STATE OF WISCONSIN
Department of Employee Trust Funds
Eric O. Stanchfield
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
TTY (608) 267-0676
http://etf.wi.gov

CORRESPONDENCE MEMORANDUM

DATE: **March 30, 2004**

TO: **Group Insurance Board**

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

SUBJECT: **Guidelines and Uniform Benefits for the 2005 Benefit Year**

Background

Annually, the Group Insurance Board (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.

A guidelines discussion group met on February 26 and March 16 to establish recommendations contained in this memo for the Board's consideration. The attached tables also include other relevant clarifications that are not specifically discussed in this memo.

The Group Insurance Board member on the guidelines discussion group was Marty Beil. Others in attendance included Barb Belling, Office of Commissioner of Insurance (OCI); Brian Fusie, Office of State Employment Relations (OSER); Jim Pankratz, OSER; John Vincent, OSER; Jon Kranz, Department of Administration (DOA); and the following Department of Employee Trust Funds (Department) staff: Dave Stella, Tom Korpady, Bill Kox, Joan Steele, Arlene Larson, Kari Jo Zika, Pam Henning, Nancy Nankivil Bennett, Vicki Poole, Liz Doss-Anderson, Christina Licari, and Sonya Sidky.

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.

Please note that as staff continues to refine Uniform Benefits, further contract changes may be necessary. For example, we may need to further clarify the pharmacy benefit. Staff will bring any substantive changes back to the Board but is also requesting authority to proceed with any needed technical clarifications.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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Attached are the following:

- **Attachment A** – This table explains the basis for any substantive changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B** - Excerpts from the Guidelines, Addendum, and State and Local Contracts with recommended modifications for 2005. There are no net cost implications for these recommended changes.
- **Attachment C** – This table explains the basis for any substantive changes to Uniform Benefits.
- **Attachment D** - Excerpts from Uniform Benefits, with recommended modifications for contract year 2005.

The impetus for these changes comes from the Board, participants, health plans and staff. Health plans were informed of some proposed changes via e-mail on January 15. A meeting with all health plans was held on January 27 to discuss changes for 2005. 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 a few changes shown in Attachments B (Guidelines/Addendum/Contracts) and D (Uniform Benefits) that are not described on the tables or discussed below. These are all considered to be minor modifications or clarifications of current practice.

The guidelines discussion group was cautious about adding any new benefits or otherwise altering copayments and deductibles to Uniform Benefits given the other major program changes that are being implemented in 2004. Therefore, the guidelines discussion group recommends no benefit changes to Uniform Benefits for 2005.

Where appropriate, the recommendations also apply to the Blue Cross Blue Shield of Wisconsin (BCBSWI) contracts for the Standard Plans and staff will make the necessary changes.

DISCUSSION OF GUIDELINES

1) **State Maintenance Plan (SMP):** The group recommends SMP be aligned with Uniform Benefits ensuring equitable access to the same benefit level throughout the state. The group believes such a change is within the statutory authority of the Board as SMP would be similar to a qualified alternate health plan. The group recognizes that some participants currently enrolled in SMP may be unhappy with the change if they value SMP benefits “richer” than Uniform Benefits, such as therapy, home health, skilled nursing facility, inpatient mental health, and optional preventive dental. We are seeking guidance from OSER on whether they foresee any collective bargaining issues with this change. Final approval of any action will be contained in the actuary’s rate recommendation presented at the Board meeting in August.

In 2004, only those participants residing in an SMP county were eligible for SMP, which was a change from past practice and a concern for some. The group recommends the residency requirements remain unless SMP qualifies as a Tier 1 plan.

2) **Qualification Criteria For Hospitals:** Current qualification criteria requires a plan to have in its network at least one hospital per county or major city. However, the following eight counties do not have hospitals: Bayfield, Buffalo, Florence, Forest, Iron, Kewaunee, Marquette and Menominee. Therefore, it is not possible for a plan to qualify in those counties. The group discussed this and reviewed access to nearby hospitals. To address potential access issues that could result, the group recommends the hospital qualification criteria be waived for those counties without hospitals when a qualified plan in contiguous counties has the nearest hospital in its network. This will be determined by staff on a county by county basis and presented at the Board meeting in August. Plans requesting such a qualification must also submit an explanation describing their ability to comply with access standards under Wis. Adm. Code § INS 9.34 (2).

