AGENDA AND NOTICE OF MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD (GIB) MEETING

Holiday Inn Hotel and Suites 1109 Fourier Dr. Madison, WI	Tuesday June 9, 2009 9:00 a.m.

Times shown are estimates only. ⊢ *Denotes action item.*

9:00 a.m. 1. **Call to Order**

9:00 a.m. ⊢ 2. **Consideration of April 14, 2009, GIB Meeting Minutes**

9:05 a.m. ⊢ 3. **Income Continuation Insurance (ICI) Program (Tim Gustafson, Deloitte Consulting)**
- Acceptance of State and Local Actuarial Valuations

9:35 a.m. ⊢ 4. **Consideration of Long-Term Care Insurance Program Replacement Policy**
- United of Omaha

9:40 a.m. ⊢ 5. **Request for Delegation Authority for Data Collection and Analysis**

10:00 a.m. 6. **Operational Updates**
- 2008 Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report
- 2008 Ombudsperson Annual Complaint and Inquiry Summary
- Legislative/Budget Update
- Pending Appeals Status Report
- 2009 GIB Roster
- Future Agenda Items

10:20 a.m. ⊢ *7. **Health Insurance Program**
- Technical Changes to 2010 Guidelines and Uniform Benefits
- Self-Insured Health Plans Presentation by Wisconsin Physicians Service (WPS)
- Consideration of Contract Amendments for Self-Insured Health Plans
- *Alternate Plan Financial Status
- *Consideration of New Participating Health Plan

11:30 a.m. 8. **Announcement of Action Taken on Business Deliberated During Closed Session**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Cindy Gilles, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931. Telephone number: (608) 261-0736. TTY #: (608) 267-0676. E-mail: cindy.gilles@etf.state.wi.us.

11:35 a.m. 9. **Adjournment**

*** The GIB may be required to meet in closed session pursuant to the exemptions contained in Wis. Stat § 19.85(1)(e) to discuss the use of public employee trust funds. If a closed session is held, the GIB will reconvene into open session for further actions on these and subsequent agenda items.**

The meeting location is handicap accessible. If you need other special accommodations due to a disability, please contact Cindy Gilles, Department of Employee Trust Funds, PO Box 7931, Madison, WI 53707-7931. Telephone number: (608) 261-0736. TTY #: (608) 267-0676. E-mail: cindy.gilles@etf.state.wi.us.

MINUTES OF APRIL 14, 2009, MEETING

STATE OF WISCONSIN
GROUP INSURANCE BOARD
Holiday Inn and Suites
1109 Fourier Drive, Madison, WI

DRAFT

BOARD PRESENT:

Steve Frankel, Chair Esther Olson, Secretary Robert Baird Marty Beil Janis Doleschal	Paul Ostrowski (representing Jennifer Donnelly) David Schmiedicke Kimberly Shaul (representing Sean Dilweg) Gary Sherman

BOARD NOT PRESENT:

Cindy O'Donnell, Vice-Chair	

PARTICIPATING ETF STAFF:

Dave Stella, Secretary Bob Conlin, Deputy Secretary Cindy Gilles, Board Liaison	Tom Korpady, Division of Insurance Services Bill Kox, Division of Insurance Services

OTHERS PRESENT:

Office of the Secretary: Rhonda Dunn, Sharon Walk Office of Budget and Trust Finance: Jon Kranz Office of Legislative Affairs, Communications, and Quality Assurance: Vickie Baker, Liz Doss-Anderson, Christina Keeley, Matt Stohr Office of Policy, Privacy and Compliance: Steve Hurley Division of Insurance Services: Michelle Baxter, Marcia Blumer, Lisa Ellinger, Arlene Larson, Sonja Sidky, Joan Steele, Betty Wittmann Aetna: Chris Burke American Federation of Teachers-Wisconsin: John Verberkmoes Bultman Financial: Mary Kay Bultman, Ralph Bultman	Legislative Audit Bureau: Brian Bellford Medical Associates Health Plans: Joy Kaiser Mercy Care: DuWayne Severson Minnesota Life Insurance Company: Chris Schmelzer, Kjirsten Elsner Office of the Commissioner of Insurance: Barb Belling Physicians Plus Insurance Corporation: Ron Sebranek Security Health Plan: Becky Gorst Senior Care Insurance: Bill Krumpf, Kevin Krumpf State Engineers Association: Bob Schaefer United Health Care: Brandon Widell Unity Insurance: Kathy Ileman UW System Administration: Beth Ritchie

Dean Health Plan: Deb Treinen, Penny Bound Department of Justice: Charlotte Gibson Group Health Cooperative-SCW: Emily Halter, Paul Perkins Health Choice, LTC: Bob Pearson, Juliet Dykstra Humana: David Fee, Roxanne Perillo, Robin Peterson	Wisconsin Association of Health Plans: Phil Dougherty Wisconsin Education Association Trust: Ross Hampton Wisconsin Physicians Service Insurance Corp.: David Grunke, Greg Nelson

Steve Frankel, Chair, Group Insurance Board (Board), opened the meeting by thanking everyone for their support during his years as Chair of the Board, especially Tom Korpady. This is Mr. Frankel's last meeting. Mr. Frankel then called the meeting to order at 9:00 a.m.

CONSIDERATION OF MINUTES OF FEBRUARY 17, 2009, MEETING

Motion: Mr. Baird moved approval of the minutes of the February 17, 2009, meeting as submitted by the Board Liaison. Mr. Beil seconded the motion, which passed without objection on a voice vote.

Mr. Frankel announced that the Board would convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for quasi-judicial deliberations on appeal matters. Ms. Gibson, Ms. Gilles, and Ms. Walk were invited to remain for discussion of the appeal.

Motion: Mr. Beil moved to convene in closed session, pursuant to the exemptions contained in Wis. Stat. § 19.85 (1) (a) for quasi-judicial deliberations. Mr. Baird seconded the motion, which passed on the following roll call vote.

Members voting aye: Baird, Beil, Doleshal, Olson, Ostrowski, Schmiedicke, Shaul, Sherman and Frankel

Members voting nay: none

The Board convened in closed session at 9:10 a.m. and reconvened in open session at 9:27 a.m.

ANNOUNCEMENT OF ACTION TAKEN ON BUSINESS DELIBERATED DURING CLOSED SESSION

Mr. Frankel announced that the Board took the following action during the closed session:

- **Appeal 2008-006-GIB and 2008-027-GIB**. The Board adopted the hearing examiner's proposed decision with modifications.

HEALTH INSURANCE PROGRAM

Dual-Choice Enrollment Period

Motion: Mr. Beil moved to approve the Dual-Choice enrollment period for October 5-23, 2009. Ms. Olson seconded the motion, which passed without objection on a voice vote.

Guidelines/Uniform Benefits Timeline: Bill Kox, Division of Insurance Services, discussed the Guidelines and Uniform Benefits for contract year 2010. The study group met to establish recommendations for changes to the benefits package. Included in the study group were representatives from the Office of the Commissioner of Insurance, Department of Administration, Office of State Employment Relations, the University of Wisconsin and the Department of Employee Trust Funds (Department). Changes recommended by the Study Group follow:

Recommended Changes to Administration

Non-Payment for Medical Errors: Adding language stating that health plans are expected to incorporate the Centers for Medicare and Medicaid Services policy into their contracts with network providers and hospitals.

Medicare Rate Calculation: Modifying the calculation of the Medicare-reduced rate, pending the recommendation of the Board's actuary.

Medicare Rate Categories: Revising the Medicare-reduced family rate categories so that the Medicare Family 2 rate applies only after all insured family members are covered by Medicare. Approximately 40 contracts in the Medicare Family 2 rate category do not have all family members covered by Medicare. The study group recommends these contracts be grandfathered.

Recommended Changes to Eligibility/Enrollment

Dependent Coverage: Requiring subscribers to list all family members on the application that are eligible for coverage when applying for family coverage. The group also recommended eligible dependents not listed on an application for family coverage can be added to the policy effective the first of the month following the employer's receipt of the application. Newborns and adopted children are exceptions, as state statute provides coverage from birth and placement for adoption.

Retrospective Premium Adjustments: Modifying the provision to limit retrospective premium adjustments to six months.

Rehired Annuitants at the University: Adding the rehired annuitant language as requested by the University.

Recommended Changes to the Local Contract

***65*% Participation Requirement:** Adopting a minimum 65% participation requirement before a new group is able to join the health insurance program and allowing large employers with more than 50 employees to retain a second plan for up to four years due to the timing of collective bargaining, provided the employer meets the minimum 65% participation requirement.

Continuation Coverage for Participants Subsequently to be Eligible: Adding language to allow participants who are subsequently found to be ineligible to elect continuation coverage for up to 36 months.

Recommended Changes to Benefits

Pharmacy Annual Out-of-Pocket (OOP) Maximum: Increasing the OOP maximum for 1½ years. Mr. Beil would like to be on record as voting against the study group's recommendation.

Breast Implant Coinsurance: Clarifying the benefit administration so that the coinsurance is not applied to breast implants for reconstruction following mastectomy.
Case Management/Alternate Treatment: Allowing the members' attending physician to make recommendations for alternate treatment with the health plan, coming to agreement with the course of treatment before the recommended alternate treatment is provided and covered under the contract.

Federal Mental Health Parity: Changing language to remove the dollar and day maximums for mental health and alcohol and other drug abuse (AODA) treatment.

Other State Mandates: The future of several mandates (providing autism benefits and domestic partner coverage) is unknown at this time. The contract language will be updated as necessary to comply if the mandates are passed for 2010 before the premium bidding process is completed.

Mr. Kox answered questions from the Board.

Motion: Ms. Olson moved to accept the recommendations with respect to changes to the Guidelines and State and Local Contracts. Mr. Baird seconded the motion, which passed on the following voice vote.

Members voting aye: Baird, Doleschal, Frankel, Olson, Schmiedicke, Shaul and Sherman

Members voting nay: Beil and Ostrowski

LONG-TERM CARE INSURANCE PROGRAM

Mr. Kox discussed the long-term care insurance (LTC) replacement policy from John Hancock. SeniorCare would replace the current Custom Care II policy (no longer available as of April 1, 2009) with its updated Custom Care II Enhanced policy. The premium increase would be approximately 10-15%. The proposal, when sold with the 5% compound inflation rider plus Guaranteed Purchase Option, meets the requirements outlined in the Board's guidelines and Wis. Admin. Code.

On January 1, 2009, the Wisconsin Partnership Program was implemented. This program allows individuals who purchase LTC policies to disregard assets from their estate in an amount equal to the benefits they were paid by the policy on behalf of the individual who has received medical assistance (Medicaid).

Motion: Ms. Doleschal moved to approve John Hancock's long-term care insurance replacement policy. Mr. Baird seconded the motion, which passed without objection on a voice vote.

INCOME CONTINUATION INSURANCE (ICI)/LONG-TERM DISABILITY INSURANCE (LTDI) PROGRAMS

Mr. Korpady introduced Christopher Burke, Aetna Group Insurance. Mr. Burke reviewed the 2008 projects and approaches, executive summary and performance.

Projects and Approaches

- A five-year contract was awarded to work with the Board.
- Aetna staff will continue to integrate and partner with the Department.
- Ombudsperson activity continues to be at a low level and has a high level of resolved cases.
- Customer service remains a priority.

Executive Summary

- Experienced staff has led to more resolution, reducing Ombuds activity. Contacts have dropped from 171 in 2004 to 13 in 2008.
- Aetna met, or exceeded, customer service levels.
- A summary of state and local ICI and LTDI claims was presented.

Performance Measures

- Performance measures for 2008 were calculated based on phone statistics, evidence of insurability and customer service measurements.

Mr. Burke answered questions from the Board.

MISCELLANEOUS

Health Insurance Enrollment, Validation, and Payment (EVP) Project Update
Mr. Korpady gave an update on the EVP Project. Phase 1 gives employers access to their enrollment data on the Department's system. Phase 2 will match the enrollment data on the Department's system with the employer's data. It is anticipated that on-line enrollment will occur in Phase 4.

Mr. Korpady referred to the remaining miscellaneous items included in the Board packet and the letter from Minnesota Life Insurance Company as "for informational purposes only."

PLAQUE PRESENTATION

This was Mr. Frankel's last meeting. He served 21 years on the Group Insurance Board and in fact was Board Chair for 20 of those 21 years. Secretary Stella presented Mr. Frankel with a plaque from the Governor. Mr. Korpady presented Mr. Frankel with a plaque from the Department and the Board for his years of service and dedication. Mr. Frankel thanked everyone and shared that this was one of the "neatest experiences" he has had – learning a lot about state government.

As the most senior member on the Board, Mr. Beil shared some warm thoughts about the leadership of Mr. Frankel over his years as Chair and his ability to work with the different Board members.

ADJOURNMENT

MOTION: Mr. Beil moved to adjourn the meeting. Ms. Olson seconded the motion, which passed without objection on a voice vote.

The Board adjourned at 10:35 a.m.

Dated Approved:_____

Signed: _____
Esther Olson, Secretary
Group Insurance Board

Deloitte.

The State of Wisconsin

Local Income Continuation Insurance Plan Actuarial Review as of December 31, 2008

Audit . Tax . Consulting . Financial Advisory .

Prepared By:
Timothy D. Gustafson, FSA, MAAA
Deloitte Consulting LLP

Table of Contents

I. Overview

The purpose of this report is to summarize our review of the Local Income Continuation Insurance Plan. Included are a brief review of the Plan's experience during 2008, an estimate of the Plan's liability as of December 31, 2008, and an analysis of current funding levels.

In preparing this report, we have relied on claim information provided by Aetna and the Department of Employee Trust Funds ("ETF"). We have not audited this information, but have relied on it as submitted after making reasonableness checks as we deemed appropriate under the circumstances.

The results of this review indicate that the Local Income Continuation Insurance Plan (including supplemental benefits) is in a strong financial position, with assets of $25,871,414 and estimated liabilities of $3,886,827. The asset balance does not include $5.5 million in deferred market losses which will be smoothed in over the next four years. The large net fund balance is primarily due to a valuation methodology change, which took place at December 31, 1996.

We do not recommend a change in premium rate at this time.

The remainder of this report summarizes the review in more detail. A number of assumptions have been made in estimating the Plan's liability. These assumptions are described throughout the report and summarized in Exhibit 1.

II. 2008 Experience Review

Fund Balance

During 2008, the fund balance increased from $24,150,025 to $25,871,414. Total revenues were $2,494,275, with paid claims and administrative expenses totaling $745,131. These components are shown in the following table along with figures for the previous three years for comparison purposes.

	2008	2007	2006	2005
Beginning Balance	24,150,025	20,919,663	18,604,406	16,708,151
Closing Adjustments	(27,755)	(25,656)	(125,560)	(3,488)
Adjusted Beginning Balance	**24,122,270**	**20,894,007**	**18,478,846**	**16,704,664**
Revenues				
Contributions	1,716,186	1,602,545	1,504,430	1,397,588
Investment Earnings	778,089	2,644,345	1,857,528	1,111,424
Total	**2,494,275**	**4,246,890**	**3,361,958**	**2,509,011**
Expenses				
Paid Claims	594,077	828,881	760,539	487,853
Administrative Expenses	151,054	161,991	160,602	121,416
Total	**745,131**	**990,872**	**921,141**	**609,269**
Net Income	**1,749,144**	**3,256,018**	**2,440,817**	**1,899,743**
Ending Balance	**25,871,414**	**24,150,025**	**20,919,663**	**18,604,406**
Investment Earnings/Mean Balance	**3.2%**	**12.5%**	**9.9%**	**6.5%**

The following table shows the number of open and closed claims by year incurred and the average net monthly benefit.

Claims By Year of Incurral

	Open Claims		Closed Claims		All Claims	
Year Incurred	Number	Average Benefit	Number	Average Benefit	Number	Average Benefit
2008	17	$ 2,279	36	$ 2,519	53	$ 2,442
2007	0	-	22	2,329	22	2,329
2006	4	625	3	879	7	734
2005	9	1,115	2	2,004	11	1,277
2004	6	934	0	-	6	934
2003	4	932	1	3,588	5	1,463
2002	2	1,089	0	-	2	1,089
2001	2	99	0	-	2	99
2000	3	394	0	-	3	394
1999	0	-	0	-	0	-
1998	0	-	0	-	0	-
1997	1	1,067	0	-	1	1,067
1996	1	238	0	-	1	238
1995	0	-	0	-	0	-
1994	0	-	0	-	0	-
1993	1	464	0	-	1	464
Total	**50**	**$ 1,319**	**64**	**$ 2,377**	**114**	**$ 1,913**

The following table shows the claim count and average net benefit amount for open, closed and total claims, respectively, as of December 31, 2008. In addition, historical claim counts and net benefit amounts for the last ten years are provided for comparison.

