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Correspondence Memorandum

Date: May 17, 2017

To: Group Insurance Board

From: Renee Walk, Strategic Health Policy Advisor
Office of Strategic Health Policy

Subject: 2018 Group Health Benefit Program Changes

ETF requests Group Insurance Board (Board) approval for the following health benefit program changes:

1. **Wellness premium differential for 2019;**
2. **Medication Therapy Management (MTM) expansion for the pharmacy benefit;**
3. **Addition of comprehensive audit reporting requirements; and**
4. **Contract changes resulting from the self-insuring/regionalization procurement and negotiation process.**

Wellness Premium Differential for 2019

Following the Board's approval of a wellness incentive redesign in February 2017, ETF staff began to investigate the feasibility and best timeline for implementing a premium differential for members who participate in wellness activities through the Board's new wellness and disease management vendor, StayWell. This differential would replace the current Well Wisconsin gift card incentive. The current incentive is taxable at a 40% rate as a gift card; providing that same incentive as a premium reduction would not be taxable.

ETF staff discussed requirements with both Department of Administration (DOA) and University of Wisconsin System Administration (UWSA) payroll managers. Based on these meetings, both DOA and UWSA should be able to accommodate the premium differential change. Both payroll managers did, however, recommend that ETF delay the implementation of the premium differential to 2019 in order to accurately build capabilities into all affected systems. ETF is also evaluating its enrollment systems to determine how to process the change.

Implementation of the premium differential in 2019 has the added benefit of allowing sufficient time to promote the change. Communications for year one of the StayWell contract have primarily focused on the new portal and driving initial engagement in the

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy
Lisa Ellinger Electronically Signed 5/18/17

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Board's new wellness platform. Promoting the new incentive structure in the fall 2017 It's Your Choice enrollment period will allow StayWell to fully develop and carry out its 2018 communications plan on this topic. This timeframe will also afford employers time to plan for increased on-site health screenings, and a full year for participant outreach and education.

ETF also plans to explore requiring additional wellness-related activities for 2018, beyond the current screening and health assessment requirements.

Pharmacy Benefit Program Changes
ETF recommends expanding access to Medication Therapy Management (MTM) services to the entire participant population. MTM is a type of medication counseling provided by pharmacists. The goal is to help members who are filling prescriptions through the pharmacy benefit program understand what their medications do, how they should be taking those medications, and what interactions might occur between medications.

Currently, MTM is only available to participants who are enrolled in Medicare as a part of the Employer Group Waiver Plan (EGWP). Expanding MTM will help the Board deliver the most effective drug coverage program. MTM would be optional to participants. MTM is available from all PBM RFP proposers, with cost to be determined through contract negotiations.

Audit Reporting Requirements
ETF audit staff recommends adding a requirement for Service Organization Controls (SOC) 1, Type 2 reporting to all future vendor contracts. Type 2 reporting is done over a specific audit period, and also demonstrates how the organization operated over the audit period under the specific procedures and controls in place. This type of SOC 1 report provides assurance not only on the design but also the effectiveness of controls.

Self-Insuring/Regional Structure Changes
In August 2016 ETF brought Agreement changes to the Board to consider in preparation for changing to a self-insured program model. Several of those changes are recommended regardless of the program's funding model, while others apply only to a self-insured program.

Table 1 lists a brief description of the changes that would apply in both a self-insured and fully-insured model. ETF plans to use the updated Agreement in either a fully- or self-insured program model.