3) **Segregating Provider Groups By Costs:** Currently, plans can segregate its provider network into separate plans based on distinct geographic regions. In some areas of the state, there are distinct provider groups that vary greatly in cost. The group recommends allowing a plan the option of segregating its provider network into separate plans based on the cost of provider groups and, if appropriate, share specialty providers. We believe this would provide plans with the ability to negotiate better pricing arrangements with higher cost provider groups while at the same time maintaining competition under the program.

4) **Three-Year Opt Out Provisions:** Per Article 3.17 (5) of the contract, plans opting out of participation in our program are prohibited from rejoining the program for three years. This was instituted to prevent plans from dropping out to shed risk and then quickly returning to the program. The group requests a one-time suspension of the three-year requirement to allow any plan that had opted out to rejoin our program under the tiered premium contribution structure. The rationale is that the new three tier system substantially alters the dynamics of the program. Plans who were not competitive under the old system who wish to demonstrate their ability to effectively manage risk under the new system should be given the opportunity to do so. The group further recommends an abbreviated submission process be utilized during this one-time suspension for any plans that had recently participated in our program. In addition, the group recommends the plan rejoining the program commit to participate for a minimum of one year. This recommendation would affect Security Health Plan in the northern part of the state.

DISCUSSION OF CHANGES TO THE WISCONSIN PUBLIC EMPLOYERS (WPE) PROGRAM

1) **Deductible Option:** For 2004, language was added to Article 3.1 (2) in the WPE (local) contract allowing the addition of a deductible option that local employers can choose to offer their employees in response to recommendations from Representative McCormick's Local Government Task Force. However, due to other significant program changes, a deductible option was not pursued at that time. A survey was administered to assess interest from participating and non-participating local employers in a deductible option. Based on survey results, the group recommends the Board authorize the Department to proceed with one of the two following options after consulting with the Board's actuary:

a) $250 individual / $500 family deductible with a $20 office visit copayment that would be assessed after the deductible is met for non-preventive office visits. *(10.5% premium savings)*

b) $500 individual / $1000 family deductible *(12% premium savings)*

If approved, staff will work with the Department's Division of Trust Finance and Employer Services and others who are affected to make sure the final form of the recommended option is consistent with our ability to administer it.

2) **Underwriting:** In recent years, several large local employers have joined our program and, due to poor risk characteristics of their groups, have had a significant adverse impact on certain plans. To protect our program, the group recommends that all new groups with 100 or more eligible employees be assessed a variable surcharge for two years based on the risk of the group. Groups with moderate risk would be assessed a moderate surcharge, while groups with better risk would be assessed a lesser surcharge and groups with worse risk would be assessed a higher surcharge. The surcharge would be passed back proportionately to the health plans selected by the group's enrollees. The Board's actuary supports implementing a process to protect the risk pool for locals and will be consulted when establishing the risk surcharge for a given employer.

   BCBSWI estimates the cost to underwrite a group of 100 or more employees at $1200. We would expect the employer to bear the cost of the underwriting upon application to join the program.

3) **Premium Tiering:** The parameters for local employers' share of the premium contribution is defined by administrative rule to be between 50% and 105% of the lowest cost qualified plan for full-time employees. It is possible for local employers wanting to base contribution on the tier placement of a plan to be limited by the 105% parameter. Therefore, the group recommends local employers be allowed to exceed the 105% parameter for employer contribution if using the tiered premium approach. This will also require an administrative rule change, which the Department is pursuing.

4) **Allowing Local Retirees To Escrow Sick Leave:** Currently, local annuitants who opt out of our program are unable to rejoin at a later date. The group considers it to be worthwhile extending the concept to escrow sick leave to the local program. However, it must be administered similarly to our program for those participants opting out due to comparable coverage. The recommendation is to delay implementation to such time the Department has the resources to implement and oversee it.

5) **Prohibiting Local Employers To Incent Employees To Opt Out:** We have been made aware of a few instances where employers are providing a financial incentive to employees to decline coverage under our program. Employees may decline coverage for a number of reasons, including having coverage through a spouse or the belief that they do not need coverage (i.e., they are healthy). We believe this practice will have an adverse impact on our risk pool. Therefore, the group recommends contract language be added to prohibit local employers from providing incentives for employees to decline coverage under our program.

DISCUSSION OF UNIFORM BENEFITS

The guidelines discussion group does not recommend any benefit changes to Uniform Benefits for 2005 in light of the significant program changes implemented in 2004.

