

Department of Employee Trust Funds
STATE AGENCY HEALTH INSURANCE ADMINISTRATION MANUAL

CHAPTER 2 — HEALTH PLAN AND PROGRAM INFORMATION

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The Wisconsin State Employee Group Health Insurance program consists of three types of plans: Alternate Health Plans, Standard Plan and State Maintenance Plan.

201 Alternate Health Plans (HMOs)

Alternate health plans are typically Health Maintenance Organizations (HMO) that provide comprehensive benefits at a lower cost than the Standard Plan in exchange for some health care provider limitations. All alternate health plans participating in the Group Health Insurance program offer the same level of coverage, called Uniform Benefits, with the exception of dental coverage that may be offered at the discretion of the health plan. Uniform Benefits are designed to ease employee health plan selection and assist ETF's efforts to negotiate quality care at the lowest possible cost. With Uniform Benefits, employees can select a health plan based on cost, quality of services, and access to specific physicians or other health care providers.

202 Standard Plan

The Standard Plan is a self-insured plan that pools the combined claims experience of its State employees and retirees. The Standard Plan is a fee-for-service indemnity plan. That is, employees enrolled in the Standard Plan can see a provider of their choice and are not restricted to specific providers, as with HMOs. However, the Standard Plan is a Preferred Provider Plan (PPP) meaning that participants are allowed to see the provider of their choice, but with differences in benefit levels depending on whether participants go to an in-network (higher benefit level) or an out-of-network (lesser benefit level) provider.

203 State Maintenance Plan (SMP)

The State Maintenance Plan (SMP) is another self-insured plan, but is available only in those counties that do not have a qualified Tier 1 alternate health plan (qualified HMO) as designated in the current *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127). To be qualified, a plan must meet minimum provider availability requirements. SMP offers Uniform Benefits and subscribers must live or work in a Wisconsin SMP county to be eligible to enroll in SMP.

204 Three-Tier Health Insurance Program

Nationally, health insurance costs have been rising at double-digit rates for the last five years, and this trend is expected to continue for several years to come. The State of Wisconsin implemented changes to the Wisconsin State Employee Health Insurance program that are helping the State to avoid this trend of escalating costs. One of those changes is the 3-Tiered approach to health insurance purchasing.

Prior to the passage and signing of the 2003-2005 biennial budget during July of 2003, state statutes required the state to pay health plan premiums of up to 105% of the lowest-cost health plan in a particular county. Any health plan that bid within 5% of the lowest-cost health plan was provided at no cost to employees, just like the health plan that submitted the lowest bid. This 105% formula had some significant shortcomings and did not create incentives for health plans to hold down premium costs. Because health plans are priced by county, employees in different counties often paid different amounts for the same health plan. Finally, the formula drove up the cost of the Standard Plan to the point that this health plan became unaffordable for many state employees.

The 3-Tier model, recommended by the Group Insurance Board and adopted in the 2003-2005 biennial budget, was designed to address these problems while maintaining high-quality, low-cost health care coverage. While still maintaining a uniform medical insurance benefits package, each health plan has now been assigned to one of three tiers based on the relative efficiency with which a health plan is able to provide the benefits and the quality of care required by the Board. Plans were given extra credit in the tier assignment process if they scored well on measures of quality, patient safety, and customer satisfaction. This approach has created significant incentives for health plans to hold down the costs they charge the state while guaranteeing that all state employees have access to a Tier 1 health plan. In addition, monthly premium contributions for the Standard Plan have been capped.

205 Pharmacy Benefit Manager (PBM)

A Pharmacy Benefit Manager (PBM) is a third party administrator of the prescription drug program and is primarily responsible for processing and paying prescription drug claims. All participants in the Group Health Insurance program receive their pharmacy benefits through the PBM regardless of the health plan they have chosen. The PBM allows ETF to uniformly administer pharmacy benefits for all participants.

Subscribers receive separate identification (ID) cards from the PBM and must present that ID card to their pharmacist when filling a prescription. Please contact the PBM for questions pertaining to the pharmacy benefit (e.g. drug formularies, claims, replacement ID cards, etc.) Refer to subchapter 107 for information on contacting the PBM.

206 Health Plan Contacts

Health premiums, benefits, provider networks and program policies and procedures may change annually. Such changes are communicated to employers through *Employer*

Bulletins and to employees through the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127) as well as through communications from the health plans (e.g., provider listings). Contact the health plan representative directly with specific questions regarding such topics as referral policies, benefits, filing of claims, and/or provider networks. Health plan addresses and phone numbers are listed in the *It's Your Choice* booklet. A listing of *Health Plan Contacts* (ET-1728) is available online at ETF's Web site (<http://etf.wi.gov>) under the "Employer" section.

207 Coordination of Benefits (COB)

For a variety of reasons, some individuals are covered under more than one group health insurance plan. When this occurs, the benefits are paid, or "coordinated," according to insurance regulations used to determine the order in which the plans will pay benefits. The plan that pays first is called the "primary plan" and the plan that pays next is the "secondary plan." The insurance regulations for determining the order in which plans will pay benefits are described in the *It's Your Choice* booklet (ET-2107; Graduate Assistants, ET-2127). Questions about COB can also be directed to health plans.