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CORRESPONDENCE MEMORANDUM

DATE: March 24, 2006

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 2007 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 health insurance contract and the Uniform Benefits package. As in the past, there will be no net material change in the overall benefit level.

A guidelines discussion group met on February 28 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 guidelines discussion group was attended by Barb Belling, Office of Commissioner of Insurance (OCI); Paul Hankes, Office of State Employment Relations (OSER); Jim Pankratz, OSER; Paul Ostrowski, OSER; and the following Department of Employee Trust Funds (Department) staff: Tom Korpady, Bill Kox, Joan Steele, Arlene Larson, Nancy Nankivil Bennett, Liz Doss-Anderson, and Christina Keeley.

Action Requested

The guideline discussion group and staff recommend that the Board adopt the changes discussed in this memo and make additional 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 for participants on Medicare Part D. Staff will bring any notable 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 notable 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 2007. There are no net cost implications for these recommended changes.
- **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 2007.

The impetus for these proposals comes from the Board, participants, health plans and staff. Health plans were informed of some proposed changes via e-mail on January 20. In response to comments from plan administrators, some minor revisions were considered and/or made when developing the recommendations contained in this memo. Comments on these recommendations from specific plan administrators 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 Wisconsin Physicians Service (WPS) contracts for the Standard Plans and staff will make the necessary changes.

DISCUSSION OF GUIDELINES AND STATE AND LOCAL CONTRACTS

1) **Modification to Health Plans' Optional Offering of Dental Benefits:** It was discussed whether optional dental benefits offered by health plans should be set at a uniform benefit level to better coordinate with the employee-pay-all plans currently available. In 2002, the Board recommended that dental be provided through collective bargaining at which time it could be removed from the health plan package. The current system is somewhat inefficient and inequitable. There have been indications that plans have been increasing benefits to gain competitive advantage. One alternative is to set the benefit level based on the average of the benefits currently offered by health plans. If such a benefit level becomes available, the group notes that based on benefits currently offered by the health plans, some participants may be significantly impacted by an increase or decrease in dental benefit. The group does not recommend modifications to the optional offering of dental benefits at this time but will continue working on this issue and review it at a future date.

2) **Requiring Annual Estimated Premium Bids:** It was discussed that health plans be required to submit an estimated premium bid every year, beginning in 2006. The estimated bids provide the Board's actuary with helpful and useful information for the bidding process that must be completed within a tight timeline. A few health plans expressed concern over lack of notice in allocating resources to submit an estimated premium bid in 2006. The group recommends that health plans submit an estimated premium bid every year, beginning in 2007.

3) **Segregating State Maintenance Plan (SMP) Based on Efficiency of Provider Groups:** In follow-up to the Board's request several years ago, the group discussed providing flexibility in the guidelines that would allow the SMP to be split into different tiers if it is determined that certain provider groups in the SMP network are higher cost and should be Tier 2. According to the Board's actuary, the SMP is currently not a true Tier 1 plan. As a result, only those participants residing in an SMP county are eligible for SMP, which is a change from past practice and a concern for some. The group recommends language be added allowing the Board to determine whether the SMP should be split based on the premium setting process, and that residency requirements for eligibility for the SMP be removed.

4) **Health Plans' Educational Efforts About Quality Initiatives:** The group discussed ways to provide greater clarity to health plans as to their accountability on quality performance. In the past, health plans have been asked only to respond to questions about their quality improvement efforts. The group recommends that health plans submit further documentation to the Department detailing their efforts. For example, in the past health plans have been asked whether they have provider contract language encouraging agreement by the provider to participate in quality improvement initiatives and/or patient safety measurement; now health plans will be asked to show the Department that contract language.

DISCUSSION OF CHANGES TO THE LOCAL CONTRACT:

1) **Allowing SMP as Low-Cost Plan:** In counties that do not have a qualified plan, the Standard Plan is used as the low-cost, qualified plan for purposes of determining employer contribution under the 105% approach. Periodically, employers have requested the Standard Plan not be considered the low-cost, qualified plan for determining employer contribution parameters as it can create tremendous financial hardship for municipalities. In those counties with no qualified alternate health plan, the group recommends the SMP be the low-cost qualified plan when the SMP meets the minimum provider requirements used for qualifying the alternate health plans.

2) **Underwriting:** In the past, the Board has approved implementing an underwriting process to protect the program from large employers (100 or more eligible employees) with poor risk characteristics from adversely impacting the pool at the time they join the program by assessing a variable surcharge for up to 24 months based on the risk of the group. At this time, no employers participating in the program are being assessed a surcharge.

   The process was designed for employers who join the program at one time as a group. In the past, however, the Department has allowed employers to temporarily retain a separate group health plan outside this program for one or more of its bargaining units by temporarily waiving the 65% participation requirement. There is now a concern that a large employer may come into the program with a relatively small portion of its group to serve its surcharge period. This would potentially allow a large portion of the group to come in later and avoid the surcharge.

   Staff consulted with the Board's actuary to determine whether the surcharge requirement can be modified to address this situation. The Board's actuary supports a requirement whereby at least 50% of eligible employees are enrolled initially with the appropriate surcharge applied to those employees until the remaining eligible employees are enrolled, at

which time the variable surcharge for the group will be assessed for up to 24 months based on the risk of the entire group. It is recommended that this process be implemented immediately so that the surcharge is not limited to 24 months for those large employers who do not join the program at one time as a group.