Claims By Valuation Date

	Open Claims		Closed Claims		All Claims	
Plan Year	Number	Average Net Benefit	Number	Average Net Benefit	Number	Average Net Benefit
2008	50	$ 1,319	64	$ 2,377	114	$ 1,913
2007	51	1,164	94	866	145	971
2006	62	1,183	62	1,170	124	1,176
2005	52	1,376	49	1,195	101	1,288
2004	37	1,368	47	1,798	84	1,609
2003	27	1,276	48	1,746	75	1,577
2002	34	1,569	46	1,299	80	1,414
2001	33	1,643	14	1,479	47	1,594
2000	24	1,326	60	1,256	84	1,276
1999	21	$ 919	43	$ 1,041	64	$ 1,001

III. Estimated Liability as of December 31, 2008

The Plan's liability for outstanding claims under the Local Income Continuation Insurance program was estimated in two parts — reported claims and incurred but unreported claims. The following paragraphs summarize the method used and results.

Reported Claims

Disabled life reserve factors were calculated using the 1987 Commissioner's Group Basic Disability table adjusted for the State's own termination experience. These factors represent the present value of future payments, at 7.8% interest, to a disabled person with a monthly benefit of $100. The WRS valuation interest rate was reduced from 8% to 7.8% as of February 1, 2004, and has since remained at 7.8%. For consistency, and at the direction of ETF personnel, the valuation interest rate is tied to the WRS valuation rate; therefore a 7.8% discount rate was used in the December 31, 2008, valuation. The factors are indexed by age at disablement, duration of disablement, and duration to the end of the benefit period.

Aetna provided a listing of those persons known to be disabled as of December 31, 2008. The age at disablement, duration of disability, and duration to the end of the benefit period was calculated for each individual. The appropriate factors were then multiplied by the amount of benefit for each disabled person. The results were summarized by year incurred and in total.

For disabilities that last over one year, an additional $75 per month is included in the normal benefit amount for the purpose of defraying medical costs. This supplemental benefit was effective January 1, 2002, for all claims in pay status. A liability was added for those claims incurring in 2008 representing the probability that claims will continue beyond the first year and the present value of the additional benefit. The liability for the $75 supplement is already included in the liability for claims over one year.

Incurred But Unreported Claims

In addition to those claims reported as of December 31, 2008, there presumably are other claims incurred prior to that date but which are not yet reported. The Plan's liability for long-term disability claims begins on the date an employee is disabled, even though the employee is not eligible for payments during the waiting period or has not yet filed a claim. Thus, it is necessary to estimate the additional liability for claims incurred but not reported as of the valuation date.

Besides the waiting period, delays in the reporting and processing of claims normally occur. From the Plan's own experience, we observed that approximately 25% of claims incurred during any twelve month period are unreported as of the end of that twelve month period. Thus, the Plan's liability for claims incurred but not yet reported was calculated as the estimated number of incurred but not yet reported claims times an average liability for reported claims.

Results

The total estimated liability as of December 31, 2008 for the Local Income Continuation Insurance program is $3,886,827, developed as follows:

Reported Claim Liability	$3,186,208
$75 Supplement	27,445
Total Reported Liability	3,213,653
Incurred But Not Reported Liability	673,174
Total Liability	$3,886,827

This total liability is 2% higher than the liability determined as of December 31, 2007. The increase can be attributed to an increase in the average net benefit and a smaller decrease in the number of open claims, as shown on page 4 of this report.

Exhibit 2 contains a breakdown of the $3,213,653 reported liability by year of disability.

IV. Analysis of Funding Levels

The Local Income Continuation Insurance Plan continues to be in a strong financial position with assets of $25,871,414 and estimated liabilities of $3,886,827 which produces a net fund balance of $21,984,587.

A reasonable long-term objective would be to maintain a net fund balance of more than 100% of the estimated liabilities as a hedge against future adverse experience. Substantial year-to-year fluctuations can occur under disability income programs, particularly for the relatively small size of this program. Thus, in the near term, it is prudent to maintain a large fund balance in excess of estimated liabilities — perhaps 200%. The excess now represents 566% of the estimated liabilities. The following table shows the net fund balance as a percentage of the estimated liability by year. It is clear that this excess fluctuates from year to year.

	2008	2007	2006	2005	2004	2003
Assets	25,871,414	24,150,025	20,919,663	18,604,406	16,708,151	14,715,244
Estimated Liability	3,886,827	3,822,315	4,307,964	3,669,243	2,584,522	2,295,121
Net Fund Balance	21,984,587	20,327,710	16,611,699	14,935,163	14,123,629	12,420,123
Percentage	566%	532%	386%	407%	546%	541%

The employer's premium contribution rate was reduced from .375% of covered payroll to .25% effective March 1, 2002. The $75 Supplemental Add-on benefit was effective January 1, 2002. We will continue to monitor the experience under the revised plan. We do not recommend additional benefit or premium rate changes at this time.

Exhibit 1

Elimination Period — 90 days average. Actual waiting period can vary between 30 and 180 days.

Benefit Period — The maximum duration of benefits for disabled insured employees is:

Age at Disablement	Maximum Duration of Benefits in Years
61 or Younger	To age 65
62	3.50 years
63	3.00 years
64	2.50 years
65	2.00 years
66	1.75 years
67	1.50 years
68	1.25 years
69	1.00 years

In no event are benefits payable beyond the 70th birthday.

Termination Rates — Percentage of the 1987 Commissioner's Basic Disability Table three month elimination period termination rates based on the State's own experience, as shown below:

Duration of Disablement	Termination Rate Adjustment
First Year	280%
Second Year	260%
Third Year	240%
Fourth Year	220%
Fifth Year	200%
Sixth Year	180%
Seventh Year	160%
Eighth Year	140%
Ninth Year	120%
Tenth Year & Later	100%

Interest — 7.8% per year.

Contingency Margins — None.

Exhibit 2

Reported Claim Liability by Year of Disability

Open Claims as of December 31, 2008[1]								
Year of Disability	**Count**	**Gross Benefit**	**Offset Amount**	**Net Benefit**	**Estimated Liability**	**$75 Supp.**	**Ave. Benefit**	**Est'd Liability**
2008	17	$45,625	$ 6,881	$38,744	$1,033,566	$27,445	$ 2,279	$1,061,011
2006	4	10,697	8,197	2,500	159,723		625	159,723
2005	9	24,090	14,052	10,038	757,955		1,115	757,955
2004	6	15,400	9,797	5,603	465,696		934	465,696
2003	4	12,230	8,503	3,727	345,492		932	345,492
2002	2	3,300	1,121	2,179	168,812		1,089	168,812
2001	2	3,413	3,214	198	618		99	618
2000	3	7,388	6,204	1,183	122,831		394	122,831
1997	1	2,017	950	1,067	111,234		1,067	111,234
1996	1	600	362	238	9,582		238	9,582
1993	1	908	444	464	10,698		464	10,698
Total	**50**	**$125,666**	**$59,726**	**$65,941**	**$3,186,208**	**$27,445**	**$ 1,319**	**$3,213,653**

[1]Open Claims presented by year of disability. For certain disability years (e.g. 2007, 1999, etc.), no claims remained open as of December 31, 2008.

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The State of Wisconsin

State Income Continuation Insurance Plan Actuarial Review as of December 31, 2008

Audit . Tax . Consulting . Financial Advisory.

Prepared By:
Timothy D. Gustafson, FSA, MAAA
Deloitte Consulting LLP

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I. Overview

The purpose of this report is to summarize our review of the State Income Continuation Insurance Plan. Included are a brief review of the Plan's experience during 2008, an estimate of the State's liability as of December 31, 2008, and an analysis of current funding levels.

In preparing this report, we have relied on claim information provided by Aetna and the Department of Employee Trust Funds ("ETF"). We have not audited this information, but have relied on it as submitted after making reasonableness checks and recommended corrections to Aetna as we deemed appropriate under the circumstances.

The results of this review indicate that the State Income Continuation Insurance Plan (including supplemental benefits) has assets of $60.4 million and estimated liabilities of $72.8 million as of December 31, 2008. The asset balance does not include $13.1 million in deferred market losses which will be smoothed in over the next four years. The net fund balance is $(12.4) million. This net fund balance represents approximately (17.1)% of liabilities. Traditionally, a long-term objective of maintaining a net fund balance of 15% to 25% of estimated liabilities has been considered reasonable.

Premiums were reinstated for this plan on August 1, 1996. These premiums stabilized the funded status of the plan for a number of years. The annual net fund balances (as a percentage of liabilities) were 13% in 2002, 17% in 2003, 10% in 2004, (1.5)% in 2005, (9.4)% in 2006 and (4.3)% in 2007. Since 2005, the funded status of the plan has been deteriorating and has not been in the targeted range, despite an increase in premium revenue of approximately 7% that took effect February 1, 2007. Although the premium increase lead to a slight improvement in the net fund balance from 2006 to 2007, the improvement in the net fund balance was diminished throughout 2008, as the plan experienced a 12% increase in liabilities and poor asset yield experience (despite the plan showing positive investment earnings, $13.1 million in 2008 investment losses remain to be recognized in 2009 and later).

As a result of the worsening funded status of the plan and known, yet unrealized investment losses, we are recommending a 7.0% increase to plan premium to be implemented in 2010. Further, based on current financial projections, it is anticipated that additional 7% premium increases will be recommended in future years to be implemented in 2012 and 2014 in order to return the net fund balance to target levels over the longer term.

The remainder of this report summarizes the review in more detail. A number of assumptions have been made in estimating the State's liability, which are described throughout the report and summarized in Exhibit 1.

II. 2008 Experience Review

Fund Balance

During 2008, the fund balance decreased from $62,022,782 to $60,358,843; Total revenues were $14,166,024 with paid claims and administrative expenses totaling $16,549,706. As shown below, investment earnings dropped by approximately $5.2 million, resulting in a 23% decrease in total revenue. The 2008 asset experience is the leading cause of the negative cash flow at year end 2008. These components are shown in the following table along with figures for the previous three years for comparison purposes.

	2008	2007	2006	2005
Beginning Balance	62,022,782	60,722,872	62,548,480	64,107,888
Closing Adjustments	719,743	(47,211)	22,594	(18,654)
Adjusted Beginning Balance	**62,742,525**	**60,675,661**	**62,571,074**	**64,089,234**
Revenues				
Contributions	12,327,669	11,430,510	9,961,219	9,777,198
Investment Earnings	1,838,355	7,011,277	5,812,959	3,986,175
Total	**14,166,024**	**18,441,787**	**15,774,178**	**13,763,373**
Expenses				
Paid Claims	14,335,283	14,875,149	15,345,079	13,341,722
Administrative Expenses	2,214,424	2,219,517	2,277,300	1,962,404
Total	**16,549,706**	**17,094,666**	**17,622,379**	**15,304,126**
Net Income	**(2,383,682)**	**1,347,121**	**(1,848,201)**	**(1,540,754)**
Ending Balance	**60,358,843**	**62,022,782**	**60,722,872**	**62,548,480**
Investment Earnings/Mean Balance	**3.0%**	**12.1%**	**9.9%**	**6.5%**

As of December 31, 2008, there were 1,130 open claims. During 2008, 1,440 claims were closed. Total reported claims incurred during 2008 were 2,570. The following table shows the number of open and closed claims by year incurred and the average net monthly benefit.

Claims By Year of Incurral

	Open Claims		Closed Claims		All Claims	
Year Incurred	Number	Average Net Benefit	Number	Average Net Benefit	Number	Average Net Benefit
2008	338	$ 2,329	777	$ 2,352	1,115	$ 2,345
2007	133	1,242	554	2,106	687	1,939
2006	107	1,041	25	1,345	132	1,098
2005	93	1,065	21	1,165	114	1,084
2004	87	739	17	875	104	761
2003	52	651	10	1,033	62	713
2002	52	818	1	-	53	803
2001	34	748	1	549	35	742
2000	31	705	2	1,975	33	782
1999	28	743	1	230	29	725
1998	24	691	3	1,288	27	758
1997	21	558	-	-	21	558
1996	26	696	3	1,691	29	799
1995	19	674	3	596	22	663
1994	19	563	6	769	25	612
1993	10	677	1	427	11	654
1992	8	778	3	1,155	11	881
1991	12	1,230	-	-	12	1,230
1990 & Prior	36	783	12	693	48	760
Total	**1,130**	**$ 1,325**	**1,440**	**$ 2,160**	**2,570**	**$ 1,793**

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The number of open and closed claims and their respective average benefit amounts in 2008 increased compared to last year. The following table shows this comparison for the last ten years.

Claims By Valuation Date

	Open Claims		Closed Claims		All Claims	
Plan Year	Number	Average Net Benefit	Number	Average Net Benefit	Number	Average Net Benefit
2008	1,130	$ 1,325	1,440	$ 2,160	2,570	$ 1,793
2007	1,064	1,128	1,412	997	2,476	1,065
2006	1,123	1,146	1,295	881	2,418	1,004
2005	1,054	1,211	1,215	1,009	2,269	1,103
2004	972	1,168	1,205	1,042	2,177	1,098
2003	876	1,255	1,148	1,261	2,024	1,258
2002	895	1,042	1,086	1,012	1,981	1,025
2001	1,084	1,132	662	2,044	1,746	1,478
2000	809	1,078	1,246	1,465	2,055	1,313
1999	757	998	1,323	1,381	2,080	1,242

III. Estimated Liability as of December 31, 2008

The State's liability for outstanding claims under the State Income Continuation Insurance Plan was estimated in two parts — reported claims and incurred but unreported claims. The following paragraphs summarize the method used and results.

Reported Claims

Disabled life reserve factors were calculated using the 1987 Commissioner's Group Basic Disability table adjusted for the State's own termination experience. These factors represent the present value of future payments, at 7.8% interest, to a disabled person with a monthly benefit of $100. The WRS valuation rate was reduced from 8.0% to 7.8% as of February 1, 2004, and has since remained at 7.8%. For consistency and per the direction of ETF personnel, the valuation interest rate is tied to the WRS valuation rate; therefore a 7.8% discount rate was used for the December 31, 2008, valuation. The factors are indexed by age at disablement, duration of disablement, and duration to the end of the benefit period.

Aetna provided a listing of those persons known to be disabled as of December 31, 2008. The age at disablement, duration of disability, and duration to the end of the benefit period was calculated for each individual. The appropriate factors were then multiplied by the amount of benefit for each disabled person. The results were summarized by year incurred and in total.

For disabilities that last over one year, an additional $75 per month is included in the normal benefit amount for the purpose of defraying medical costs. A liability was added for those claims incurring in 2008 representing the probability that claims will continue beyond the first year and the present value of the additional benefit. The liability for the $75 supplement is already included in the liability for claims over one year.

Incurred But Unreported Claims

In addition to those claims reported as of December 31, 2008, there presumably are other claims incurred prior to that date but which are not yet reported. The State's liability for long-term disability claims begins on the date an employee is disabled, even though the employee is not eligible for payments during the waiting period or has not yet filed a claim. Thus, it is necessary to estimate the additional liability for claims incurred but not reported as of the valuation date.

Besides the waiting period, delays in the reporting and processing of claims normally occur. From the State's own experience, we observed that approximately 25% of claims open and closed during the previous twelve months are unreported as of year end. Thus, the State's liability for claims incurred but not yet reported was calculated as the estimated number of incurred but not yet reported claims times an average benefit amount times an average disabled life reserve factor. This methodology has produced stable results over the past several years.

Results

The total estimated liability as of December 31, 2008, for the State Income Continuation Insurance Plan is $72,801,768, developed as follows:

Reported Claim Liability	$64,114,147
$75 Supplement	486,391
Total Reported Liability	64,600,538
Incurred But Not Reported Liability	8,201,229
Total Liability	$72,801,768

This total liability is 12% higher than the liability determined as of December 31, 2007, due to the combined effect of an increase in the count of open claims and an increase in the average net benefit.

Exhibit 2 contains a breakdown of the $64,600,538 reported liability by year of disability.

IV. Analysis of Funding Levels

The State Income Continuation Insurance Plan has assets of $60.4 million and estimated liabilities of $72.8 million, producing a net fund balance of $(12.4) million. The collected premiums covered 75% of paid claims and administrative expenses, while investment earnings covered only 11% of the remaining claims and administrative expense balance. Thus, cash flow in the trust was negative this year. Cumulative cash flows for plan years 2004 through 2008 are $(4,162,658).

