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CORRESPONDENCE MEMORANDUM

DATE: April 2, 2009

TO: Group Insurance Board

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

SUBJECT: Guidelines and Uniform Benefits for the 2010 Benefit Year

The study group recommends that the Group Insurance Board (Board) adopt the Guidelines and Uniform Benefits changes discussed in this memo and grant staff the authority to make additional technical changes as necessary.

Background

Annually, the Board reviews its *Guidelines for Comprehensive Medical Plans Seeking Group Insurance Board Approval to Participate in the State of Wisconsin Group Health Benefit Program*. As part of this review, necessary changes are made to the health insurance contract and the Uniform Benefits package. As in the past, there will be no net material change in the overall benefit level.

A study group met on February 24 and March 10, 2009, to establish recommendations contained in this memo for the Board's consideration. The attached tables also include other relevant clarifications that are not specifically discussed in this memo.

The study group meetings included: Barbara Belling, Office of Commissioner of Insurance (OCI); Caitlin Morgan Frederick, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Jim Pankratz, OSER; Beth Ritchie, University of Wisconsin (UW); and the following Department of Employee Trust Funds (Department) staff: Lisa Ellinger, Bill Kox, Joan Steele, Arlene Larson, Jeff Bogardus, Michelle Baxter, Brian Schroeder, Matt Stohr, Sari King, Liz Doss-Anderson, Christina Keeley, and Vickie Baker.

Please note that as staff continues to refine Uniform Benefits, further contract changes may be necessary. For example, we may need to revise the contract to reflect changes that may be required if other state mandates are passed before the bidding process is completed. Staff will bring any notable changes before the Board but is also requesting authority to proceed with any needed technical clarifications.

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

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Signature Date

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Attached are the following:

- **Attachment A** – Explains the basis for any notable changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B** – Excerpts from the Guidelines, Addendum, and State and Local Contracts with recommended cost-neutral modifications for 2010.
- **Attachment C** – Explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** – Excerpts from Uniform Benefits, with recommended modifications for contract year 2010.

The impetus for these proposals comes from the Board, participants, health plans and staff. Health plans were informed of some proposed changes via e-mail on January 23, 2009. In response to comments from health plans, some minor revisions were considered and/or made when developing these recommendations. Specific health plan comments are available from staff upon request.

Some changes are clarifications or specific statements of existing practice; other revisions are more substantive. Changes under discussion are shown with shading of new language and ~~striking out~~ of language to be deleted. There are also a few changes shown in Attachments B (Guidelines/Addendum/Contracts) and D (Uniform Benefits) that are not described on the tables or discussed below. We consider these to be minor modifications or clarifications of current practice.

Where appropriate, the recommendations also apply to the Wisconsin Physicians Service (WPS) contracts for the Standard Plans and staff will make the necessary changes.

RECOMMENDED CHANGES TO ADMINISTRATION

1) **Non-Payment for Medical Errors:** The group discussed the Federal Centers for Medicare and Medicaid Services (CMS) policy effective in October 2008 in which payments are withheld from hospitals for care associated with treating certain infections and medical errors. The group recommended adding language stating that health plans are expected to incorporate the CMS policy into their contracts with network providers and hospitals.

2) **Medicare Rate Calculation:** The group discussed and recommended modifying the calculation of the Medicare-reduced rate, pending the recommendation of the Board's actuary. This will impact those health plans with Medicare-reduced rates within the acceptable range, but could be lower, based on participants' experience. Staff will report to the Board when the analysis is complete.

3) **Medicare Rate Categories:** The group discussed and recommended revising the Medicare-reduced family rate categories so that the Medicare Family 2 rate applies only after all insured family members are on Medicare. This is viewed as a fairness issue, as currently an insured family with one person over (i.e., on Medicare) and one person under (i.e., not on Medicare) pays more in premium than a family with two persons over and one or more family members under. Currently, there are approximately 40 contracts in the Medicare Family 2 rate category that do not have all family members on Medicare and the group recommends these contracts be grandfathered.

RECOMMENDED CHANGES TO ELIGIBILITY/ENROLLMENT

4) **Dependent Coverage:** The group discussed and recommended requiring subscribers to list on the application all family members that are eligible for coverage when applying for family coverage. This has been an issue in the past when a subscriber with family coverage does not list an eligible dependent on the application, such as a stepchild, and files an application at a later date, sometimes years later, to add the dependent. Current contract language states the newly-added dependent has coverage based on when family coverage went into effect, if the dependent was eligible at that time. This can cause significant administrative issues for the health plans to reprocess claims from past years. The group recommends that 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.

5) **Retrospective Premium Adjustments:** The group feels that having a set time period for retrospective premium adjustments is a more equitable approach. Currently, the contract allows for premium adjustments to occur back to January 1 of the previous year. Due to enhanced system tracking capabilities, the group discussed and recommended modifying the provision to limit retrospective premium to six months.

