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Correspondence Memorandum

Date: February 1, 2018

To: Group Insurance Board

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

Subject: Health Benefit Program Agreement & Uniform Benefits for the 2019 Plan Year

This memo is for informational purposes only. No Board action is required.

This memorandum provides an overview of proposed changes to the Group Health Insurance Program (GHIP) Agreement and related pharmacy benefit changes. This memo also describes improvements in how ETF solicits feedback on changes from affected stakeholders.

Background
ETF typically seeks input on program changes primarily through the Study Group process. The Study Group was made up of industry and employer representatives, as well as ETF staff, and would meet over the course of several days to discuss potential changes. While this process allowed many voices to be heard, it did not include all vendors participating in the GHIP. It also created challenges for ETF in terms of developing a cohesive benefit strategy, instead focusing on individual components of the program. Lastly, this approach was done on such a short timeline that it limited our ability to investigate the impacts of changes and stakeholder concerns, while leveraging stakeholder expertise. These limitations, coupled with the revision of GHIP contracts in 2018, have created an opportunity to revise the input process.

In 2014, ETF established the Member Communication and Education Workgroup (MC&E). This group comprises employer representatives and ETF staff, all of whom have expertise in employee benefits. The workgroup provides input on member-facing communications materials related to the GHIP, including potential member and employer perceptions of benefits changes.

In 2017, ETF established the ETF Council on Health Program Improvement (CHPI). The original goal of the CHPI was to find opportunities for the various vendors serving the GHIP to better address the population health of GHIP members. These meetings have

Reviewed and approved by John Voelker, Deputy Secretary

Electronically Signed 2/5/18

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also provided opportunities for vendors and ETF to identify ways to improve the GHIP contract and benefits to promote population health.

Improved Input Process

For 2019 benefit and contract changes, ETF will leverage existing groups to provide input on the GHIP. ETF aggregated potential changes throughout 2017 from internal and external stakeholders as issues were raised. In December 2017, ETF asked all vendors participating in CHPI to propose any changes to the health plan contract and benefits, as well as any pilot programs that they would like to implement in 2019. For any benefits-related changes, plans were asked to submit supporting literature and cost and member impact analyses.

ETF reviewed the proposals during the final weeks of 2017 and discussed potential health contract and benefit changes with vendors at a CHPI meeting in January. The resulting concepts are included below. Based on Board feedback at the February 21 meeting, ETF will solicit input from employers on these changes through the MC&E workgroup and other stakeholders. Final recommended changes will be presented to the Board in May.

Health Contract Change Concepts

To date, proposed changes to the health plan contract can be categorized as follows:

- **Modifications to performance standards requirements.** In CHPI meeting discussions the health plans raised questions regarding how to report performance standards and expressed concerns regarding certain items that do not conform to industry standards, or might have unintended consequences. ETF proposes to work with plans during 2018 standards implementation to determine modifications to those standards as necessary, and will report these modifications to the Board.
- **Primary care provider requirement.** In the initial version of the Agreement, health plans were required to ensure that each member designate a primary care provider. The original language requires that this be an individual provider, not a clinic. Following discussions with health plans and Truven, the Board's data warehouse vendor, ETF proposes revising this requirement to allow members to designate a primary care clinic. Health plans indicate this will allow for better promotion of a medical home model for member care. Truven will be able to attribute services to individual providers based on claims data.
- **New ETF Initiatives.** For several years, the Board has included five ETF initiatives in the GHIP contract: care coordination, high-tech radiology, low back surgery, shared decision-making, and advanced care planning/palliative care. While ETF believes these are still important health initiatives to pursue, we would like to ensure that these initiatives are current with market standards. The health plans have been asked to review the current initiatives, the requirements surrounding those initiatives, and the focus areas they pursue in their commercial business, and provide any revisions or additions to that list of initiatives.