Table 1. Agreement Changes for All Program Structures

Topic	***Description of Change***	***Rationale***
Plan qualification status	Remove references to qualification status.	Per the regionalization requirements, contractors must meet the minimum provider availability requirements in all counties in the region where the plan is offered.
Primary care provider (PCP) required	Add requirement that each participant must select or be assigned to a PCP.	Supports data warehouse vendor requirements and strategic program goals related to population health management.
Biometric screenings	Clarification of intent that incentive payments issued to participants must be reported to ETF for tax reporting purposes, as well as coverage language to reflect sole-source wellness vendor.	Clarifies the reporting requirements when incentive payments are issued to participants, which are needed for tax reporting purposes. Also removes additional screening language from uniform benefits that is appropriately addressed by preventive screening coverage.
Definition of DEPENDENT for legal wards	Clarification	Clarifies that a legal ward must be a permanent legal ward for benefits to apply.
Definition of SUBSCRIBER	Clarification	Clarifies that subscribers include annuitants.
Re-enrollment rights due to member fraud Re-enrollment rights due to member acts of abuse	Modify language to reflect the Board's authority to limit re-enrollment following member fraud.	Following the alignment of benefits between the IYC Access Plan (formerly the Standard Plan), the Board would determine re-enrollment rights of a member.
Provider guarantee	Replace existing provider guarantee language with continuity of care provisions from Wisconsin Statutes.	Administrative simplification
Clinical performance guarantees	Add performance measure requirements as outlined in GIB Item 3C.	Clarifies clinical performance measures are tied to gain sharing arrangements.

Table 2 lists changes that would only apply to a self-insured program.

Table 2. Agreement Changes for Self-Insured Program Only

Topic	***Description of Change***	***Rationale***
Organ re-transplantation	Remove limitation of one transplant per organ, per participant, per health plan during the lifetime of the policy.	The original limitation related to risk burden of plans in cases where a member may require subsequent transplants. Spreading risk is not necessary in a self-insured plan.
Rate-making process	Remove description of the rate-making process.	If self-insured, the Board's actuaries will determine premium rates based on claims experience and other financial data.
Proposal process	Remove description of proposal process and requirements.	This procurement process would no longer apply in a self-insured program.
Independent/external review	Modify review process to reflect HHS-administered federal external review language.	If self-insured, contractors would be required to use the federal process to handle external reviews.
Mid-year plan transfers	Modify language to allow accumulations for deductibles, out-of-pocket limits, and maximum out-of-pocket limits to transfer when a member makes a mid-year plan change.	In a self-insured model, there is no need to spread costs that might be incurred by moving a member's cost sharing accumulations with that member.

Other clerical changes have been made to the Schedule of Benefits within UB as a result of the contracting process. These have been noted in Attachment A, the Summary of Contract Changes, and are available in Attachment B.

Other Items of Note

At the February 2017 Board meeting, ETF presented the possible removal of the dual-enrollment requirement for the High Deductible Health Plan (HDHP). Under that requirement, State GHIP participants electing the HDHP must also enroll in the Board's Health Savings Account (HSA). The dual-enrollment requirement is intended to help participants successfully plan for health care expenses. However, some participants may be negatively impacted by the requirement. Annuitants and continuants are not eligible for the employer contribution to the HSA. This often results in annuitants and continuants electing the HSA solely to meet the dual-enrollment requirement and shouldering the monthly account maintenance fees that would otherwise be covered by the employer.

ETF legal counsel has advised that no federal law would prohibit offering the HDHP decoupled from the HSA. However, changes are required to Wisconsin law in order for the dual-enrollment requirement to be removed. In light of the Board's direction to make minimal benefit changes for plan year 2018, as well as the necessary change to state law, ETF does not recommend pursuing the removal of the HDHP and HSA dual-enrollment requirement for plan year 2018.

Staff will be at the Board meeting to answer any questions.

Attachment A: 2018 Health Benefit Program Agreement Changes
Attachment B: State of Wisconsin Health Benefit Program Agreement (Red-line Draft)

2018 Health Benefit Program Agreement Changes

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Organ Retransplantation		
2018 Agreement: 200 Program Requirements: 230 PROVIDER CONTRACTS **2017 Contract:** Guidelines: II. General Requirements, E. Provider Agreements, 6.	If self-insured, this limitation will be removed. [In a self-insured model, there is no longer the need to spread the risk among the plans.]	Provider agreements for transplants are expected to specify that re-transplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered ~~and is not subject to the Uniform Benefits exclusion on re-transplantation~~.
2018 Agreement: 400 Uniform Benefits: III. BENEFITS AND SERVICES, A., 18. **2017 Contract:** Uniform Benefits: III. BENEFITS AND SERVICES, A., 18.		~~Limited to one transplant per organ (which applies to items b., e., f., and g. as listed below) per PARTICIPANT per HEALTH PLAN during the lifetime of the policy, except as required for treatment of kidney disease.~~
2018 Agreement: 400 Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, A., 6., c. **2017 Contract:** Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, A., 6., c.		~~Retransplantation or any other costs related to a failed transplant that is otherwise covered under the global fee. Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.~~
2018 Agreement: 400 Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, B., 8. **2017 Contract:** Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, B., 8.		~~Only one transplant per organ per PARTICIPANT per HEALTH PLAN is covered during the lifetime of the policy, except as required for treatment of kidney disease.~~

