Important Considerations Regarding the Department of Employee Trust Funds Group Health Plan Analysis

The Data Warehouse Should be Implemented Before Making Changes

1. The Data Warehouse needs to be implemented for the state to make strategic decisions about its health plan, quality and efficiency initiatives, employee health status and chronic disease management.
2. The Data Warehouse will allow the state to standardize, aggregate and analyze robust data creating a data platform that will serve as a foundation for:
    - Identifying high performing providers and health plans based on outcomes, quality, total cost of care and participant satisfaction
    - Identifying and quantifying opportunities for improvement in:
        - Wellbeing, condition management, adherence and compliance
        - Plan design, incentives and disincentives to optimize utilization of healthcare services
        - Literacy efforts, provider and health plan initiatives, and overall communications to participants
3. Once the Data Warehouse has been established and "loaded" with multiple years of claims, sophisticated and insightful analytics can provide longitudinal analysis

The State Already Collects the Data it needs to Make Informed Decisions on a plan by plan basis

1. The concern that health plans don't provide sufficient data for the state to make informed decisions about potential cost savings is not well-founded
2. The state collects significant and detailed information from health plans when they file their premium rate proposals; this information (which must be certified by an actuary or the health plan's chief financial officer) is used in the negotiating process
3. The information currently collected by the state already contains comprehensive information about how premiums are being spent, including:
    - Financial cost and utilization by segment (state employees, local employee, active employees, annuitants and graduate assistants
        - Utilization data includes: inpatient, outpatient, physician and other services
        - Detailed service line information was added in 2015
    - Disease management reporting regarding DETF-specific initiatives
    - Wellness incentive participation

- Aggregate health assessment data

4. The real proof is in the medical trend. As the DETF staff notes, the average annual increase in premium has been 3.7 percent since 2009, which is well below the national average; this has occurred even with a plan design that encourages utilization due to its minimal cost sharing.

The Comparison of ETF and ACA Exchange Plan Premiums is Flawed

1. Comparing ETF and exchange plan premiums akin to comparing apples and oranges because the premiums are calculated using different actuarial criteria. For example, ACA exchange premiums are calculated as individual rates; in the ETF plan, family rates are required to be 2.5 times the individual rate. This means that ETF's individual rates partially subsidize family rates. Some analyses have indicated that this could account for between 4% and 6% of the difference between ACA exchange premiums and ETF premiums.
2. Other factors accounting for the difference between premiums charged in the federal exchange and ETF premiums:
    a. Some provider delivery systems may have agreed to temporary or product-specific pricing arrangements for the federal exchange plan due to the number of Medicaid and uninsured people moving into the exchange in the first few years; this would result in lower exchange premiums
    b. The ETF actuarial value (as reported in Segal's second report) was 92%, which exceeded the actuarial value of all platinum plans found in Wisconsin's marketplace. The actuarial value of the midpoint gold plan in the exchange is 81% percent. This means that ETF's plan design requires significantly less employee cost-sharing, which in turn encourages health care utilization and increases premiums
3. The federal exchange market is not stable, which means the current premiums do not yet reflect the actual costs incurred on the exchange
    a. Several health plans have pulled out of the Wisconsin exchange due to medical losses and the non-profit Milwaukee cooperative that is heavily dependent on exchange business is approaching insolvency
    b. Exchange plans have seen annual premium increases that are four to five times higher than DETF premium increases

Segal's Regionalization Strategy Would Reduce Competition, Plan Efficiency

1. Current provider regions are "organically grown" by plans and providers based on the provider service territory they can sustain both in terms of cost efficiency and quality; this ensures future stability built on historical success
2. The Segal approach would create a top down structure that would not be aligned with existing provider networks and dilute the delivery system strength
3. The Segal approach favors out-of-state national plans that blanket the country with provider networks built based on geographical access not quality and efficiency
    a. The primary focus would be on administration; less focus on locally targeted quality and cost-efficiency initiatives
4. The Segal approach would harm local community plans because they would have to shift their focus from quality and efficiency improvement to network adequacy issues
    a. In order to build adequate provider networks in the new arbitrarily defined networks, plans would be at a negotiating disadvantage with new providers, which could lead to increased costs; it could also jeopardize the ability to provide clinically integrated care, which has been a hallmark of

Wisconsin's quality health care delivery system Some local community plans may not be able to compete as effectively throughout the new regions, reducing competition for both the ETF plan and private-sector employers

5. Any administrative efficiencies the state would realize with fewer plans would be offset by lost negotiating leverage (because there are fewer plans); this may not be readily apparent in the early years, but would evolve over time
6. There could be considerable disruption to long-standing patient-provider relationships, especially with smaller plans that could not compete in new geographical regions
7. Once the Segal strategy is implemented, it would be very difficult to "roll back" if it failed to achieve goals

The Higher Illness Burden in State Group Health Program Population Drives Costs

1. Participants in the State Group Program have a higher illness burden than typical employer groups possibly due to lower turnover and longer tenure of employees
2. HCTrends study using WHIO data indicated that integrated delivery systems treat chronic care more efficiently (use less overall resources) with higher overall quality
3. Changing the current structure could jeopardize the efficient delivery of chronic care services by integrated providers, which may increase costs and lower quality due to the lack of clinical integration