- **Telehealth/nurse line clarification.** During negotiations, health plans indicated a wide variety of implementation strategies surrounding telehealth. Several stated the dual requirement of telehealth and a nurse line requirement needed clarification. ETF proposes to modify the language to clarify the intent of services to be received, while allowing plans to implement either service in a way that is appropriate for their business model. This change would coincide with a benefits change offered in the Health Benefit Change Concepts section below.
- **Out-of-area student coverage clarification.** The 2018 It's Your Choice open enrollment period raised issues related to coverage for students who live out of state, and what services they can receive from out of state providers. ETF provided guidance that coverage should be limited to emergency, urgent, and certain mental health services for all plans except the Access Plan. ETF proposes clarifying this in the Agreement language so that nationwide in-network coverage is only offered by the Access Plan. ETF would further work with health plans to communicate out-of-state student coverage to members from the MC&E and CHPI.
- **Fully-insured contract revisions.** Despite the GHIP continuing with a fully-insured model for 2018, the Board approved the use of the GHIP Agreement that was created during the development of the self-insurance request for proposals. When self-insurance contracts were rejected by the Joint Committee on Finance, ETF modified the Agreement to remove concepts that only applied to a self-insured program. However, a small number of reports remained in the Reporting Requirements section of the Agreement that are not of use to the Board to collect in a fully-insured program. ETF proposes removing the requirement to collect those reports.
- **Administrative/technical clarifications.** In addition to these changes, ETF proposes other technical changes to either clarify acceptable practices or the Board's authority within the contract.

All proposed contract language changes are included in Attachment A to this memorandum.

Health Benefit Change Concepts

In addition to the administrative contract changes described above, ETF also solicited suggestions from health plans for changes to the health benefit in 2019. These changes were also discussed at the January CHPI meeting. The following change proposals are pending cost review and impact review by both the health plans and the Board's actuary.

- **Adding a telehealth benefit category**. This benefit category would be separate from office visits in the Schedule of Benefits. Due to the reportedly minimal cost of these visits, plans have been asked to evaluate the cost impact of offering this benefit at a $0-member copay for members not in the high deductible health plan (HDHP). Plans have also been asked to quantify the volume of telehealth service use they experience in their non-ETF populations, and to analyze the number of telehealth visits that result in definitive care, versus those where the member seeks additional care post-visit. ETF recommends considering this for addition

with a concurrent exclusion stating that telehealth devices (e.g. smart phones, computers, etc.) and internet/cellular service are not covered.

- **Coinsurance alignment.** Currently, most services subject to coinsurance in both the HDHP and non-HDHP plans are 90% plan-paid, 10% member-paid. The exceptions to this are durable medical equipment (DME), cochlear implants, and hearing aids, which are 80% plan-paid, 20% member paid. A health plan requested that ETF investigate whether it is possible to align the coinsurance for all benefits at one of these two levels. Health plans have been asked to return a cost estimate for moving all benefits to either 90/10 or 80/20. ETF will make a recommendation on changes following this analysis.
- **Removing copays from the HDHP.** Health plans stated that in the commercial marketplace HDHPs usually do not have a mixture of copays and coinsurance once the deductible has been met, and suggested the Board modify its plan to only have coinsurance after the deductible. This would also reduce plan complexity for members. Health plans have been asked to return a cost estimate for this change. ETF recommends considering this change, pending the cost review.
- **Extraction and replacement of natural teeth.** A health plan shared confusion regarding the health policy's inclusion of extractions for erupted teeth, as well as language limiting extractions to "infected teeth." ETF will investigate whether the language can be changed to accommodate coding limitations. Delta Dental reported at the January CHPI meeting that adding extractions to the dental benefit would result in an approximately 4-5% increase in premium on the dental plan. ETF recommends considering moving this benefit to Uniform Dental.
- **Aggregating all therapy limits**. The current policy covers an aggregate 50 visits for physical therapy, occupational therapy, and speech-language pathology without prior authorization. Following the initial 50, the policy allows for an additional 50 visits of each therapy type to be separately approved. Plans noted that exceedingly few members reach these limits – and those who do reach these limits do not exceed a total of 50 visits for each therapy. Many plans must track the individual visit limits manually, an administrative burden. Health plans will return a cost and impact analysis of aggregating the additional prior-authorized visit limits, at both 50 and 150 additional visits. ETF recommends exploring these options, pending the cost analysis.
- **Lens coverage for keratoconus treatment.** Current policy language excludes coverage of rigid, gas-permeable contact lenses for any condition except cataract surgeries. One health plan notified ETF that this is an appropriate treatment for keratoconus, a condition causing gradual deformity of the eye and that can lead to blindness. Lenses help the eye retain its shape; the alternative to this treatment is eventual corneal transplant. ETF suggests revising the contract language to allow for one set of lenses to manage treatment following diagnosis mid-plan year, and referral of the member to obtain vision coverage through the vision supplement plan for replacement lenses during any plan year following the initial diagnosis.