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Rate-Making Process		
2018 Agreement: 100 General: 130 PREMIUMS **2017 Contract:** Guidelines: II. General Requirements, H. Rate-Making Process	If self-insured, the Board's actuaries will determine premium rates based on claims experience and other financial data.	~~Each plan must include in its proposal to the BOARD a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the BOARD insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans are encouraged to separate higher cost providers within geographic areas under the tiered structure into separate plans. The state and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. Plans shall provide rates for each of the program options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.~~ ~~The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The DEPARTMENT reserves the right to audit, at the expense of the plan, the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.~~ ~~Any health plan approved by the BOARD will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. The BOARD reserves the right to reject any plan's bid when the BOARD believes it is not in the best interests of the State of Wisconsin Group Health Benefit Program. The BOARD reserves the right to reopen the bid process after final bids are submitted when the BOARD determines that it is in the best interests of the State of Wisconsin Group Health Benefit Program. The BOARD limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:~~ ~~• Individual (Employee Only)~~ ~~• Family (Employee Plus Eligible Dependents)~~ ~~• High Deductible Health Plan (HDHP) Option for eligible non-Medicare individual and family health insurance premium rates.~~ ~~•Medicare Coordinated~~ ~~- Individual~~ ~~- Family 2 (all insureds under Medicare)~~ ~~- Family 1 (at least 1 under Medicare, at least 1 other not under Medicare)~~ ~~• Graduate Assistants1:~~ ~~- Individual~~ ~~- Family~~ ~~• Deductible, Coinsurance and HDHP Options for Local Program~~ ~~- Individual~~ ~~- Family~~ ~~1. Family rates (regular coverage) must be 2.5 times the individual rate.~~ ~~2. Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in Table 7 of Addendum 1 without written justification. It may not exceed 50% of the single rate for regular coverage, unless determined by the BOARD's actuary to be lower; Medicare family 2 eligible rate shall be 2 times the individual Medicare coordinated rate; Medicare family 1 rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).~~

Section Reference	Description of Change	Proposed Language in 2018 Agreement
(Cont.) **2018 Agreement:** 100 General: 130 PREMIUMS **2017 Contract:** Guidelines: II. General Requirements, H. Rate-Making Process	*(Cont.)* If self-insured, the Board's actuaries will determine premium rates based on claims experience and other financial data.	~~3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate. It may not exceed the calculated rate in Table 7 of Addendum 1 without written justification.~~ ~~4. Deductible, Coinsurance and HDHP Options for Local Program: The ratio is to be determined annually by the BOARD's actuary based on the relative value of these plans to the Traditional plan.~~ ~~5. Local Program: Rates must be no greater than 1.5 times the rate for the state program unless the local group is sufficiently large that the rate is justified by experience, as determined by the BOARD's actuary.~~ ~~6. The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of genuine demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within-range percentage to conform with these Guidelines. The plan will then have the option of accepting the adjusted rates or withdrawing from the State of Wisconsin Group Health Benefit Program.~~ ~~7. The BOARD will assess administration fees to cover expenses of the Department of Employee Trust Funds. This charge is added by the BOARD to the rates quoted by each alternate health plan and is collected prior to transmittal of the premiums to the alternate health plans.~~ ~~8. Include completed Table contained in Addendum 1.~~ ~~9. Plans shall not include in their rate any claims that they decide to pay outside the Uniform Benefits contract.~~ The BOARD determines the PREMIUM for its self-insured benefit plans as part of the HEALTH BENEFIT PROGRAM. This PREMIUM is established after review of claims experience, trends, and other factors, after consultation with the BOARD'S consulting actuary. To assist the DEPARTMENT and the BOARD'S consulting actuary with determining PREMIUM projections, the CONTRACTOR shall provide rate renewal reports that shall include, but not be limited to: 1) Projection of incurred claims costs for the renewal benefit period. 2) The most recent thirty-six (36) months of incurred/paid triangular reports for the current benefit period. 3) Complete documentation of the methodology and assumptions utilized to develop the projected costs. 4) Disclosure of supporting data used in the calculation, including monthly paid claims and enrollment, network provider fee-structure analysis, provider negotiations updates, utilization analysis to report on unusual patterns, large claims analysis, trend analysis, and demographic analysis. 5) Substantiation of any proposed increase in fixed costs, such as administrative costs, via a thorough analysis of activities and costs covered by those fees. 6) Explanations for any unusual trend results (high or low relative to the market). The CONTRACTOR will work with the BOARD'S consulting actuary independently to agree on a format, and the frequency of providing this data.