6) **Rehired Annuitants at the University:** The group recommended adding the rehired annuitant language as requested by the University. The University, on behalf of the Board of Regents, requested the Board put into contract the University's current policy that rehired annuitants are not eligible for the graduate assistant plan offered under Wis. Stat. § 40.52 (3) (see attachment E). This plan is priced lower than the regular active plan because it is expected to cover graduate assistants who are typically younger and consequently a lower risk than the general population.

RECOMMENDED CHANGES TO THE LOCAL CONTRACT

7) **65% Participation Requirement:** The group discussed the potential risk to the program for participation waivers filed by new groups joining our health insurance program, which may allow for the new group to waive out those members with better risk. The Board's actuary supports a minimum 65% participation requirement before the new group is able to join the health insurance program. The group recommends adopting this change 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.

8) **Allow Continuation Coverage for Participants Subsequently Found to be Ineligible:** Several situations arose in the past whereby a local employer joins our health insurance program and later discovers that some insured participants will not be eligible. The group recommended adding language to allow the participants who are subsequently found to be ineligible to elect continuation coverage for up to 36 months.

RECOMMENDED CHANGE TO BENEFITS

As described below, the group recommends the following benefit changes that are cost-neutral.

9) **Pharmacy Annual Out-of-Pocket (OOP) Maximum:** The group recommends increasing the OOP maximum for 1½ years, which is consistent with recent past practice. The annual OOP maximum is currently $385 per individual/$770 per family. Periodically, the Board revises the OOP maximum in accordance with the change in relative value of the original Uniform Benefits maintenance drug list. It was not increased from 2004 through 2006. For 2008 and 2009, it was increased in relative value for 1½ years to make up for some of the lag. The Board's actuary calculated the following OOP maximum amounts for various changes in its relative value:

   - $455/$910 for the two years during which it was not adjusted.
   - $410/$820 for the 1½ years adjustment.
   - $400/$800 for the one year adjustment.

10) **Breast Implant Coinsurance:** It has come to staff's attention that health plans are inconsistent in benefit administration of breast implants for reconstruction following mastectomy. Five health plans process claims for the breast implant under the medical supplies and durable medical equipment benefit that is payable at 80%. Ten health plans pay for the breast implants at 100%. The group discussed and recommended language to clarify the benefit administration so that the coinsurance is not applied to breast implants for reconstruction following mastectomy. According to the Board's actuary, the cost to specify that the coinsurance does not apply is $0.01 per member per month (PMPM), which has always been viewed as a rounding issue and not subject to a benefit offset.

11) **Case Management/Alternate Treatment:** This provision states the health plan must recommend the alternate treatment. The group discussed and recommended broadening the contract's case management/alternate treatment provision to allow the member's attending physician to make recommendations for the 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. The Board's actuary states this change should not have an impact on cost.

Other potential changes affecting costs. As described below, the group acknowledges the following benefit changes that have a fiscal impact and are or may be required by law.

12) **Federal Mental Health Parity:** Pursuant to the recently passed Federal Mental Health Parity Act (FMHPA) as contained in the stimulus package, the group recommended language changes to remove the dollar and day maximums for mental health and alcohol and other drug abuse (AODA) treatment. As this is a federal mandate, no benefit offset is needed. FMHPA provides an exemption next year if the costs rise more than 2% in the first year. Department staff will work with the Board's actuary to monitor the cost impact.

13) **Other State Mandates:** As of today, the status of several mandates is unknown. The mandates have a fiscal impact and include providing autism benefits and coverage for domestic partners. The contract language will be updated as necessary to comply if the mandates are passed for 2010 before the premium bidding process is completed.

Summary of Cost Impact of Potential Changes

Benefit Increase	PMPM
Breast Implant Coinsurance	$0.01
Total	**$0.01**

Benefit Reduction	PMPM
Total	**$0.00**

DISCUSSION OF OTHER ISSUES

Other issues were considered by the study group but did not result in recommended changes. The most notable issues are summarized below. Staff will provide additional information upon request.

1) **Medicare Prescription Drug Plan (PDP):** After reviewing timelines and requirements, Department staff indicated the PDP is likely to be pursued for 2011 at the earliest. Therefore, no changes are needed at this time. For 2010, we will again seek the Retiree Drug Subsidy (RDS), if eligibility continues.

2) **Office Visit Copayment Option & Two-Person Rate (Local Program):** The group considered recommendations from a local employer that requested an option that included copayments for office visits and a two-person rate category. The group recommends pursuing a benefit option that includes office visit copayments at such time when there is sufficient interest expressed by local employers to justify the administration of a different benefit level. The two-person rate category would require a statutory change and is not warranted, based on past cost analysis that does not show enough cost difference between two-person contracts and family contracts that cover three or more individuals.

3) **Emergency Room (ER) Copayment:** The group discussed possible changes to the copayment assessed during ER visits when not admitted directly to the hospital as an inpatient. One possible change based on a participant recommendation is to waive the copayment when admitted for observation. The Board's actuary estimates a PMPM cost of $0.02 to make this change. The group does not recommend pursuing this benefit change because there are no benefit decreases to offset its cost.