- **Skin tag exclusion.** The Board's current policy excludes cosmetic procedures, but plans note that a lack of language specific to skin tags means that each skin tag must go to medical review before it is denied. ETF suggests including specific language to define the removal of skin tags as a cosmetic procedure.
- **Custom orthotics exclusion.** Health plans have indicated that the current policy is not specific regarding coverage of custom orthotics, but there is limited evidence that these are more effective than over-the-counter orthotics. According to ETF Ombudsperson Services, however, ETF regularly receives complaints regarding custom orthotics coverage. ETF will review whether there are ways to manage utilization that can be better reflected in policy.
- **Coverage of home sleep studies.** Home sleep studies can be as or more effective in diagnosing conditions than lab-based studies for individuals with low-severity sleep-related health conditions. Further, home sleep studies are generally less expensive than lab-based studies. ETF will present more information regarding the addition of coverage for this service.
- **Coverage of labs related to biometric screenings.** ETF regularly receives complaints from members who are trying to fulfill their wellness program requirements by seeing a primary care provider instead of attending a screening event. However, the U.S. Preventive Services Task Force intervals for screening-type lab services are not always recommended yearly. This can result in members receiving tests at the physician's office that the health plan processes with member cost sharing. ETF will investigate both the health program policy language and the wellness screening policy to determine how to minimize member burden.
- **Transplant coverage language clarification.** The Board's current language related to coverage of transplants includes a significant amount of detail in terms of clinical conditions that are covered. Maintaining and updating this language to follow best clinical practices requires medical expertise, which ETF does not have on staff. ETF reviewed transplant coverage language from the ETF essential health benchmark plan, the State of Wisconsin benchmark plan, Wisconsin Medicaid, and ETF's three largest participating health plans, and none of these policies are written in the same level of detail as ETF's policy. ETF will bring recommendations to revise the transplant policy language to defer to the clinical decision making of health plans and providers for these procedures through the prior authorization process.
- **Drugs administered in an outpatient setting.** Navitus and ETF occasionally encounter confusion regarding which program pays for drugs administered in an outpatient setting. ETF will provide recommendations to clarify that such drugs should be covered by the health plan.
- **Bariatric surgery coverage.** ETF received a request to consider coverage for bariatric surgeries. In discussion with health plans, those plans that do cover the service indicate that the volume of services requested are low, and that the rate and cost of complications continues to diminish. The outcomes of these surgeries as they relate to conditions associated with obesity (e.g. diabetes, hypertension) are reported to be beneficial. ETF asked health plans that cover these services to

provide a cost analysis related to the surgeries, and the associated complications. ETF will make a final recommendation pending that analysis.

- **Additional administrative clarifications.** Some plans offered additional language that clarifies current intent related to topics such as surrogacy coverage, residential mental health treatment, and autism mandatory minimum coverage limits. These changes appear to have no impact on how the plan is currently administered, except to support health plans in making coverage determinations without requesting additional interpretation.
- **Additional Cost Savings Measures**. In order to achieve cost-savings targets set by the most recent biennial budget, ETF will be required to explore increasing copays, deductibles, and premium contributions.

All proposed changes to benefits are listed in Attachment B to this memorandum.

Pharmacy Benefit Change Concepts.
In addition to health program changes, ETF is investigating concurrent options for pharmacy benefit changes. These changes are designed to coordinate with the health program, while promoting clear coverage requirements between the health plans and Navitus, the pharmacy benefit manager (PBM). These changes are also designed to move the GHIP towards more value-based benefit plan designs.

