore work
- Individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries.

A retiree with at least 20 years of employment in a high-risk profession is also eligible for the increased threshold.

The self-only threshold is increased by $1,650 and the threshold for all other coverage tiers is increased by $3,450.

Additions to Thresholds for Coverage of Retirees

Threshold amounts are also increased for "Qualified Retirees," which are defined as any individuals who are receiving coverage by reason of being a retiree, have attained age 55, and are not entitled to benefits or eligible for enrollment under Medicare. The self-only threshold is increased by $1,650 and the threshold for all other coverage tiers is increased by $3,450.

Benefits Included in Excise Tax Calculation

In general, all group health plans, including retiree-only plans, are subject to the excise tax. The statute explicitly includes medical, mental health, prescription drug and similar benefits, as well as employer contributions to Health Savings Accounts (HSAs) and to Archer Medical Savings Accounts (MSAs), and with respect to Health Flexible Spending Arrangements (FSAs), salary reduction contributions plus any available reimbursement in excess of the salary reduction.

However, the statute excludes many types of HIPAA excepted benefits that are generally not considered health coverage, such as coverage only for accident, AD&D, disability income insurance and liability insurance. The statute also excludes coverage for long-term care (whether insured or self-insured) and separately insured dental and vision coverage. Finally, the statute excludes coverage for a specified disease or illness, as well as hospital indemnity or other fixed indemnity insurance, but only if the employee pays the full cost of the coverage with after-tax dollars.

Notice 2015-16 provides some insights into how Treasury and the IRS may approach the following types of coverage in a future proposed rule:

- **HSAs/Archer MSAs:** Treasury/IRS anticipate that employer contributions, and employee pre-tax salary reduction contributions, will be included in the cost of coverage. The IRS has historically taken the position that salary reductions are employer contributions – thus the approach is consistent with past regulations. Employee after-tax contributions will be excluded.
- **Health Reimbursement Arrangements (HRAs):** Treasury/IRS anticipate that HRAs will be included and request comments on how to determine the cost of coverage for an HRA. One option being considered is including the amounts made newly available to a participant each year (ignoring carry-over amounts). Another option would permit employers to add together all claims and administrative expenses attributable to HRAs for a specific period and dividing by the number of employees covered for that period. Another option is requiring employers to use the actuarial method (discussed below) rather than the past cost method to determine the cost for an HRA. Treasury/IRS also request comments on the relevance of what the HRA may reimburse to how its cost is calculated (e.g., HRAs that may only be used to fund the employee contribution or HRAs that reimburse for benefits that are not included).
- **On-Site Medical Clinics:** Treasury/IRS anticipate that on-site clinics providing only de minimis medical care to employees will not be included. They seek comment on specific types of care that such clinics could provide without becoming subject to the excise tax. Possibilities include (1) on-site clinics that are not subject to COBRA (i.e., those where free care provided to current employees only consists primarily of first aid provided during working hours for treatment of a condition, illness or injury that occurs during working hours), and (2) other services provided in addition to, or in lieu of, first aid such as immunizations, allergy shots, aspirin and other nonprescription pain relievers, and treatment of work-related injuries beyond the provision of first aid.
- **Limited-Scope Dental/Vision:** Treasury/IRS are considering whether to exercise their regulatory authority to exclude self-insured dental/vision benefits that qualify as excepted benefits under HIPAA. Such an approach would exclude self-insured benefits that participants may decline (including through an opt-out) or that are administered under a contract separate from any other benefits.
- **Employee Assistance Programs (EAPs):** Treasury/IRS are considering whether to exercise their regulatory authority to exclude EAPs that qualify as excepted benefits under HIPAA. That would mean EAPs that do not provide significant benefits in the nature of medical care and that are not coordinated with benefits under another group health plan.
- **Executive physical programs:** Treasury/IRS are likely to require that executive physical programs be included in the cost of coverage.

Determining the Cost of Coverage: How to Group Employees

The statute generally provides that the cost of coverage is determined under rules similar to the rules that apply in determining COBRA premiums. Notice 2015-16 states that this is the cost of coverage in which each employee is actually enrolled, rather than the cost of coverage offered. This means that plan sponsors will not be able to offer a low-cost plan (that employees generally do not elect) as a way of avoiding the excise tax.

