

Overview of the 3-Tier Managed Health Care Model And Pharmacy Benefit Manager

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What is the 3-Tier Health Insurance Program?

- The cost of state employee health insurance is rising by over 10% every year. The 3-Tier Health Insurance Program is an innovative approach that will hold costs down by creating incentives for health plans to reduce their costs to the state, and by encouraging state employees to choose the plans that are most efficient in providing quality health care.
- Each plan is analyzed by the Department of Employee Trust Funds (ETF) to evaluate its true cost of providing benefits under the state employee health insurance program. The most efficient plans are placed in Tier 1, the moderately efficient plans in Tier 2, and the least efficient plans in Tier 3.

How is the 3-Tier Health Insurance Program Better Than the Current Program?

The tiered approach addresses the following **problems** of the current program, while maintaining or enhancing the competitive pressures of the program.

- “Shadow pricing”: Under the current formula, the state pays health plan premiums of up to 105% of the lowest-cost health plan. Any plan that can remain within 5% of the lowest bid is provided at no cost to employees, just like the plan that submits the lowest bid. This formula encourages health plans to bid 5% above what the plans “guess” will be the lowest bid from their competitors. The plan with the lowest bid gains no competitive advantage in attracting members, because the cost of the plan to their members is the same as the cost of more expensive plans. In fact, the current formula discourages plans from being the low cost plan.
- Rewards plans with younger and healthier population: The current formula tends to reward plans that serve younger and healthier populations, leading to rising costs for plans with older or less healthy populations. This led in some cases to plans withdrawing from the state employee health insurance program because they faced ever-increasing adverse selection (attracting less healthy people into the plan). The 3-Tier approach analyzes the risk factors of the populations served by each health plan and considers the plan’s efficiency in light of the population it serves. This is a more equitable evaluation of the plans than the current formula, which considers only the health plan’s cost for providing service, regardless of the population it serves.
- Different employee contribution rate just for residing in a different county: The current formula is calculated on a county-by-county basis. As a result, employees who select the same plan may be forced to pay significantly different out of pocket premium shares, just because they may live in different counties. The 3-Tier approach is more equitable as the contributions will be the same for any plan within a Tier throughout the state.

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Will there be Different Benefit Levels in Each Tier?

- No. The level of medical insurance benefits will be the same, regardless of the tier to which the plan is assigned. Plans must meet requirements for uniform medical insurance benefits to qualify for participation in the state health insurance program. Individual plans may offer additional benefits, such as dental or vision coverage.
- If different benefit levels were provided, the lower cost/lower benefit level plans would attract people who need the least health care, while the higher cost/higher benefit tiers would attract people who need the most care. This would shift costs to employees with the most pressing health needs, without creating any incentives for plans to operate efficiently.

If I drop my health insurance coverage through the State because I have coverage under my spouse's private employer plan for 2004, what are my options for coming back to the State program in the future?

- In the event you lose eligibility for the coverage under your spouse's plan, or if your spouse's employer premium contribution ends for that plan, you have a special 30-day enrollment opportunity to become insured in the State group health insurance program without waiting periods for pre-existing conditions, if otherwise eligible.
- However, if you do not have a special enrollment period as described above and wish to enroll at a later date in the State's program, assuming you are otherwise eligible, you (and your family members if you elect family coverage) will be limited to the Standard Plan with a 180-day waiting period for all pre-existing medical conditions except pregnancy.

Will all State employees have access to a Tier 1 plan, even if there are no qualified plans in their county?

- To ensure that State employees have access to a Tier 1 health plan, the Group Insurance Board (GIB) directed ETF to develop a self-insured plan that qualifies for Tier 1 assignment. As a result, the State Maintenance Plan (SMP) will be available in the counties that do not have a qualifying Tier 1 plan including, by definition, those counties with no qualifying Health Maintenance Organizations (HMOs).

Will the State Maintenance Plan still be offered?

- Yes, but only in those counties in which there are no qualifying Tier 1 plans available.

