State of Wisconsin Group Insurance Board

Department of Employee Trust Funds

Health Care Benefits Consultant

First Report – Observations and 2016 Recommendations

March 25, 2015

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75 THE SEGAL GROUP Founded in 1939

Segal Consulting

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Introduction

- The authority of the Wisconsin Group Insurance Board (GIB) was recently expanded to provide additional oversight and strategic direction for the state employee health insurance program.
- Segal was retained by the GIB in November 2014 to conduct a full review 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 reviewed data from a variety of sources, including WHIO, health plan submissions, market survey data, and discussions directly with current ETF vendors.

Introduction

- 98% of members covered in Uniform Benefit Design (UBD)
  - Primarily insured HMOs – 18 plan options
- Standard Plan PPO provides national and "gap" coverage (and is self-insured)
- The Pharmacy Benefit is carved-out with Navitus and is self-insured
- Estimate of 2015 costs based on premiums, admin costs and latest claims and enrollment (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)*	($370)
Net ETF Costs	$1,043	$0	$1,043

* Retiree premium contributions include sick leave funding from the State

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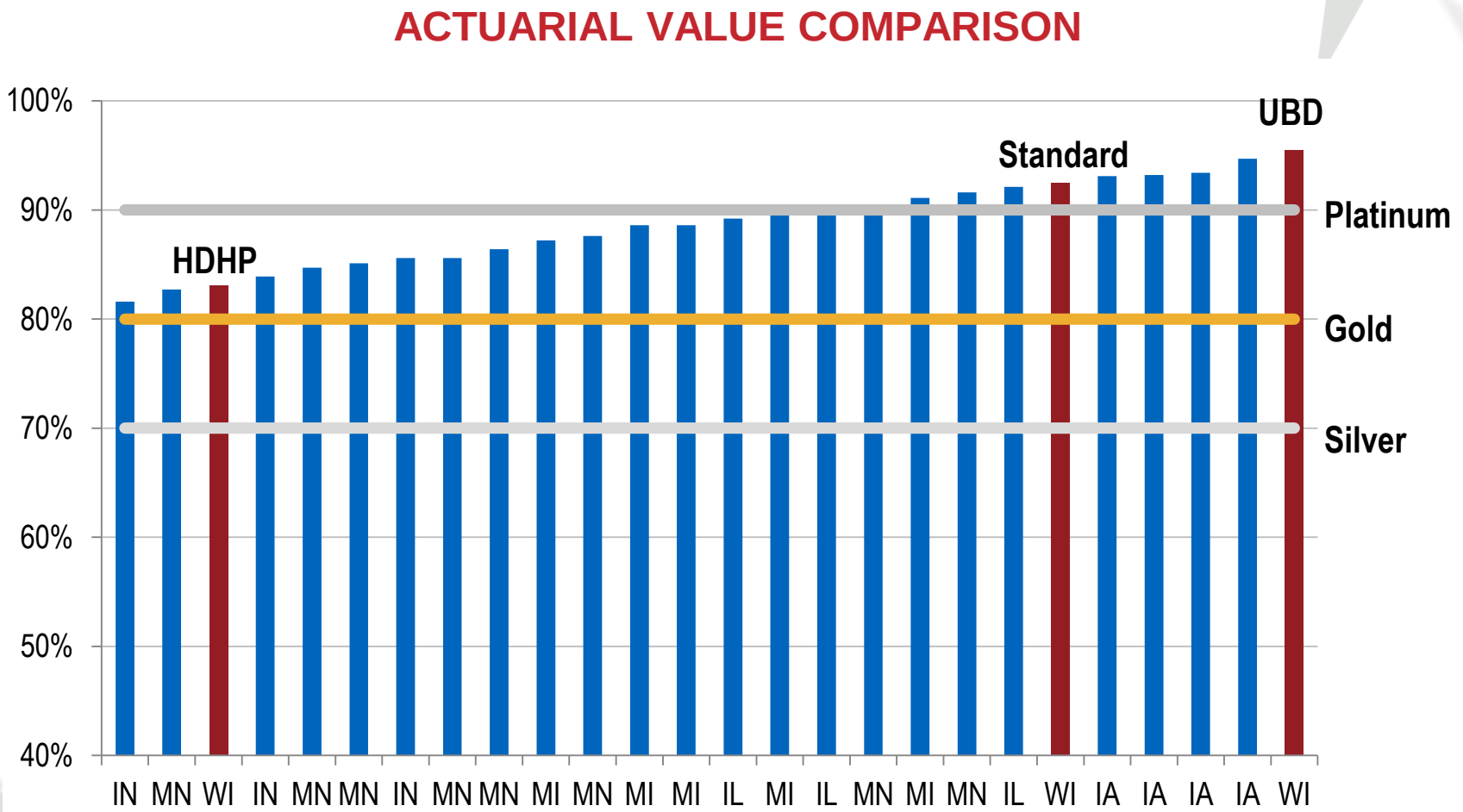
Benchmarking and Plan Design

