



STATE OF WISCONSIN

## Department of Employee Trust Funds

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**DATE:** January 27, 2003

**TO:** Group Insurance Board

**FROM:** Bill Kox, Director, Health Benefits & Insurance Plans  
Joan Steele, Manager, Alternate Health Plans

**SUBJECT:** GUIDELINES/Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2004

For the past five years, a discussion group of the Board has participated in the development of recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year. Should the Board wish to continue this process for contract year 2004, we are providing the following information on the expected issues and timelines for the GUIDELINES development.

The anticipated timeline for the 2004 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2004 contract year. The Plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits.
- On or about February 25, an ETF staff discussion group will meet and identify those issues to be included in the first draft of GUIDELINES.
- On or about February 28, we will send Plans the draft of the 2004 GUIDELINES/ Administrative Provisions and Uniform Benefits. Plans' comments on the draft changes will be due on or about March 14.
- On or about March 19, the discussion group will meet to finalize recommendations to the GIB. The discussion group's written recommendations are due by March 25.
- The recommendations will be presented for GIB approval at its April 8 meeting.

The following briefly summarizes several issues that may be reviewed during this process, but is not exhaustive. Participants, health plans or staff have raised these issues over the course of the past year. We also welcome any comments or suggestions from the Board about issues to be reviewed for the 2004 contract.

Some items may have a cost impact while others are clarifications of existing practice with no expected cost. Such costs, if any, will be discussed by the discussion group and presented to the Board in the final recommendation.

### **GUIDELINES/Administrative Provisions:**

- Possibilities of carving out the pharmacy benefit from Uniform Benefits and having a Pharmacy Benefit Manager (PBM) administer the benefit for all participants. This would likely include a provision on sharing pharmacy data with Plans.

- Deleting the option for Plans to provide dental benefits.
- Changing the current 105% premium contribution structure.
- Incorporate specific hospital safety standards, such as Leapfrog and the National Quality Forum (NQF) into contract for 2004. Some examples include encouraging Plans to:
  - ⇒ work with its network hospitals to increase patient safety in health care by implementing intensive care unit staffing; Computerized Physician Order Entry (CPOE) for prescriptions, and utilizing Evidence-Based Hospital Referral (EHR), and
  - ⇒ inform and educate members about using health care performance measures to make informed health care choices as well as providing incentives to network providers to improve on performance measures.
- Decreasing the required participation level for Wisconsin Public Employers (WPE) from 65% to 50%.
- Adding ability to underwrite or otherwise address concerns under WPE for employers who wish to join the program. This may include an option of being able to charge an additional plan stabilization fee if it is determined the employer experience would be detrimental to the program.
- Offering another benefit plan option to WPE that would include a deductible and coinsurance.

***Uniform Benefits:***

- Consideration for requiring Plans to cover two (2) follow-up visits with a non-network provider following emergency care outside the Plan's service area.
- Coordinate the lifetime maximum across all health plans so that it is not to be re-set if a new health plan is selected.
- Clarify the hearing aid benefit to the state indicating that a model or type of hearing aid will not necessarily be approved, even if it costs less than \$1000, if a less expensive model or type is medically appropriate.
- Delete the following from the outpatient physical, speech and occupational therapy benefit: "Additional Medically Necessary visits may be authorized by the Plan, up to a maximum of 50 visits per therapy per contract year."
- Clarify the existing practice that Usual & Customary is not applied to referrals that are prior approved by the Plan.
- Clarify that intersession courses at educational institutes do not qualify a dependent as a full-time student.
- Clarify coverage for over-the-counter medications (e.g. Claritin).
- Discussion of mental health parity costs if the federal law is extended through 2004.
- Clarify the existing interpretation that retransplantation of tissue is a covered benefit (e.g. cornea).
- Clarify the existing interpretation that malocclusions may be payable under temporomandibular joint (TMJ) even though they are excluded under oral surgery.
- Clarify existing interpretation that therapies rendered through home care benefits apply to the therapy maximum.
- Clarify the existing interpretation that benefit accumulations for orthodontia carry over from prior Plans to new Plans selected during Dual Choice.
- Review prescription drug co-pays and consider implementing three-tier coverage. This is dependent upon carving out the pharmacy benefit and having a PBM administer the benefit for all participants.
- Delete limitations 4 and 5 under Section IV., B.: "Major Disaster or Epidemic" and "Circumstances Beyond the Plan's Control."