   The group also considered the option of removing the waiver so the ER copayment is assessed even when the member is admitted directly from the ER as an inpatient. This may avoid complaints from members who were admitted from the ER for observation who believe their copayment should be waived. According to the Board's actuary, the PMPM savings for this benefit change is $0.25. However, a concern was expressed that if the copayment is not waived, it could deter some members from seeking care in the ER for emergency situations. The Board's actuary felt this was not an issue because the copayment currently applies to the benefit and members use the ER not knowing if they will be admitted and have the copayment waived. Health plans indicate that it is standard in commercial business to waive the ER copayment when the member is admitted as an inpatient directly from the ER. The group does not recommend pursuing a benefit decrease that is outside the industry norm.

   The group also discussed increasing the ER copayment from $60 to $70. According to an informal survey of health plans, the average ER copayment for commercial business ranges between $75 to $100. The Board's actuary indicates this benefit change would have an approximate PMPM savings of $0.17. The group does not recommend pursuing a benefit decrease that may be punitive in rural areas where there are limited choices due to fewer urgent care facilities or limited urgent care hours.

4) **Acute Inpatient Rehabilitation:** The group discussed a health plan's recommendation to limit the benefit for acute inpatient rehabilitation to 90 days so that it aligns more closely to its commercial business for ease of administration. Currently, the benefit is unlimited. The Board's actuary indicates this benefit decrease would generate a PMPM savings of $0.00 to $0.01. The group does not recommend this benefit change because it is cost neutral and would impact those rare situations when a member needed prolonged rehabilitation.

5) **Weight Loss Surgery (Gastric Bypass) Benefits:** The group again considered coverage for the surgical treatment of obesity (e.g., gastric bypass), which has been requested by numerous participants. The estimated PMPM cost to add the benefit is $7.02 initially, due to pent-up demand, and $4.68 thereafter. If benefits were added for 80% coverage, the estimated PMPM cost is $5.48 initially and $3.65 thereafter. Even though costs for the procedure are decreasing, the PMPM has risen due to increased utilization. The group concurred that adding gastric bypass to Uniform Benefits for the surgical treatment of obesity will require substantial benefit decreases in order to maintain the overall benefit level as required by statute. As the treatment may be covered under the Standard Plan if it meets WPS's medical necessity criteria, the group does not recommend adding this benefit for 2010.

6) **Dental Implants Following Accidental Injury:** The group considered allowing coverage for dental implants under the accidental loss of teeth provision, as dental implants are becoming the standard of care as well as a more cost-effective treatment option in some situations. If the benefit is capped at $1,000 per tooth, the cost impact is $0.18 PMPM. If the benefit is capped at $1,000 per year, the cost impact is $0.12 PMPM. The group does not recommend pursuing this benefit change because of its cost.

7) **Acupuncture:** The group discussed a request from several participants to add benefits for acupuncture. The PMPM estimated cost to add this benefit would be $0.50. If the benefit was capped at $1,000 per year, the estimated PMPM cost would be $0.45 PMPM. The group does not recommend pursuing this change because the contract currently has a provision for alternate treatment that would allow a health plan to extend coverage to acupuncture in limited situations when it is determined to be medically appropriate.

8) **Flexible Flat Feet:** The group discussed a participant's request to add coverage for the treatment of flexible flat feet, which is currently excluded. The Board's actuary indicates that almost half of children ages three through six have this condition and outgrow it. The PMPM cost to add this benefit is $0.05 to $0.10. The group does not recommend pursuing this benefit change because of its cost and that it may encourage treatment for a condition that often corrects itself with time.

9) **Orthognathic Surgery:** The group discussed a health plan's request to add coverage for orthognathic surgery, which is currently excluded. The Board's actuary estimates the PMPM cost of $0.35 to add this benefit. The group does not recommend pursuing this benefit change due to its high cost and because the benefits are available under the Standard Plan.

10) **Orthoptics (Eye Training or Vision Therapy):** The group discussed a participant's request to expand the benefits for orthoptics. Currently, two visits are covered per lifetime, one for training and the second for follow-up. The Board's actuary estimates the PMPM cost would be $0.10 to $0.15 to provide an unlimited benefit for orthoptics. The group does not recommend pursuing this benefit change due to its cost and because a limited benefit is currently available.

11) **Intrauterine Devices (IUD) Coinsurance:** The group discussed a participant's request to provide full benefits for IUDs. Currently, IUDs are covered under the medical supplies benefit, subject to 20% coinsurance. Removing the coinsurance from this benefit would cost approximately $0.04 PMPM. According to the health plans and the Board's actuary, the available medical information does not support the participant's claims on safety and cost. Hence, the group does not recommend pursuing this benefit change.

If the Board chooses to add any of the benefits listed in the section above, the pharmacy copayments could be increased to finance them. Currently, the pharmacy copayments are **$5/$15/$35**. The Board's actuary calculated the savings for the following pharmacy copayments, assuming an OOP maximum of $410/$820:

- $5/$16/$35 would generate $0.18 PMPM.
- $5/$16/$40 would generate $0.33 PMPM.
- $5/$18/$40 would generate $0.66 PMPM.

Staff will be available at the Board meeting to respond to any questions or concerns. We again thank the guidelines discussion group members for their participation in this process.