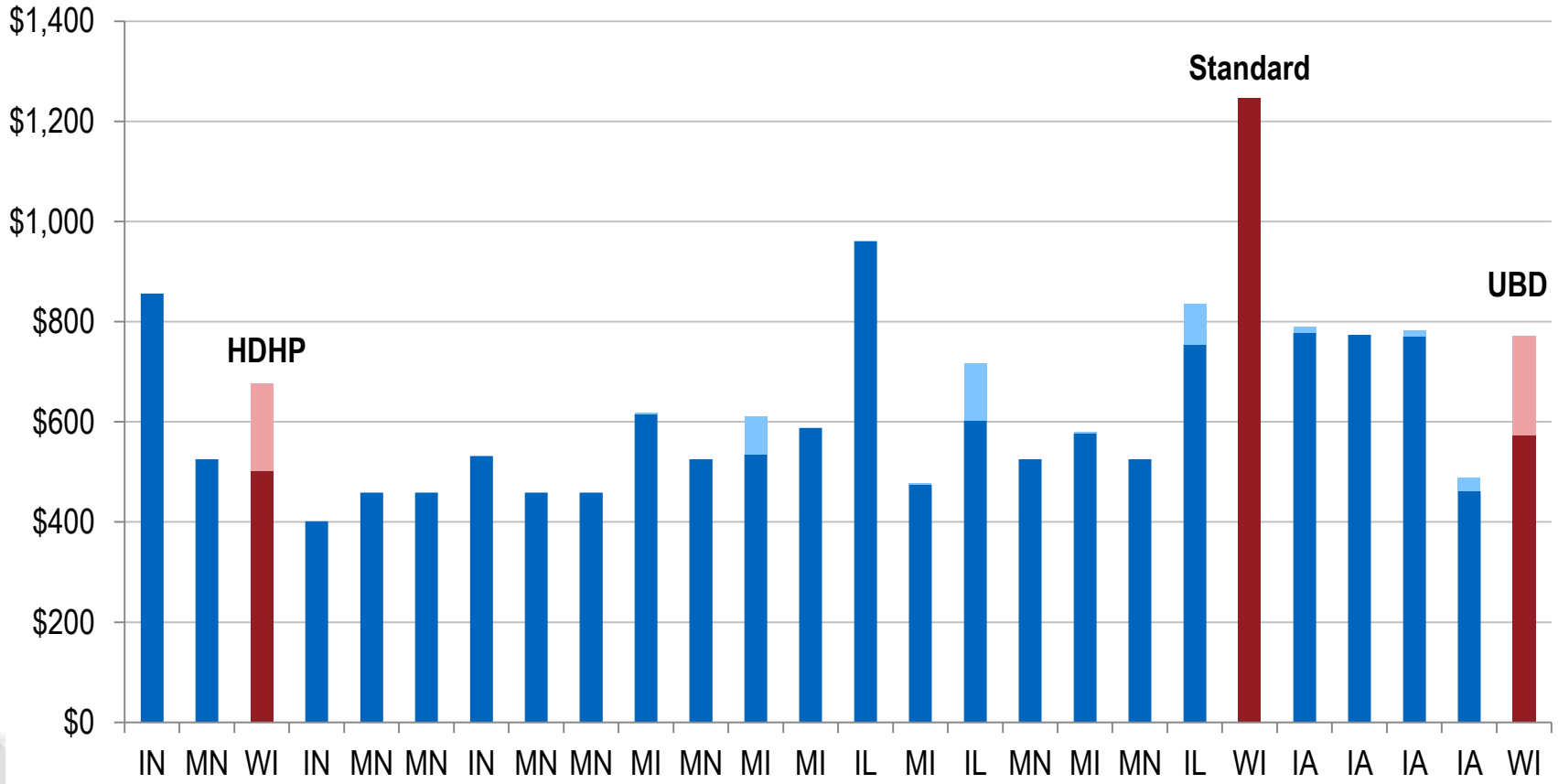
- Compared to other states in your region (Illinois, Indiana, Iowa, Michigan and Minnesota), ETF has richest plan design



Benchmarking and Plan Design

- With the richest plans comes the highest cost

REGIONAL FULL MONTHLY PREMIUM RATE COMPARISON
Single Coverage



Benchmarking and Plan Design

- ETF received a directive to reduce General Purpose Revenues by $25 million for 2016.
- With HMO/PPO plans higher than benchmarks, and the HDHP lower than benchmarks, we recommend:
  - **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.
- New deductible and max out-of-pocket would still be competitive
  - UBD and Standard Plan remain Platinum Plans
- State HSA contribution would be in line with market levels and more competitive
- Overall savings approximately 3% - $35M

Benchmarking and Plan Design

- Premium costs for UBD plans vary widely. In aggregate, the levels are higher than the benchmark plans but some plans fall at the lower end of the range. All plans currently on Tier 1—implying lowest cost HMOs.

- Employee contribution rates (Using Tier 1) are similar to the benchmarks on a percentage basis, but with the higher total costs the absolute dollars are higher than the averages.
  - Tiering strategy may move some HMOs between Tiers, altering this percentage.

- Premium rates and contributions are currently on a 2-tier system: single/family.
  - The majority of other state 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 for all numbers covered.
  - This could be designed to be budget neutral, having no financial impact to ETF.
  - Opt-out incentive considered to have negligible financial impact overall

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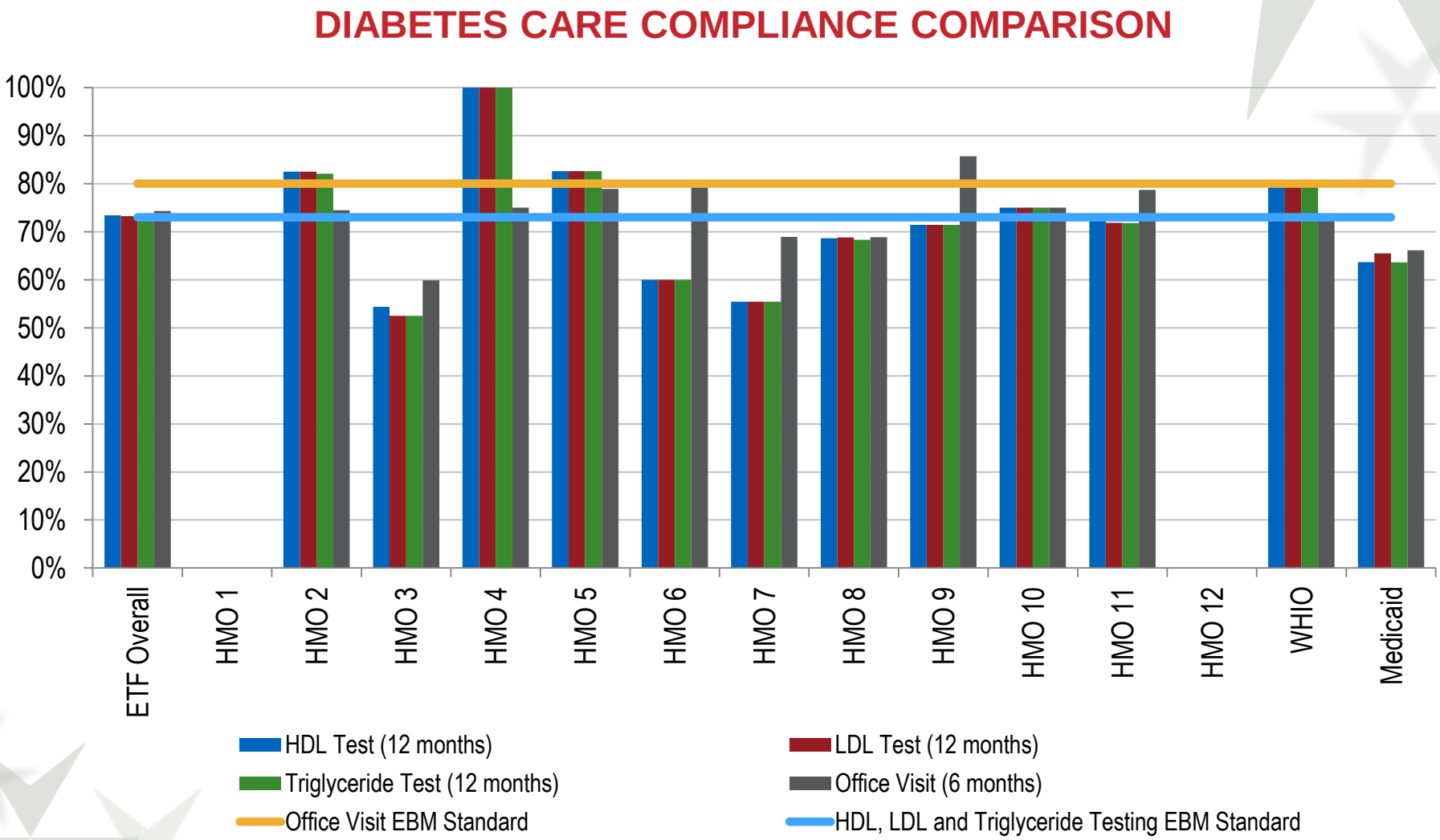
Total Health Management