Considerable year-to-year fluctuations can occur under disability income plans, even for a plan as large as that of the State. Thus, it is prudent to maintain a fund balance in excess of estimated liabilities. A reasonable long-term objective has been to maintain a net fund balance of 15% to 25% of estimated liabilities as a hedge against future adverse experience. The current total fund balance covers 82.9% of liabilities (as compared to 96.8% last year). The net fund balance is not in the targeted range for the third consecutive year. As part of the December 31, 2005, valuation, Deloitte recommended a 7% increase in premium revenue, which took effect February 1, 2007. The increase in premium revenue led to a slight improvement in the funded status in 2007. However, an increase in the total estimated liability and the poor asset experience in 2008 led to further deterioration of the net fund balance. Additionally, there is currently $13.1 million of deferred investment losses which will be gradually smoothed into the fund by 2012. Hence we recommend a 7.0% increase to plan premium to be implemented in 2010. Further, based on current financial projections, it is anticipated that additional 7% premium increases will be recommended in future years to be implemented in 2012 and 2014 in order to return the net fund balance to target levels over the longer term.

Exhibit 1– Summary of Actuarial Assumptions

Elimination Period — 90 days average. Actual waiting period varies with accumulated sick leave and for University faculty, the elimination period selected.

Benefit Period — The maximum duration of benefits for disabled insured employees is:

Age at Disablement	Maximum Duration of Benefits in Years
61 or Younger	To age 65
62	3.50 years
63	3.00 years
64	2.50 years
65	2.00 years
66	1.75 years
67	1.50 years
68	1.25 years
69	1.00 years

In no event are benefits payable beyond the 70th birthday.

Termination Rates — Percentage of the 1987 Commissioner's Basic Disability Table three month elimination period termination rates based on the State's own experience, as shown below:

Duration of Disablement	Termination Rate Adjustment
First Year	280%
Second Year	260%
Third Year	240%
Fourth Year	220%
Fifth Year	200%
Sixth Year	180%
Seventh Year	160%
Eighth Year	140%
Ninth Year	120%
Tenth Year & Later	100%

Interest — 7.8% per year.

Contingency Margins — None.

Exhibit 2: Reported Claim Liability by Year of Disability

Open Claims as of December 31, 2008								
Year of Disability	**Count**	**Gross Benefit $**	**Offset Amount $**	**Net Benefit $**	**Estimated Liability $**	**$75 Supp**	**Ave. Ben $**	**Est'd Liability $**
2008	338	870,545	83,506	787,038	17,559,055	486,391	2,329	18,045,446
2007	133	358,601	193,399	165,202	8,136,482	-	1,242	8,136,482
2006	107	277,236	165,874	111,361	7,416,693	-	1,041	7,416,693
2005	93	226,085	127,031	99,054	7,331,323	-	1,065	7,331,323
2004	87	198,996	134,728	64,268	4,740,531	-	739	4,740,531
2003	52	114,725	80,867	33,858	2,690,750	-	651	2,690,750
2002	52	119,644	77,100	42,544	2,832,144	-	818	2,832,144
2001	34	70,327	44,912	25,415	2,194,811	-	748	2,194,811
2000	31	61,683	39,813	21,870	1,585,302	-	705	1,585,302
1999	28	65,144	44,336	20,808	1,562,713	-	743	1,562,713
1998	24	55,520	38,928	16,592	1,015,132	-	691	1,015,132
1997	21	42,437	30,712	11,725	587,428	-	558	587,428
1996	26	48,317	30,222	18,095	1,308,974	-	696	1,308,974
1995	19	35,597	22,798	12,799	734,241	-	674	734,241
1994	19	32,939	22,251	10,688	731,152	-	563	731,152
1993	10	16,411	9,643	6,767	487,594	-	677	487,594
1992	8	13,563	7,343	6,221	464,833	-	778	464,833
1991	12	20,590	5,833	14,757	1,020,890	-	1,230	1,020,890
1990	7	9,621	4,364	5,257	345,908	-	751	345,908
1989	9	12,589	5,864	6,725	345,168	-	747	345,168
1988	7	12,004	4,152	7,852	528,549	-	1,122	528,549
1987	4	5,161	2,108	3,053	109,526	-	763	109,526
1986	2	2,199	1,415	784	48,474	-	392	48,474
1984	2	2,173	1,046	1,127	98,314	-	563	98,314
1983	2	2,303	431	1,872	141,422	-	936	141,422
1982	1	900	416	484	43,673	-	484	43,673
1980	1	802	308	494	34,068	-	494	34,068
1979	1	900	362	538	18,999	-	538	18,999
Total	**1,130**	**2,677,011**	**1,179,763**	**1,497,248**	**64,114,147**	**486,391**	**1,325**	**64,600,538**

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CORRESPONDENCE MEMORANDUM

DATE: May 27, 2009

TO: Group Insurance Board

FROM: Tom Korpady, Administrator
Division of Insurance Services

SUBJECT: Acceptance of State and Local Income Continuation Insurance Actuarial Valuations

Staff requests that the Group Insurance Board (Board) approve both the State and Local Income Continuation Insurance Plan Actuarial Review as of December 31, 2008.

Deloitte recommends a 7% increase to premiums for the State plan and no change for the Local plan. A brief summary is found on page one of each report.

Attachments

Board	Mtg Date	Item #
GIB	6/9/09	3

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May 8, 2009

Ms. Betty Wittmann
Manager, Optional Insurance Plans & Audits
Division of Insurance Services
Department of Employee Trust Funds
801 West Badger Road
Madison, WI 53702

Re: Assessment of Request for Mutual of Omaha's United of Omaha Long-Term Care Policy Replacement from HealthChoice™ Long-Term Care Solutions

Dear Betty:

We have reviewed the proposal materials submitted by HealthChoice™ Long-Term Care Solutions ("HealthChoice") related to the Mutual of Omaha subsidiary United of Omaha (MoO) replacement long-term care ("LTC") policy form #LTC09U-AG-WISE ("the proposed policy"). The proposed policy only applies to new applicants and not those covered under the current policy form, #LTC06UI-TQ-WIN ("the current policy"). The proposal materials we reviewed included a summary of the policy's coverage and benefits, a summary of policy changes between the current and proposed policies, corresponding premium rate schedules, and the supporting actuarial memorandum.

The sections below address the specific focus areas of our review, as discussed between Deloitte Consulting LLP and Wisconsin Department of Employee Trust Funds ("ETF") staff:

- Individual/Association Group Rating
- Adherence to ETF 41 Inflation Protection Guidelines
- Guaranteed Purchase Option
- Review of Proposed Premium Rates
- Review of the Lifetime Loss Ratio Projection
- Pricing Assumptions Review / Moderately Adverse Experience

Based on our review, we believe the proposed policy and associated premium rates are reasonable and in line with current industry trends. The materials reviewed provide adequate assurance that the plan design is sound and that the premium rates are reasonable in relation to the benefits provided. Finally, we note that MoO is a leading LTC provider and is rated A+ (Superior) by AM Best as of the date of this letter.

It should be noted that the comparisons enumerated below are on a high level and may not be meaningful indicators of the relative values of the plans and rates for all prospective insureds. Benefit design differences that do not appear significant overall may have significant value for certain individuals depending on their circumstances and insurance protection needs. In addition, other factors such as the quality of the customer service provided, claim processing standards, etc. should be considered by applicants based on their own unique criteria in evaluating the relative values of the plans.

Individual/Association Group Rating

The proposed policy is being treated as a hybrid of an individual policy and an association group policy. Though sold and underwritten individually, the product was specifically designed for ETF employees. MoO has indicated its intent to group the proposed policy with a similar policy form to be sold in Wisconsin outside of the state employee pool for the purposes of evaluating experience and consideration of rate adequacy. However, to our knowledge, MoO's intent to group the policy forms for such purposes is not bound by any regulation or statute.

Adherence to ETF 41 Inflation Protection Guidelines

The proposed policy provides two options for inflation protection. The first provides a minimum 5% annual compound increase in the monthly and remaining maximum benefit amount for the lifetime of the policy. The second provides for a 5% annual increase in the monthly and remaining maximum benefit amount for 20 years.

Additionally, the policy provides for a Guarantee Purchase Option (GPO) in which the insured is offered the option to purchase an increase in the maximum daily and lifetime benefit by 10% of the original amounts every two years without evidence of insurability. If an insured declines three consecutive purchase options, the plan will not offer any additional purchase options. As outlined by ETF 41.02, the proposed policy provides the required option to purchase additional benefits at least as great as the inflation protection percentage at least every three years.

According to the report "Trends in Wisconsin Nursing Homes: 1990-1999" published by the Wisconsin Bureau of Health Information, over the past two decades, nursing home costs for private pay residents have increased from 4-6% annually. The 5% annual compound increase options (both the lifetime and 20-year options) with the required GPO feature meet the minimum standard as outlined by chapter ETF 41.02 Section 5. However, the 20-year option would be more reliant on the additional GPO feature assuming inflation remains consistent with past trends, especially for those individuals under age 65. In addition to meeting these minimum requirements, the 5% annual compound lifetime increase benefit would appear to allow the benefits of the policy to match the rate of increase of the underlying nursing home costs they are intending to insure.

Guaranteed Purchase Option

We considered MoO's motivation for filing of two separate policies in 2009 (the proposed policy specifically designed for state employees and another, more broad policy) that are essentially the same except for the inclusion of the GPO feature in the proposed policy. We reviewed the language regarding the GPO in the new policy and found it to be reasonable. We noted that the proposed rates include an additional 2% premium load for the GPO feature, which we believe is reasonable for the benefit provided.

We specifically looked to see if the GPO required the insured to be re-underwritten in order to purchase more insurance, which is contrary to the spirit of the purchase being "guaranteed". However, the language in the proposed policy specifically states that underwriting will not be required.

We find it reasonable that MoO file two separate policies, one that would conform to the ETF's guidelines, and another that would conform to MoO's specific marketing goals for the rest of their business in Wisconsin.

Review of Proposed Premium Rates

We reviewed the provided premium rates for the current and proposed policies. The increase in premium from the current policy to the proposed policy ranges from 8% to 15% depending on the marital status, benefit period, and other optional benefit elections. Such an increase is commensurate with increases seen in the industry generally, and appears to be only in part attributable to enrichments in benefits (most notably an increase to the "Cash First" benefit percentage); the remaining increase would be attributable to experience adjustments in pricing assumptions.

Additionally, we reviewed the single and married premium rate comparison exhibits provided by HealthChoice. These exhibits also compare the proposed premium rates to the latest LTC policy issued by John Hancock Life Insurance Company. The premiums presented in these exhibits are relatively comparable to a similar policy offered by John Hancock. We noted that the premiums on the proposed policy are in some cases slightly higher than the comparable John Hancock rates (especially for non-married policyholders), but to the extent that these additional benefits (i.e. the "Cash First" benefit) are valued by applicants, the higher premium is reasonable.

In general, we believe the proposed premium rates for the policy are reasonable and in line with our observed industry experience.

Review of the Lifetime Loss Ratio Projection

The provided actuarial memorandum shows a projection of the expected premium and incurred claims over a 50-year period. These projections, discounted at 4% as permitted under state regulatory guidelines, are then used to develop a lifetime loss ratio of 65.4%. We reviewed the loss ratio calculations and underlying assumptions, and we conclude that the product is priced reasonably in relation to the benefits provided.

Pricing Assumptions Review / Moderately Adverse Experience

We reviewed the pricing assumptions listed in the actuarial memorandum for the proposed policy, and from a high level found them to be reasonable, if not conservative in some instances. Particularly, we noted that the ultimate lapse rate assumption used (1.0%) is on the low (conservative) end of what we have typically seen in the marketplace. The main driver of rate increases for LTC products in recent years has been an inadequate ultimate lapse rate assumption. This low lapse rate assumption leads us to conclude that future rate increases are less likely for this policy than others with higher lapse rate assumptions.

As required by the NAIC's Long-Term Care Rate Stabilization Act, a credentialed actuary must attest that that premium levels can accommodate "moderately adverse experience" without the need for a rate increase. In the policy's actuarial memorandum, the details behind the moderately adverse assumptions are outlined. MoO's sensitivity tests include the following moderately adverse scenarios:

- Morbidity 10% higher than expected,
- Mortality 10% lower than expected,
- Voluntary lapses 25 basis points lower than expected, and
- Investment earning 25 basis points lower than expected.

Overall we believe the assurances provided in MoO's actuarial memorandum that "the initial premium rate schedules are sufficient to cover anticipated costs based under moderately adverse experience, and the premium rate schedules are reasonably expected to be sustainable over the life of the forms with no future premium increases anticipated" are reasonable and in line with industry norms.

Based on our review we believe the proposal is reasonable and MoO's pricing appears to be in line with current industry trends. The proposal provides adequate assurance that the plan design is sound and that the premium rates are reasonable in relation to the benefits provided.

Timothy D. Gustafson

Timothy D. Gustafson
Principal

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: May 22, 2009

TO: Group Insurance Board

FROM: Betty Wittmann, Manager
Optional Insurance Plans & Audits

SUBJECT: Long-term Care Insurance Rate Increase Proposal – United of Omaha

Staff recommends the Group Insurance Board (Board) approve the Long-Term Care Insurance (LTC) replacement policy from The United of Omaha Insurance Company, submitted by HealthChoice™ Long-Term Care Solutions (HealthChoice) as provided in Wis. Stat. § 40.55 and Wis. Admin. Code Chapter ETF 41.

Background

The United of Omaha Insurance Company, a Mutual of Omaha Company, is one of two companies currently marketing LTC policies to state employees and annuitants. The Board has previously approved several Mutual of Omaha LTC policies under the Board's Optional Insurance Plan Guidelines. The proposal from HealthChoice will replace its current United of Omaha Long-Term Care plan #LTC06UI-TQ-WI (Assured Solutions Plus) with the United of Omaha Long-Term Care Insurance policy #LTC09U-AG-WISE Series (ETF/WISE) upon release by the State of Wisconsin Office of the Commissioner of Insurance (OCI) and will no longer be available for sale. The ETF/WISE policy is anticipated to be released by OCI as early as July 1, 2009, if not before.

HealthChoice, the marketing arm for Mutual of Omaha, has been marketing Board-approved long-term care products since 1995. HealthChoice agents sell only long-term care products to state employees, annuitants and eligible family members. United of Omaha Life Insurance Company, an affiliate of Mutual of Omaha Insurance Company, underwrites the replacement policy. Mutual of Omaha and United of Omaha currently carry A.M. Best ratings of "A+" (Superior). Mutual of Omaha, including its affiliates, is a reputable leader in the long-term care insurance industry, as noted by the actuary.

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

_____ _____
Signature Date

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Discussion

The ETF/WISE policy offering will be either a Partnership or a Non-Partnership policy. Board members may recall that a Partnership policy is designed to allow participants in claim status to disregard assets from their estate in an amount equal to the benefits paid by the policy should Medical Assistance (Medicaid) be needed. The ETF/WISE policies will be offered to our members upon Board approval. All state employees, state annuitants, and their eligible family members that have purchased the current Assured Solutions Plus policy will continue to hold those policies uninterrupted.

United of Omaha is requesting a premium increase of approximately 8-15% (varying by age and marital status). In addition, the ETF/WISE policy will be a separate offering to our members, as it was specifically designed to meet the inflation protection (Guaranteed Purchase Option) requirements of ETF § 41.02. Mutual of Omaha indicates it intends to pool the ETF/WISE policy with a similar policy form sold in Wisconsin when evaluating its experience and rate adequacy. The Board's consulting actuary, Deloitte Consulting, LLP (Deloitte), has reviewed the proposal (copy attached) finding this to be reasonable and further indicates the pricing assumptions are sufficient to cover anticipated costs. However, Deloitte does note on page 2 of its memo that even though Mutual of Omaha intends to pool the policies, they are not bound to do so.

The ETF/WISE policy also includes the required 5% compound inflation option with the Guaranteed Purchase Option (GPO). The policy provides for the inflation to increase for 20 years or the remainder of the beneficiaries lifetime. Deloitte indicates, on page 3 of its memo, that based on past nursing home trends in Wisconsin, the 20-year inflation option will be more reliant upon the GPO offerings, especially for those under age 65. Staff analysis of this trend determined inflation would need to be below 4% to keep pace, and we do not believe this is likely. Therefore, staff recommends the Board limit the 5% compound 20-year inflation offering to members 65 years of age and above.

Below is a brief overview of the different options policyholders would have to receive their benefits for the ETF/WISE policy. HealthChoice's proposal includes sample brochures that provide the full details.

- **The Cash-First**^{SM} (Cash) option allows policyholder's greater flexibility to receive benefits. When the member applies for coverage, they will select an initial monthly benefit and a separate maximum lifetime pool of money to access future benefits. The beneficiary, upon qualification, may immediately access a cash benefit equal to 40% of the total monthly benefit for care provided by family and friends. The beneficiary may choose to combine the cash benefit with a traditional benefit design at any time by first satisfying the elimination period. The policy will reimburse actual cost incurred for care received in a nursing home, assisted living, or home health care at 100%, and for professional home

care services at 200%, up to the maximum monthly benefit. However, this greater flexibility may alter the amount of time benefits will last.