- **Carve out Pharmacy Uniform Benefit language from the GHIP Agreement.** This change would be consistent with the carve out of Uniform Dental Benefits. Pharmacy benefits are integrated into both the PBM Agreement and the GHIP Agreement. This change will make identification of pharmacy benefit specific provisions easier to identify and allow staff to implement updates in either program without needing to update both contract documents.
- **Value-based plan design.** Members who work with a disease management program on a consistent basis would be eligible for reduced copays or coinsurance. ETF staff are investigating the logistics of implementing this change with Navitus, StayWell, and the health plans.
- **Increased cost sharing for DAW-1 drugs.** Currently, members whose physician writes a prescription to be “dispensed as written” (DAW-1) without additional information on medical need are only subject to the Level 3 coinsurance. Navitus has recommended that members be subject to additional cost sharing in order to drive utilization to preferred drugs. Members who must take a non-preferred medication due to medical reasons could have their prescriber submit an Food & Drug Administration MedWatch form or prior authorization request depending on the drug, to Navitus on their behalf to receive the medication at a lower cost sharing level. Pending a review of impact, ETF recommends making this change to further promote lower-cost drug utilization.
- **Remove out-of-pocket limits (OOPLs) for drugs in the non-HDHP.** Navitus also proposed removing the OOPL for non-HDHP members, meaning that all covered drug costs would accrue to the federal maximum out of pocket limit (MOOP). Navitus indicated that few members actually reach this limit, and it would be further incentive to choose lower-cost medications. ETF will investigate

the cost in considering this change as complementary to the value-based plan design, as well as the projected impact to members.

- **Removing copay maximums and increasing OOPL for MedicareRx.** ETF and Navitus are working on a means to leverage greater CMS subsidies for members who have significant pharmaceutical needs in the MedicareRx population. The intent is to move a MedicareRx member into the Medicare Part D catastrophic coverage phase sooner, in order to take advantage of greater subsidies. ETF is investigating this change to determine whether it can be successfully implemented while maintaining compliance with CMS guidelines and minimizing the cost impact to members.

Health Plan Pilot Programs.
In prior years, ETF has gathered pilot programs mid-way through the year to determine whether these programs can be offered to GHIP members. In order to foster a holistic program development approach, ETF solicited pilot proposals and will report appropriate results to the Board.

ETF staff will be available at the Board meeting to address any questions.

Attachment A: 2019 Proposed Contract Changes
Attachment B: 2019 Proposed Benefit Changes

2019 Proposed Contract Changes

Description of Change Requested	ETF 2018 Contract Reference	Original Language	Proposed Change / Language
Rate-setting process	130B	The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any rate or take other action up to and including limiting new enrollment with the CONTRACTOR when the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.	The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserved the right to reject any rate, limit new enrollment with the CONTRACTOR, or take other action as appropriate if the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.
TTY Line	140A c)	TTY note in non-discrimination statement	CLARIFICATION: TTY is one example of an acceptable approach to providing accessible phone service. If plans offer another service please notify the Health Program Manager, and ensure that your notice either clearly denotes the separate accessible phone number or instructs members how to access using the main phone line
Clarify enrollment discrepancy modifications	150A 4) a)	a) The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.	The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) outside of the exception report described in item b) below as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.

Remove nondiscrimination testing requirement	155C	155C Nondiscrimination Testing The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete Internal Revenue Code (IRC) Sec. 105 (h) compliant nondiscrimination testing for the DEPARTMENT at least annually. The DEPARTMENT or its designee will provide a schedule, process for testing, and data requirements. The CONTRACTOR shall complete any necessary requirements by the due date(s) specified by the DEPARTMENT or its designee.	Remove text
Contract Termination	155I 1)a)	a) The CONTRACT maximum is reached.	The BENEFIT maximum is reached
Contract Termination	155I 2)	1) If the BOARD terminates this CONTRACT, then all rights to BENEFITS shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include, but are not limited to: transferring the patient to another facility; billing the BOARD a fee for service rendered; or permitting out-of-network providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.	1) If the BOARD terminates this CONTRACT, then all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include, but are not limited to: transferring the patient to another facility; or permitting out-of-network providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.
ID Card turnaround time	205B	1) The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 2) below. 2) For elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID cards were issued.	The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, or at least 10 days prior to the effective date of coverage. The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing ID cards. The CONTRACTOR shall send a written notice to the DEPARTMENT Program Manager following the IT'S YOUR CHOICE OPEN ENROLLMENT period regarding the expected mailing date of ID cards for the following enrollment year, as well as a confirmation email indicating the dates that the ID cards were actually sent.