- Care management varies by ETF health plan



Total Health Management

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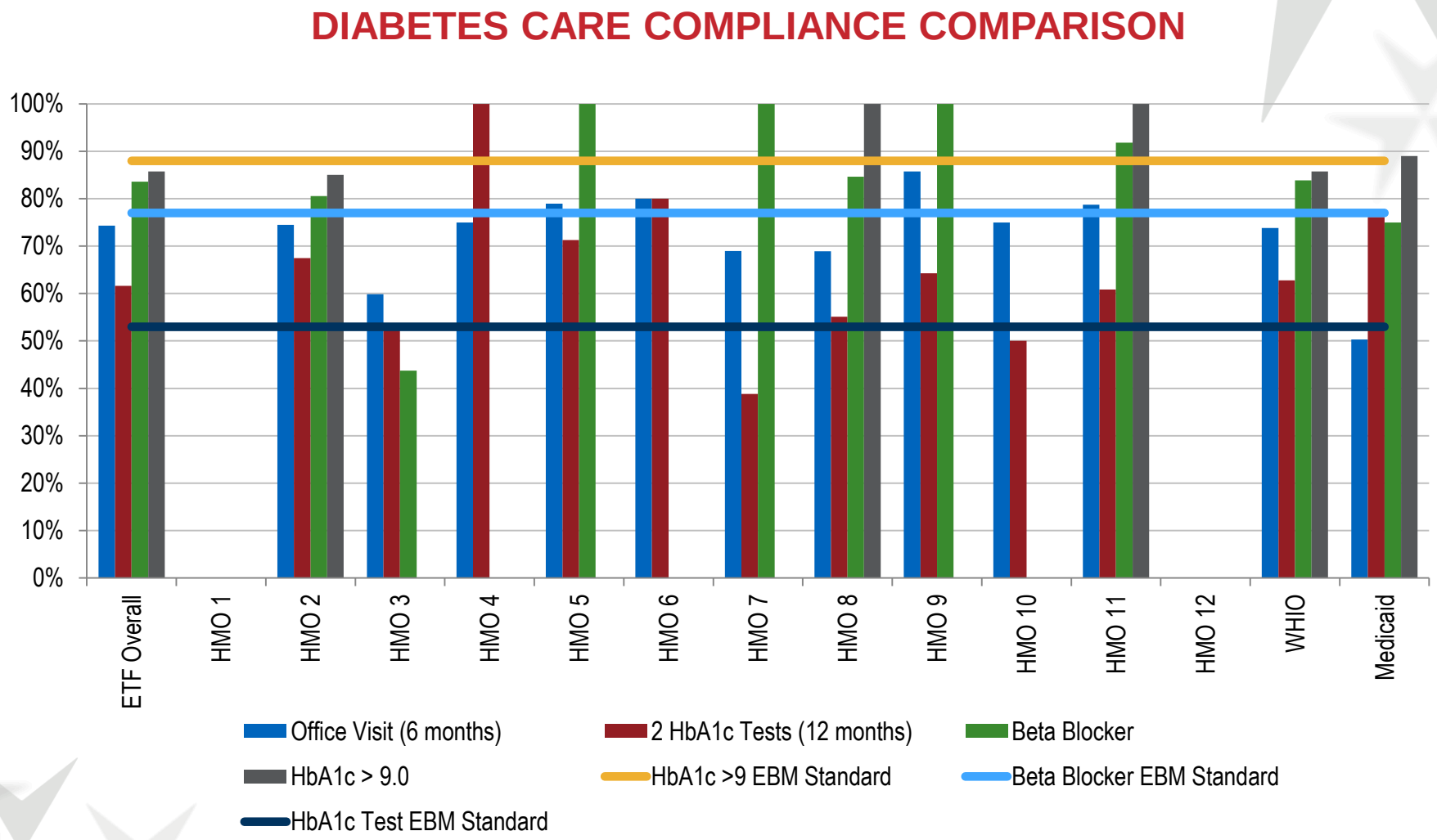
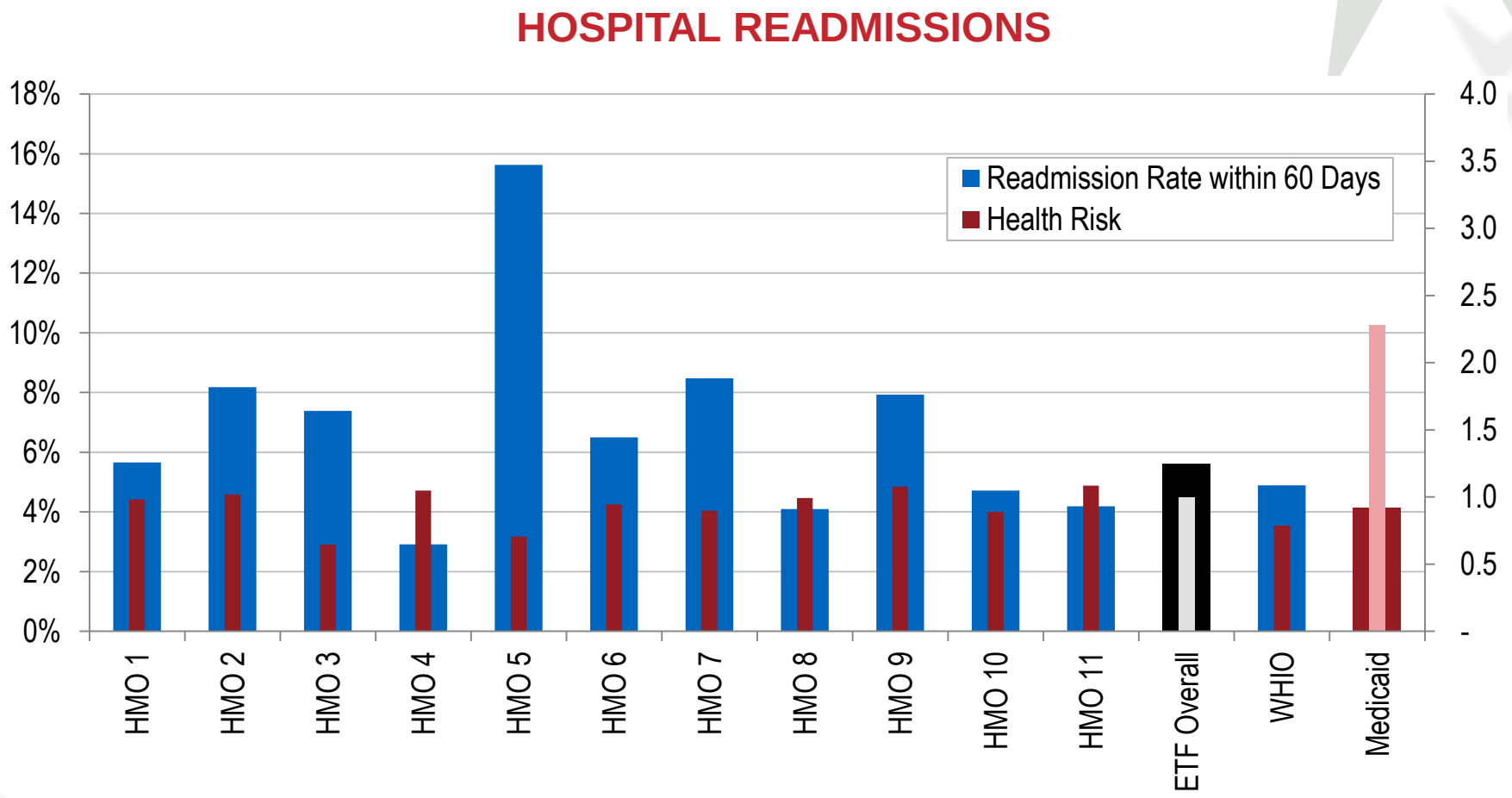