- **The Assured Solutions Gold** (Gold) policy offers the traditional benefit design. The beneficiary must first satisfy their elimination period prior to receiving reimbursement for actual cost incurred. In addition, the Gold policy allows the policyholder to purchase a rider to add the Cash-First[SM] benefit features.

Conclusion

Based on staff review and the attached Deloitte evaluation, the staff recommends approval of the United of Omaha proposal limiting the 5% compound 20-year inflation protection offering to those members age 65 years and above.

Staff will be available at the meeting to answer any questions you may have regarding this proposal.

Attachment

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CORRESPONDENCE MEMORANDUM

DATE: May 20, 2009

TO: Group Insurance Board

FROM: Tom Korpady, Administrator
Division of Insurance Services

SUBJECT: Delegation of Authority to Contract for Data Collection and Analysis Services

Staff recommends that the Board delegate authority to solicit proposals for, and contract with, qualified entities to perform data collection and analysis services as allowed under Chapter 40 of the Wisconsin State Statutes.

Wisconsin Statute section 40.03 (6) (j) authorizes the Group Insurance Board to contract for data collection and analysis services, on an as-needed basis, for the administration of the Group Health Insurance program. Periodically, staff need to access special expertise to assist in the analysis of complex health related data to facilitate the efficient and effective administration of the health programs. The Department has utilized this provision previously to contract for the services of Dr. Ron Harms, who helped us develop the disease management survey, among other projects.

Contracts awarded under this delegated authority will continue to comply with Department and Board procurement policies and procedures. This reaffirms current practices and is consistent with prior actions.

Board	Mtg Date	Item #
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CORRESPONDENCE MEMORANDUM

DATE: May 26, 2008

TO: Group Insurance Board

FROM: Christina Keeley, Ombudsperson
Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson

SUBJECT: 2008 Health Plan and Pharmacy Benefit Manager Grievance and Independent Review Report

This memo is for informational purposes only. No Board action is required.

This information is used to identify trends within the health insurance and pharmacy benefit manager (PBM) programs that warrant attention by the Department. A summary of this information will also be included in the *2010 It's Your Choice* booklet.

I. 2008 Grievances

Below is a summary of annual grievance data provided to the Department of Employee Trust Funds (ETF) by all plans participating in the Group Health Insurance Program for State of Wisconsin (State) and Wisconsin Public Employees (WPE). This report includes grievance data for Navitus Health Solutions, pharmacy benefits manager (PBM) for all members excluding WPE Medicare-eligible annuitants. WPE Medicare-eligible annuitants (approximately 1,900 members) are covered under Medicare D and their pharmacy benefit is administered by DeancareRx.

This summary was compiled by reviewing each plan's annual grievance report, provided to ETF every March. A grievance is a written request to the plan -- by (or on behalf of) a member -- expressing dissatisfaction with a plan decision about a benefit denial or the provision of services under the contract. Highlights of the data include:

- The number of Navitus grievances totaled 192, which is considerably lower than 2004, when the PBM program began. (Attachment C)

Reviewed and approved by Matt Stohr, Office of Legislative Affairs, Communications and Quality Assurance.

Signature _____ Date _____

Board	Mtg Date	Item #
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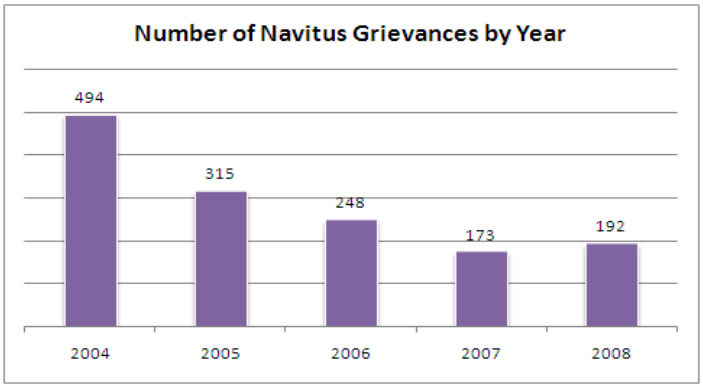
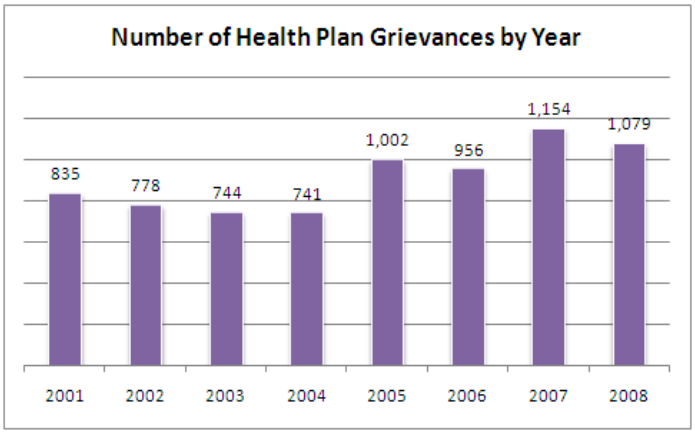


- Health plans reported 1,079 grievances for 2008, compared to 1,154 for 2007.



- On average, one grievance was filed per 100 covered individuals in the entire group health insurance program. Notably, Anthem NW had a grievance rate of nearly five grievances filed per 100 individuals covered. (Attachment A)

- For the third consecutive year, Humana Eastern had the highest percentage of grievances of all participating health plans, with approximately 18% of all grievances. Humana Eastern holds approximately 7% of the total health insurance contracts.

- For 2008, 58% of all health plan grievances had outcomes either partly or fully in favor of the member (favorable outcome). Four plans had approval/compromise rates greater than 80%. Medical Associates had only one grievance, which was overturned, resulting in a 100% favorable outcome rate. Dean Health Plan had a 92.8% favorable outcome rate. Anthem NW had an 81.8% favorable outcome rate. MercyCare had an 87.5% favorable outcome rate (with only 7 grievances filed). (Attachment B)

  Moderate rates of favorable outcomes demonstrate to members the value of utilizing the plan grievance process. However, high rates of favorable outcomes with a high number of grievances may indicate a need for a plan to examine its administration of plan benefits. When a plan has a high number of grievances and the majority result in overturning the plan's original

decision, it is reasonable to conclude that the majority of initial denials were incorrect. For plans with few grievances, high rates of favorable outcomes are not a reliable indicator of incorrect denials.

- Grievances over Emergency Room (ER) services have been high for Humana Eastern and Humana Western over the past several years. For 2008, however, Humana's nine ER grievances are much more in line with normal levels. Anthem SE had 19 ER grievances. Staff will continue to monitor use of this grievance category over the coming years. (Attachment B)

- Two plans submitted relatively high numbers of grievances they categorized as "other" (OT). The total number of grievances reported in this category for all plans was 171. Humana Eastern and Western combined reported 113 (66%) OT grievances and UnitedHealthcare NW and SE combined reported 34 (20%). Together, Humana and UnitedHealthcare account for nearly 85% of all grievances in this category. UnitedHealthcare has improved somewhat in this regard, while Humana's use of OT increased from 2007. (Attachment B)

  ETF discourages plans from using the "other" category unless no appropriate category can be identified. ETF will continue to work with Humana and UnitedHealthcare to address overuse of this category.

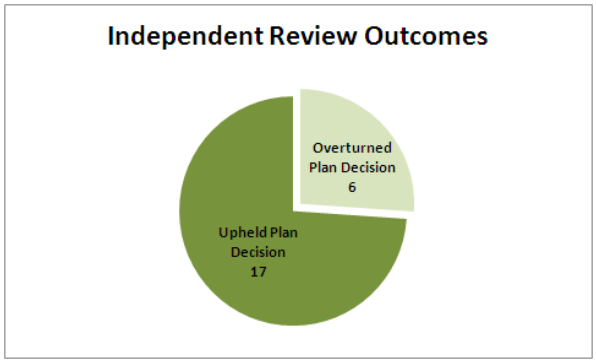
II. 2008 Independent Reviews

This report summarizes Independent Review (IR) requests by State Group Health Insurance Program members. Members who request IRs must have completed the plan grievance process and may have completed a portion of the administrative review process available within ETF.

To be eligible for a review through an Independent Review Organization (IRO), a member must have an adverse determination (grievance decision) involving a medical judgment where the amount at issue is in excess of $296. Typically, these are denied requests for out-of-network referrals or denials of a claim or service that the plan (or PBM) has deemed experimental or not medically necessary. The IR process allows members the opportunity to have an independent consultant review their grievance to determine if benefits are payable. Members must pay a $25 fee to request an IR, and the IRO's decision is binding on both the plan and the member.

Ombudsperson Services is responsible for educating members about the IR process. When the Department processes a new health insurance complaint, an ombudsperson reviews it and, if appropriate, contacts the member to educate them about the IR option. We also monitor health plan grievance decision letters to ensure that members are given IR rights whenever applicable.

For 2008, plans reported receiving 23 requests for independent reviews by Group Health Insurance Program members. In 17 cases, the IRO upheld the plan's original decision. In 6 cases, the IRO overturned the plan's original decision. (Attachment C)



Health plans are required to report member requests for IR to ETF at the time the request is made. This year, only one plan (Humana) failed to report IR requests to ETF. Humana has since corrected the source of this problem and says it will improve the accuracy and timeliness of IR reports filed in 2009.

As in past years, the number of **reported IR requests** remains low when compared to the total number of grievance decisions that were eligible for IR. This indicates that only a small percentage of members entitled to an IR elect to take advantage of this option. The Department will continue to work with plans to ensure compliance with the contractual requirement of including IR language with the plan's grievance decision letters and in reporting all IR requests to ETF.

The attached charts provide more detailed information on grievances and outcomes. Percentages in the attached charts are approximate due to rounding.

Ombudsperson program staff will be available at the meeting to answer questions.

Attachments

Grievances Filed
2006-2008

Health Plan Name	Grievances 2006	Grievances 2007	Grievances 2008	Net Change (2007 to 2008)	Number of Grievances Filed per 100 Covered Individuals
Anthem NW	19	12	44	32	4.9
Anthem SE	16	35	59	24	1.2
Arise Health Plan	22	8	11	3	0.6
Dean Health Plan	143	141	111	-30	0.2
GHC Eau Claire	6	17	17	0	0.1
GHC South Central Wisconsin	34	21	21	0	0.1
Gundersen Lutheran	14	11	25	14	0.4
Health Tradition	34	39	14	-25	0.3
Humana Eastern	252	251	192	-59	1.2
Humana Western	73	63	53	-10	2.9
Humana PFFS*	NA	NA	11	11	1.1
Medical Associates Health Plan	7	1	2	1	0.2
MercyCare Health Plan	7	12	8	-4	0.5
Network Health Plan	37	31	54	23	0.5
Physicians Plus	24	25	20	-5	0.1
Security Health Plan	NA	40	25	-15	0.2
Self-funded Plans**	57	127	105	-22	1.2
UnitedHealthcare NE	104	132	117	-15	1.1
UnitedHealthcare SE	23	66	68	2	1.1
Unity Community	7	18	19	1	0.3
Unity UW Health	50	89	79	-10	0.3
WPS Patient Choice 1	7	14	21	7	2.6
WPS Patient Choice 2	3	1	3	2	1.5
Grievance Totals (Health)	**939**	**1,154**	**1,079**	**-75**	**1.0**

**Humana Private Fee for Service (PFFS) Plan was first introduced to ETF members for coverage effective January 1, 2008.*
***Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance Plan (administered by WPS Health Insurance)*

Grievances by Plan, Grievance Type and Outcome - 2008

Plan Name	Access to Care	Continuity of Care	Drug & Drug Formulary	Emergency Services	Experimental Treatment	Prior Authorization	Non-Covered Benefit	Not Medically Necessary	Other	Plan Administration	Plan Providers	Request for Referral	Total	% of All Grievances	Approved	Denied	Compromise	Withdrawn	% with Favorable Outcome (approval or compromise)
Arise Health Plan	0	0	0	0	2	5	2	1	1	0	0	0	**11**	1.0%	3	8	0	0	27.3%
Anthem NW	0	0	0	0	0	0	9	2	1	8	18	6	**44**	4.1%	36	8	0	0	81.8%
Anthem SE	0	0	0	19	6	0	11	6	1	10	6	0	**59**	5.5%	38	21	0	0	64.4%
Dean Health Plan	0	1	0	1	2	20	30	14	2	9	1	31	**111**	10.3%	44	6	59	2	92.8%
GHC Eau Claire	2	0	0	0	1	0	8	2	1	0	3	0	**17**	1.6%	2	9	0	6	11.8%
GHC SCW	0	1	0	6	0	0	4	1	1	0	8	0	**21**	1.9%	11	10	0	0	52.4%
Gundersen Lutheran	0	0	0	0	1	5	13	0	2	0	0	4	**25**	2.3%	12	12	1	0	52.0%
Health Tradition	0	0	1	0	0	1	7	1	2	0	0	2	**14**	1.3%	8	5	1	0	64.3%
Humana Eastern	1	2	0	9	2	29	52	2	84	9	1	1	**192**	17.8%	153	36	1	2	80.2%
Humana Western	0	0	0	0	0	8	4	4	29	2	1	5	**53**	4.9%	31	19	3	0	64.2%
Humana PFFS*	0	0	0	0	0	1	6	3	0	1	0	0	**11**	1.0%	4	7	0	0	36.4%
Medical Associates Health Plan	0	0	0	0	0	0	0	0	2	0	0	0	**2**	0.2%	2	0	0	0	100.0%
MercyCare Health Plan	0	0	0	0	0	4	2	0	1	0	0	1	**8**	0.7%	7	0	0	1	87.5%
Network Health Plan	3	1	0	1	7	13	20	2	6	0	1	0	**54**	5.0%	17	37	0	0	31.5%
Physicians Plus	0	0	0	2	0	7	11	0	0	0	0	0	**20**	1.9%	6	12	2	0	40.0%
Security Health Plan	0	0	0	0	2	10	2	0	3	0	0	8	**25**	2.3%	15	10	0	0	60.0%
Self-funded Plans**	0	0	0	0	11	0	37	27	1	29	0	0	**105**	9.7%	32	70	3	0	33.3%
UnitedHealthcare NE	8	0	0	2	3	2	13	0	21	59	9	0	**117**	10.8%	55	33	2	27	48.7%
UnitedHealthcare SE	1	0	0	0	10	2	11	0	13	28	3	0	**68**	6.3%	32	22	0	14	47.1%
Unity Community	0	0	0	0	1	0	12	2	0	4	0	0	**19**	1.8%	2	16	0	1	10.5%
Unity UW	0	0	0	0	2	1	60	11	0	5	0	0	**79**	7.3%	19	48	7	5	32.9%
WPS Patient Choice 1	0	0	0	0	0	0	3	1	0	15	0	2	**21**	1.9%	13	6	2	0	71.4%
WPS Patient Choice 2	0	0	0	0	0	0	0	0	0	3	0	0	**3**	0.3%	2	1	0	0	66.7%
Total	**15**	**5**	**1**	**40**	**50**	**108**	**317**	**79**	**171**	**182**	**51**	**60**	**1079**	100.0%	**544**	**396**	**81**	**58**	**54.7%**
% of Total Grievances	1.4%	0.5%	0.1%	3.7%	4.6%	10.0%	29.4%	7.3%	15.8%	16.9%	4.7%	5.6%	100.0%		50.4%	36.7%	7.5%	5.4%	

**Humana Private Fee for Service (PFFS) Plan was first introduced to ETF members for coverage effective January 1, 2008.*

***Self-funded Plans include: Standard Plan; Medicare Plus $1,000,000; Local Annuitant Health Plan; and State Maintenance Plan (administered by WPS Health Insurance)*

Pharmacy Benefit Manager Grievances – 2008

Grievance Category	Totals	% of Total Grievances
Copayment Reduction	65	33.85%
Experimental	2	1.04%
Non-Covered Drug	94	48.96%
Not Medically Necessary	0	0.00%
Prior Authorization	15	7.81%
Quantity Limit	13	6.77%
Reimbursement Request	3	1.56%
Total	**192**	100.00%

Resolution Category	Total Grievances
Approved	52
Denied	137
Compromised	0
Withdrawn	3

Independent Review (IR) Requests – 2008

(listing only those plans that had IR requests during 2008)

Plan Name	Number of IRs Requested	Overturned	Upheld	Compromise	Other/ Declined by IR Organization
Arise	1	0	1	0	0
Dean Health Plan	3	3	0	0	0
GHC-SCW	1	0	1	0	0
Gundersen Lutheran Health Plan	2	0	2	0	0
Humana PFFS*	5	0	5	0	0
Self-funded Plans**	4	0	4	0	0
UnitedHealthcare NE	2	0	2	0	0
UnitedHealthcare SE	3	2	1	0	0
Unity UW Health	2	1	1	0	0
IR Totals	**23**	**6**	**17**	**0**	**0**

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: May 26, 2009

TO: Group Insurance Board

FROM: Liz Doss-Anderson, Ombudsperson
Vickie Baker, Ombudsperson
Christina Keeley, Ombudsperson

SUBJECT: 2008 Ombudsperson Annual Complaint and Inquiry Summary

This memo is for informational purposes only. No Board action is required.

