

Board	Mtg Date	Item #
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**STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
801 WEST BADGER ROAD
MADISON, WISCONSIN 53702**

CORRESPONDENCE MEMORANDUM

Date: March 17, 2003

To: Group Insurance Board

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

Re: GUIDELINES and Uniform Benefits for the 2004 Benefit Year

Background

Annually, the Board reviews its Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program (ET-1136). At this time, necessary changes are made to the Board's requirements for health plan participation, the health insurance contract and the Uniform Benefits package. As in the past, there will be no net material change in premium.

The Board's guidelines discussion group met with staff twice to establish these recommendations. This memo discusses the most significant issues to provide a basis for the Board's consideration. The attached tables also include a few relevant clarifications that are not specifically discussed in this memo.

Group Insurance Board members on the guidelines discussion group were Bob Alesch and Marty Beil. Others who assisted included Eileen Mallow, Barb Belling, John Vincent, Brian Fusie, Jim Pankratz, Tom Korpady, Bill Kox, Joan Steele, Arlene Larson and Kari Jo Zika.

(Please note: at the time of this mailing, staff is reviewing additional cost data and other considerations relating to the Uniform Benefits recommendations. If these materially affect the attached recommendations, staff will present an alternative at the Board meeting.)

Action Requested

The guideline discussion group and staff recommend that the Board adopt the changes discussed in this memo. Staff also requests that the Board authorize staff to make technical changes as necessary. In addition, contract changes will be necessary for HIPAA compliance unified pharmacy benefit manager (PBM) services, and tiered contribution modifications.

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Attached are the following:

- **Attachment A** – This table explains the basis for any substantive changes to the GUIDELINES and State and Local contracts.
- **Attachment B** - Excerpts from the GUIDELINES, Addendum 2, State Contract and Local Contract with recommended modifications for 2004. There are no net cost implications for these recommended changes.
- **Attachment C** – This table explains the basis for any substantive changes to Uniform Benefits. Any cost implications for these changes are described in this memo.
- **Attachment D** - Excerpts from Uniform Benefits, with recommended modifications for contract year 2004.

The impetus for these changes comes from the Board, participants, plans and staff. Plans were informed of some proposed changes via email on January 16. A meeting with all plans was held on February 27 to discuss changes for 2004. In response to comments from plan administrators, some minor revisions were considered and/or made when developing the recommendations contained in this memo. Comments from specific plan administrators on these recommendations are available from staff upon request.

Some changes are clarifications or specific statements of existing practice; other revisions are more substantive. Changes under discussion are shown with **redlining** of new language and ~~striking out~~ of language to be deleted. **There are also changes shown in Attachment D that are not described on the tables or discussed below.** These are all considered to be minor modifications or clarifications of current practice.

No significant net change in cost due to the modifications is expected, according to Deloitte & Touche, the Board's actuary. Thus, the Uniform Benefits will, relative to the value of the Standard Plan, maintain the actuarial equivalent benefit factor of 1.04, which has been the Board's standard of equivalence since the inception of Uniform Benefits in 1994.

The guidelines discussion group was cautious about changing the Uniform Benefits given the other major program changes that may be implemented in 2004. Therefore, following is the only recommended benefit change, which is cost neutral.

Benefit Change	PMPM
Non-surgical removal of wisdom teeth	Cost Neutral

Where appropriate, the recommendations also apply to the Blue Cross Blue Shield United of Wisconsin contracts for the Standard plans and staff will make the necessary changes.

DISCUSSION OF GUIDELINES

- 1) Section I. and Article 3.1 (2), (4), (5) & (6) and Article 3.2 (3) address the 65% required participation level for Wisconsin Public Employers (WPE). Representative McCormick's Local Government Task Force, as well as some public employers, had requested the 65% participation level be reduced to 50% in order to make participation by small employers more flexible.

Plan administrators, as well as the Board's actuary, expressed concerns over potential adverse selection if this change were made. After discussion, the guideline discussion group recommends that for small public employers (employing an average of at least 2 but not more than 50 employees on business days) the participation level be changed in accordance with Wis. Admin. Code § INS 8.46 (2). This change addresses a need raised by Representative McCormick's Local Government Task force for more small employers to have the opportunity to join the local government health insurance pool. The Office of the Commissioner of Insurance (OCI) suggested using these rules as they would address most of Representative McCormick's concerns. In addition, it would be consistent with the commercial market's participation rules. There is a state and national trend to find more ways to allow people to participate in health insurance pools. Making this change can help accommodate that need without any significantly negative long-term effect.

- 2) The Board is a Leapfrog member and has previously discussed the notion of moving forward to adopt Leapfrog standards. Section II., D., 4. and Addendum 1C have been revised to require plans to demonstrate effort to have eligible hospitals participate in Leapfrog and to educate and encourage all other hospitals to participate as well.
- 3) Addendum 2 addresses the provider guarantee. Current language states that if a provider is terminated for formal disciplinary action, the provider guarantee does not apply. For 2004, formal disciplinary action is clarified to relate only to quality of care. For example, provider guarantee would still apply when a provider is terminated as the result of formal disciplinary action that is not related to the quality of care, such as for non-compliance with the plan's referral process
- 4) Dependent is defined in Article 1.6. The definition of dependent has been clarified to indicate that dependents must be attending the institution they are enrolled in and that intersession courses, which are held for several weeks between the first and second semesters, are not included when determining full-time student status. Current language does not specify dependents physically attend the institution and is silent on intersession courses. This change is being proposed as the result of more questions being raised about eligibility when a dependent is taking courses via the internet and during intersession.
- 5) Article 3.1 (1) in the local contract will have language added if it is recommended by the Department's actuary and approved by the Board, to allow underwriting requirements for municipalities joining the program. This results from staff concerns over the possibility of large employers with adverse risk joining the program and

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potentially jeopardizing the stability of the program.