Total Health Management

- Utilization varies by health plan and not health risk



Total Health Management
Recommendations

- Significant variation among health plans in performance
- Establish uniform metrics to measure health plan performance
- Standardize reporting and data submission requirements
- Develop common medical management requirements across plans
- Improve wellness incentive
  - Current voluntary incentive ($150) has only 12% participation
  - Build on Well Wisconsin current platform, utilizing Optum Health
  - Premium-based incentives generate much higher compliance
  - Could be converted for 2016
  - Sets the stage for further expansion

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Pharmacy Benefits

- Below is a brief summary of the pharmacy pricing in the market. Our review shows that the current PBM pricing overall is comparable.

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/MO	$97.00	$62.00 – $130.00
Administration Fee	$1.74	$0.75 – $3.50

- Contract lacks pricing guarantees – recommend negotiating for 2016

Pharmacy Benefits

Opportunity to Reduce Costs

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

- 3.5% pharmacy cost savings - $7M in 2016
- Brand cost share keeps pace with trend
- Improved pricing efficiency – incents use of generic and lower cost brands
- Raise Out-of-Pocket limit to benchmark in subsequent years

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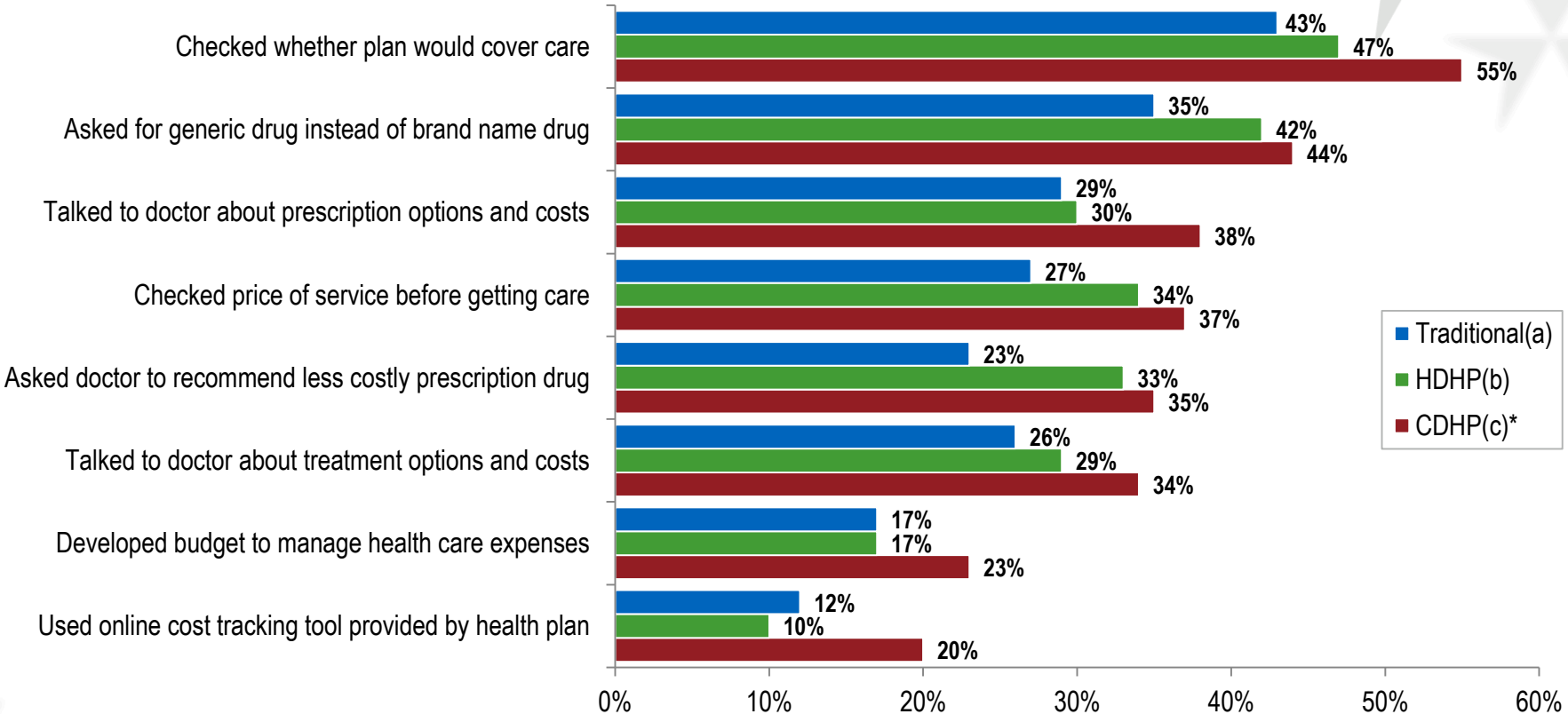
Consumer Directed Health Care Plan Design

- CDH plans result in more engaged members

COST-CONSCIOUS DECISION-MAKING BY TYPE OF HEALTH PLAN 2014

(Percentage of privately insured adults 21 – 64 who received health care in the last 12 months)



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

(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.