This summary contains information and statistics about the complaints, issues or inquires raised by members, their families, employers and external advocacy organizations relating to benefits that fall under the authority of the Group Insurance Board (GIB).

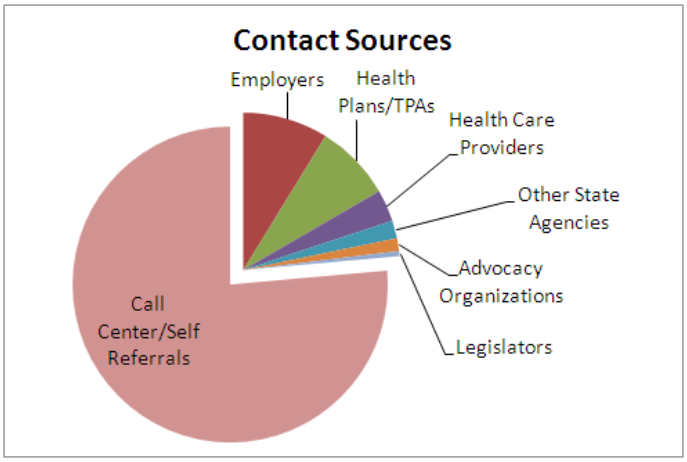
Ombudsperson Services is within the Office of Legislative Affairs, Communications and Quality Assurance. We attempt to resolve member issues, provide education and outreach to our members and work to ensure that all Wisconsin Retirement System (WRS) members have access to timely, accurate and thorough information regarding benefits administered by the Department. Ombudspersons work closely with the health plans, third-party administrators such as WPS, Navitus, Epic and our other benefit programs to ensure WRS members continue to receive the high quality of service they expect regarding the management of their benefits.

Typical issues that we help members with include appeals for denied requests for prior authorization of services, billing or claims payment issues, coordination of benefits with Medicare difficulties, and assistance in resolving enrollment and eligibility issues with our plan contacts. In addition, members can request an Ombudsperson review as it pertains to the administration of or denial of their benefits. If unable to resolve the issue, the Ombudsperson provides information about the Administrative Review process (whereby a member can request an Ombudsperson review, Departmental Determination, and ultimately a Board appeal), and if applicable, the Independent Review Process, whereby a member can request a binding external third-party review.

Reviewed and approved by Matt Stohr, Office of Legislative Affairs, Communications and Quality Assurance.

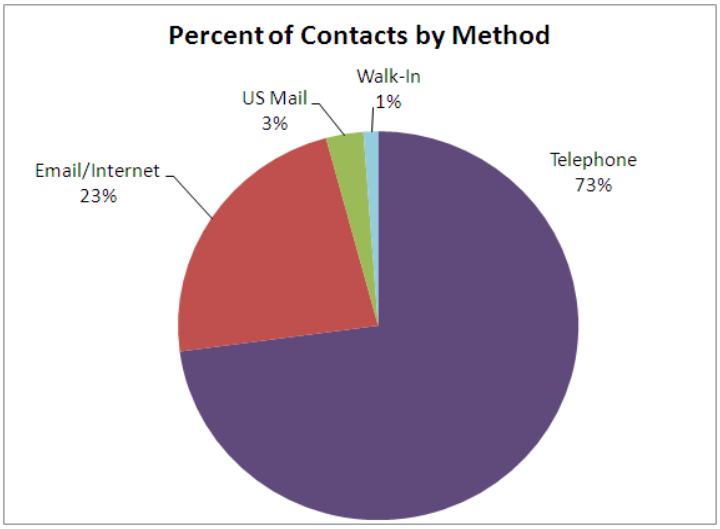
_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	6/9/09	6



In 2008, Ombudspersons received 1,284 contacts across all programs. Of the 1,284 contacts, 763 (59%) required additional assistance to resolve their issues, while 521 members (41%) asked for benefit clarifications assistance in navigating the health care system, help in locating providers or education about their administrative review process at ETF. Contacts from members often come to our attention through the Department's Call Management Section, the Benefit Payments Section that handles annuitant Health Insurance changes, or the Member Services Bureau. Some members are familiar with our services and contact us directly. Other contact sources include a variety of external partners, such as employers, health plans, third-party administrators, and other state agencies. In an effort to increase awareness, we created a new brochure to educate members about the availability of our services. The *Ombudsperson Program* brochure is attached for your reference.

The following information provides more detail on the 763 contacts that required our intervention to resolve over the past year.



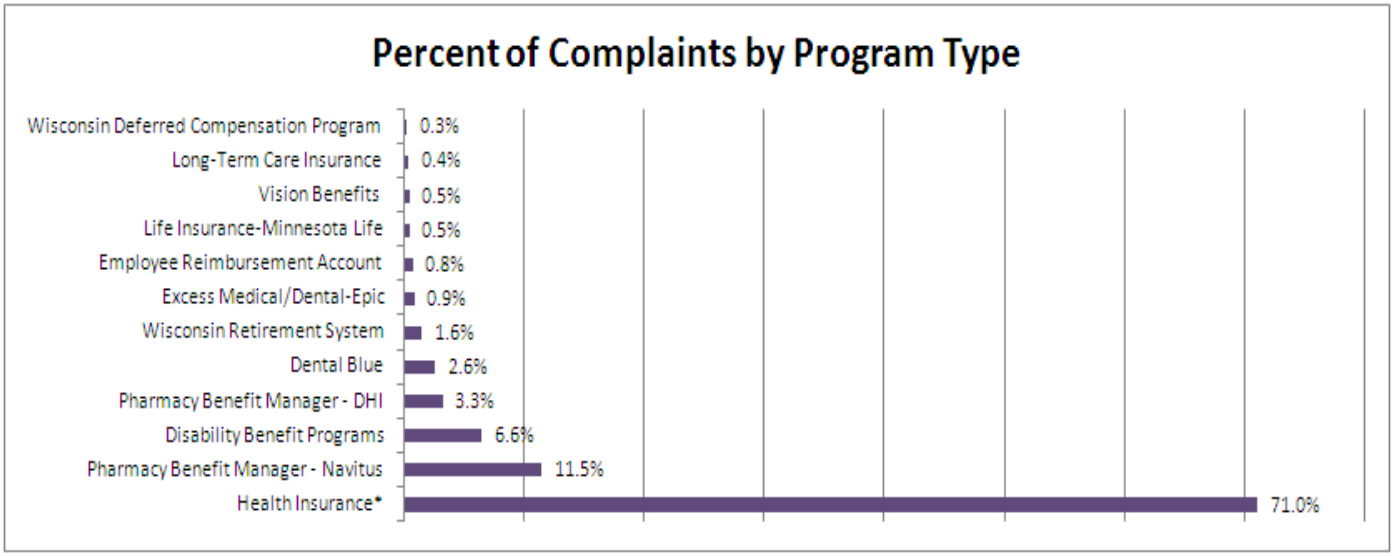
As in prior years, Ombudspersons received a high volume of calls at the beginning of the year. Often, these calls come from members needing assistance in navigating their new health plan, maintaining continuity of care or solving enrollment and eligibility issues. Throughout the year, billing and claims processing discrepancies remained the most common reason ombudsperson services were needed to intervene on the member's behalf with the plan or the provider. In many cases, the member needed help understanding a claim processing issue, how a claim was paid or why it was denied, and what ETF could do to resolve the problem on behalf of the member.

Enrollment and eligibility discrepancies between the employer, ETF and the plans can result in a member having difficulty obtaining health care services or prescription drugs. In these situations, Ombudspersons facilitate a resolution with all of the parties involved to ensure the most favorable resolution possible within contract provisions.

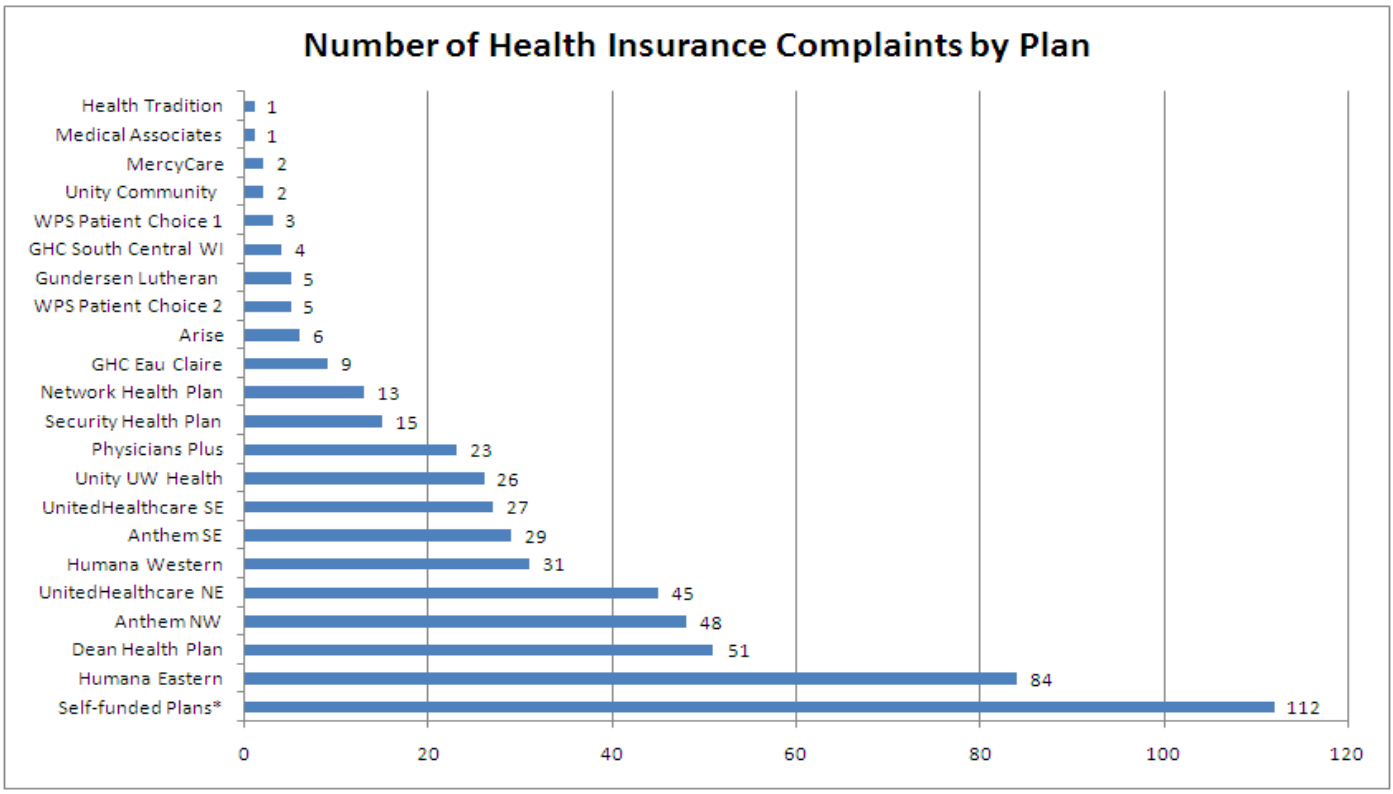
Complaints by Complaint Type	Total	% of Total
Billing/Claim Processing	235	30.8%
Enrollment and Eligibility	150	19.7%
General Program Provision or Design	93	12.2%
Excluded or Non-covered Benefit	55	7.2%
Coordination of Benefits	35	4.6%
Access to Care	27	3.5%
Unauthorized Services	22	2.9%
Prescription Drug	22	2.9%
Other	21	2.8%
Plan Service & Administration	19	2.5%
Prior Authorization	15	2.0%
Not Medically Necessary	15	2.0%
Referral	9	1.2%
Usual, Customary & Reasonable	9	1.2%
Experimental or Investigational	8	1.0%
Copayment Reduction	7	0.9%
Dental	6	0.8%
Disability Medical Evaluation	3	0.4%
Payment or ACH Issues for ICI/Disability Benefits	3	0.4%
Overpayment	3	0.4%
Annual Deductible	3	0.4%
Mail Order	2	0.3%
Quality of Care	1	0.1%
Total	**763**	100%

Ombudspersons continue to experience an increase in contacts from members who needed assistance in working out complicated and time-consuming coordination of benefits problems with Medicare A, B, D and Medicare Private Fee-for-Service plans. Frequently, members, ETF staff and health plans spend hours working with the Center for Medicaid and Medicare Services and health care providers to work towards resolution.

As expected, Health Insurance continues to be the program that generates the majority of the contacts to the Ombudspersons, with 542 contacts. These issues also have historically proven to be the most complex in nature and take the most time to resolve.



The 542 Health Insurance complaints are detailed below by plan.



*Self-funded plans are administered by WPS and include: Standard Plan, State Maintenance Plan, Medicare Plus $1 Million, and the Local Annuitant Health Plan.

In 2008, approximately 47% of issues handled by Ombudspersons resulted in a decision fully in favor of the member, 37% were “inquiry only” in nature, 4% had outcomes that resulted in a compromise, and 11% resulted in no change to the plan’s original decision.

Ombudsperson program staff will be available at the meeting to answer questions.

Attachment

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: May 27, 2009

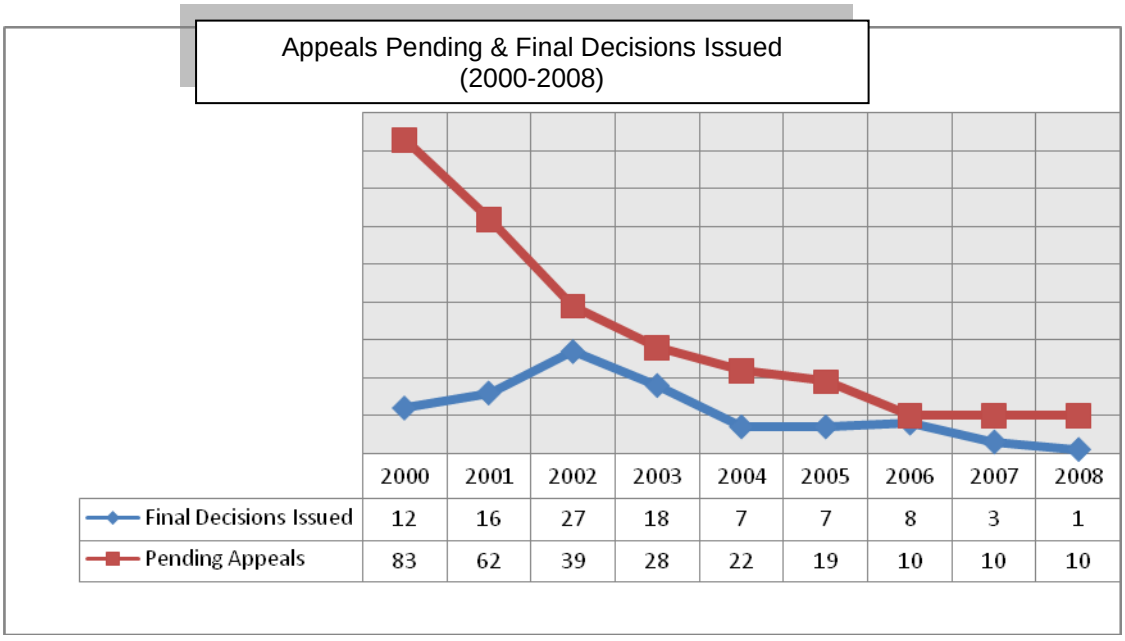
TO: Group Insurance Board

FROM: Sharon Walk, Appeals Coordinator

SUBJECT: Pending Appeals

This memo is provided for informational purposes only. No Board action is necessary.