Change PCP assignment to primary care clinic assignment	210	Primary Care Provider [entire section]	Subscribers and Dependents shall be required to select a primary care clinic (PCC). Replace provider with clinic in the remainder of the text
Updates to PCP language	210		The CONTRACTOR must monitor all PARTICIPANT records to ensure there is an assigned, INNETWORK 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. The CONTRACTOR can assign a temporary PCP when deemed necessary.
Nurseline / Telehealth Requirement	220B	220B Telehealth / Nurse Line 1) The CONTRACTOR must provide telehealth services as directed by the DEPARTMENT. 2) The CONTRACTOR must provide a twenty-four (24)-hour nurse line available at no cost to all PARTICIPANTS.	220B Telehealth / Nurse Line The CONTRACTOR must provide access to immediate care services such as telehealth and/or a twenty-four (24)-hour nurse line to PARTICIPANTS. Such services must provide at minimum consultation services that assist PARTICIPANTS in determining whether additional treatment for a condition should be sought. Such consultation services that result in referral to physical site care instead of definitive treatment should be provided at no cost to all PARTICIPANTS.
Remove quarterly requirement to supply out-of-network claims report to department	220C & 305, item 7	The CONTRACTOR must submit to the DEPARTMENT a QUARTERLY report of all claims (including non-urgent and non-emergent) paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT.	Remove language.

Update emergent care language	220C Emergency / Urgent / Catastrophic Care	The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK or OUT-OF-NETWORK providers at the IN-NETWORK level of benefits. This OUT-OF-NETWORK care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in UNIFORM BENEFITS unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger nationwide networks may offer coverage through affiliated networks as long as there is no additional cost to the HEALTH BENEFIT PROGRAM or PARTICIPANT for doing so. The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, and/or a transfer to a more suitable facility when appropriate.	The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK or OUT-OF-NETWORK providers at the IN-NETWORK level of benefits. This OUT-OF-NETWORK care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in UNIFORM BENEFITS unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, authorizing follow up care on a case-by-case basis, and/or a transfer to a more suitable facility when appropriate. The CONTRACTOR will provide coverage certain mental health services OUT-OF-NETWORK as required by law for college students who are PARTICIPANTS in the HEALTH PLAN.

Clarify carryover of benefit accumulators when changing plans	220J 1)	1) 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: a) If a PARTICIPANT changes the level of coverage (e.g., single to family, but does not change benefit plans, b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change benefit plans. 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 in the following situations: a) If a PARTICIPANT changes benefit plans, b) If a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.	1) 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: a) If a PARTICIPANT changes the level of coverage (e.g., single to family) or changes benefit plans, but does not change CONTRACTORS. b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change CONTRACTORS. 2) 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.
Provider Access standards, clarifying that Chiros are considered under GeoAccess	230A	In addition to the access standards set forth in Wis. Stat. § 609.22, the CONTRACTOR must meet at least 90% geoaccess in the county for INPATIENT HOSPITALS and PCPs (includes Internal Medicine, Family Medicine and General Medicine) or the following minimum requirements for all counties and major cities in the county to be qualified:	In addition to the access standards set forth in Wis. Stat. §609.22, the CONTRACTOR must met at least 90% geoaccess in the county for INPATIENT HOSPITALS, chiropractors and PCPs or the following minimum requirements for all countie and major cities in the county to be qualified:

Direct pay premium process	255 / 305 1) / 315E 5)	The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.	The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving written notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.
Conversion / Marketplace Notification	260C	The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.	The CONTRACTOR mst provide the SUBSCRIBER, upon request, written notification of how to enroll in a conversion policy set forth in Wis. Stat. 632.897, and/or a Marketplace plan, in the event of termination of employment

Attachment B

2019 Proposed Benefit Changes

Description of Change Requested	ETF 2018 Contract Reference	Rationale and Requested Follow Up
Add new benefit category for online care at 100% coverage, not subject to deductible	400 - Uniform Benefits I. Schedule of Benefits	Telehealth visits with definitive treatment are generally lower cost than services received at physical sites of care. Requesting follow up with cost analysis
Coinsurance - have all medical services that apply to coinsurance have the same level of coinsurance	400 - Uniform Benefits I. Schedule of Benefits	Differentials in coinsurance may be confusing to members Requesting follow up with cost analysis at 90%/10% and 80%/20% coinsurance
HDHP Plan Only - Remove the copays and structure with a straight deductible/coinsurance plan design.	400 - Uniform Benefits I. Schedule of Benefits	Blended copay/coinsurance in HDHPs is not industry standard and may be confusing to members. Requesting cost analysis of moving copays to coinsurance.
Consider moving the coverage of extraction of infected teeth to the Dental benefit.	400 - Uniform Benefits I. Schedule of Benefits 16) Oral Surgery	Industry standard is to cover extraction of non-errupted teeth in medical plan and errupted teeth in dental plan. Requested cost analysis from plans and dental carrier
Therapies (Physical, Speech and Occupational) - Change the 50 additional visits from per therapy to a combined benefit.	400 - Uniform Benefits, I. Schedule of Benefits	Management of individual additional visits after aggregate initial visits is a manual process for some plans, and few members exceed 50 total additional visits. Requested cost and member utilization impact analysis.
Modify residential treatment exclusion to comply with federal mental health parity law.	400 Uniform Benefits, IV Exclusions, 4 (ak)	Clarification that plan complies with the Mental Health Parity and Addiction Equity Act. No follow up requested