Consumer Directed Health Care Plan Design

Studies show more engaged members produce behavior changes and positive outcomes

The 9th Annual NYSE Aetna HealthFund® Study

- 2.2 million members, 760,000 in CDHP
- Reduction in ER visits, Specialist Visits and Pharmacy Costs
- Spend 11% more on preventive care and use of PCPs
- Higher rates of cancer screening and immunizations
- Saves $350 per member per year

The 8th Annual Cigna Choice Fund Experience Study

- 3.4 million members, 600,000 in CDHP
- 50% more likely to fill out a health risk assessment
- 41% more likely participate in a disease management program
- 12% savings in medical spend

Third Year Health Care Service Corporation (HCSC) Study

- 316,000 BCBS plan members in IL, MT, NM, OK & TX
- 3-year average showed a 10.5% decrease in Rx and Medical costs

Consumer Directed Health Care Plan Design

- HDHP plan design is competitive and meets the federal requirements
- Annual State HSA contribution is NOT market competitive, contributing only $170 per year.
- Variance among health plans in capabilities
  - Not all can support self-insurance (but can do HSAs?)
  - Not all HMOs are built appropriately for CDHP
  - Recommend moving to statewide plan, likely for 2017
- Previously recommended increasing HSA plan value
  - Increasing the State's HSA contribution to $750 annually per employee ($1,500 for family coverage)
  - When looking at the HDHP $1,500 Annual Deductible, the doughnut hole would be much narrower, resulting in a more attractive design and likely generate a significant increase in enrollment, savings cost for both ETF and the members.

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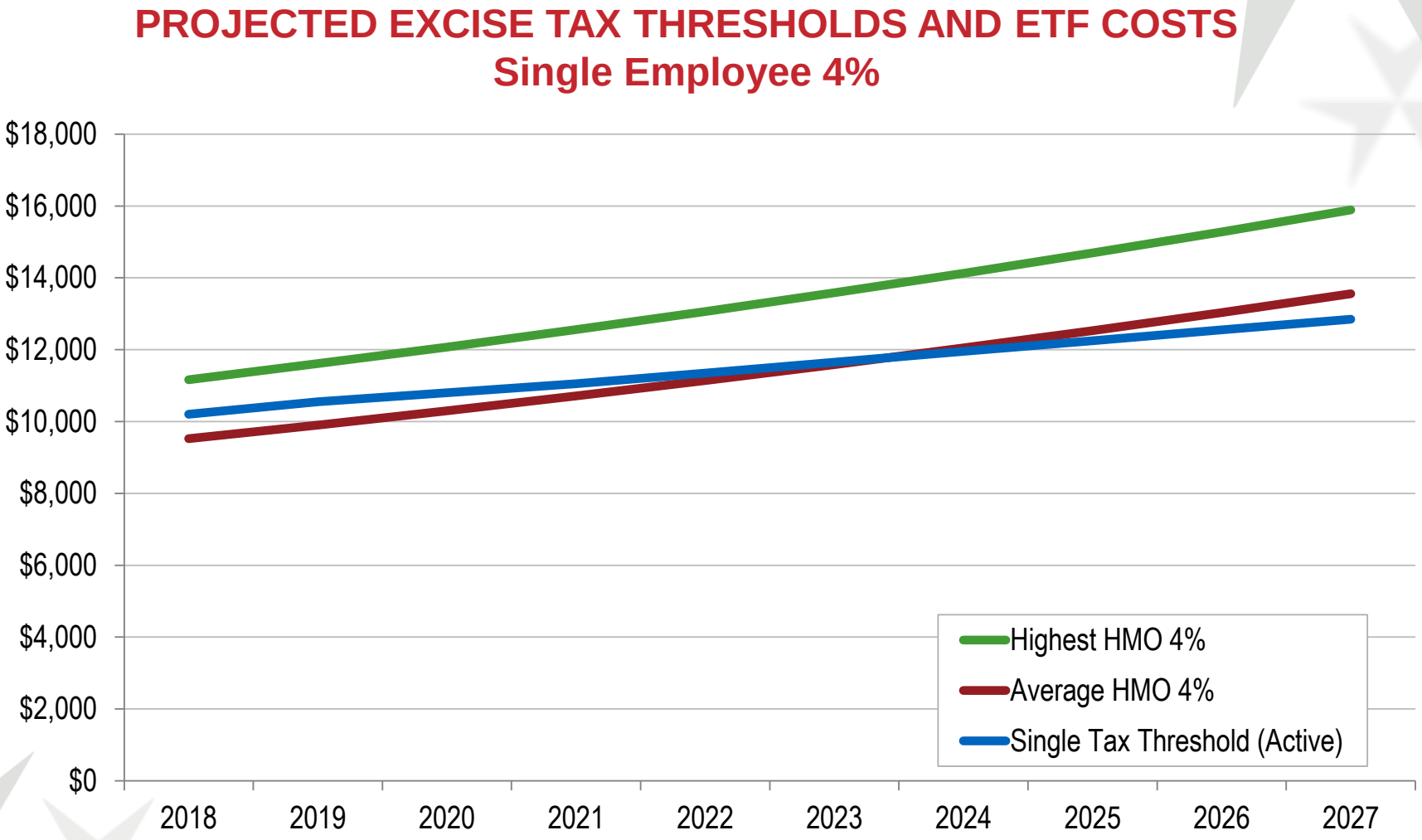
Affordable Care Act – 40% Excise Tax

- Based on value of medical and pharmacy
  - Other benefits count under certain circumstances
  - FSA and HSA employee and employer contributions count
- 2018 thresholds: $10,200 (single) and $27,500 (family)
  - Higher for pre-Medicare retirees and hazardous duty employees
- Based on total cost—can't shift premium cost to employees to manage tax
- No regional adjustments
- Paid by plan administrator—but unclear if benefit provided by multiple plan sponsors
- Measured on individual member basis
- Variance in health plan premiums generates tax exposure to ETF