Over the past eight years, since the inception of the Independent Record Review process, the Department has made significant progress in reducing the number of appeals pending before all of the Boards. At the present time, the total number of pending appeals is 35; ten of these are appeals to the Group Insurance Board (Board). Some Board members will recall a time when almost every Board meeting ended with a closed session for the deliberation of appeals. The chart below shows the number of appeals pending before the Board from 2000-2008 as well as the number of final decisions issued by the Board



	2000	2001	2002	2003	2004	2005	2006	2007	2008
Final Decisions Issued	12	16	27	18	7	7	8	3	1
Pending Appeals	83	62	39	28	22	19	10	10	10

Department staff will be available at the June 9, 2009, Board meeting to answer any questions you may have.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	6/9/09	6

2009

GROUP INSURANCE BOARD

MEMBERSHIP ROSTER

MEMBER NAME	TERM BEGAN	TERM EXPIRES	MEMBERSHIP REQUIREMENTS
Baird Robert	05/07/2007 (5/03-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant who is an employee of a local unit of government.
Beil Martin	05/08/2007 (10/83-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is not a teacher.
Vacant * (Bell)			§ 15.165 (2). 2-year term Appointed by Governor. Chief executive or member of the governing body of a local unit of government that is a participating employer in the WRS.
Doleschal Janis	05/08/2007 (5/05-5/07)	05/01/2009	§ 15.165 (2) 2-year term Appointed by Governor. Insured participant in WRS who is a retired employee.
Donnelly Jennifer	03/21/07	Ex Officio	§ 15.165 (2). Ex Officio Director of the Office of State Employment Relations or his/her designee.
Vacant ** (Frankel)			§ 15.165 (2). 2-year term Appointed by Governor. No membership requirement.
Mallow (V) Eileen	09/18/2006	Ex Officio	§ 15.165 (2) Ex Officio Commissioner of Insurance or his/her designee.
O'Donnell (C) Cindy	10/12/2005	Ex Officio	§ 15.165 (2) Ex Officio Attorney General or his/her designee.
Olson (S) Esther	05/09/2007 (5/01-5/07)	05/01/2009	§ 15.165 (2). 2-year term Appointed by Governor. Insured participant in WRS who is a teacher.
Schmiedicke David	11/14/2003	Ex Officio	§ 15.165 (2) Ex Officio Secretary of Dept. of Administration or his/her designee.
Sherman Gary	1/24/2005	Ex Officio	§ 15.165 (2) Ex Officio Governor or his/her designee.

*Jeannette Bell resigned in April 2008. A replacement has not yet been appointed.

**Steve Frankel resigned in April 2009. A replacement has not yet been appointed.

(C) – Chair (V) – Vice-Chair (S) – Secretary

MAILINGS FOR BOARD MEMBERS SHOULD BE SENT TO:

Group Insurance Board
c/o Cindy Gilles, Board Liaison
Department of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
Phone (608) 261-0736

(Rev. 06/05/09)

Board	Mtg Date	Item #
GIB	6/9/09	6

Department of Employee Trust Funds
Summary of Fiscal 2009-2011 Biennial Budget Request
Updated June 8, 2009

Segregated Trust Fund Dollars Only

	FY 2010		FY 2011	
	FTE	**Funding**	**FTE**	**Funding**
Base Budget (FY 2009)	220.8	$26,030,300	220.8	$26,030,300
ETF Request Over Base*	25.0	$9,927,300	49.0	$11,956,200
Governor's Recommendations	(2.1)	$806,700	3.9	$1,543,700
Joint Committee on Finance	(2.1)	$129,500	3.9	$866,500
Legislature				
Final Enacted Budget				

* Includes new initiatives and standard technical adjustments

New Department Initiatives

1. Continuation of Critical Customer Service Functions

	FY 2010		FY 2011	
	FTE	**Funding**	**FTE**	**Funding**
ETF Request	33.1	$9,806,700	57.1	$11,835,600
Governor's Recommendations	6.0	$946,400	12.0	$1,683,400
Joint Committee on Finance				
Legislature				
Final Enacted Budget				

Funding and positions to address current work backlogs and anticipated workload growth due to the retirement of the "baby boom" generation. Addresses need to continue core customer service functions.

Including in this initiative were the following three statutory changes to increase the administrative flexibility available to the Department to more effectively meet the anticipated increased demand on customer service functions.

a) **Passive review process for the creation and deletion of positions**. This change would allow the Department to request changes in the authorized position level throughout the biennium based on workload metrics. To create or delete position authority, the Department would forward a request to the Joint Committee on Finance (JCF). During a 14 day review period, either the

Governor or a member of JCF could register an objection to the Department request. The JCF would schedule a meeting to discuss the request if either party registered an objection. If no action is taken by either the Governor or JCF member, the request would be considered approved after 14 days. As part of this change, the Department would need to seek Board approval for any position request that would increase the position authority over the peer system median of the ratio of participants to full-time equivalent staff. The Department would report quarterly on any positions created or deleted under this provision quarterly to the JCF, Governor, and Employee Trust Funds Board.

b) **Passive review process for the establishment of expenditure authority for the costs of administering benefit programs.** This change would allow the Secretary to establish the annual level of spending for administrative functions based on workload metrics, membership levels, and an analysis of expenditure levels of peer public systems. The Secretary would forward the annual expenditure authority recommendation to JCF and the Governor. A passive review process similar to the one described in the previous item would be utilized. The current "annual" appropriation used for administrative operations would be changed to a "continuing" appropriation allowing unused funds in one year to be carried over to subsequent years.

c) Clarification of the ETF Board's procurement authority. This change would clarify certain ambiguities regarding the Department's procurement authority. This change more clearly indicates that for the purposes of the Public Trust Fund, the Board is the procurement authority (as opposed to the Department of Administration).

Governor's Recommendation: Provides 6.0 FTE permanent positions and $946,400 in FY 2010 and 12.0 FTE permanent positions and $1,683,400 in FY 2011 to accommodate the additional workload.

Creates the passive review process for creating and deleting positions as described in item "a" of the administrative flexibility initiatives described above except that there is no requirement to obtain ETF Board approval prior to exceeding the participant to staff ratio of peer public systems.

The statutory changes related to expenditure authority (Item b) and clarification of procurement authority (Item c) were not included in the Governor's recommendations.

Joint Committee on Finance: Deleted the provisions that created a passive review process for creating and deleting positions as these provisions were deemed non-budget policy items that will be introduced as separate legislation. The Committee indicated that the Department could request additional resources via the s. 13.10 process should workload metrics indicate a need for additional positions or expenditure authority. Retained additional funding and positions as recommended by the Governor.

2. Group Insurance Program Efficiencies

Statutory changes to provide additional efficiencies for the administration of the group insurance programs.

a) **Wellness incentives for the Group Health Insurance Program.** This statutory change would allow the Group Insurance Board (GIB) to incorporate a wellness incentive component into the health plans without having to reduce another benefit as currently required by the statutes. This change will allow the GIB to better encourage member participation in wellness and disease management programs developed or sanctioned by the GIB.

b) **Expansion of GIB authority to contact for data collection and analysis services.** This change would expand the GIB's authority for obtaining consulting services related to insurance programs offered by the Board. The current authority under this provision is limited to contracting for data collection and analysis related to the health insurance programs.

c) **Elimination of the requirement for GIB approval of payroll deduction of optional insurance plans.** This change would eliminate the requirement that state agencies obtain GIB approval prior to offering payroll deduction for optional employee-pay-all insurance plans.

d) **Additional flexibility to determine long-term care insurance options.** This change would allow the GIB to limit the number of long-term care plans offered. Currently, the GIB must offer to employees any plan that meets the standards established by the GIB.

Governor's Recommendation: The wellness incentives (item #a) and GIB contracting authority (item #b) statutory changes are included in the Governor's recommendations.

Joint Committee on Finance: Both the wellness incentives (Item a) and the GIB contracting authority item (Item b) were deemed non-budget policy items and removed from the biennial budget bill. These items will be introduced as separate legislation.

3. New Headquarters Facility

Approval and expenditure authority for the design and construction/purchase of a new Department headquarters facility. Note that the majority of the request associated with this item will be handled via the Governor's Capital Budget request which is anticipated to be released sometime in March 2009.

This item includes a request for a sum sufficient appropriation to fund costs associated with the design and related pre-construction costs. The appropriation is requested so that the building related costs do not compete with the resource needs for day-to-day departmental operations.

Governor's Recommendation: Not included in the Governor's budget recommendations.

Summary of Department FTE Positions by Fund Source

	FY 2009 (Base)	FY 2009-11 Department Request	FY 2008-09 Governor and JCF	Change Base to Governor and JCF
SEG Permanent	212.7	269.8	224.7	12.0
SEG Project	8.1	-	-	(8.1)
SEG Total	**220.8**	**269.8**	**224.7**	**3.9**

Summary of Department Budget Request By Fund Source Through the Joint Committee on Finance (5/29/09)

	FY 2010	FY 2011
SEG Funding Adjusted Base (FY 2007)	$26,030,300	$26,030,300
Standard Technical Adjustments	120,600	120,600
New SEG Funded Initiatives	**8,900**	**745,900**
Total SEG Funded Budget Request	**$26,159,800**	**$26,896,800**
GPR Funding Adjusted Base (FY 2007)	1,062,900	1,062,900
Standard Technical Adjustments	(220,700)	(392,400)
Total GPR Funded Budget Request*	**$842,200**	**$670,500**
All Funds Total	**$27,002,000**	**$27,567,300**

* GPR includes $30,000 per year for BadgerRx Gold advances (a program that allows non-WRS individuals to purchase prescription drugs from the State prescription drug plan at discounted prices)

FY = Fiscal Year - the state fiscal year begins July 1 and ends June 30.

FTE = Full-time Equivalent position

GPR = General Purpose Revenues – represents appropriations from the general fund; these are primarily funds derived from income and sales taxes.

SEG = Segregated Funds – for ETF, this represents appropriations from the Public Employee Trust Fund; the source of funds included employer/employee contributions and investment earnings.

Governor's Initiatives

1. Across-the-Board One Percent Reductions

	FY 2010		FY 2011	
	FTE	Funding	FTE	Funding
ETF Request				
Governor's Recommendations	-	($260,300)	-	($260,300)
Joint Committee on Finance				
Legislature				
Final Enacted Budget				

Governor's Recommendation: Reduce most non-federal state agency state operations appropriations by one percent to create additional efficiencies and balance the state budget. This cut is applied equally to the three Department administrative appropriations.

2. Domestic Partner Status For Certain WRS Benefit Programs

Governor's Recommendation: Modify the definition of a dependent for the purposes of certain WRS programs including health insurance, duty disability, accumulated sick leave conversion credits, joint survivor annuity options, long-term care insurance, division of a WRS or WDC account due to a domestic relations order, death benefits, and beneficiary designations to include a domestic partner. A domestic partner is defined as an individual who is in a relationship with another individual where both individuals are at least 18 years of age, neither individual is married or in another domestic partner relationship, the two individuals are not related by blood in any way that would prohibit marriage, the two individuals consider themselves to be members of each other's immediate family, and the two individuals agree to be responsible for each other's basic living expenses. This provision would be effective for insurance coverage that begins on or after 1/1/2011 and immediately upon enactment into law for other provisions.

Joint Committee on Finance: Included the Governor's recommendations with the following modifications: changed the effective date for all provisions to 1/1/2010 (if the budget is not enacted into law by August 1, 2009, the insurance coverage provisions will be effective on 1/1/2011); requires an affidavit to attest that individuals meet the requirements of a domestic partnership (also applies to changes and dissolution of a domestic partnership); requires a six-month waiting period between the termination of a domestic partnership and any subsequent domestic partnership; and includes a requirement that both parties to a domestic partnership share a common residence.

Note: The above provisions apply to domestic partnerships only for the purposes of benefits provided under Chapter 40 of the statutes.

3. WRS Benefits for Certain Part-time Staff

Governor's Recommendation: Modify WRS eligibility standards for educational support staff to use the teacher definition of full-time (440 hours per year) when determining if individuals meet the one third time requirement for WRS participation. Under current law, education support staff must meet the one third time requirement used for non-teacher participants (600 hours per year). In addition, for the purposes of calculating the actuarial reduction for certain early retirement participants with part-time service in at least five of the 10 years immediately preceding termination, creditable service shall be calculated using the full-time definition of a year for teacher participants (full-time = 1320 hours per year). Under current law, creditable service for the purposes of determining the actuarial reduction is calculated using the equivalent of 1904 hours as one year of service for non-teacher participants. These provisions would be effective immediately upon enactment into law.

Joint Committee on Finance: Included the Governor's recommendations with a clarification that the change in WRS eligibility standards only applies to service earned after the effective date of the bill (participants will not be eligible to receive service credits for work prior to the effective date of the bill).

4. Transfer of the BadgerRx Gold Program to the Department of Health Services

Governor's Recommendation: Transfer the administration of the BadgerRx Gold program from the Department of Employee Trust Funds to the Department of Health Services. The BadgerRx Gold program allows Wisconsin residents with prescription drug coverage to purchase prescription drugs included on the formulary for the Group Insurance Board administered health plans at discounted prices. The transfer is effective on 1/1/2011.

Joint Committee on Finance: Included the Governor's recommendations.

5. Consolidation of Human Resource Staff Into the Office Of State Employment Relations

Governor's Recommendation: The Secretary of Administration along with the Director of the Office of State Employment (OSER) relations will identify and abolish all positions used for human resource functions in executive branch agencies other than the University of Wisconsin by July 1, 2011. Some of the affected individuals would be transferred to OSER. Human resource functions currently performed by agencies would be performed by the OSER. OSER would be authorized to bill executive branch agencies for all human resource services.

Joint Committee on Finance: Deleted the provisions and included a provision to allow the OSER and the Department of Administration to forward a request to the Committee to consolidate human resources functions of agencies into OSER when a detailed analysis is completed. ETF was included as an agency that would be exempt from consolidation.

6. Health Insurance Coverage of Children to age 27

Governor's Recommendation: Requires the Group Insurance Board administered health plans to provide coverage for children up to age 27 unless that child is married, has other health coverage, or is working full-time and is eligible for employer sponsored health coverage. This provision would be effective for the 2011 plan year.

Joint Committee on Finance: Included the Governor's recommendation.

7. Consolidation of Various State Agency Functions

Governor's Recommendation: This provision allows the Secretary of Administration to consolidate various state agency functions such as call centers, payroll functions, customer service functions, and legal services. The Secretary is authorized to reassign employees to other agencies to effect these consolidations.

Joint Committee on Finance: Deleted these provisions as they were deemed non-budget policy and will be introduced as separate legislation.

8. Elimination of Positions that Have Been Vacant for One Year or More

Governor's Recommendation: Authorizes the Secretary of Administration to eliminate any state agency position that has been vacant for at least one year. The associated funding would lapse to the underlying fund source.

Joint Committee on Finance: Deleted this provision.

9. Includes Proposed Regional Transit Authorities As Eligible WRS Employers

Governor's Recommendation: Modifies the definition of a state agency for the purposes of the WRS to include the proposed regional transit authorities.

Joint Committee on Finance: Included the Governor's recommendation.

Joint Committee on Finance Initiatives

1. Annuity Deduction for Dues for Retiree Organizations

Joint Committee on Finance: Allows annuitants to require ETF to withhold dues from their monthly annuity payment and to transmit those amounts to retiree organizations that are affiliated with an employee organization. This provision would be effective on 1/1/2010.

2. Sharing of the Annuitant Mailing List with Retiree and Employee Organizations

Joint Committee on Finance: Requires ETF to provide a list of names and addresses of all annuitants, at the request of a retiree organization or employee organization, to vendor (selected by ETF) for the purposes of sending mailing. The requesting organization would provide the printed information and pay the vendor directly for the costs associated with the mailing. The vendor would be prohibited from sharing the mailing list and would be required to return the list to ETF upon completion of the mailing. This provision would be effective on 1/1/2010.

3. Reporting of Survivor Benefits

Joint Committee on Finance: Requires ETF to gather sufficient information to determine the non-taxability of survivor benefits and ensure that this information is reported to the Internal Revenue Service (IRS) in a manner that would not result in an erroneous tax liability for the recipient.

4. Additional Reductions to the ETF Operating Budget

	FY 2010		FY 2011	
	FTE	Funding	FTE	Funding
ETF Request		-		-
Governor's Recommendations				
Joint Committee on Finance		(677,200)		(677,200)
Legislature				
Final Enacted Budget				

Joint Committee on Finance: Reduces the ETF operating budget by $677,200 annually. These amounts are associated with the 2% general wage adjustment that is effective for all state employees in June 2009 ($267,400 annually) and the executive action requiring all employees to be furloughed for eight days per year during the FY 2009 – 2011 biennium ($409,800 annually). The increase was eliminated for non-represented employees as part of the modifications to the non-represented employee compensation plan approved in May 2009. While the modifications only affect non-represented employees (24% of ETF staff), the budget action reduces the entire salary base by 2%.

5. Coverage of Autism and Autism Related Disorders in ETF Administered Health Plans

Joint Committee on Finance: Requires health plans administered by ETF to include coverage for autism and autism related disorders for coverage effective 1/1/2010. The provisions would be similar to those contained in Substitute Amendment 1 to 2009 Senate Bill 3 except for the change of definition of "post-intensive-level services" to "non-intensive level services."

