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: January 27, 2005

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans

SUBJECT: GUIDELINES/Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2006

In the past, a staff discussion group has developed recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year and Board members or their designated staff have participated. Should the Board wish to continue this process for contract year 2006, we are providing the following information on the expected issues and timelines for the GUIDELINES development.

The anticipated timeline for the 2006 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2006 contract year. The Plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits.
- On or about February 23rd, an ETF staff discussion group will meet and identify those issues to be included in the first draft of GUIDELINES.
- On or about March 1st, we will send plans the draft of the 2006 GUIDELINES/ Administrative Provisions and Uniform Benefits. Plans' comments on the draft changes will be due on or about March 11th.
- On or about March 16th, the discussion group will meet to finalize recommendations to the GIB. The discussion group's written recommendations are due by March 24th.
- The recommendations will be presented for approval at the April 19th meeting of the Board.

<u>The following briefly summarizes several issues that may be reviewed during this process, but is not exhaustive.</u> Participants, 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 2006 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 considered by the discussion group and presented to the Board in the final recommendation.

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

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	2/15/2005	5

In addition, we anticipate substantial procedural and policy issue changes to the contract relating to the Medicare Part D prescription benefit available in 2006. The impact of the changes may not be known by the April meeting and staff may request flexibility in addressing changes to the contract.

GUIDELINES/Administrative Provisions:

- Require health plans to give reasonable notice to participants who are reaching a benefit maximum, e.g., lifetime maximum, transplant maximum, etc.
- In order to continue to move away from Department use of the social security number, require health plans to track the 8-digit Department assigned unique member ID number.
- In order to ensure the Board's actuary has full confidence in data during bid negotiations, add language stating the Department has the right to audit addendum data.
- Strengthen the collection of coordination of benefits (COB) information.
- Consider requiring plans to send a notification to members prior to COBRA (continuation of health insurance) ending, for example, a 30-day notice.
- Clarify that it is the health plan's responsibility to respond to Medicare on data match inquiries.
- Clarify the existing practice that a participant's residential move across county lines creates an enrollment opportunity to select a different plan, even though both counties may be within the health plan's service area.
- Consider requiring participants to enroll in Medicare when they have End Stage Renal Disease (ESRD).
- Revise language about the carrier responsible for charges when a participant is confined on the date the policy goes into effect with a succeeding carrier so that it is consistent with state and federal law.
- Require health plans to include ETF participants in HEDIS prescription drug measures. HEDIS stands for the Health Plan Employer Data and Information Set and is a registered trade mark of the National Committee for Quality Assurance (NCQA).

Changes to the Local Contract:

- Consider specifying a surcharge following underwriting is determined by the Board's actuary and cannot be appealed.
- Specify that employers are prohibited from reimbursing employees for any patient liability [(e.g. deductible, copayment, and coinsurance) unless it is through a qualified medical expense account such as the Employee Reimbursement Account (ERA)].
- Consider allowing local employers to rejoin the health insurance program without having to wait the full three years if they are underwritten and assessed a surcharge if it is determined its risk is detrimental to the risk pool.

Uniform Benefits - Medical:

- Consider increasing the lifetime maximum for transplant benefits and/or limiting the services that get applied to the maximum.
- Consider adding coverage for gastric bypass or listing gastroesophageal reflux as an example of a comorbidity of obesity for which surgical treatment for obesity is excluded.
- Consider covering medically necessary services for travel related to work or education.

- Clarify the definition of “Medically Necessary” to state it must serve an underlying medical purpose.
- Clarify the exclusion for coverage for complications resulting from non-covered services.
- Consider changing the eligibility for dependents that are full-time students from the end of the calendar year in which they cease being a full-time student to 6-months after they cease being a full-time student.
- Consider clarifying the lifetime maximum in situations when a dependent is covered under two policies through our program.
- Consider adding language specifically excluding massage therapy.
- Consider deleting the exclusion for expenses related to planned medical or surgical treatment which the participant subsequently refuses against medical advice.
- Discussion of mental health parity costs if the Federal law is extended through 2006.

Uniform Benefits - Pharmacy:

- Adjust the pharmacy out-of-pocket (OOP) maximum consistent with past Board practice or, as alternatives, consider changing the pharmacy OOP maximum to be different for each level, e.g., Level 1 = $100, Level 2 = $300, Level 3 = no OOP maximum, or consider a nominal copayment amount (e.g. $2-Level 1; $5-Level 2) after the OOP maximum is met, which is similar to what Medicare has proposed.
- Consider requiring providers to obtain certain injectables administered in physicians’ offices from the Pharmacy Benefit Manager’s (PBM) specialty injectable vendor.
- Discussion of impact of Medicare Part D prescription drug benefits.