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Proposal Process		
2018 Agreement: N/A **2017 Contract:** Guidelines: II. General Requirements, I. Submission of Proposals	If self-insured, these requirements will be removed, as they do not apply under the new procurement process.	~~Proposals to participate in the State of Wisconsin Group Health Benefit Program must be submitted to the BOARD and address each of the requirements in Section II of the Guidelines. In addition to requirements previously cited, each plan proposal must be received by April 15 and include:~~ ~~1. Fifteen (15) copies.~~ ~~2. Specific listing of the plan's pre-authorization and referral requirements.~~ ~~3. A description of case management and disease management activities.~~ ~~4. A list and count of providers under contract arranged by county of practice for state employees, and by zip code for local employees. An electronic version of the listing must also be made available. The BOARD will expect an updated listing by July 23 in order to determine what areas will constitute your service area.~~ ~~5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must be in writing and address the method used for providing services and processing claims under such circumstances.~~ ~~6. An organizational chart.~~ ~~7. Statement of agreement to abide by all the terms and conditions set forth in the "Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits" document.~~ ~~8. If a PPP, include a schedule of benefits.~~
TOPIC: Independent / External Review		
2018 Agreement: 200 Program Requirements: 245F EXTERNAL REVIEW **2017 Contract:** State and Local Contracts: ARTICLE 2 ADMINISTRATION 2.10 GRIEVANCE PROCEDURE, (2)	If self-insured, contractors will be required to use the federal process and vendor to handle external reviews.	The PARTICIPANT shall have the option to request an HHS-administered federal external review. In accordance with federal law, any decision by an Internal Review Organization (IRO) is final and binding. PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the external review decision is rendered. Within fourteen (14) calendar DAYS of the CONTRACTOR'S receipt of the notification of the external review's determination, the CONTRACTOR must notify the DEPARTMENT of the outcome. The CONTRACTOR shall not be in breach of this AGREEMENT solely because the external reviewer does not comply with the timeframes set forth in the statutes or regulations. ~~may also request an independent review as provided under Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11. In this event, the DEPARTMENT must be notified by the HEALTH PLAN of the PARTICIPANT'S request at the same time the Office of the Commissioner of Insurance is notified in a manner that is defined by the DEPARTMENT. In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.~~
2018 Agreement: 400 Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, J. **2017 Contract:** Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, J.		All participating ~~HEALTH PLANS~~ TPAs and the PBM are required to make a reasonable effort to resolve ~~members'~~ PARTICIPANTS' problems and complaints. If YOU have a complaint regarding the ~~HEALTH PLAN'S~~ TPA's and/or PBM's administration of these benefits (for example, denial of claim or REFERRAL), YOU should contact the ~~HEALTH PLAN~~ TPA and/or PBM and try to resolve the problem informally. If the problem cannot be resolved in this manner, YOU may file a written GRIEVANCE with the ~~HEALTH PLAN~~ TPA and/or PBM. Contact the ~~HEALTH PLAN~~ TPA and/or PBM for specific information on its GRIEVANCE procedures. If YOU exhaust the ~~HEALTH PLAN'S~~ TPA's and/or PBM's GRIEVANCE process and remain dissatisfied with the outcome, YOU may appeal to the DEPARTMENT by completing a DEPARTMENT complaint form. YOU should also submit copies of all pertinent documentation including the written determinations issued by the ~~HEALTH PLAN~~ TPA and/or PBM. The ~~HEALTH PLAN~~ TPA and/or PBM will advise YOU of YOUR right to appeal to the DEPARTMENT within 60 days of the date of the final GRIEVANCE decision letter from the ~~HEALTH PLAN~~ TPA and/or PBM.