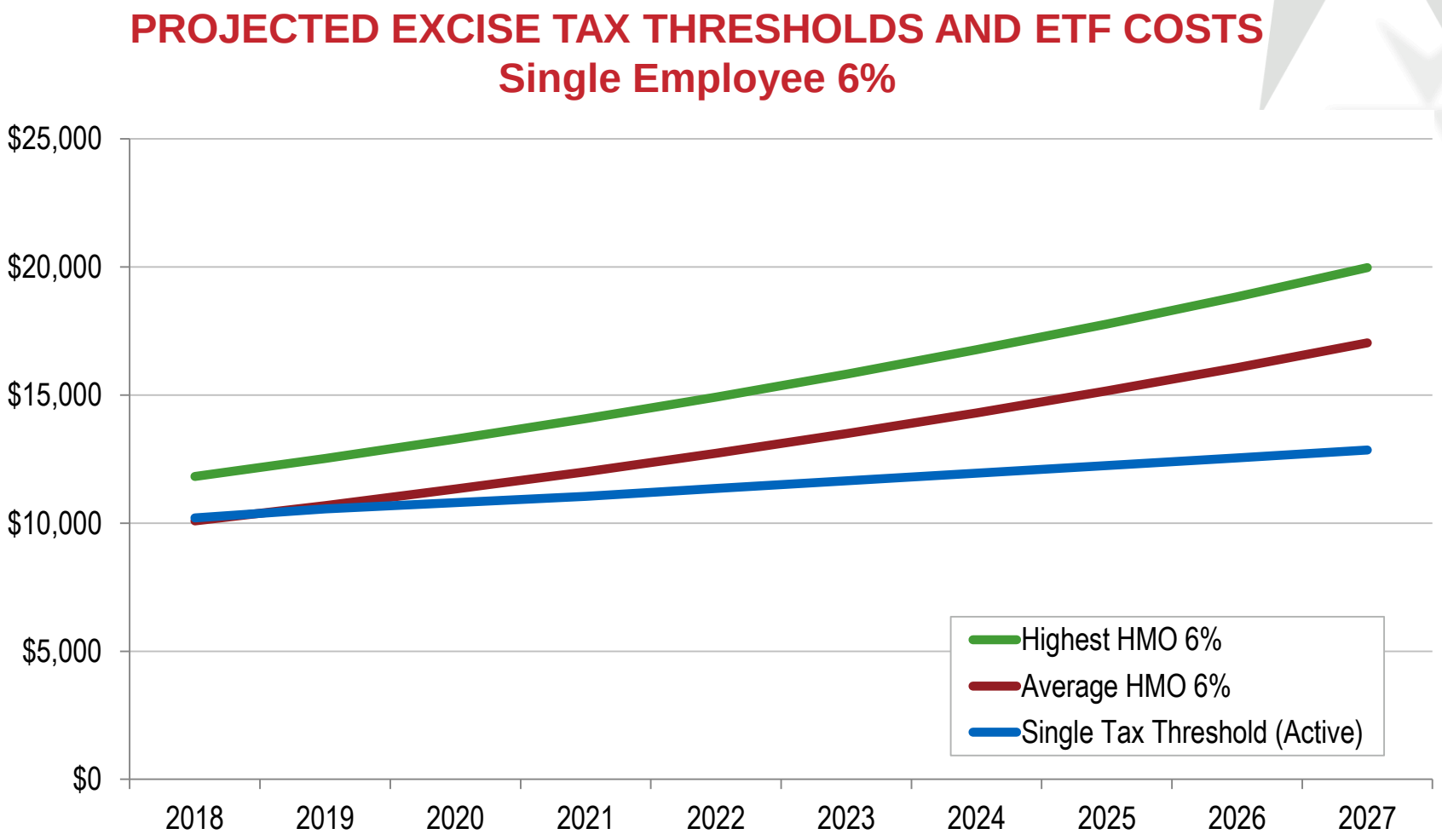
Affordable Care Act – 40% Excise Tax

- At 4% trend, average premium below threshold, but highest cost plan is above



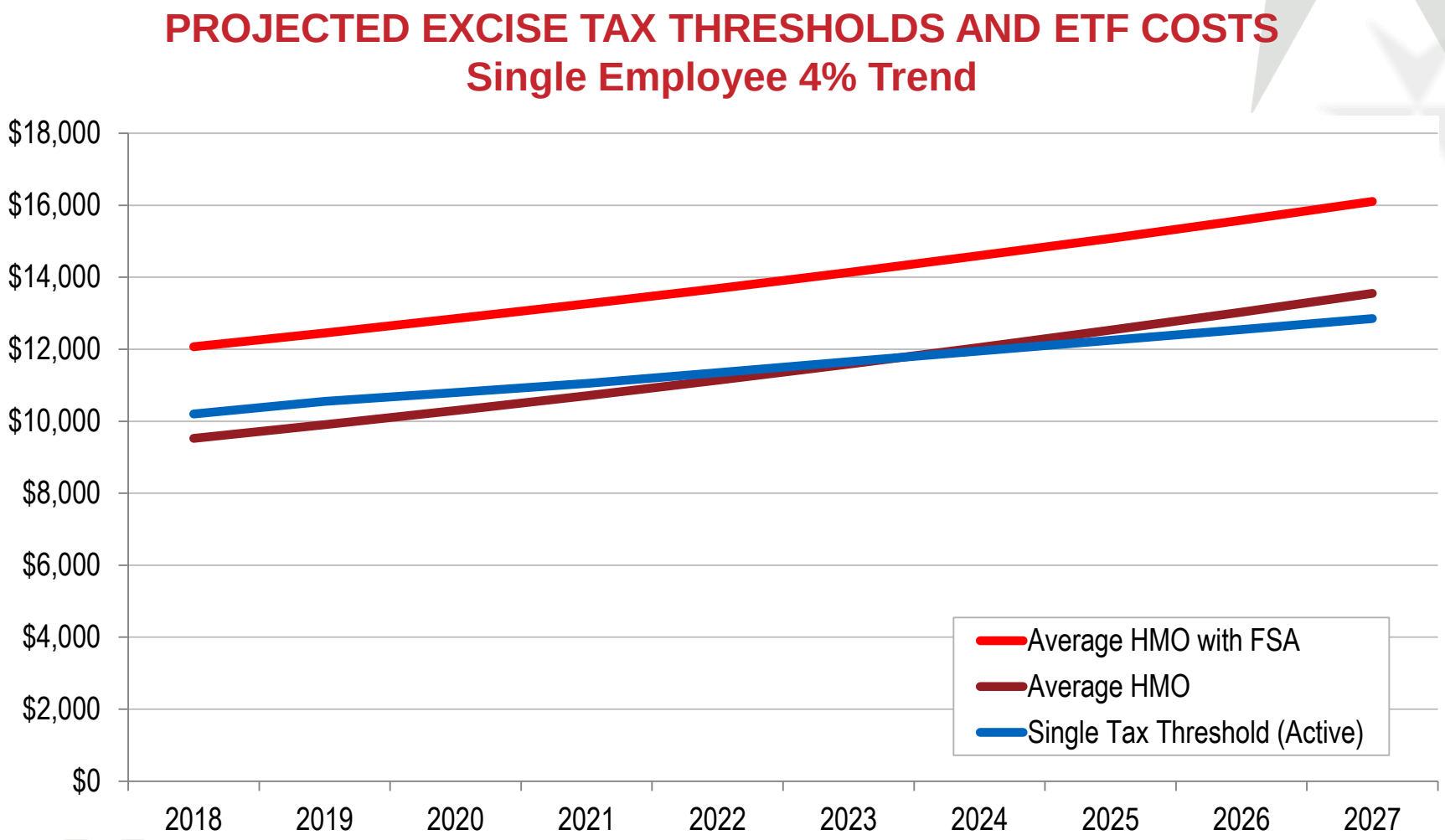
Affordable Care Act – 40% Excise Tax

- At 6% trend, average is at threshold in 2018



Affordable Care Act – 40% Excise Tax

- Add FSA and exposure increases



Affordable Care Act – 40% Excise Tax

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

*Based on current understanding of processes prior to IRS published regulation

Affordable Care Act – 40% Excise Tax

Strategies to Manage Costs

- Calculation Strategies
  - Aggregation and disaggregation protocols
- Retiree Strategies
  - Separate plans for retirees
- Cost Control Strategies
  - Vendor management
  - Health management