Clarify Medicare Part B coverage requirement when Medicare is primary per federal Medicare Secondary Payer rules.	400 Uniform Benefits, IV Exclusions A (11) (b)	Requesting follow up from plans on how best to coordinate care with members.
Clarify surrogacy coverage exclusion.	400 Uniform Benefits, IV Exclusions and Limitations	Clarifying to comply with Wisconsin Supreme Court ruling that as long as surrogate is a plan member, coverage cannot be revoked. No follow up requested.
Remove reference to state's mandatory minimum coverage requirements related to autism spectrum services	400 Uniform Benefits, III. Benefits and Services, C (6)	Clarifying language to remove limit reference; plans indicated this limit is no longer needed. No follow up requested.
Add coverage for contact lenses for the treatment of keratoconus	400 Uniform Benefits, IV. Exclusions & Limitations (11) General (p)	Contact lenses for the treatment of keratoconus is the standard of care; the alternative treatment is corneal transplant. ETF will investigate coordination with supplemental vision plan to communicate with members who will need subsequent lenses. No follow up requested.
Add "removal of skin tags" to Exclusions	400 Uniform Benefits, IV. Exclusions & Limitations, 11) General ad)	This is largely considered cosmetic in nature, but failure to note means that claims must be reviewed for medical necessity. Most plans explicitly exclude this coverage. No follow-up requested.
Consider limits for custom molded foot orthotics	400 Uniform Benefits, III. Benefits and Services, C (3)(b)	Prefabricated orthotics are often sufficient according to plans; many plans have limitations per year. ETF will investigate modifying this language. No follow-up requested.

Add coverage of home sleep studies prior to approval of inpatient sleep studies when clinically appropriate	400 Uniform Benefits, III. Benefits and Services	Home sleep studies are less costly and can be appropriate in some circumstances. No follow-up requested.
Add coverage of lipid panel/glucose/biometric screening related tests as preventive	400 Uniform Benefits, III. Benefits and Services, C.	ETF staff investigating how to modify language so that biometric screening-related tests are covered if requested for wellness requirement.
Drugs Administered in OP Setting should be paid by health plan	400 Uniform Benefits, III. Benefits and Services, D.	Clarification to appropriate setting. No follow-up requested.
Add exclusion for equipment required for telehealth visits	400 Uniform Benefits, IV. Exclusions and Limitations	Adding in coordination with coverage change. No follow-up requested.
Remove exclusion for maternity services received out of plan area	400 Uniform Benefits, IV. Exclusions and Limitations, A (7)	Adding to comply with federal law. No follow-up requested.

Revision of transplant coverage language	400 Uniform Benefits, III. Benefits and Services, A.	(Draft Transplant Language Replacement) Transplants and related services are covered when ordered by a Physician. All transplants except corneal transplants require PRIOR AUTHORIZATION. The MEDICAL APPROPRIATENESS and MEDICAL NECESSITY of a transplant will be determined by medical professionals reviewing on behalf of the HEALTH PLAN. Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ from a cadaver or compatible living donor. Organ procurement costs include organ transplantation, compatibility testing, hospitalization, and surgery (when a live donor is involved). Donor expenses are covered only when the recipient of the transplant is a PARTICIPANT in this plan and when such charges are included as part of the PARTICIPANT'S (as the transplant recipient) bill. Transplants must be performed at a facility designated by the HEALTH PLAN. IV. EXCLUSIONS Transplantation of and related health services for mechanical or animal organs. Transplants not performed at a facility designated by the HEALTH PLAN.
Bariatric Surgery Coverage	400 Uniform Benefits, III. Benefits and Services, A.	Consideration of coverage requested. Follow-up requested from plans who currently cover in their commercial population on cost and utilization.