The Notice also discusses the following potential approaches to determining the cost of coverage, and requests comments on each:

- **Benefit Packages:** The cost of coverage would be determined by aggregating all employees (including former employees, surviving spouses and other primary insureds) covered by a particular benefit package (e.g., standard vs. high option, PPO vs. HMO, each PPO). Treasury/IRS request comments on the extent to which benefit packages must be identical to be considered the same benefit package.
- **Self-Only vs. Other-Than-Self-Only:** After aggregating all employees covered by a particular benefit package, the employer would then disaggregate these employees based on whether the employee is enrolled in self-only coverage or in other-than self-only coverage.
- **Other Coverage Tiers:** An employer would be permitted (but not required) to determine the cost separately for each tier that qualifies as "other-than-self-only." Under such an approach, an employer could either calculate either one cost for all employees who do not enroll in self-only coverage or calculate a separate cost for each coverage tier (e.g., employee plus one, employee plus child, family, etc.).
- **Other Subgroups of Employees:** An employer would be permitted (but not required) to further subdivide the groups of employees whose costs would be aggregated (within a benefit package). Treasury/IRS are considering two options: (1) a broad standard that would permit subdividing based on bona fide employment-related criteria (such as nature of compensation, specified job categories, collective bargaining status, etc.); or (2) a more specific standard that would list permissible groups (e.g., current employees vs. retirees, bona fide geographic differences such as place or residence or workplace, or the number of individuals in the family with coverage).
- **Pre-65 Retirees and Retirees Age 65+:** Treasury/IRS seek comments on whether additional guidance would be helpful to interpret the part of the statute that allows employees to treat pre-65 retirees and age 65+ as similarly situated.

Determining the Cost of Coverage: Calculation Methods for Self-Insured Plans

The Notice discusses the following potential approaches to calculating the cost of coverage (both of which are currently options for setting COBRA premiums), and requests comments on each, as well as on when plan sponsors should be allowed to switch methods:

- **Actuarial Basis Method:** Under this method, the plan would use reasonable actuarial principles and practices to determine an estimate of the actual cost the plan is expected to incur for a determination period. Treasury/IRS has requested comments on whether regulations should require some accreditation of the individual making actuarial estimates,

whether regulations should specify a list of factors that must be satisfied to make an actuarial determination, and whether a similar standard should apply to determining COBRA premiums.

- **Past Cost Method:** Under this method, actual costs would be calculated over a measurement period and that cost would be adjusted by an inflation factor. The inflation factor would be the one that applies to COBRA: the percentage increase or decrease in the implicit price deflator of the gross national product for the 12-month period ending within six months before the determination period. For excise tax purposes, the costs could include claims, stop-loss premiums, administrative expenses and reasonable overhead expenses (such as salary, rent supplies, and utilities allocated to the cost of administering the plan). Claims could be based on claims incurred during the measurement period (whether paid or unpaid) or claims submitted (regardless of when incurred).

Additional Considerations

- **Determination Period:** Treasury/IRS anticipate that plans would elect the method for calculating cost before the determination period for which the cost is determined. For example, a plan using the calendar year as the 12-month determination period would elect the method before the beginning of the calendar year. This means that the amount of any excise tax liability would be known at the beginning of the taxable year generating the liability. Treasury/IRS request comments on the feasibility of using actual costs incurred in a particular year for determining excise tax liability in the same year. That would mean that liability would not be known until after the end of the year.
- **Employees with Some Self-Only Coverage and Some Other-Than-Self-Only Coverage:** Treasury/IRS are considering a rule that would apply the applicable dollar limit based on

Appendix 3: Private Exchange Details

When considering selection of an exchange partner, it is important to evaluate the financial elements of each exchange and weigh the cost of plan options, the level of fees and their transparency, and the overall financial stability of the exchange. In addition to price, it is also crucial to consider and compare the variety of features and support that each exchange offers. Each exchange has different employer requirements and limitations and these are very important to consider. The main elements that distinguish one exchange from another include:

Number of Clients/Members

The size of private exchanges in numbers of employer clients varies greatly in the market, ranging in size from dozens to more than 200. The total membership on each exchange varies as well with ranges from 150,000 to almost one million members. There are wide contrasts in the plan sponsor targets for each exchange, with some targeting small to medium sized plan sponsors with 100+ employees and others focused on national level plan sponsors with 5,000 or more employees.

Funding Mechanisms

Exchanges may offer their plans on a fully insured basis, a self-insured basis, or propose plans that utilize a combination of these funding arrangements. In a fully insured exchange environment, the insurer underwrites the health policy. This model allows the plan sponsor to define its financial commitment on an annual basis and reduces cost fluctuations usually associated with self-insuring. With a self-insured exchange solution, as with traditional self-insurance, the plan sponsor's overall health care spend is not as predictable. In addition, the funding alternative selected may affect the plan's benefits design structure. For example, in a fully insured exchange environment, designs are usually fixed and filed at the state-level.

Bundled Coverage

Health benefits are also bundled differently among the different exchanges. Some private exchanges offer plans that bundle medical, prescription drug, dental and vision coverage only, while others have plans that include those traditional options plus a portfolio of ancillary and voluntary benefits such as accident, critical illness, hospital indemnity, life, and disability. Some exchanges also integrate services like COBRA and FSA services.

Number of Medical Carriers

Each exchange has a distinct number of carriers through which health coverage may be provided. One primary exchange uses as few as four carriers, while another employs all major and many local carriers. A number of the mainline health insurers now offer their own single-carrier private exchanges, which, as the name implies, offer only options from the carrier sponsoring the exchange.