Section Reference	Description of Change	Proposed Language in 2018 Agreement
(Cont.) **2018 Agreement:** 400 Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, J. **2017 Contract:** Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, J.	*(Cont.)* If self-insured, contractors will be required to use the federal process and vendor to handle external reviews.	However, YOU may not appeal to the DEPARTMENT issues which do not arise under the terms and conditions of Uniform Benefits, for example, determination of MEDICAL NECESSITY, appropriateness, health care setting, level of care, effectiveness of a covered benefit, EXPERIMENTAL treatment, ~~pre-existing condition,~~ or the rescission of a policy or certificate that can be resolved through the HHS-administered federal External Review Process ~~Independent Review Organization process under Wis. Stat. § 632.835 and Wis. Adm. Code INS § 18.11~~. YOU may request an ~~independent~~ external review pursuant to federal law ~~Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11~~. In this event, YOU must notify the ~~HEALTH PLAN~~ TPA and/or PBM of YOUR request. In accordance with federal law~~Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11~~, any decision by an ~~Independent Review Organization~~ HHS-administered federal External Review is final and binding ~~except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate~~. ~~Apart from these two exceptions,~~ YOU have no further right to administrative review once the ~~Independent~~ external ~~R~~review ~~Organization~~ decision is rendered.
TOPIC: Mid-Year Plan Transfers		
2018 Agreement: 200 Program Requirements: 220J TRANSFER OF BENEFIT MAXIMUMS / DEDUCTIBLE / OUT-OF-POCKET LIMITS **2017 Contract:** State and Local Contracts: ARTICLE 3 COVERAGE, 3.20 ADMINISTRATION OF BENEFIT MAXIMUMS, DEDUCTIBLES, AND OUT-OF-POCKET LIMITS UNDER UNIFORM BENEFITS	If self-insured, the annual benefit maximums and accumulations to the deductible or out-of-pocket limits will continue to accumulate when a member changes plans during a benefit period. [This is consistent with the approach used in our other self-insured benefits, such as the pharmacy benefit, where there is no need for accumulations to start over.]	PARTICIPANTS may have the opportunity to change benefit plans during a benefit period in certain situations (e.g., due to a change in residence, change from or to the IYC HDHP). Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under Uniform Benefits will continue to accumulate for the benefit period in the following situations: 1) If a PARTICIPANT changes benefit plans HEALTH PLANS during a CONTRACT year (e.g., due to a change in residence), any annual BENEFIT maximums, deductibles, or out-of-pocket limits under Uniform Benefits will start over at $0 with the new HEALTH PLAN as of the EFFECTIVE DATE of coverage with the new HEALTH PLAN with the exception of the prescription drug BENEFIT annual out-of-pocket maximum for the IYC Health Plan. The deductibles and out-of-pocket limits are combined for the HDHP, therefore, the prescription drug BENEFIT annual out-of-pocket accumulation will start over if the PARTICIPANT changes insurers. 2) If a PARTICIPANT changes the level of coverage (e.g., single to family), transfers to another State agency, or has a spouse-to-spouse or DOMESTIC PARTNER to DOMESTIC PARTNER (or combination of spouse-to-DOMESTIC PARTNER) transfer resulting in a change of SUBSCRIBER, but does not change benefit plans HEALTH PLANS, the annual BENEFIT maximums, deductibles, and out-of-pocket limits will continue to accumulate for that year. NOTE: No accumulations transfer if an employee moves from state to local (or vice versa) coverage, regardless if they remain covered by the same insurer. (3) The HEALTH PLAN shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of a plan explanation of benefits. Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under Uniform Benefits will start over at zero ($0) dollars as of the EFFECTIVE DATE of the change if a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.Accumulations to the annual pharmacy and uniform dental (if applicable) benefits continue to accumulate for the benefit period regardless of a benefit plan/CONTRACTOR change. For HDHPs, medical and pharmacy accumulations are combined. The CONTRACTOR must cooperate with the DEPARTMENT and the new CONTRACTOR to transfer BENEFIT accumulations upon a PARTICIPANT'S mid-year transfer to coverage under a new CONTRACTOR. The CONTRACTOR shall provide the PARTICIPANT with medical BENEFIT accumulations upon request. This requirement can be satisfied through the mailing of an explanation of benefits. (4) The HEALTH PLAN CONTRACTOR shall apply any and all Maximum Out-of-Pocket (MOOP) limits as required by state and federal law.