If a plan is not in the first tier, does that mean it provides lower quality health care?

- No. The GIB will not allow such a plan into the program. This is verified by ETF's collection of data from the Consumer Assessment of Health Plans (CAHPS) survey, the Health Plan Employer Data and Information Set (HEDIS), and other quality measures.

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Plans that do not make Tier 1 placement are those that are less cost effective in managing care, costs, and quality.

Will Co-Pays and Deductibles Change Under the 3-Tier Model?

- The GIB establishes these rates based upon extensive analysis to encourage health care consumers to utilize the most efficient and medically appropriate alternatives available to them. There are no plans to revise the current co-pays and deductibles for 2004 for non-prescription drug benefits.

Has the One-Plus-One (2 person family group) Been Considered as an Option Under the 3-Tier System?

- This approach was considered, but it was not adopted because it would not reduce the premiums charged to the state. Premiums for family coverage are currently set at 2.5 times the premium rate for single coverage. The GIB is responsible for setting that ratio, and closely monitors costs to make sure that the ratio remains reflective of costs.
- After analysis of the costs, the GIB has decided not to recommend changes to the current premium structure. This decision is supported by ETF's analysis of the actual health care costs of families consisting of two persons as compared to the costs of families with three or more persons.
- Two person family groups are frequently couples in their 50s and 60s. Health care costs typically increase dramatically for people over 50 years old. Their costs are comparable to family groups with three or more people, who are most frequently couples in their 20s, 30s and 40s. It is often as cheap, or cheaper, to insure larger family groups whose adult members are younger, even though more people are covered.

What Kind of Quality Checks will this New 3-Tier Program Have?

- Wisconsin's state employee health insurance program already incorporates quality reporting requirements into the evaluation of health plans that wish to participate in the state program.
- In addition, the state will begin requiring health plans to collect and report the quality and health outcome data of their hospitals and other providers in a format that was recently approved by the National Quality Forum (NQF). The NQF is a private, nonprofit entity that is developing comprehensive hospital quality measurements and a public reporting strategy consistent with national aims for quality improvement in health care. This information will be shared with state employees through the open enrollment materials and other ETF publications.

When will the 3-Tier Health Insurance Program Become Effective?

- The 3-Tier program is scheduled to become effective in January of 2004. The annual fall open enrollment brochure will provide specific information on each of the qualifying health plans.

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Will the tiered rate structure affect any of the normal operations of health plans, such as the payment of claims?

- The three-tier rate structure will not affect the operation of the current plans or their current method of paying medical providers.

How is the Standard Plan with a preferred provider network different from the current Standard Plan and Standard Plan II?

- The current Standard Plan has become the in-network level of benefits, and the Standard Plan II has become the out-of-network benefits. Refer to the *It's Your Choice* book, page G-46 and G-47 for more details. After December 31, 2003 the current Standard Plan and Standard Plan II will no longer be available.
- On January 1, 2004, under the Standard Plan, when you receive services from network providers, you will need to meet an up-front deductible. The in-network deductible will be \$100 single/ \$200 family. However you will not have to pay the 80% co-insurance under the old major medical portion of the plan. All benefits will be paid at 100% of charges, after the deductible.
- If you use out-of-network providers, you will have a \$500 single/\$1,000 family deductible and co-insurance costs. Please keep in mind that these deductibles accumulate separately, so the in-network deductible does not apply to the out-of-network deductible, and vice versa.
- A few other benefits have been adjusted to keep the overall benefit level comparable and to fit in with the preferred provider network concept. The lifetime maximum benefit will increase to \$2,000,000 to more closely match Uniform Benefits. Prescription drug coverage will be administered by the PBM so the drug co-payments will align with those of Uniform Benefits, except the annual prescription out-of-pocket maximum for drug co-payments is \$1,000 single/\$2,000 family. The Standard Plan and Standard Plan II did not have an out-of-pocket drug maximum before. These out-of-pocket maximums are separate from your medical out-of-pocket costs.

