The State of Wisconsin's Employee Group Health Benefit Program: An Overview

by Tom Korpady
Administrator, Division of Insurance Services, State of Wisconsin Employee Trust Funds

The State of Wisconsin has taken a different approach in its Employee Group Health Benefit Program by combining consumer involvement with pay for performance. A major advantage of this new approach is that it accurately compares the efficiency of the plans using not just price, but also utilization and intensity of health care services. Certain providers may have low prices, but may actually end up costing more through over prescribing services or prescribing more expensive services. The Group Insurance Board redesigned the program by: (a) developing a three tier-employee contribution system in response to calls for greater employee participation in the cost of their health care, (b) incorporating a reward system to provide an incentive for health plans to deliver exceptionally high-quality care, and (c) consolidating prescription drug coverage in the state's health plans to leverage the state's huge purchasing power. When most employers are facing double-digit increases in health care costs, Wisconsin has held premium increases to only 5% for current employees and actually decreased premiums by over 6% for retired state workers. At the same time, benefit levels have been maintained, and high-quality health care has been encouraged and rewarded.

In its Employee Group Health Benefit Program, the State of Wisconsin has taken a different approach to improving health care quality and curbing costs by combining consumer involvement with pay for performance (i.e., value purchasing). This approach differs from using only the consumer-directed model in that the payor (i.e., the state) also takes responsibility for deciding which providers offer the best value, rather than leaving that task entirely to the consumer (i.e., the employee). A major advantage of this new approach is that it accurately compares the efficiency of the plans using not just price, but also utilization and intensity of health care services. Certain providers may have low prices, but may actually end up costing more through over prescribing services or prescribing more expensive services.

Building on a successful managed competition approach in effect since 1984, the Group Insurance Board redesigned the program in a way that incorporates pay for performance techniques, while maintaining the value added by the participating health plans. Specifically, the Board

- developed a three-tier employee contribution system in response to calls for greater employee participation in the cost of their health care,

- incorporated a reward system to provide an incentive for health plans to deliver exceptionally high-quality care, and
- consolidated prescription drug coverage in the state's health plans to leverage the state's huge purchasing power.

In the face of double-digit increases, Wisconsin's health insurance premiums increased only 5% for current employees and decreased 6% for retired state workers.

The cumulative results from each of these initiatives have been very encouraging. At a time when most employers are facing double-digit increases in the cost of their health insurance, the State of Wisconsin will see an increase of less than 5%. The premiums for retired State employees will actually go down by over 6% next year. At the same time, benefit levels have been maintained, and high-quality health care has been encouraged and rewarded. Each aspect of the State's program redesign are described in more detail below.

Three-Tier Employee Contribution System that Rewards High Quality Care

The three-tier employee contribution system was developed to address several problems that existed under the old method of determining the employee's share of the premium, two of which are described here. First, for almost 20 years, the State would pay up to 105% of the low-cost health plan in each county. This system did create some competition between the plans, but it also had some unintended consequences. For example, the employer contribution was tied to 105% of the low cost plan, with employees required to pay anything that exceeded that amount. Thus, plans that bid within 5% of the low cost plan were shielded from the consequences of their bids because the employee's out-of-pocket cost would not vary. Therefore, rather than striving to submit the lowest-cost bid, plans targeted their premiums at 5% above what they estimated the low-cost bid would be. This created a situation of shadow pricing that tended to drive up premiums higher than necessary.

Second, the system also failed to account for differences in the risks faced by the participating plans. Plans that could attract a younger and healthier population could easily keep their premiums low, regardless of how efficient they were at delivering care. However, plans that attracted older or higher-cost enrollees could not compete, even if they delivered care very efficiently.

For years, the Board had collected HEDIS (Health plan Employer Data Information Set) quality measures from all of the participating health plans. Yet the Board did not have a way to reward plans for very high performance under the old premium-contribution formula. The Board did publish the HEDIS results on quality annually in the Dual Choice Enrollment Booklets distributed to all state employees, but there was little evidence that members took these measures into account when they made their enrollment decisions.

The new three-tier system has addressed these problems. Under this new system, plans are placed in one of three tiers, and the employee's share of premium varies according to that tier placement. Plans in Tier 1 cost the employee the least; plans in Tier 2 cost the employee more, while plans in Tier 3 cost the employee the most. Plans have a strong incentive to be placed in Tier 1, because the low cost share required of employees may attract the most enrollees.