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Provider Guarantee		
2018 Agreement: 200 Program Requirements: 230C CONTINUITY OF CARE **2017 Contract:** Addendums: ADDENDUM 2: PLAN QUALIFICATIONS / PROVIDER GUARANTEE, Provider Guarantee	Aligns the program with continuity of care provisions as required by Wisconsin Statute.	The CONTRACTOR must comply with ~~In addition to~~ the continuity of care provisions under Wis. Stat. § 609.24~~, the following provider guarantee provision applies. Providers listed here and/or on any of the plan's publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department's request.~~ for providers listed in the IT'S YOUR CHOICE OPEN ENROLLMENT materials and listed in the provider data submission. In the event a provider or provider group terminates its contract with the CONTRACTOR during a benefit period, the CONTRACTOR will follow the continuity of care provisions and pay claims for covered services at the negotiated rate. In this case, the SUBSCRIBER shall be held harmless and indemnified. This does not apply in the loss of providers due to normal attrition (death, retirement, a move from the service area) or as a result of a formal disciplinary action relating to quality of care. ~~If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant's options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.~~ At least thirty (30) DAYS prior to the termination of a provider agreement, or the closing of an IN-NETWORK clinic, provider location, or HOSPITAL during the benefit period, the CONTRACTOR 1) Send written notification, as approved by the DEPARTMENT, to all PARTICIPANTS who have had services from that provider in the past twelve (12) months that includes the following information: a) How to find a new IN-NETWORK provider or facility; b) The continuity of care provision as it relates to this situation; and, c) Contact information for questions. 2) Update the provider directory on the CONTRACTOR'S website. The CONTRACTOR shall keep a record of this notification mailing and shall provide documentation, by SUBSCRIBER and indicating the mailing address used, upon the DEPARTMENT'S request. The CONTRACTOR will assist the PARTICIPANT in selecting a new IN-NETWORK provider or facility and obtaining any necessary referrals and/or authorizations. If the CONTRACTOR removes providers from its network for the next benefit period, the CONTRACTOR is prohibited from adding those providers back to the network until the subsequent benefit period unless approved by the DEPARTMENT. This provision does not apply to normal attrition.

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Re-Enrollment Rights Due to Member Fraud and Committed Acts of Abuse		
2018 Agreement: 100 General: 155F FRAUD AND ABUSE, 1), a) **2017 Contract:** State and Local Contracts: ARTICLE 3 COVERAGE, 3.18 INDIVIDUAL TERMINATION OF COVERAGE, (5)	Reflects the Board's authorty to limit renrollment.	No person other than a PARTICIPANT is entitled to ~~eligible for health insurance~~ BENEFITS under this AGREEMENT. The SUBSCRIBER or any of his or her DEPENDENTS are not authorized by this AGREEMENT to assign or transfer their rights under the AGREEMENT, aid any other person in obtaining BENEFITS to which they are entitled or knowingly present or cause a false or fraudulent claim. The SUBSCRIBER'S rights to coverage under the HEALTH BENEFITS PROGRAM are ~~group health insurance coverage is~~ forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise falsely or fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment rights may be limited as determined by the BOARD ~~is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN~~. ~~Change to an alternate HEALTH PLAN is available during a regular DUAL CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date.~~ The DEPARTMENT may at any time request such documentation as it deems necessary to substantiate SUBSCRIBER or DEPENDENT eligibility. Failure to provide such documentation upon request shall result in the suspension of BENEFITS.
2018 Agreement: 100 General: 120 BOARD AUTHORITY, 7) **2017 Contract:** State and Local Contracts: ARTICLE 3 COVERAGE, 3.18 INDIVIDUAL TERMINATION OF COVERAGE, (6)		The BOARD may initiate disenrollment efforts i~~I~~n situations where a PARTICIPANT has committed acts of physical or verbal abuse, or is unable to establish/maintain a satisfactory physician-patient relationship with the current or alternate primary care provider ~~physician, disenrollment efforts may be initiated by the HEALTH PLAN or the BOARD~~. The SUBSCRIBER'S disenrollment is effective the first of the month following completion of the grievance process and approval of the BOARD. The BOARD may limit re-enrollment options in the HEALTH BENEFITS PROGRAM ~~Coverage may be transferred to the STANDARD PLAN only, with options to enroll in alternate HEALTH PLANS during subsequent DUAL CHOICE enrollment periods. Re-enrollment in the HEALTH PLAN is available during a regular DUAL CHOICE enrollment period, which begins a minimum of 12 months after the disenrollment date~~.
2018 Agreement: 400 Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, D. **2017 Contract:** Uniform Benefits: VI. MISCELLANEOUS PROVISIONS, D.		No person other than a PARTICIPANT is eligible for health insurance benefits. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to occur during the annual It's Your Choice Open Enrollment period. Re-enrollment options may be limited under the Board's authority. ~~Change to an alternate HEALTH PLAN via It's Your Choice enrollment is available during a regular It's Your Choice enrollment period, which begins a minimum of 12 months after the disenrollment date.~~