By placing the now State Standard Plan (Preferred Plan Provider – PPP) in the highest cost tier (Tier 3) and capping the employee contribution, is that the same as applying a catastrophic cap?

- This is not the same as a catastrophic cap. By placing the new Standard Plan (PPP) in a tier, the employee's out-of-pocket *premium contribution* will be capped.

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What is the Pharmacy Benefit Manager (PBM) and how will it work?

- The PBM is a third party administrator of a prescription drug program. The PBM manages the relationship between the state, pharmacies, and drug manufacturing companies. PBMs are primarily responsible for processing and paying prescription drug claims. They also negotiate discounts with large drug manufacturing companies, and develop contracts with pharmacies.
- The procedures employees use to fill and acquire prescriptions will be very similar to the current process, including picking up their prescriptions at the pharmacies they currently use. In addition, more options will be provided, such as mail order for some prescriptions.
- PBMs do not manage the prescriptions that are written. The PBM will help the state to negotiate better prices from drug companies and pharmacies, and hold down the dramatic increases in prescription drug costs. Prescription drug cost increases are one of the major contributing factors to the rising cost of health care nationwide.
- Because the claims are processed through the system managed by the PBM, the PBM will serve as a check and balance over harmful drug interactions.
- The PBM will not determine the co-payments paid by employees for prescription drugs. Co-payments for prescription drugs are determined by the GIB. Effective January 2004, the following is the co-payment schedule approved by the GIB.

Level 1	\$5.00 (unchanged from current)
Level 2	\$15.00 (reduced from \$17.25)
Level 3	\$35.00 (new level)

What is a formulary and how is it developed?

- A formulary is a list of preferred prescription drugs that are determined to be medically-effective and cost-effective. The Navitus formulary has been developed by a pharmacy and therapeutics committee, which includes a statewide group of physicians and pharmacists. Drugs are evaluated on the basis of effectiveness, side-effects, drug interactions, and then cost. On-going efforts to review new drugs will keep the formulary up-to-date and ensure that patient needs are being met.

How will I know if my prescription drug is on the formulary and which level it is in?

- Navitus will mail an abbreviated formulary to all participants in mid-December. In addition, the complete formulary will be listed on its Web site, www.navitushealth.com, after October 1, 2003. You may also contact Navitus customer service toll-free at 1-866-333-2757 with questions about the formulary.

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Why won't the Level 3 co-payment be applied towards my annual prescription drug out-of-pocket maximum?

- The three-level prescription drug benefit is designed to encourage participants to use prescriptions listed on the formulary when possible. This allows our PBM to negotiate greater cost savings because these drugs will likely be prescribed more often than equivalent non-formulary prescription drugs.

Will there be prescription drugs that require a prior authorization from the PBM?

- Yes. Navitus will identify some prescription drugs that will require prior authorizations, which are typically initiated by the prescribing physician on behalf of the member. More information about prior authorizations will be available on their Web site after October 1, 2003. All participants will receive information from Navitus in December.

Can I continue to purchase prescriptions from my current pharmacy, even when my pharmacy is part of my clinic or urgent care center?

- In most cases, you will be able to continue using your current pharmacy. Navitus contracts with most national pharmacy chains and due to affiliations with other pharmacies in the State, members may have more choices than in the past. Navitus will post a list of network pharmacies on their Web site, or you can call their customer service to check if your pharmacy is in its network.
- If you previously received your prescription from a mail order company, you will likely need to re-submit the prescription to the PBM mail order vendor if you wish to use mail order services.

Where can I get more information?

For the very latest information on health insurance program changes, please check the following resources:

- DETF's Internet site at <http://etf.wi.gov>.
- *It's Your Choice* book
- DETF's Telephone Message Center at 1-800-991-5540 or (608) 264-6633.
Attend a health fair in your area during the Dual-Choice period, which begins October 6. The schedule is posted on our Web site and can be found in *It's Your Choice*.