6. Coverage of Services Provided by Licensed Mental Health Professionals

Joint Committee on Finance: Modifies the coverage of mental health services provided by certain licensed mental health professionals. These provisions are similar to those contained in 2007 Senate Bill 246 as amended by Amendment 1. These provisions would be effective for coverage under the ETF administered plans on or after 1/1/2010.

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CORRESPONDENCE MEMORANDUM

DATE: June 8, 2009

TO: Group Insurance Board

FROM: Jon Kranz, Director
Office of Budget and Trust Finance

SUBJECT: 2009-2011 Department Biennial Budget Update

This memo is for informational purposes only. No Board action is required.

Attached is a document that summarizes the status of the biennial budget request for the Department of Employee Trust Funds through the actions taken by the Joint Committee on Finance (JCF) through May 29, 2009. In addition, the document includes other provisions recommended by the Governor and provisions included by the JCF that could affect the Department.

The 2009-2011 biennial budget request for the Department of Employee Trust Funds was submitted to the Department of Administration on September 26, 2008. The period covered by the budget request is July 1, 2009 - June 30, 2011. The schedule for review and action by the Governor and Legislature is anticipated to be as follows:

Stage	Anticipated Schedule
Agency Budget Request Due	Submitted September 26, 2008
Governor Issues Budget Recommendations	February 17, 2009
Review and Action by the Joint Committee on Finance (JCF)	**Completed May 29, 2009**
Action by Full Legislature	June 2009
Final Enacted Budget	July 2009

In addition to the biennial budget request, the Department also submitted a capital budget request for the authority to acquire a new headquarters facility. The Governor's capital budget recommendations submitted in March 2009 did not include this request.

Please contact me at (608) 267-0908 should you desire any additional information.

Reviewed and approved by Robert J. Conlin, Deputy Secretary.

Dated: June 8, 2009

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CORRESPONDENCE MEMORANDUM

DATE: June 8, 2009

TO: Group Insurance Board

FROM: Matt Stohr, Director of Legislative Affairs, Communications and Quality Assurance

SUBJECT: Legislative Report

This memorandum is for informational purposes only. No Board action is required.

At the April 14, 2009, Board meeting, I distributed a memorandum that highlighted the 2009-2010 Legislative Session bills that will, if enacted, have an impact on the State of Wisconsin Group Health Insurance Program and other health insurance programs. Following is an update on each of those bills.

- 2009 Senate Bill 3 and 2009 Assembly Bill 15, both relating to health insurance coverage of treatment for autism spectrum disorders, affect the health programs administered by the Department. Substitute Amendment 1 to Senate Bill 3 was passed (5 ayes, 0 noes) by the Senate Committee on Public Health, Senior Issues, Long-Term Care, and Job Creation on February 10, 2009. The Committee on Senate Organization referred the bill to the Joint Committee on Finance on February 18, 2009. The Assembly Committee on Insurance held a public hearing on Substitute Amendment 1 to Assembly Bill 15 on February 19, 2009. Lastly, the provisions of the substitute amendment were included in the Joint Committee on Finance's version of the 2009-2011 state biennial budget.

- 2009 Senate Bill 27 (Assembly Bill 16 was the companion bill) was signed into law by the Governor on May 21, 2009, as 2009 Wisconsin Act 14. Generally speaking, 2009 Wisconsin Act 14 requires health insurance coverage of hearing aids and cochlear implants for eligible persons less than 18 years of age. The Act was published on June 5, 2009, and the effective date is January 1, 2010.

- 2009 Senate Bill 70 and its companion bill Assembly Bill 118, generally increases the health coverage age limit for eligible dependents to the age of 27. The Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue held a public hearing on Senate Bill 70 on April 22, 2009. In addition, the Joint Committee on Finance included this provision in its version of the budget bill. The provision was also in the Governor's budget proposal.

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- 2009 Senate Bill 161 (Assembly Bill 194 was the companion bill) was signed into law by the Governor on May 26, 2009 as 2009 Wisconsin Act 15. 2009 Wisconsin Act 15 requires the Department of Health Services to create a Milwaukee County Enrollment Services unit for income maintenance. It also provides that certain Milwaukee County employees in this unit who are hired into state positions may elect to participate in the Wisconsin Retirement System (WRS) but will retain their coverage under the Milwaukee County plan if they do not choose WRS coverage. If they choose not to elect to participate in the WRS, they will nevertheless be eligible employees under the state health insurance program. State contributions for these employees will be available as soon as the insurance goes into effect.

Unfortunately, I will not be able to attend the June 9, 2009 Board meeting due to a prior commitment. Please contact me at 608/266-3641 if you have any questions about the bills listed above or other legislative matters.

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CORRESPONDENCE MEMORANDUM

DATE: May 27, 2009

TO: Group Insurance Board

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

SUBJECT: Guidelines and Uniform Benefits for the 2010 Benefit Year – Technical Changes

This memo is for informational purposes only. No Board action is required.

At its April 14, 2009, meeting, the Group Insurance Board (Board) reviewed and approved changes for the 2010 benefit year. In addition, the Board granted staff the authority to proceed with needed technical clarifications. The following is a brief description of those technical clarifications and corresponding language changes. New language is shaded and underscored and language to be deleted is ~~stricken~~.

Please note that further contract changes may be necessary if other state mandates are passed before the bidding process is complete.

Section	Technical Clarification	Language Change
State & Local Contract *Article 2.2 (6)*	Language was clarified at the recommendation of the Department's legal counsel.	The HEALTH PLAN shall maintain a written contingency plan describing in detail how it will continue operations and administration of benefits in ~~the~~ certain events including, but not limited to, ~~of~~ strike~~,~~ and disaster, ~~etc.,~~ and shall submit it to the DEPARTMENT upon request.
State & Local Contract *Article 3.12 (1)*	Language clarifies the return to work provision in Wis. Stat. § 40.02 (40).	. . . If the EMPLOYEE does not complete 30 days of duty, the EMPLOYEE is not deemed to have returned to work and coverage as an active EMPLOYEE shall not be resumed.

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

_____ _____
Signature Date

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Section	Technical Clarification	Language Change
Uniform Benefits *Section III., C., 3.*	Language was clarified at the recommendation of the Department's legal counsel.	Rental or, at the option of the Health Plan, purchase of equipment ~~such as~~ including, but not limited to~~:~~. wheelchairs and hospital-type beds.

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

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CORRESPONDENCE MEMORANDUM

DATE: May 29, 2009

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Arlene Larson, Manager, Self-Insured Health Plans

SUBJECT: Recommendations for Benefit Clarifications and Changes to the Standard Plans Group Health Insurance Program Effective January 1, 2010

Staff requests Group Insurance Board (Board) action on the following changes in order to finalize the Standard Plans contract for 2010.

1. **Staff recommends the Board approve the contractual clarifications and updates described below.**
2. **Staff recommends the Board provide staff the authority to include any changes to the draft following input from the Board and for any technical issues that may arise thereafter.**

Background:

The purpose of this memo is to discuss the proposals for Board action on the Standard Plans. Wisconsin Physician's Service Health Insurance (WPS) and ETF staff has suggested changes to the contract to address various items. Some issues discussed were identified during the audit of claims paid in 2006/2007. The auditor, Claim Technologies, Inc. (CTI), found areas of concern and these were presented at the February 17, 2009, Board meeting. In addition, recommendations for clarifying existing practice and attempts to make the plan easier to understand for our members are also being proposed.

WPS has provided a grid of the proposed changes (attached). This document details the suggestions and explains WPS's rationale for each item. In addition to the WPS grid, relevant portions of the *Health Benefit Plan* (HBP) contract are attached. The new material is highlighted and material being proposed for deletion is ~~stricken~~. Changes that the Board previously approved in the Guidelines that apply to the Standard Plans are being made in this contract, but those pages are not shown here. In addition, changes required by federal and state mandates will also be included.

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

_____ _____
Signature Date

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As staff works with WPS on its administration of the benefit plan, we will continue to refine these provisions and bring them back to the Board as necessary.

Discussion of Proposed Changes:

Following discussion and approval, staff will incorporate any changes suggested by the Board and finalize the contract with WPS in order to allow for member notification prior to the It's Your Choice enrollment period. Final formatting of the contract text will be submitted to the Board chair for signature.

Changes recommended to target various issues in the contract not related to the audit:

1. *Clarify the current benefit for injectables that are provided during home care, office setting, confinement, emergency or urgent care visits.*

   The Standard Plan benefit for injectables and the exclusion for self-administered injectables that are allowable under Navitus are intended to mirror the benefit under Uniform Benefits. However, the contract language in the Standard Plan is not as clear. Staff recommends clarifying the current language to match that in Uniform Benefits so our members have a consistent benefit for injectable medications. WPS concurs.

2. *Clarify existing practice to specifically exclude orthopedic shoes.*

   WPS has informed us that orthopedic shoes have not been paid under the contract; however, there is no specific exclusion nor is there a specific benefit for them. Orthopedic shoes would normally be excluded as they are not durable medical equipment or prosthetics. WPS has used the medical necessity criteria to deny them, but would prefer a clear exclusion. Staff agrees and recommends adding such an exclusion to clarify existing practice.

3. *Clarify the Medicare Plus $1,000,000 inpatient facility benefit.*

   For inpatient hospital facility stays, it has been the plan's longstanding practice to supplement Medicare's payment, and in medically-appropriate cases, pay beyond. Medicare will allow for payment of hospital stays up through day 90 as medically-necessary. However, beginning on the 91st day, they will also allow for an additional 60 "lifetime reserve days" (which is a one-time benefit) for payment up to 150 inpatient days. Our plan is designed to supplement Medicare's payment and will allow for payment past the 90th day up to 120 medically-necessary inpatient days regardless of Medicare's payment.

The Medicare Plus $1,000,000 booklet includes a benefit grid that describes how the plan will supplement the lifetime reserve days from day 121 through 150. However, the contract is not clear on this point. WPS proposes the attached language to clarify this benefit in the contract. Staff agrees with the clarification.

Change recommended to target contract issue related to the audit:

1. *Clarify coverage for therapy training services in a hospital following an inpatient stay and prior to discharge.*

   The audit found that WPS allows for payment of therapists who bill separately for teaching patients techniques prior to discharge for care at home following an illness or surgery. WPS states that these services are medically-necessary in preparation for patient discharge and such claims are becoming more common as a separately billed item from physical therapy departments in hospitals. WPS allows for such payment under its commercial business. Our contract specifically excludes educational training, but the exclusion is designed to protect the program from educational therapies that are required under the law to be provided by schools to children. The auditor found the payment of 64 claims could have been paid in error. They tested two claims and found they were paid appropriately, but stated the potential exists for overpayment in the remainder of untested claims. WPS recommends language to specifically allow for coverage of this inpatient therapy training as a clarification of existing practice.

   Deloitte says that claims like this for diabetes training, nutritional counseling and educational services from facilities are not uncommon. Deloitte also stated the proposed language from WPS seems to capture the non-school related education therapy, thus providing for specialized instruction to a patient concerning their illness prior to discharge.

   Staff concurs with this assessment.

Clarification of existing practice on issues related to the audit:

1. *Massage therapy.*

   The auditor, CTI, found that WPS was allowing coverage for massage therapy; however, CTI informed staff that excluding such therapy is the standard in the industry. It should be noted that massage therapy is specifically excluded in Uniform Benefits. However, the Standard Plans have allowed for coverage of massage therapy subject to the administrator's determination of medical necessity for many years.

WPS allows massage therapy under our plan and its commercial policies when performed by a physical therapist or a chiropractor in the course of a medically necessary treatment for an illness or injury. The prior administrator, Blue Cross & Blue Shield of Wisconsin (BCBSWI), also allowed for coverage under the plan subject to medical policy.

Deloitte has found that most plans are silent on payment for massage therapy and will allow it based upon the determination of medical necessity. They found that it is paid for acute care but not for maintenance care.

Staff recommends that the contract remain silent and continue to allow WPS the ability to use medical policy to determine if massage therapy should be allowed or denied.

2. *Clarify the exclusion for vision exams to specify that all refractions are excluded.*

The auditor found that the Standard Plans contract excludes coverage for preparation, fitting or purchase of eye glasses or contact lenses; however, both WPS and BCBSWI paid for refractions where CTI determined they should have been denied. BCBSWI defended its position following the audit, stating that refractions are medically necessary when affiliated with certain medical diagnoses. WPS followed this existing practice, but stated that it does not consider refractions to be a treatment for an illness or injury, rather simply provided to measure a person's ability to see an object at a distance in order to provide a prescription for glasses or contacts. However, WPS notes that refractions are required more often for members with illnesses like diabetes to monitor progression of their disease.

Deloitte found that while some plans exclude refractions, a number of plans allow them-for example, when used due to an accidental injury, following cataract surgery or for the management of diabetes. Due to the fact that the plan has paid these as a long-standing practice, there would be no cost impact to continue to do so.

Staff concurs with Deloitte and will work with WPS to make the contract consistent to allow for payment of refractions in limited circumstances where the claim is submitted with a valid medical diagnosis.

Attachments

May 20, 2009

To: Arlene Larson
Manager, Self Insured Plans
Division of Insurance Services
Department of Employee Trust Funds

Arlene:

The following is a brief overview of proposed new benefit provisions that we suggest be added to your health plan effective January 1, 2010 as well as the reason to incorporate that language. New wording appear as bolded. Whenever the same provision is being changed on multiple pages in the contract and the text is repeated, we are only attaching one example of the change in red line/strike out text. However, the grid does include the reference to all affected pages.

Section and Page Number	**New Language for Health Benefit Plan**	**Reason for New Language**
Standard Plan Section IV. B. 29 Page 41 Medicare Plus $1,000,000 Section VII. B. 5. q. Page 74 Section XII. Exclusions Page 90	Add the following to the list of covered professional services: **29. Self Injectable Medication and Prescription Drugs Provided in a Physician's Office, Hospital or by a Home Health Agency.** BENEFITS are payable for CHARGES for self injectable medication, injectable and infusible medication, and prescription drugs provided in a physician's office, a hospital, or by a home health agency during home care. Modify exclusion as follows: Charges for injectable medications and prescription drugs, except as specifically stated in the PLAN.	Currently in the exclusion section, self-injectables are excluded with an exception made within that exclusion to allow benefits for these when provided in certain settings. We recommend moving the benefit portion of the exclusion to the benefit section and modify exclusion to refer the exception to the specific benefit stated in the PLAN.
Section XII. Exclusions Page 90	Add the following exclusion: Orthopedic shoes;	Currently there is no specific exclusion for orthopedic shoes. WPS considers these types of shoes to be convenience because they are not medically necessary to "treat" an illness. We recommend adding a specific exclusion.

Medicare Plus $1,000,000 Section VII. B. 1. Page 69, 70	Change benefit language for inpatient hospital services to the following: HOSPITAL SERVICES for other than Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS are payable at 100% of the CHARGES for a maximum of 120 days during any one BENEFIT PERIOD less the number of days specified under MEDICARE for INPATIENT HOSPITAL SERVICES. **If a PARTICIPANT elects to use the MEDICARE lifetime reserve days, BENEFITS will continue to be payable for any reserve days paid for by MEDICARE.**	The outline in the current Medicare Plus $1,000,000 plan allows the Plan to supplement Medicare through the end of any lifetime reserve days. However, contract language does not match the outline. We recommend the addition of the new language to allow for continued payment in the event a participant elects to use their lifetime reserve days.
Standard Plan, Section IV. A. 1. Page 29 WPE Standard Plan Section VI., B., 1., a. (1) Page 44 Section XII., Exclusions Page 89	Add language the following language under Inpatient Hospital Services: **(5) CHARGES for educational therapy that provides specialized instruction to a PARTICIPANT concerning their illness or injury prior to discharge.** Replace current educational training exclusion with the following: **A.** HEALTH CARE SERVICES used in educational or vocational training or testing, **except as specifically stated in the PLAN.**	This type of educational services are provided at the end of a participant's hospital confinement following a surgery or illness where the participant is given instructions for care at home for that illness or surgery. These services have been paid as a miscellaneous hospital expense even though there is an exclusion for "educational training". WPS does not feel that the educational therapy described above falls under this exclusion. Therefore, we recommend adding a specific benefit as well as modifying the current exclusion.

If you have any questions, please do not hesitate to contact me.

Cheryl Forrer, Director, Contract Development

STATE OF WISCONSIN

GROUP INSURANCE BOARD

HEALTH BENEFIT PLAN

b. routine taking and reading of pap smear or routine papanicolaou smear;

c. mammograms, pap smears and PSA tests provided in connection with an ILLNESS.