DISCUSSION OF UNIFORM BENEFITS

1) **Pharmacy Annual Out-Of-Pocket (OOP) Maximum:** Prior to the 2004 benefit year, the OOP maximum was increased periodically, and often annually, in accordance with the change in relative value of the original Uniform Benefits maintenance drug list. It is currently $300 per individual/$600 per family. Since 2004, the Board has not increased the amount. According to the Board's actuary, if the OOP maximum is increased according to the change in its relative value since the 2004 benefit year, it should be $390/$780 in 2007. An alternative is to increase it enough to maintain its value for one year and to at least keep it from falling further behind. To maintain the OOP value from last year, the OOP maximum would be $320/$640. The group recommends the OOP maximum be increased to at least $320/$640 in 2007.

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 request.

1) **Nominal Copayment After OOP is Met:** The group considered implementing a plateau for the OOP whereby a nominal copayment is applied for Level 2 drugs that are not split after the annual OOP plateau is met. According to the actuary, the cost savings of implementing a nominal copayment are:

   $2 copayment = $0.29 PMPM (Per Member Per Month)
   $3 copayment = $0.43 PMPM
   $4 copayment = $0.57 PMPM
   $5 copayment = $0.71 PMPM

   Although the group acknowledged this benefit change creates a stronger incentive to utilize drugs in Level 1 whenever possible, there was concern about the financial impact of the benefit change on those participants in the program with greater health needs. The group acknowledged that implementing a nominal copayment in addition to increasing the OOP maximum would have the greatest impact on those same participants. Due to a lack of consensus, the group does not recommend implementing a nominal copayment in 2007.

2) **Dental Implants Following Accidental Injury:** The group considered allowing coverage for dental implants under the accidental loss of teeth provision as dental implants are becoming a standard of care as well as a more cost-effective treatment option in some situations. The cost impact is $0.25 - $0.30 PMPM. If the benefit is capped at $1000 per tooth for the implant, the cost impact is $0.17 - $0.20 PMPM. In general, health plans had a mixed response to adding this benefit. Although the group considered this benefit change worthwhile, there were no cost savings available to offset the addition of this benefit.

3) **Osteotomy and/or Orthognathic Surgery:** The group discussed including this benefit in follow-up to a request by a participant who appealed the denial of the procedure. The cost impact to add coverage is $0.10 - $0.25 PMPM. The group acknowledged that it may be medically necessary even when there is not a diagnosis of temporomandibular joint (TMJ). In general, health plans did not support this change because of difficulty in determining medical necessity. Because coverage is available under the Standard Plan when medically necessary and under the Uniform Benefits when there is a diagnosis of TMJ, the group does not recommend adding coverage in Uniform Benefits for osteotomy and/or orthognathic surgery. The group notes that this can be very costly for local government employees whose employers still operate within the 105% premium contribution formula.

4) **Complications from Non-Covered Services:** The group discussed and does not recommend changes to the exclusion for treatment due to complications from services that are not covered under any plan in the program. The group discussed the possibility of adding a time limit to the exclusion so it would not apply to complications arising beyond the time limit. The cost impact of adding a three-year time limit is $0.06, while a five-year time limit will cost $0.02 PMPM. Removing the exclusion in its entirety will cost $0.30 PMPM. The actuary expressed concern over any changes to this exclusion that would result in an increase to benefits because of the unknowns of future experimental drugs and surgeries that would likely not be covered under this program and could result in costly complications.

5) **Education Therapy/Developmental Delay:** The group discussed contract language and benefits to ensure the contract provides for the benefits that are intended to be covered under the program. It has been suggested that health plans may be inappropriately using the exclusion language to deny services for school-aged participants that might otherwise be covered under Uniform Benefits. This benefit is complicated because it excludes those services that schools are obligated to provide under Federal law, regardless of whether or not the school provides the services. Several health plans noted they provide a benefit specific to developmental delay services in which one evaluation and up to three visits per therapy (physical, speech and occupational) per member per year are covered, even though it may duplicate some services that schools are required to provide. The PMPM to add such a benefit is $0.37 - $0.57. The group agreed therapy benefits for school-aged children can be challenging to administer but acknowledged that Uniform Benefits should not provide for services that are to be covered by schools. Several other changes were considered but the group decided not to make a recommendation at this time.

6) **Weight Loss Surgery (Gastric Bypass):** The group considered whether Uniform Benefits should include coverage for weight loss surgery in response to requests from a few participants as well as a provider group, UW Health Bariatric Program, that indicates bariatric surgery is a treatment option for obesity and its comorbidities. The group acknowledged that Medicare recently modified its coverage provisions allowing for coverage of bariatric surgery in given situations. Based on PMPMs calculated in past years, adding a benefit for weight loss surgery to Uniform Benefits will require substantial benefit decreases in order to maintain the overall benefit level as required by statute. The group concluded that the nutritional counseling benefit that was added in 2006 is an appropriate first step in addressing member needs and that gastric bypass surgery may be covered under the Standard Plan if it meets WPS's medical necessity criteria. Therefore, the group does not recommend adding this benefit for 2007.

7) **Mental Health Benefits/Gambling Addiction:** Several behavioral health providers wrote to the Department Secretary requesting consideration of behavioral health benefits for treatment for “dual diagnosis”, pathological gambling, nicotine dependence, and diagnostic/consultative services. After consulting with some of the health plans regarding the administration of the behavioral health benefits, Department staff concluded that, in general, Uniform Benefits currently provides benefits for those treatments being requested, except for gambling addiction. The guideline discussion group does not recommend adding benefits for the treatment of gambling addiction due to the availability of treatment programs through other resources, such as government programs.

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.