Carrier Regions/ Number of Carriers by Region

Each exchange has a number of carriers it utilizes to provide health care coverage. The number of carriers and the number of rating regions vary by exchange vendor. One of the exchanges offers at least two carriers by region while another typically proposes one carrier per Metropolitan Statistical Area. A third exchange provides a combination of national and local carriers by region, and a fourth allows for some flexibility in the number of carriers offered based on client size and demographics.

Plan Offerings

Each exchange has a number of different plan designs from which a plan sponsor may choose. Offerings among the current private exchanges include four to seven standardized plans with varying degrees of customization available to the plan sponsor.

Network Effectiveness

Exchanges also offer different types of network tiering structures, which result in varying levels of effectiveness. While exchanges generally utilize standard broad access networks, some allow plan sponsors to offer more narrow custom networks based upon Accountable Care Organizations and other local products.

Advocacy Services

Health advocacy services, which may include direct service to the member or family as well as activities that promote health and access to health care, are available and may differ amongst the exchanges. With some exchanges, such services are integrated with the plan, while other exchanges offer these services for additional fees.

Payment Structures

Costs for plans on each exchange may be charged in a number of ways. Some exchanges collect flat fees while others receive commissions.

Administration Flexibility

It is important to consider how each exchange is administered and whether the plan sponsor has flexibility regarding the administration of the plan. Some exchanges require the plan sponsor to use their third party administrator for eligibility and recordkeeping while others do not.

Wellness Features

Often, exchanges offer a number of integrated wellness programs in their plans such as robust clinical programs or focused care management. Most exchanges include these in their plan

structure and pricing model while others do not integrate these features or leave it to the discretion of the carriers. There is also variability on whether exchanges require incentives to influence behavior or allow them as optional plan features.

Alignment of Strategy

When considering the private exchange as a health care strategy solution, an employer should also evaluate how its overall goals and philosophy align with those of the exchanges. It may be challenging for the employer to promote certain strategies or retain management control of its health care program in an exchange environment where the primary contact with employees and/or retirees is through the private exchange. Typically, plan sponsors that engage their members through consumer-driven plans, offer value-based benefit designs or tiered networks may not benefit as much from the exchanges as other plan sponsors that are more comfortable conceding their plan's stewardship to the exchange.

Resources

Segal used several analytical tools to measure, monitor, and predict the costs of ETF's health benefit programs. We also collaborated with current vendors and external market vendors to assess additional options and solutions available to ETF.

APEX *Health Plan Rating*	• Segal used this software application to estimate relative values of plan design changes and alternate plan design options. • Reflects ETF's benefit plan design, location, and industry. • Conducts annual updates underlying data and assumptions.
Discount Database *National database of provider discounts*	• Segal participates in the Uniform Data System (UDS), which has devised a common methodology of evaluating provider discounts that is accepted by most carriers. • Data is updated twice annually and can be used for client specific discount analyses by service area. • Segal used UDS to review ETF's health care operations and performance.
Prescription Drug Collaboration	• Segal worked with Navitus PBM to analyze benefits design and pricing. • Reviewed clinical programs. • Developed recommendations for alternate benefit scenarios.
Carrier Discussions	• Segal participated in individual calls with ETF's health plan carriers to better understand their core capabilities, pricing models, benefits designs, physician reimbursement methodology, tiered and high-performance network options and processes for contracting with their providers.
Health Plan Survey	• Segal conducted an online survey with all health plans participating in ETF to gather information about prevalence of certain programs, practices and plan capabilities.
Study of State Employee Health Benefits	• Segal collected and compiled state-level data on benefit designs, including types of coverage offered, the number of plans of each type offered, the number of coverage tiers offered and how costs are shared with employees • The data covers all states and the District of Columbia and reflects benefits offered to active, full-time employees of these jurisdictions in 2014

FEHB Program Website	• The Federal Employees Health Benefits (FEHB) Program website captures the covered health care services and supplies and the level of coverage under the FEHB plans
Healthcare.gov Website	• The Healthcare.gov website captures plan design information and costs available on the public exchanges
Health Research Institute of Pricewaterhouse Coopers	• The Health Research Institute researches a broad array of health care topics. For our analysis, HRI provided information in efficiencies and waste in health care spending and historical price data on the Wisconsin State Healthcare Exchange
Kaiser Family Foundation	• The Kaiser Family Foundation researches a broad array of health care topics. For our analysis, Kaiser provided information on market practices, costs and benefit design for consumer directed health plans
Aetna HealthFund® study	• This study provided benefit, cost and utilization data on approximately 760,000 Aetna HealthFund participants
The 8th Annual Cigna Choice Fund Experience Study	• This study provided benefit, cost and utilization data on approximately 600,000 Cigna ChoiceFund participants
Third Year Health Care Service Corporation (HCSC) Study	• The study tracked individual Blue Cross and Blue Shield members migrating to a CDHP plan