  - Plan design management

Continue to monitor legislation as it emerges

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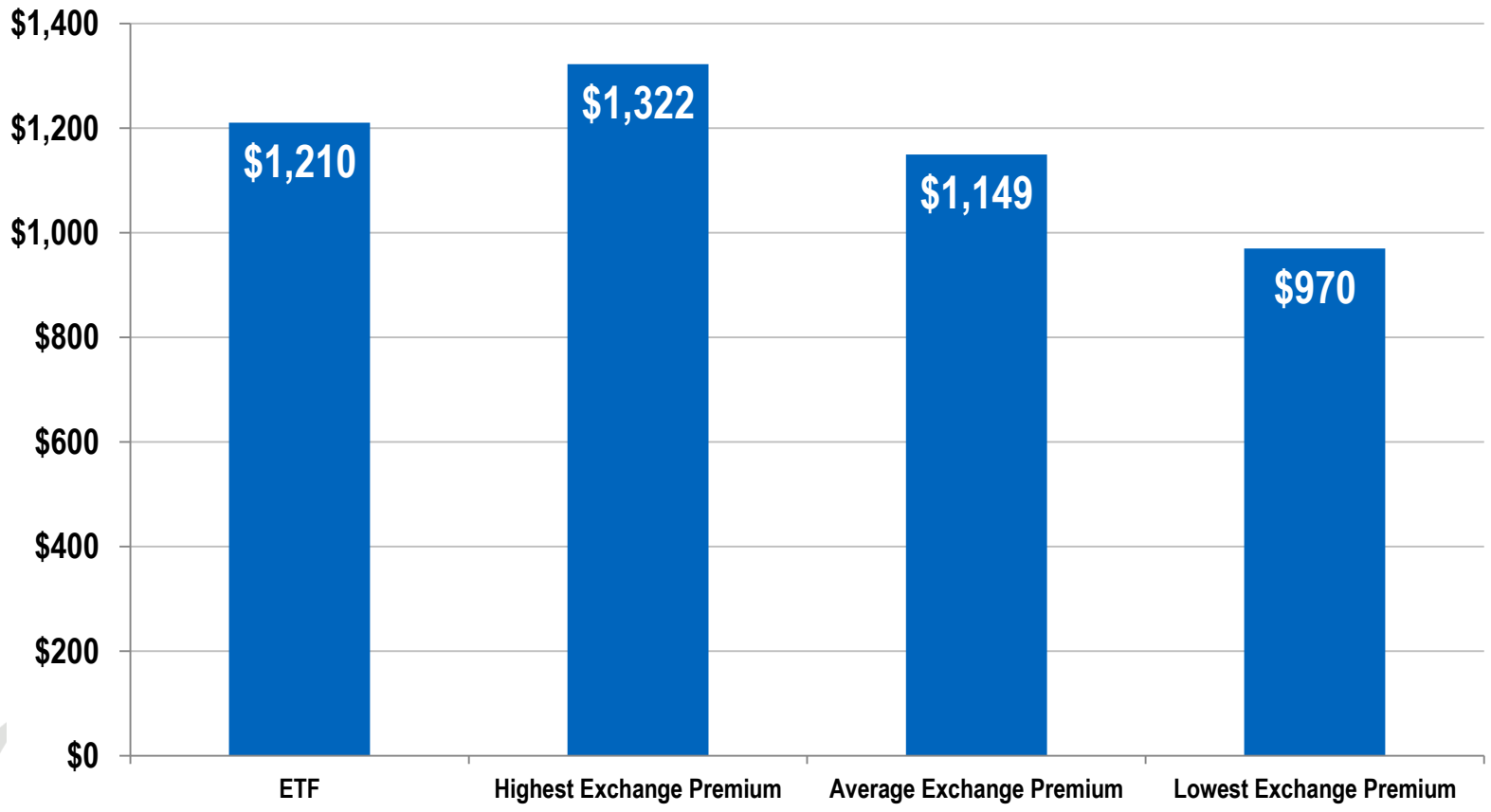
Public and Private Exchanges

- Individuals who are not Medicare-eligible may purchase coverage through their local state exchange
- ETF UBD and Standard plans are “Platinum” level plans on the exchange. The HDHP is a “Gold” level plan
- Rates are readily available and vary by plan, carrier, age, and region
- Segal used ETF eligibility and matched with similar plans on the exchange – by geography, age and plan type (Platinum/Gold)
- We then compared the current ETF premiums to those on the exchange. Identified “highest”, “average” and “lowest” premiums
- The results indicate the individual exchange has more competitive rates