DISCUSSION OF OTHER ISSUES

We would like Board members to be aware of other issues that were considered by the guidelines 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) ALLOWING EMPLOYEES WAIVING COVERAGE TO JOIN: Some local employers wanting to join the program asked that employees who previously waived coverage because of comparable coverage be allowed to join the program without enrollment restrictions. Currently, only those employees insured under the group health plan at the time the resolution is filed can select coverage without limitations. Health plans have some concerns over potential adverse selection. The group shares health plans' concerns and therefore, does not recommend this change. In addition, employees still have an enrollment opportunity if other coverage is lost.

2) PRESCRIPTION DRUG OUT-OF-POCKET (OOP) MAXIMUM: The actuary has analyzed prescription drug data submitted by the health 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 any changes to the pharmacy benefit for 2005 to allow more time for participants to get accustomed to their pharmacy benefits administered by a uniform pharmacy benefits manager (PBM).

   The group also discussed modifying the OOP maximum to be a plateau, which after it is met, copayments would be reduced, rather than waived, for Level 1 and Level 2 prescriptions. The cost impact for reduced copayments of $2 for Level 1 and $5 for Level 2 is $0.05 per member per month (PMPM). The group does not recommend this change.

   In addition, the group discussed adding a separate OOP maximum for Level 3 prescriptions. The cost impact for a $1000 individual / $2000 family OOP maximum is $0.26 PMPM. To offset this cost, the prescription OOP maximum for Level 1 and Level 2 prescriptions could be increased. However, the group believed such a change would not benefit the majority of participants and may have some detrimental effect on formulary compliance. We are currently experiencing formulary compliance of approximately 95%. Therefore, the group does not recommend applying a separate OOP maximum for Level 3 prescriptions.

3) GASTRIC BYPASS: The group discussed adding this benefit. The initial PMPM for coverage of this benefit, even if coverage was not at 100%, would require numerous other benefit adjustments. Therefore, the group does not recommend adding this benefit for calendar year 2005. The cost impact ranged from $1.66 PMPM for 50% coverage to $3.86 PMPM for 100% coverage. Finally, gastric bypass surgery may be covered under the Standard Plan if it meets BCBSWI's medically necessary criteria.

4) TRANSPLANT – UNIFORM BENEFITS: The transplant benefit maximum traditionally was half of the lifetime benefit maximum. However, when the lifetime benefit maximum was increased from $1,000,000 to $2,000,000, the transplant benefit maximum was not adjusted. An increase in the transplant benefit maximum from $500,000 to $1,000,000 would have a cost impact of $0.07 PMPM. If the transplant benefit maximum was removed, the cost impact would be $0.10. As the transplant benefit maximum is per health plan, the group agreed that participants concerned about reaching the transplant benefit maximum could switch health plans under our program. Therefore, the group does not recommend increasing the transplant benefit maximum for 2005.

5) TRANSPLANT – SMP: It has been recommended that SMP include transplant benefits. The cost impact of adding a $500,000 lifetime maximum transplant benefit is $0.65 PMPM, and a $1,000,000 lifetime maximum transplant benefit is $0.72 PMPM. As previously explained, the group recommends that SMP benefits be aligned with Uniform Benefits, which would result in SMP providing the same transplant benefits as Uniform Benefits.

6) ROOT CANALS AND DENTAL IMPLANTS: The group discussed adding benefits for root canals and/or dental implants following an accidental injury to teeth. The cost impact would be $0.02 PMPM for root canals and $0.30 for dental implants. Health plans did not support this change as they believe these benefits may be covered by dental policies. The group does not recommend this change because of health plans' concerns and its reluctance to change the benefits for 2005.

DISCUSSION OF MEDICARE PLUS $100,000

A member requested the aggregate maximum illness/injury benefit be increased from the current $100,000. This would be a cost-neutral change to the state as the members bear the entire premium cost. The group discussed changing the maximum illness/injury benefit to a lifetime maximum benefit, which is more standard in the industry and easier for participants to understand. The group recommends changing it from a $100,000 maximum illness/injury benefit to a $250,000 lifetime maximum benefit. According to BCBSWI, this change should be cost neutral. Final recommendation of this change will be in accordance with the actuary's rate development presented at the August 24 Board meeting.

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

We again thank the guidelines discussion group members for their participation in this process.