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CORRESPONDENCE MEMORANDUM

DATE: **March 31, 2005**

TO: **Group Insurance Board**

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

SUBJECT: **Guidelines and Uniform Benefits for the 2006 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, 2005 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 Board members on the guidelines discussion group were Marty Beil and Janis Doleschal. Others in attendance included Barb Belling, Office of Commissioner of Insurance (OCI); Brian Fusie, Office of State Employment Relations (OSER); Paul Hankes, OSER; Jim Pankratz, OSER; and the following Department of Employee Trust Funds (ETF) staff: Bill Kox, Arlene Larson, Kari Jo Zika, Nancy Nankivil Bennett, and Liz Doss-Anderson.

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, especially in light of any Medicare Part D requirements, 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.

Attached are the following:

- **Attachment A** – This table explains the basis for any notable changes to the 2006 Guidelines, Addendum, and State and Local Contracts.
- **Attachment B** - Excerpts from the Guidelines, Addendum, and State and Local Contracts with recommended modifications for 2006. There are no net cost implications for these recommended changes.

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

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Signature Date

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- **Attachment C** – This table explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** - Excerpts from Uniform Benefits, with recommended modifications for contract year 2006.

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 19, 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.

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 AND STATE AND LOCAL CONTRACTS

A number of changes are being made to clarify existing practice or implement minor modifications. The most significant of these are bulleted below.

- *Medicare Data Match, also known as resolution of Medicare as a Secondary Payor issues:* The contract clarifies that it is the plan's responsibility to respond to Medicare on behalf of employers when Medicare raises questions about whether or not they should have been prime on a previously paid claim. While this is typically an employer responsibility, in our experience plans are in the best position to handle these issues when they involve claims payment disputes with Medicare.

- *Health Plan Employer Data and Information Set (HEDIS®) prescription drug measures:* Currently there is no assurance that health plans are including ETF membership in their HEDIS drug measures. Staff will supply plans with additional information to assist them in meeting the requirement.

- *COBRA notification at 60 days, rather than 30 days:* In order to allow affected participants more time to research options, the group recommends that plans issue notices 60 days before COBRA coverage. Currently plans offer 30 day or 6-month notifications.

- *Notification to member upon nearing lifetime maximum limit:* Staff recommends that plans provide written notification to a member when they reach approximately 75% of the benefit maximum. Plans state that this information is available on some plan websites or via explanation of benefits (EOBs), and that other venues may increase administrative expense. Staff will work with plans and individuals as necessary to minimize administrative burdens.

- *Local group underwriting surcharge:* Clarify that the determination of surcharge amount is not appealable by the employer. The determination of the surcharge amount is done by BCBSWI and reviewed by Deloitte Consulting (Deloitte), the Board's actuary, based upon

complete information supplied by the employer. As such, the group feels that the decision is final and further review is not pertinent.

- *Prohibit employers from self-insuring deductibles in our high deductible plans:* Clarify the contract to prevent employers from reimbursing employees for their new, higher deductibles as this function could undermine the pricing of the programs. If this were allowed, higher premium costs would ultimately be expected. This change would continue to allow employees to utilize an Employee Reimbursement Account (ERA) that allows these charges to be paid on a pre-tax basis.

- *Participation of local bargaining units:* The contract's current language would be clarified to prevent individual bargaining units within a participating employer from dropping out and entering into an agreement with another insurer.

DISCUSSION OF UNIFORM BENEFITS

1) CONGENITAL AND BIRTH ABNORMALITIES: The definition of congenital that appears in the contract currently excludes hereditary conditions existing at birth. The Board is not subject to, but has adopted, OCI's congenital mandate language in the past, but the mandate does not include a definition of congenital. The group recommends removing the portion of the definition that states "but is not hereditary." In addition, staff will work with OCI to adjust the listed benefit for congenital defects and birth abnormalities to clarify coverage for secondary aspects of such defects, especially in regards to orthodontia and dental services.

2) NUTRITIONAL COUNSELING: The group considered coverage for gastric bypass surgery, as discussed below, and found the cost to be considerable and greater than the estimated cost from prior years. Discussion then centered on alternatives to care that are less invasive, such as nutritional counseling. We note that this type of counseling is more than obesity counseling. It would be available for any medically necessary condition, for example, diabetes and pre-natal care. The cost for this benefit is $.09 per member per month (PMPM) and includes consult evaluation, management for assessment and/or intervention, re-assessment (both individual and group), and dietician visit(s).

3) TRAVEL-RELATED PREVENTATIVE TREATMENT: The group recommends adding health plan coverage of medically necessary travel-related preventative treatment (excluded when required for work). Examples of this are malaria pills or hepatitis A vaccinations. The cost for this benefit is $.03 PMPM.

4) TRANSPLANT MAXIMUM: 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 has a cost impact of $0.12 PMPM.

5) EMERGENCY ROOM (ER) COPAYMENT: In order to offset the cost of these benefit increases and maintain the value of the program, the group recommends increasing the ER copayment. Some plans stated that a $75 copayment is common in the industry, however, the group recommends increasing the ER copayment from $40 to $60.

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.

1) PRESCRIPTION DRUG OUT-OF-POCKET (OOP) MAXIMUM: The group considered but does not recommend changing the prescription drug OOP maximum, as we expect more fluctuations in our Pharmacy Benefit Manager (PBM) program due to the implementation of Medicare Part D for 2006. The group felt it would be more appropriate to address the Medicare when this issue is resolved.

2) ACCESS TO MENTAL HEALTH PROVIDERS: The group considered but does not recommend adding language that would provide additional continuity of care provisions for mental health services. This issue was brought to the group by the UW System due to issues related to delivery of services to participants. Plans feel that their current systems are adequate, and increasing them to potentially include items such as indefinite continuity with partial patient copayment would be costly and difficult to administer. Staff believes this issue stems from a recent provider network change in the Milwaukee area and associated communications. The group felt that the issue in Milwaukee has been resolved, and current provisions for continuity of care address members needs until a Dual-Choice enrollment change can be made.

3) GASTRIC BYPASS: The group discussed including this benefit. The cost impact ranged from $3.66 PMPM for 80% coverage to $4.70 PMPM for 100% coverage. This change would require numerous other contract adjustments. The group concluded that providing nutritional counseling as a benefit improvement is an appropriate first step in addressing member needs. Therefore, the group does not recommend adding this benefit for calendar year 2006. It should be noted that gastric bypass surgery may be covered under the Standard Plan if it meets BCBSWI's medical necessity criteria.

4) MISCELLANEOUS BENEFIT PROVISIONS: Several other changes were considered but the group decided not to make a recommendation at this time.
   - ER copayment reducing, capping or tiering based on nature of condition.
   - ER copayment waived if member returns to ER within 24 hours of visit or inpatient stay.
   - Biofeedback exclusion deletion.
   - Apply physical, speech and occupational therapy rendered in a skilled nursing facility to the therapy maximum.
   - Require those eligible for Medicare Part B due to End Stage Renal Disease (ESRD) to enroll in Medicare Part B.
   - Require providers to obtain certain injectables administered by them in the office from the PBM's designated vendor.

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.