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Plan Qualification Status		
2018 Agreement: 200 Program Requirements: 230A PROVIDER ACCESS STANDARDS **2017 Contract:** Guidelines: I. Objectives Guidelines: II. General Requirements, C. Financial Requirements, 6.and D. Comprehensive Health Benefit Plans Eligible for Consideration, 12., 18., 21., 22., and 28 Addendum 2: Plan Qualifications / Provider Guarantee	In a regionalized program, the qualification status references will be removed because Contractors must meet the minimum provider availability requirements in all counties in the region in which it is offered.	*References in the Guidelines sections of the 2017 Contract were deleted. The Addendum 2 provision is cited below:* The CONTRACTOR must provide an annual provider submission to the DEPARTMENT containing their provider network for the upcoming benefit period. Additionally, the DEPARTMENT requires the CONTRACTOR to submit a monthly provider data submission as detailed in Section 150. The DEPARTMENT will use this data to ensure provider access standards are met. ~~Using the format provided by ETF, record the number of providers under contract sorted by zip code who are physically located within each county and major city in the service area.~~ Providers will be sorted by zip code based on where they are physically located within each country and major city in the region. Major cities are those that have over thirty-three (33%) percent of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior. These providers must agree to accept new patients unless specifically indicated otherwise. ~~This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 3; the final copy is due on July 22. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Upon request, the Department may review the qualification status of a plan on a county by county basis and make recommendations to the Board. Generally, those qualifications are:~~ In addition to the access standards set forth in Wis. Stat. § 609.22, the CONTRACTOR must meet the following minimum requirements: ~~1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a county or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.~~ ~~2~~1. There must be at least one (1) general ~~hospital~~ HOSPITAL under contract and/or routinely utilized by ~~plan~~ IN-NETWORK providers per county or major city. If a ~~hospital~~ HOSPITAL is not present in the county, ~~plans~~ CONTRACTORS must sufficiently describe how they provide access to providers. ~~1~~2. The ratio of full time equivalent (FTE) ~~primary physicians~~ PCPs accepting new patients to total ~~members~~ PARTICIPANTS in a county or major city is at least one per two thousand (1.0/2,000) with a minimum of five (5) PCPs per ~~physicians/~~county or major city. The PCPs ~~primary physicians~~ counted for this ~~qualification~~ requirement must be able to admit patients to an IN-NETWORK ~~plan hospital~~ HOSPITAL in the county or major city ~~where the plan is qualified~~. 3. A chiropractor must be available in each county ~~(~~or major city ~~if applicable)~~. ~~4. The plan must have a minimum of one year of operation.~~ ~~5. After being offered to state employees for one year, the plan must have achieved an enrollment of 100 subscribers or 10% of the employees in the service area. Service area means the entire geographic area in which the plan is qualified.~~

