

Value Purchasing for State Employee Health Insurance

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Health Benefit Program: Overview

- 236,000 covered lives
- State Group Health Plan:
 - state employees, elected officials, University of Wisconsin System, legislature, state retirees
 - 71,400 active state employees and 22,300 retired state employees
- Local Group Health Plan:
 - public employer elects to participate
 - 12,300 active local employees and 2,300 retired local employees
- Estimated \$1.3 billion in annual insurance premiums for state, local and retired participants

Health Benefit Program: Structure

- Governance
 - Group Insurance Board
- Administration of Benefits
 - 16 Competing Plans
 - Standard Plan
 - State Maintenance Plan

Health Benefit Program: History

- 1984: Managed Competition
 - ❑ State paid up to 105% of the low cost health plan in each county
 - ❑ Pros: created competition
 - ❑ Cons: plans within 5% of the low cost plan were shielded from consequences, no risk adjustment
- Results:
 - ❑ plans did not aim to be the low cost bid, but 5% higher
 - ❑ system of shadow pricing drove up premiums
 - ❑ plans with a low-risk population could keep premiums low, regardless of their efficiency
 - ❑ plans with a high-risk population could not compete, even if they delivered care very efficiently

Current Health Benefit Program

- 2003: Value Purchasing
 - ❑ Program redesign addresses problems in the managed competition model
 - ❑ Incorporates pay for performance while maintaining the value added by the health plans
 - ❑ Rewards health plans that deliver exceptionally high quality care
 - ❑ Creates incentives to encourage members to select efficient, high-quality plans

Health Benefit Program: Structure

- Uniform Benefits
 - GIB controls benefit structure
 - Eliminates risk avoidance through benefit design
- Three-tier system for plans and employee contributions
 - Tier 1 – top plans in efficiency and quality, lowest employee contribution
 - Tier 2 – lower ranking plans in efficiency and/or quality, higher employee contribution
 - Tier 3 – lowest ranking plans in efficiency and quality, highest employee contribution
- Carve-out coverage for prescription drugs
 - PBM: Navitus

Annual Negotiation Process

- ❑ Plans submit detailed cost and utilization data
- ❑ Actuary evaluates utilization data and demographics
- ❑ Actuary compares cost effectiveness of each plan using sophisticated risk adjustment system
- ❑ Plans are placed in one of three tiers
- ❑ Subsequent premium bids from plans are matched against this analysis
- ❑ Plans bidding higher or lower than data submissions warrant have tier placements adjusted accordingly
- ❑ Plans are also “credited” for reporting very high quality results (i.e., HEDIS scores)
- ❑ Plans in Tiers 2 and 3 are called in for negotiations

Annual Negotiation Process *(continued)*

- ❑ Board staff and actuary review data submission with plan representatives
- ❑ Problem areas are identified and quantified
- ❑ Plans are advised on specific areas where savings could be achieved based upon the performance of their peers
- ❑ Plans are advised of the specific dollar amount that they must reduce their premium in order to be placed in a lower tier
- ❑ Plans are then given the opportunity to submit a final bid

Prescription Drugs: History

- Each health plan included the administration of prescription drug coverage
- Actuarial analysis found considerable variance in plans' effectiveness
- Rx was identified as an area that offered opportunity for savings

Current Rx Program

- 2003: Drug Coverage Carve-Out
 - Consolidated coverage under one Pharmacy Benefits Manager (PBM)
 - Restructured drug benefit co-pay from 2-level to 3-level
 - Level 1 = low cost generics, \$5 per script
 - Level 2 = mostly formulary name brand drugs, \$15 per script
 - Level 3 = non-formulary drugs, \$35 per script

Current Rx Program

(continued)

- PBM: Navitus Health Solutions
 - ❑ WI-based company specifically created to respond program needs
 - ❑ Emphasis on quality and safety first
 - ❑ Focus on obtaining drugs at the lowest net drug spend
 - ❑ Provides complete transparency in all financial transactions
 - ❑ All rebates and discounts directly passed through

Current Rx Program

(continued)

- Pharmaceutical and Therapeutics (P&T) committee
 - ❑ Comprised of practicing pharmacists and physicians from all across Wisconsin
 - ❑ Develops formulary of preferred drugs
 - ❑ Starts with agreed upon best drugs in each class
 - ❑ After 'best in class' selection, prices are considered and final formulary selections are made

Results

- Premiums (per contract per month)
 - Pre-Tiering Increases: 2000 (10.8%), 2001 (16.6%), 2002 (13.8%), 2003 (12.1%) -- 4-year average of 15.325
 - Post-Tiering Increases: 2005 (6.1%), 2006 (8.3%), 2007 (7.6%), 2008 (6.3%) -- 4-year average of 7.075

Results

- Incentives

- ❑ Plans have strong incentives to be placed in Tier 1 to attract enrollees
- ❑ Enrollees have strong incentives to select Tier 1 plans due to the lower premium
- ❑ Risk adjustment methodology levels the playing field
- ❑ Benefit levels have been maintained and high quality and safety have been encouraged and rewarded

Future Initiatives

- Mission Statement

Consistent with our statutory responsibility and the Department's mission statement, our strategic goal for the health benefit program is to deliver quality health insurance benefits to our members while maintaining the financial integrity of the plan.

Future Initiatives

- Objectives

- ❑ Plan meets the health care needs of our members
- ❑ Plan encourages innovation and appropriately incorporates changing health care technology and medical practice
- ❑ Plan design is effective in efficiently financing health benefits and containing the growth of health care costs
- ❑ Department identifies appropriate opportunities to partner with others to create change in the broader health care marketplace
- ❑ Program challenges are responded to effectively and appropriately

Future Initiatives

- Evaluation Criteria

The following questions should be answered before we allocate resources to a proposed activity.

- What is the expected product or result of the activity?
- What is the timeline of the activity and when can we expect a product or results?
- Which objective(s) will the product or result support?
- What is the cost of the activity, both in financial and staff resource costs?
- Is there a positive return on investment from that cost?
- Is the activity crucial to the success of an objective?
- What risks are involved with the activity?

Future Initiatives

□ Member Health Care Needs

- ✓ Member Services & Education
- ✓ Disease Management & Wellness
- ✓ Benefit Design

□ Innovation & Technology

- ✓ Plan Administration
- ✓ Plan Requirements

□ Cost Containment

- ✓ Data Collection
- ✓ Plan Design
- ✓ Prescription Drugs

□ Partnerships

- ✓ National and Local Resources
- ✓ Expand External Relations Efforts
- ✓ Leverage Change in Marketplace

□ Challenges / Legislation

- ✓ Public Programs Reimbursement
- ✓ Proactive Approach
- ✓ Partner with other Stakeholders