23. **Equipment and Supplies for TREATMENT of Diabetes.**

BENEFITS are payable for CHARGES incurred for the installation and use of an insulin infusion pump, and all other equipment and supplies, excluding insulin and disposable diabetic supplies, used in the TREATMENT of diabetes. This benefit is limited to the purchase of one pump per PARTICIPANT per CALENDAR YEAR. The PARTICIPANT must use the pump for at least 30 days before the pump is purchased. BENEFITS are also payable for CHARGES for diabetic self-management education programs.

24. **Immunizations.**

BENEFITS are payable CHARGES for immunizations including, but not limited to, the following: diphtheria; pertussis; tetanus; polio; measles; mumps; rubella; hemophilus influenza B; hepatitis B; prevnar, and varicella. Immunizations for travel purposes are not covered. The annual DEDUCTIBLE and COINSURANCE amounts do not apply to immunizations provided to PARTICIPANTS to age six.

25. **Blood Lead Tests.**

BENEFITS are payable for CHARGES for blood lead tests for PARTICIPANTS age five and under.

26. **Breast Reconstruction Following Mastectomy.**

BENEFITS are payable for CHARGES for breast reconstruction of the affected tissue following a mastectomy. Benefits are also payable for CHARGES for: surgery and reconstruction of the other breast to produce a symmetrical appearance; breast prostheses; and physical complications for all stages of mastectomy, including lymphedemas.

27. **Certified Nurse Midwife Services.**

BENEFITS are payable for services provided by a nurse midwife when the services are performed in a clinic or hospital setting.

28. **Contraceptives.**

BENEFITS are payable for Intrauterine devices (IUD); diaphragms, and injections of medication for birth control, and related HEALTH CARE SERVICES. Subdermal contraceptive implants (Norplant) are not covered.

29. Self Injectable **Medication** and Prescription Drugs **Provided in a Physician's Office, Hospital or by a Home Health Agency.**

BENEFITS are payable for CHARGES for self injectable medication, injectable and infusible medication, and prescription drugs when required to be used in a physician's office, a hospital, or by a home health agency during home care.

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AA. HEALTH CARE SERVICES used in educational or vocational training or testing, except as specifically stated in the PLAN.

BB. HEALTH CARE SERVICES in connection with any ILLNESS or INJURY caused by a PARTICIPANT'S: (1) engaging in an illegal occupation; or (2) commission of, or an attempt to commit, a felony.

CC. Motor vehicles; lifts for wheelchairs and scooters; and stair lifts.

DD. HEALTH CARE SERVICES for which the PARTICIPANT has no obligation to pay.

EE. HEALTH CARE SERVICES rendered by a member of a PARTICIPANT'S IMMEDIATE FAMILY or a person who resides in the PARTICIPANT'S home.

FF. Routine periodic maintenance of covered DURABLE MEDICAL EQUIPMENT, such as, replacement batteries.

GG. HEALTH CARE SERVICES for the purpose of smoking cessation.

HH. HEALTH CARE SERVICES determined to be MAINTENANCE THERAPY by WPS.

II. Over-the-counter drugs.

JJ. Prescription drugs and BIOLOGICALS prescribed in writing by a PHYSICIAN for TREATMENT of an ILLNESS or INJURY and dispensed by a licensed pharmacist. For purposes of this exclusion, "prescription drug" means drugs that are dispensed by a written prescription from a PHYSICIAN, under Federal law, approved for human use by the Food and Drug Administration and dispensed by a pharmacist.

KK. Charges for injectable medications administered in a nursing home when the nursing home stay is not covered by the plan.

LL. Charges for injectable medications, except as specifically stated in the PLAN, ~~except for self-administered injectable medications and injectable and infusible medications administered during home care, office setting, CONFINEMENT, emergency room visit or urgent care setting.~~

MM. HEALTH CARE SERVICES to the extent the PARTICIPANT is eligible for MEDICARE BENEFITS, regardless of whether or not the PARTICIPANT is actually enrolled in MEDICARE. This exclusion only applies if MEDICARE is the primary payor.

NN. That portion of the amount billed for a HEALTH CARE SERVICE covered under the Plan that exceeds WPS' determination of the CHARGE for such HEALTH CARE SERVICE.

OO. Supportive care.

PP. Telephone, computer or internet consultations between a PARTICIPANT and any HEALTH CARE PROVIDER.

QQ. Indirect services provided by health care providers for services such as, but are not limited to: creation of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing quality assurance data.

RR. Orthopedic shoes.

VII. MEDICARE PLUS $1,000,000 COVERAGE

For PARTICIPANTS enrolled for MEDICARE PLUS $1,000,000 coverage, this Section VII. applies.

A. DEFINITIONS

For the purpose of this Section VII. only, the following terms when used AND capitalized in this Section, are in addition to, or a substitute for, the terms defined in Section I.

BENEFIT PERIOD means the total duration of all successive CONFINEMENTS that are separated from each other by less than 60 days.

BENEFITS mean payments for HOSPITAL SERVICES, EXTENDED CARE SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES.

EFFECTIVE DATE means the date as certified by the BOARD and shown on the records of WPS on which a PARTICIPANT becomes entitled to BENEFITS specified in this Section VII.

EXTENDED CARE FACILITY means the same as it does under MEDICARE.

EXTENDED CARE SERVICES means those SERVICES defined under MEDICARE and covered by MEDICARE in a MEDICARE certified EXTENDED CARE FACILITY which include: SKILLED NURSING CARE; accommodations provided in connection with the furnishing of SKILLED NURSING CARE; physical, occupational or speech therapy furnished or arranged by the EXTENDED CARE FACILITY; medical social SERVICES; prescription drugs prescribed by a PHYSICIAN and required to be administered by a professional provider and BIOLOGICALS (including whole blood and packed red blood cells) which are determined by WPS to be medically recognized as being used in the TREATMENT of an ILLNESS or INJURY; MEDICAL SUPPLIES, appliances and DURABLE MEDICAL EQUIPMENT used in and furnished by the EXTENDED CARE FACILITY for the care and treatment of INPATIENTS; MEDICAL SERVICES of interns and residents-in-training under an approved teaching program of a HOSPITAL with which the facility has in effect a transfer agreement; and other diagnostic or therapeutic SERVICES and supplies provided by a HOSPITAL with which the EXTENDED CARE FACILITY has in effect a transfer agreement.

PARTICIPANT means a PARTICIPANT, or any of his/her DEPENDENTS, eligible for MEDICARE for whom proper application for MEDICARE PLUS $1,000,000 coverage has been made and for whom the appropriate PREMIUM has been paid.

SUBSCRIBER means an EMPLOYEE, ANNUITANT or his/her surviving DEPENDENTS who have been specified by the DEPARTMENT to the PLAN for enrollment and who is entitled to BENEFITS.

B. BENEFITS AVAILABLE

Except as excluded in Sections VIII., IX., XII., and XIV., BENEFITS are payable for CHARGES for the following SERVICES and supplies on or after the EFFECTIVE DATE according to the terms, conditions and provisions of this CONTRACT, if those SERVICES and supplies are consistent with and MEDICALLY NECESSARY for the admission, diagnosis and treatment of the PARTICIPANT, as determined by WPS.

1. INPATIENT HOSPITAL SERVICES.

HOSPITAL SERVICES for other than Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS are payable at 100% of the CHARGES for a maximum of 120 days during any one BENEFIT PERIOD less the number of days specified under MEDICARE for INPATIENT HOSPITAL SERVICES. If a PARTICIPANT elects to use

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the MEDICARE lifetime reserve days. BENEFITS will continue to be payable for any reserve days paid for by MEDICARE.

However, if the PARTICIPANT occupies a private room, CHARGES for ROOM ACCOMMODATIONS are limited to the HOSPITAL'S average regular per diem CHARGES for all of its two bed ROOM ACCOMMODATIONS.

2. Alcoholism, Drug Abuse and NERVOUS and MENTAL DISORDERS.

a. INPATIENT HOSPITAL SERVICES. This paragraph applies to those PARTICIPANTS admitted as resident patients for TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS.

BENEFITS are payable at 100% after Medicare's payment up to the lesser of the CHARGES for the first 120 days or the first $6,300.00 in CHARGES each CALENDAR YEAR.

HOSPITAL SERVICES are not to exceed 365 days of CONFINEMENT throughout a PARTICIPANT'S lifetime while the PARTICIPANT is covered under this CONTRACT following the EFFECTIVE DATE under this Section VII.

b. OUTPATIENT HOSPITAL SERVICES. TREATMENT of Alcoholism, Drug Abuse and NERVOUS OR MENTAL DISORDERS for a PARTICIPANT other than as an INPATIENT is limited to the initial Part B DEDUCTIBLE and the amount which combined with the MEDICARE BENEFIT equals 90% of the first $2,000.00 in CHARGES during any CALENDAR YEAR.

Such TREATMENT SERVICES must be provided by a PHYSICIAN, a licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology, a facility established and maintained according to rules promulgated under Wis. Stats. § 51.42(7)(b), or a medical clinic or billed by a psychologist under the direction of a PHYSICIAN.

c. TRANSITIONAL TREATMENT ARRANGEMENTS. Transitional TREATMENT is limited to the initial Part B DEDUCTIBLE and the amount which combined with the MEDICARE BENEFIT equals 90% of the first $3,000.00 in CHARGES during any CALENDAR YEAR.

The criteria that WPS uses to evaluate a Transitional TREATMENT program or SERVICE to determine whether it is covered under the CONTRACT include, but are not limited to:

(1) The program is certified by the Department of Health and Family Services;

(2) The program meets the accreditation standards of the Joint commission on Accreditation of Healthcare Organizations;

(3) The specific diagnosis is consistent with the symptoms;

(4) The TREATMENT is standard medical practice and appropriate for the specific diagnosis;

(5) The multidisciplinary team running the program is under the supervision of a licensed psychiatrist practicing in the same state in which the health care provider's program is located or the SERVICE provided.

(6) See the definition of "MEDICALLY NECESSARY" in the definitions.

IV. STANDARD PLAN HOSPITAL, PROFESSIONAL AND OTHER SERVICES

Subject to the annual DEDUCTIBLE amounts stated in Section III., BENEFITS are payable as stated in subsection B. and C. of Section III. for CHARGES for covered expenses a PARTICIPANT incurs in connection with a covered ILLNESS, INJURY or specific routine/preventive services, subject to all the provisions of the PLAN. Covered expenses must be incurred while the PARTICIPANT is covered under the PLAN. The DEDUCTIBLE must be satisfied for the CALENDAR YEAR in which the covered expenses are incurred before BENEFITS are payable, unless specifically stated otherwise in the PLAN.

BENEFITS are payable for CHARGES for covered expenses as described below. The PARTICIPANT is solely responsible to pay for all HEALTH CARE SERVICES not covered by the PLAN.

BENEFITS for CHARGES for covered CONFINEMENTS are subject to: (1) preadmission and continued stay certification requirements; and (2) the reductions in benefits shown in Section X. for failure to comply with the certification requirements. Please see Section X. Value Care Program.

The following HEALTH CARE SERVICES are covered expenses. All HEALTH CARE SERVICES must be medically necessary and ordered by a physician because of an ILLNESS or INJURY, except for covered routine/preventive services. BENEFITS are not payable for MAINTENANCE THERAPY, CUSTODIAL CARE, SUPPORTIVE CARE, or any HEALTH CARE SERVICE to which an exclusion applies.

A. HOSPITAL SERVICES

Except as excluded in Sections VIII., IX., and XII., BENEFITS are payable for CHARGES for the following HOSPITAL SERVICES for each PARTICIPANT admitted to a HOSPITAL or EXTENDED CARE FACILITY on or after his/her EFFECTIVE DATE, if those SERVICES are consistent with and MEDICALLY NECESSARY for the diagnosis and TREATMENT of the PARTICIPANT, as determined by WPS.

1. PHYSICAL ILLNESS or INJURY.

a. **CONFINEMENT in a HOSPITAL.** This applies to those PARTICIPANTS admitted as INPATIENT in a HOSPITAL for TREATMENT of a PHYSICAL ILLNESS or INJURY, other than alcoholism, drug abuse and NERVOUS and MENTAL DISORDERS.

BENEFITS are payable for CHARGES as shown below for HOSPITAL expenses actually incurred during the first 365 days per CONFINEMENT.

(1) CHARGES for room and board for occupancy of semiprivate or lesser accommodations. Covered CHARGES shall include tube feedings in lieu of tray SERVICE when MEDICALLY NECESSARY, but not both. If a PARTICIPANT is in a private room, BENEFITS are payable up to the HOSPITAL'S average daily rate for all its two bed rooms;

(2) CHARGES for nursing services;

(3) CHARGES for MISCELLANEOUS HOSPITAL EXPENSES; and

(4) CHARGES for intensive care unit room and board.

(5) CHARGES for educational therapy that provides specialized instruction to a PARTICIPANT concerning their illness or injury prior to discharge.

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With respect to CONFINEMENTS for pregnancy, the PLAN shall not limit the length of stay to less than: (1) 48 hours for a normal birth; and (2) 96 hours for cesarean delivery. However, a PARTICIPANT is free to leave the HOSPITAL earlier if the decision to shorten the stay is the mutual decision of the PHYSICIAN and mother.

STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

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CORRESPONDENCE MEMORANDUM

DATE: June 8, 2009

TO: Group Insurance Board

FROM: Robert C. Willett, CPA
Chief Trust Financial Officer

SUBJECT: Financial Review of Alternate Health Providers

Staff requests that the Board approve the following named Health Maintenance Organizations (HMOs) for continued participation based on the financial review.

I have reviewed the audited financial statements of the various HMOs that have requested to participate in the state's group health insurance program in 2009. The purpose of my review was to help assure that each plan has the financial stability necessary to adequately serve our members participating in the program.

In evaluating these plans, I considered the following factors:

Earnings Experience
Reserve Accumulations
Office of the Commissioner of Insurance (OCI) Surplus Requirements
Liquidity
Reinsurance Coverage
Insolvency Protection
Risk Sharing Arrangements

The overall financial condition of these HMOs was slightly improved in 2008. The average plan's net income increased from 1.5% to 2.2% of revenues during 2008, while their average net worth increased by an average 11.6% from 2007. Only three plans experienced losses in 2008, down from five in 2007. As of year-end all plans were in compliance with OCI surplus requirements, and no plan appears to be in danger of insolvency.

Reviewed and approved by Jon Kranz, Office of Budget and Trust Finance.

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	6/9/2009	7

I have attached a schedule showing Total Revenues, Net Profit or Loss, and Net Worth for each of the participating plans as of the end of 2008 and 2007.

Health Maintenance Organizations

The following HMOs have requested to participate in our program. They have all satisfied the financial requirements for participation:

Anthem BCBS
Arise Health Plan
Dean Health Plan
Group Health Cooperative - Eau Claire
Group Health Cooperative - South Central Wisconsin
Gundersen Lutheran Health Plan
Health Tradition Health Plan
Humana
Medical Associates
MercyCare
Network Health Plan
Physicians Plus
Security Health Plan
UnitedHealthcare
Unity Health Plans
WPS Metro Choice

I will be available at your June 9th meeting if you have any questions regarding these recommendations.

Attachment

Department of Employee Trust Funds
Alternate Health Plan Financial Reports
As Of December 31, 2008
(in thousands $)

	Total Revenues [1]		Net Income/(Loss)		Net Worth	
	2008	2007	2008	2007	2008	2007
Anthem BCBS	$ 421,620	$ 358,356	$ (4,889)	$ 7,538	$ 56,307	$ 59,051
Arise Health Plan	83,496	79,606	(157)	1,106	11,050	12,571
Dean Health Plan	812,095	746,175	6,357	(168)	48,394	51,979
Group Health Cooperative of Eau Claire	203,453	170,002	2,031	(137)	19,766	17,710
Group Health Cooperative of South Central Wis.	221,748	203,553	8,540	3,957	66,201	60,389
Gundersen Lutheran Health Plan	190,501	174,894	2,130	1,259	13,631	11,505
Health Tradition Health Plan	111,790	109,567	30	755	8,238	8,052
Humana	145,349	242,098	755	(7,751)	31,775	11,620
Medical Associates	25,354	24,141	(205)	45	1,851	2,091
MercyCare	104,630	87,611	4,588	(214)	9,008	6,840
Network Health Plan	352,992	348,644	6,187	(1,285)	56,378	32,170
Physicians Plus	363,480	348,066	1,453	3,576	41,170	40,443
Security Health Plan	651,987	595,015	23,755	7,759	88,428	64,673
UnitedHealthcare	696,980	681,776	42,382	33,894	110,855	108,396
Unity Health Plans	306,043	259,441	3,713	4,264	34,279	34,346
WPS Metro Choice	450,005	475,667	15,926	17,155	143,238	141,520

[1] Total Revenues includes Insurance Premiums, Fees for Services, Investment Income and other Miscellaneous Income.