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Primary Care Provider (PCP) required		
2018 Agreement: 200 Program Requirements: 210 PRIMARY CARE PROVIDER **2017 Contract:** Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 12. (7th bullet)	Each participant must select (or be assigned) a PCP. [This change is related to the data warehouse and strategic goals related to population health.]	~~If PARTICIPANTS are required to select a primary care provider or primary care clinic, have a process to allow a PARTICIPANT to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.~~ SUBSCRIBERS and DEPENDENTS shall be required to select a primary care provider (PCP). The PCP may be a physician, physician assistant, nurse practitioner or other provider as approved by the BOARD. Limitations to this list may be approved by the DEPARTMENT. The PCP furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, twenty-four (24) hours a DAY, seven (7) DAYS a week. Primary care includes ongoing responsibility for preventive health care, treatment of illness and injuries, and the coordination of access to needed specialty providers or other services. The PCP shall either furnish or arrange for most of the PARTICIPANT'S health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services. The CONTRACTOR must monitor all PARTICIPANT records to ensure there is an assigned, IN-NETWORK PCP at all times. If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR will assign a PCP, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP. If PARTICIPANTS select a PCP that is OUT-OF-NETWORK, the CONTRACTOR must contact the PARTICIPANTS within five (5) BUSINESS DAYS to assist them in selecting an IN-NETWORK PCP. The CONTRACTOR must have a process to allow a PARTICIPANT to change PCPs in a reasonable time and to communicate to the PARTICIPANT how to make this change. The CONTRACTOR will assist the PARTICIPANT in selecting a PCP.
TOPIC: Biometric Screenings		
2018 Agreement: 200 Program Requirements: 220L WELLNESS **2017 Contract:** Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 6.	Clarification of intent	6) The CONTRACTOR ~~HEALTH PLANS~~ must report, as directed by the DEPARTMENT, all ~~provide~~ incentive payment~~s information as specified by the~~ issued to PARTICIPANTS for DEPARTMENT distribution to EMPLOYER ~~for~~ payroll centers for tax reporting purposes. The CONTRACTOR must link all payment records to the primary SUBSCRIBER and avoid duplication for instances of a reissued incentive. 7) Provider obtained biometric screenings as required by the DEPARTMENT'S wellness program shall be provided by the ~~HEALTH PLAN~~ CONTRACTOR at the PARTICIPANT'S request, for no cost to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting and shall be in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.
2018 Agreement: 400 Uniform Benefits: III. BENEFITS AND SERVICES, A., 5., j. **2017 Contract:** Uniform Benefits: III. BENEFITS AND SERVICES, A., 5., j.	Duplicate; services already covered by preventive service coverage language. Biometric screenings provided by on site events are only available through sole-source vendor.	~~PARTICIPANT requested biometric screening provided annually at no PARTICIPANT cost. Biometric screenings shall at minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.~~

Section Reference	Description of Change	Proposed Language in 2018 Agreement
TOPIC: Uniform Benefits Clarifications		
2018 Agreement: 400 Uniform Benefits: I. SCHEDULE OF BENEFITS **2017 Contract:** Uniform Benefits: I. SCHEDULE OF BENEFITS	Numerous changes to clarify information for members and align benefits with 2017 contract	Redline contract available upon request.
2018 Agreement: 400 Uniform Benefits: II. DEFINITIONS: DEPENDENT **2017 Contract** State and Local Contracts: ARTICLE 1 DEFINITIONS, 1.7 "DEPENDENT" Uniform Benefits: II. DEFINITIONS: DEPENDENT	Clarify definition of DEPENDENT for legal wards	Legal ward who becomes a permanent legal ward of the SUBSCRIBER, SUBSCRIBER'S spouse or insured DOMESTIC PARTNER prior to age 19. ….. All other children cease to be DEPENDENTS at the end of the month in which they turn 26 years of age, except when ~~that~~:
2018 Agreement: 400 Uniform Benefits: II. DEFINITIONS: SUBSCRIBER **2017 Contract:** Uniform Benefits: II. DEFINITIONS: SUBSCRIBER	Clarify definition of SUBSCRIBER to include annuitants	An ELIGIBLE EMPLOYEE or annuitant who is enrolled for (a) single coverage; or (b) family coverage and whose Dependents are thus eligible for benefits.