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CORRESPONDENCE MEMORANDUM

DATE: May 27, 2008

TO: Group Insurance Board

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

SUBJECT: WPS Recommendations for Benefit Clarifications and Changes to the Standard Plans Group Health Insurance Program Effective January 1, 2009

The purpose of this memo is to discuss the proposals for Group Insurance Board (Board) action on the Standard Plans. Wisconsin Physician's Service Health Insurance (WPS) has suggested a few changes to the contract that may make the plan more specific and easier to understand. In addition, staff recommends that provisions of the Medicare Plus $1,000,000 plan be altered (e.g. adding immunizations), as requested by some members.

WPS has provided a grid of the proposed changes (see attached). This document details the suggestions and explains WPS's rationale for each item. In addition to the WPS grid, relevant portions of the *Professional Administrative Services Agreement* (PASA) and *Health Benefit Plan* (HBP) contract are attached with new material highlighted and material being proposed for deletion ~~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.

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.

Action requested:

Staff requests Board action on these changes in order to finalize the Standard Plans contract for 2009.

1. **Staff recommendation to add immunizations to the Medicare Plus $1,000,000 plan and modify the skilled nursing facility benefit to be consistent with Uniform Benefits.**
2. **Staff recommendation that the Board approve clarifications and reasonable updates to the Standard plan and overall contract (see items 2 through 4 below).**
3. **Giving staff the authority to include any changes to the draft following input from the Board and for any technical issues that may arise thereafter.**

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

_____ _____
Signature Date

Board	Mtg Date	Item #
GIB	06/10/2008	4

Discussion of proposed changes:

Following Board 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 Dual-Choice period. Final formatting of the contract text will be submitted to the Board chair for signature.

1. *Benefit changes to the Medicare Plus $1,000,000 plan*

   Every year some members of this plan contact the Department and the plan administrator to request coverage for preventive services such as immunizations and routine care. Typically these calls come from those who were previously enrolled in Health Maintenance Organizations (HMOs) and are accustomed to routine care benefits. The Medicare Plus $1,000,000 plan supplements Medicare, which covers the treatment of illness or injury, but not preventive care.

   The Department has received many requests to cover immunizations. The shingles vaccine, in particular, has been an issue, since it is covered by all plans that offer Uniform Benefits. Medicare Part B allows coverage of the vaccines for the prevention of influenza, hepatitis B and pneumonia. Medicare Part D plans can cover shingles in some cases, but this does not work well with our current Navitus RDS subsidy. Currently, the Medicare Plus $1,000,000 plan specifically excludes coverage for all immunizations and they are not considered by WPS to be the treatment of an illness or injury.

   Deloitte has provided a cost of $.30 per member per month (PMPM) to add comprehensive immunization coverage to this plan.

   To offset this cost, staff is recommending that the skilled nursing facility benefit be made equal to that in the Uniform Benefits plan. Currently, the Medicare Plus $1,000,000 skilled nursing facility benefit has no day limit for medically necessary care. The benefit does not cover custodial care. Uniform Benefits allows coverage for up to 120 days per benefit period or spell of illness. A benefit period is a standard designation under Medicare equal to the total duration of all confinements that are separated from each other by less than 60 days. Spell of illness is an older term that has been used in the Medicare Plus $1,000,000 contract for many years. We will update this term to now read “benefit period”. Staff recommends this change to a maximum of 120 days per benefit period as it has a limited impact on our members and it will make the Medicare Plus $1,000,000 plan consistent with Uniform Benefits. Deloitte states that the savings resulting from limiting the benefit to 120 days would be $.31 PMPM.

   Please note: Deloitte’s estimated cost of adding more complete preventive care covering physical exams and routine lab work would be between $6.00 to $6.50 PMPM in the first year, due to pent-up demand. At this time, staff is not recommending this coverage, however, it could bring a proposal back to the Board at a later date if there appears to be interest.