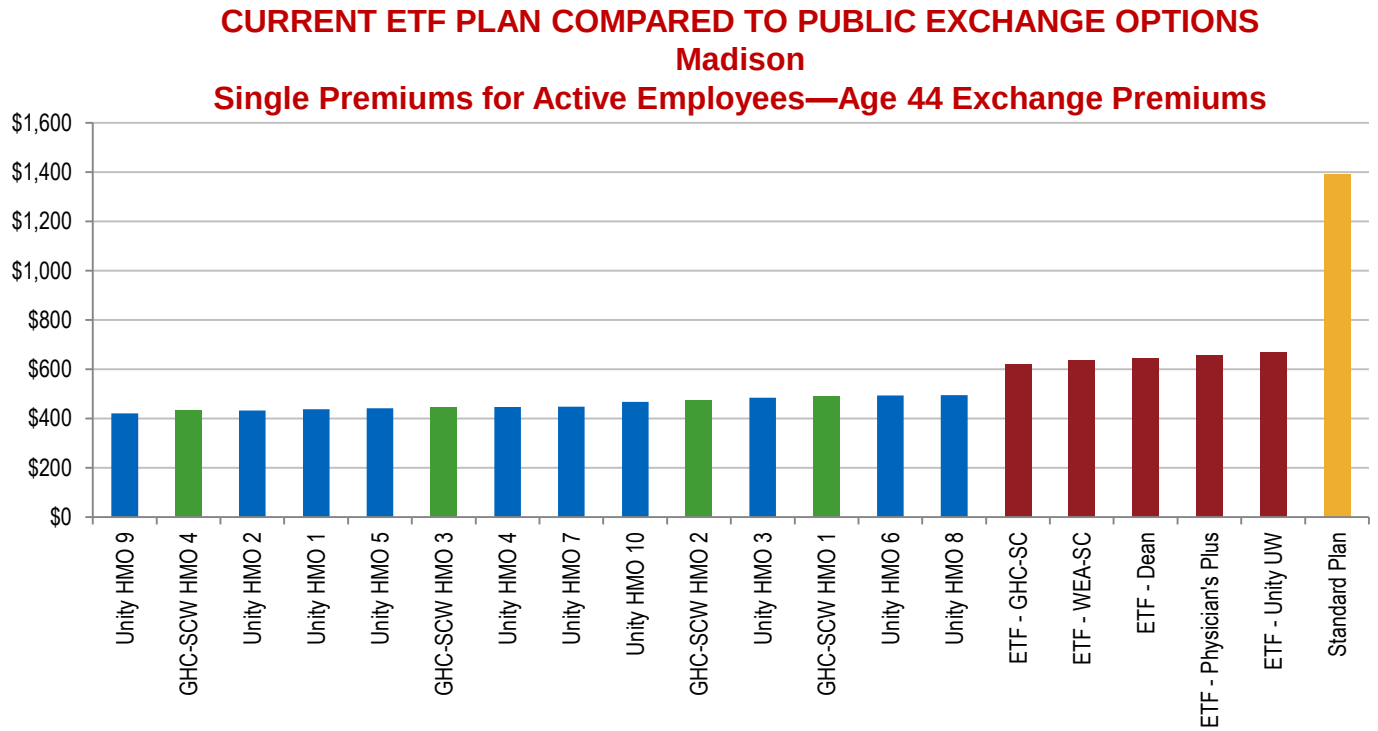
Public and Private Exchanges

PROJECTED 2015 COSTS FOR NON-MEDICARE MEMBERSHIP CURRENT ETF PLANS COMPARED WITH EXCHANGE ELECTION SCENARIOS
(IN $MILLIONS)



Public and Private Exchanges

- The State Exchange is an individual market
  - Individuals purchasing coverage on the Exchange would be expected to have higher health risk than found in a demographically similar group, particularly for Platinum Plans
- ETF should be more in line with the most competitive plans
  - Difference compared to lowest premiums is 19.9% ($240M)
  - Difference compared to average premiums 5.0% ($61M)



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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 plans within the State
  - Not all can support a self-funded ETF strategy
  - Different HMOs 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

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Self-Insurance Concepts
Reasons to Self-Insure

- **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 HMO.
- **Carrier profit margin and risk charge eliminated**—The profit margin and risk charge of an insurance 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.

Self-Insurance Concepts
Potential Drawbacks

- **HMO 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 HMOs. 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.

Self-Insurance Concepts
Recommendations

For 2016:

- Improve the HMO fully-insured renewal process
  - Enhanced focus on quality
  - Not all health plans should be Tier 1—drive enrollment towards more efficient plans
  - Improved data reporting and submissions
  - Detailed claims and encounter data
  - Expected 1-3% savings
- Self-insurance not feasible for 2016 within the current structure

For 2017:

- We believe entire program could be self-insured with appropriate structure
- Preliminary savings range from $50M to $70M if implemented
- Integrated with 2017 recommendations and part of Report 2 to GIB

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WHIO Database

- The WHIO database, as currently configured, does not provide ETF with access to the information and analytics tools needed to effectively manage the program.
- We recommend further evaluation of the WHIO Database relative to the plan management needs of ETF staff and determination of the most favorable course of action to close the gaps.
- There are four likely courses of action for ETF:
  1. Work with WHIO and Optum to expand the WHIO capabilities, reporting and data array for WHIO to become the data warehouse
  2. Continue to use WHIO for clinical and enrollment reports, but collect and develop plan financial information independently
  3. Bid and contract a new data warehouse system with a qualified contractor.
  4. Builds your own data warehouse

Our recommendation would be to start with (1) above.

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Summary

Key Recommendations for 2016

- Change Medical Plan Design
  - UBD – introduce deductibles/raise Out-of-Pocket Max/change office visit to copay
  - Standard Plan– increase deductibles/raise Out-of-Pocket Max
  - HDHP-raise HSA contribution
- Employee Contributions
  - Move from 2-tier to 4-tier structure
- HMO Negotiations & Renewal Process
  - Work with ETF to modify the tiering process
  - Update addenda to collect additional financial exhibits and require CFO/Actuary signature
  - Require detailed data submission to match addenda
- Convert Well Wisconsin from incentive to premium reward

Summary

Key Recommendations for 2016

- Pharmacy Program
  - Introduce coinsurance for brand drugs
  - Negotiate pricing guarantees in PBM contract
- Self-Insurance
  - Continue to self-insure the Standard Plan and SMP, as well as Pharmacy and Dental Benefits
  - Self-insuring HMOs for 2016 is not feasible
- Enhance WHIO capabilities to meet ETF management needs
- Establish uniform metrics to measure health plan performance
- Develop common medical management performance requirements

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

Next Steps

Going Forward the Major Steps Include:

- 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 such a 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.

Questions & Discussion

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