- 6) Article 3.1 (2) in the local contract will have language added explaining that the local employer shall be able to adopt a resolution for either the regular or the deductible option (\$500 individual / \$1000 family) coverage. This change will allow the addition of a deductible option that local employers can choose to offer their employees. In addition, language is being clarified to specify that when a new local employer joins our program, its eligible employees that are not insured at the time the resolution is filed are required to file evidence of insurability to participate in our program. This change was recommended by the Employer Services Division.
- 7) Article 3.3 (4) addresses enrollment periods for employees called into active military leave. It is being clarified to include enrollment periods as required under Wis. Stat. § 40.05 (4g) for those employees whose coverage lapses.
- 8) Article 3.4 (4) addresses enrollment periods when subscribers move from their plans' service area. It is recommended to add language noting that a move from a medical facility to another facility by the subscriber is not considered a residential move that creates an enrollment opportunity to switch plans. This change is to prevent potential risk to plans in cases where subscribers are confined as inpatients and they or their families request to be transferred/discharged to another facility outside their plans' service area so they can switch plans and have access to different plans' provider networks.
- 9) Article 3.18 (1) addresses individual termination of coverage. Language is being added to indicate the employer may collect premiums retroactively from the subscriber if a divorce was not reported in a timely manner and there were no other eligible dependents which necessitated that family coverage remain in effect. This is currently stated in the question and answer section of the *It's Your Choice* book on action needed following personal event of a divorce. However, the contract is currently silent on this issue.

DISCUSSION OF UNIFORM BENEFITS

Following is the list of changes to Uniform Benefits that have been discussed by the group.

- 1) **NON-SURGICAL REMOVAL OF THIRD MOLARS:** The guidelines discussion group recommends adding coverage for the non-surgical removal of third molars when performed by an oral surgeon. This benefit change has been previously suggested by a plan administrator and Department staff. Currently, only the surgical removal of third molars is covered, which can cause issues for members who require third molars to be removed surgically and non-surgically. On occasion, the member is "in the dentist chair" when the appropriate removal method is determined. This benefit change does not include the extractions of other teeth. According to our actuary, this benefit change is cost neutral since some third molars are potentially being removed surgically in order to have benefits when non-surgical removal may be appropriate but is not a covered benefit.

- 2) LIMITATION FOR MAJOR DISASTERS OR EPIDEMICS (Section IV., B., 4) & CIRCUMSTANCES BEYOND THE PLAN'S CONTROL (Section IV., B., 5.): Based on a recommendation from OCI, statements are being removed that indicate plans and their providers have no liability or obligation of failure to provide services or other benefits in the event of a major disaster or epidemic and circumstances beyond the plan's control. Removing this language is consistent with OCI's requirement for plans' commercial certificates.
- 3) MENTAL HEALTH PARITY: Last year the Board continued mental health parity, although not required by law. In January 2003, President Bush signed into law an extension of the Mental Health Parity Act (MHPA), effective through December 31, 2003. As the current discussion focuses on the plan year beginning in January 2004, provisions of the MHPA would not still apply. However, because the board has acted to incorporate these provisions, Uniform Benefits will continue to provide the level of benefit in the MHPA in 2004.

DISCUSSION OF OTHER ISSUES

We would like Board members to be aware of other issues that were considered by the guideline discussion group but resulted in no recommended changes. Staff will provide additional information about any of these issues upon your request. The first item could have affected the GUIDELINES. The remaining items could have affected Uniform Benefits.

- 1) PRESCRIPTION DRUG OUT-OF-POCKET (OOP) MAXIMUM: The actuary has analyzed prescription drug data submitted by the plans in order to establish the appropriate annual OOP maximums (single and family) to maintain the actuarial equivalent of the value of the maintenance drug list in today's dollars. The actuary has determined this amount to be \$340 per individual/\$680 per family. The group discussed this and does not recommend increasing the OOP maximum for prescription drugs in 2004 because it believes the brand name prescription copayment increased dramatically in 2003 and that members who require many prescriptions may not be able to endure another increase.
- 2) GASTRIC BYPASS: The group discussed adding this benefit. The initial per member per month (PMPM) for coverage of this benefit, even if coverage was not at 100%, would require numerous other benefit cuts. In addition, many plans expressed concerns over adding this benefit as they believe it to be considered experimental. Therefore, the group does not recommend adding this benefit for calendar year 2004. The cost impact ranged from \$1.05 PMPM for 50% coverage to \$2.46 PMPM for 100% coverage. Finally, we would note that gastric bypass is not excluded from the Standard Plan, and may be covered if it meets Blue Cross Blue Shield United of Wisconsin's medically necessary criteria.
- 3) POINT OF SERVICE VISIT COPAYMENTS: Various copayments were discussed as a means of offsetting the cost of adding coverage for gastric bypass. These included increasing the emergency room copayment from \$40 to \$50 and implementing copayments on urgent care visits; outpatient hospital or ambulatory care visits; physical, speech and occupational therapies; and MRIs. Plans indicated

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concerns on implementing a copayment for urgent care as it is not always easy to identify an urgent care visit and would require manual intervention in the claims process. The cost reduction of implementation of all the copayments named above would not be sufficient to offset the benefit of 80% coverage for gastric bypass. Therefore, the group chose not to recommend any changes to copayments at this time.

- 4) PHARMACY COPAYMENTS: The group also discussed the potential for revising the pharmacy copay once a uniform Pharmacy Benefits Manager (PBM) is instituted. It is believed that cost savings from such a change could potentially be used to offset the cost of adding coverage for gastric bypass.

Staff will be available at the Board meeting to respond to any questions or concerns.

We again thank the guideline discussion group for its participation.