2. *Modify the Standard Plan's criteria to determine member qualification for gastric bypass surgery.*

   Annually, WPS reviews its medical policy on gastric bypass, or bariatric surgery, and makes recommendations to align it with standards of practice in the medical community, evidence-based medicine, and standards in the insurance community. For 2009 WPS has changed its medical policy to allow bariatric surgery for members with a body mass index (BMI) of 35 who can prove the existence of certain co-morbidities. Deloitte indicates that this change is becoming the industry standard. This BMI number is lower than the current requirement of a BMI of 40 for the surgery. This change also impacts the definition of 'morbid obesity' used in the contract. The new policy includes language that is more specific regarding what members are required to do or what types of medical documentation must be submitted to qualify for the surgery. WPS states that this policy change will likely result in an increase in utilization.

3. *Incorporate language into the overall contract to allow for the underwriting of prospective Wisconsin Public Employers (local government) groups down to a group size of one.*

   At its April 15, 2008, meeting the Board approved the underwriting process for small prospective local government employers with 50 employees or fewer. WPS provides this service and the contract must be updated to reflect this change. Currently, WPS charges $1,200 for underwriting each group of 51 or more. Small group underwriting follows a different process and the cost differs depending on the size of the group. The WPS fees are included in the PASA contract and appear in the grid below. Staff is also presenting Deloitte's fees in the grid. Deloitte's role is to verify WPS's calculation and establish the surcharge amount for the group. Deloitte's contract does not need to be updated to reflect this change.

Size of Group	WPS's Underwriting Fee	Deloitte's Underwriting Fee
1	$100	$100
2 to 9	$175	$200
10 to 25	$275	$300
26 to 35	$450	$450
36 to 50	$550	$600

   Staff is concerned that this cost, if passed on to employers in its entirety (as it is with large groups), would create a barrier preventing small employers from joining our group. Thus, staff recommends that the cost be absorbed by the current local participating groups, as this service will help to protect the pool from adverse selection. Staff considered recommending a nominal application processing fee of $50 to $100, depending upon group size, as this is consistent with ETF's approach in other programs. However, the fee presents administrative challenges so we do not recommend it at this time. If this policy presents a problem in the future, we will recommend reconsideration.

4. *Clarify the entire contract for the Alternative Care provision to allow a member's physician to have the ability to recommend the consideration of alternate care.*

   The contract states currently that "WPS may recommend" alternate care for the treatment of a member's illness or injury. Alternate care is considered when a member could receive a different course of treatment that is therapeutically equivalent to the current treatment, is not expected to jeopardize the member's health, and will probably cost less. Current contract language can be misinterpreted to mean that only WPS can propose the alternative. Our past practice has been to allow a member's physician to also submit recommendations for such alternate care. The plan administrator holds the final authority for approving or denying the request. Staff recommends modifying current language by adding language to allow a physician to suggest such treatment, while continuing to state that WPS has the final authority in determining if the alternative benefit is allowable or not.

5. *Clarify the entire contract's existing practice by adding a definition for Incidental Services and an exclusion for Indirect Services.*

   WPS recommends two clarifications to the contract by adding a definition and an exclusion to make the program easier to understand.

   a. WPS recommends defining the term "incidental" in the contract. Incidental services are those that occur at the same time as another service, but do not add significant time or effort so the charge for that secondary service is denied. Examples of incidental surgical services could be the removal of an appendix, gallbladder or hernia repair during an abdominal surgery for a reason not requiring these services.

   b. WPS recommends adding an exclusion for indirect services. These services include the creation of a laboratory's standards and the calibration of equipment. Currently these types of services are denied. WPS is recommending adding the exclusion for clarification of existing practice.

The grid also describes language being added to the schedule of benefits of the Standard Plans, to specifically state that the overall annual out-of-pocket amounts do not include benefits for the treatment of alcoholism, drug abuse, and nervous and mental disorders. This language is consistent with current practice and Wis. Stat. § 632.89, on which it is based.

Attachments

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