Each year, the Board collects from each plan detailed cost and utilization data prior to the plan's bid submission. The Board's actuary evaluates this data. Using the demographics of each plan and a sophisticated risk-adjustment system, the Board actuary compares how cost effective each plan is in delivering health care. Because of this risk adjustment, the comparison is accurate, and plans do not benefit by having a younger or healthier population. The plans are then placed in one of three tiers. The most cost-effective plans are placed in Tier 1, moderately cost-effective plans are placed in Tier 2, and the least cost-effective plans are placed in Tier 3.

If the plans' subsequent premium bids match their data submissions, their placement in the tiers remains. If the plans bid higher or lower than their data submissions, their tier placement is adjusted accordingly. Also, at this point, plans that have very high quality results are given credit. A plan that may have been originally placed in Tier 2, but had very high quality scores could move into Tier 1. Plans that still remain in Tiers 2 and 3 are then called in for negotiations.

During the negotiation process, the Board's staff and the actuary reviews the data submission with plan representatives. Areas where the plan may be less cost effective are identified and quantified. In some cases, plans may be paying very high physician charges, or may have longer average lengths of stay. Plans are advised of specific areas where savings could be achieved based upon the performance of their peers. Finally, each plan is 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.

The negotiation process with health plans this past year saved Wisconsin more than $14.5 million.

This new system has proven to be very cost effective. Savings from the negotiation process this past year were in excess of $14.5 million.

Consolidating Prescription Drug Coverage

The other major strategy in the Board's new approach involved changing the way prescription drugs were purchased. In previous years, each plan was responsible for managing and covering prescription drugs. Based on the actuary's analysis of their data, some plans did this very effectively, while others did not do as well. Since prescription drug costs are one of the fastest-rising components of health care, the Board felt this area offered a real opportunity for savings.

To leverage the purchasing power of a large employer like the State, the Board carved the drug coverage out of state health plans and consolidated it under one Pharmacy Benefits Manager (PBM). The PBM that was chosen, Navitus Health Solutions, is a Wisconsin company that was specifically created to respond to the Board's needs. The Board wanted to emphasize quality and safety first, while obtaining the drugs at the lowest net drug cost. The Board (a) demanded complete transparency in all financial transactions with the drug manufacturers, and (b) required that all rebates and savings from discounts be passed through to the plan. This allowed the Board to avoid the misaligned incentives that have plagued the more traditional Pharmacy Benefits Management Industry.

The new Pharmacy Benefits Manager created a Pharmaceutical and Therapeutics (P&T) committee comprised of practicing pharmacists and physicians from all across Wisconsin. This committee developed a formulary of preferred drugs.

First, the committee decided on the absolute best drugs in each class. Then, once those "best in class" drugs were chosen, the prices were considered and final formulary selections were made.

In order to encourage state employee members to support this formulary, the Board changed the drug benefit under the program from a two-level to a three-level copay structure. The first level consists mostly of low-cost generics and costs the consumer a $5 copay per prescription. The second level consists mostly of formulary brand name drugs and cost the consumer a copay of $15 per prescription. The third level is primarily nonformulary drugs with a $35 copay per prescription.

For the coming year, the state employee plan will spend 6% less on prescription drugs than it did in 2003.

This new prescription drug initiative has succeeded beyond the most optimistic projections. In the first year, tens of millions of dollars have been saved. For the coming year, the State employee plan will actually spend over 6% less than it did in 2003.

Conclusion

In summary, the State of Wisconsin's employee group health benefits system has included pay for performance (i.e., value purchasing) and consumer involvement through its (a) three-tier employee contribution system that rewards high-quality health care and (b) consolidated prescription drug coverage. The State of Wisconsin has taken responsibility for deciding which provider offers the best deal rather than leaving the decisions entirely to the consumer. For example, a consumer may select a hospital based on the lowest daily rate, but the State has additional information which also allows factoring in other drivers of the total cost of health care, such as the average length of hospital stays for a particular health condition. The State of Wisconsin was also able to leverage its purchasing power as a large employer to negotiate with prescription drug companies in ways that an individual consumer is unable to do. Consumers were also more involved in health care decisions through the development of a three-tier employee contribution system.

The initial results of this approach are promising. When most employers are facing double digit increases in health care costs, Wisconsin has held premium increases to only 5% for current employees and actually decreased premiums by over 6% for retired state workers.

Tom Korpady have been with the Wisconsin Department of Employee Trust Funds for 27 years, and is currently the Administrator of the Division of Insurance Services. His division is responsible for program design, policy development, and administrative oversight of all the insurance and disability benefit programs for public employees in the Wisconsin Retirement System.