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CORRESPONDENCE MEMORANDUM

DATE: August 9, 2010

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits and Insurance Plans
Arlene Larson, Manager, Self-Insured Health Plans
Joan Steele, Manager, Alternate Health Plans

SUBJECT: Guidelines/Uniform Benefits/Standard Plan: Changes/Comparison of Amendments to Health Insurance Contract

Staff recommends that the Group Insurance Board (Board):

1. **Remove "grandfather" status for the local program but retain it for the state;**
2. **Adopt the Guidelines, Uniform Benefits and Standard Plan amendments as discussed below and authorize staff to make additional technical clarifications as may be required.**

At its April 13, 2010, meeting, the Board reviewed and approved changes for the 2011 benefit year. At that time, staff noted further amendments might be necessary. Staff has identified additional amendments needed to conform to the federal Patient Protection and Affordable Care Act (PPACA) on health care reform and state mandates that recently passed.

The following is a brief description of the amendments for 2011. In addition to the amendments, there is one discussion item relating to grandfathering as required under PPACA.

Attached are the corresponding language changes for the amendments for 2011. New language is shaded and underscored and language to be deleted is ~~stricken~~. Where appropriate, the recommendations also apply to the Standard Plan contracts (both the Health Benefit Plan and Professional Administrative Services Agreement (PASA)) and staff will make the necessary changes.

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

Signature

8/11/2010
Date

Board	Mtg Date	Item #
GIB	8.24.10	3A

- **Attachment A** – Provides the language changes for the amendments to the Guidelines, State and Local Contracts and Uniform Benefits for the alternate health plans.
- **Attachment B** – Provides the language changes for the amendments to the Standard Plan contracts administered by Wisconsin Physicians Service (WPS).

At the time this memo was written, the cost impact of the amendments was not fully known. However, pursuant to Wis. Stat. § 40.03 (6) (c), the Board is not prohibited from making material changes to the benefit plan or premium if those changes are required by law.

In the past, it has been determined that once the premium bidding is finalized, any additional changes required by law will go into effect the following contract year.

Further technical clarifications may be necessary, as staff continue to review PPACA. Staff will advise the Board at a later date, but is also requesting authority to proceed with any needed technical clarifications.

DISCUSSION ITEM:

Grandfathering: As discussed below and under **Amendments for 2011,** PPACA allows health insurance programs to temporarily retain (grandfather) their existing benefit plans and avoid certain mandates. PPACA provides that all groups will lose grandfathered status at some time in the future as yet undetermined by federal law.

A group's grandfathered status is lost under several circumstances. Three of these affect our Wisconsin Public Employer (local) program. These include:

- When a group raises deductibles significantly. In our program, this occurs when a local government employer changes program options from the Traditional HMO to the Deductible HMO plan.

- When a fully insured group changes insurers, such as local government employers who join our program.

- With a decrease in employer contribution rate by more than 5% below the current contribution. The Department Employee Trust Funds (ETF) does not track employer contributions.

In discussions with Deloitte and after reviewing available federal guidance on this issue, it is not clear if such changes would result in a loss of grandfathering only for those employers, or if it would jeopardize grandfathering for any/all health plans that the subscribers choose under the local program.

Several policy alternatives should be considered for 2011, as some local employers have passed resolutions that, in our view, will force the loss of grandfathering status for

2011. In addition, absent additional reporting requirements, ETF would not typically know of other situations that would affect grandfathering, such as a change in employer contribution.

Policy alternatives for 2011 include:

A. Prohibit local employers from changing program options or entering the program after September 23, 2010. This will eliminate the forced loss of grandfathering. However, one employer has already passed a resolution to change program options from the traditional to the deductible plan effective January 1, and two have passed resolutions to join the program effective October 1, 2010. Staff would have to advise these employers that this change could no longer be accepted.

B. Voluntarily eliminate grandfathering status for the local program as a whole. While this would increase premiums and benefits, in discussions with Deloitte and based upon information available, we feel that any increase would be very small, though it would likely be material for the Standard Plans and those employers in the deductible option.

C. Establish a grandfathered local employer program alongside a non-grandfathered local program to allow for changes and additions. This would result in an administrative burden for our participating health plans as well as ETF in tracking groups as they change over time.

D. Voluntarily eliminate grandfathering status for both state and local employers. However, such a change would likely result in benefit offsets for the Standard Plan since there appears to be no requirement that the state program remove grandfathering for 2011, and since it could have a material effect on that plan.

For 2011, loss of grandfathering status means that the plan must comply with the following provisions:

- First dollar coverage for in-network preventive services. (The specific services are described on a federal website, www.healthcare.gov. These must be reviewed and updated annually.)

- Choice of a PCP (primary care physician) that includes in-network pediatricians for children.

- Access to in-network OB/GYNs without prior-authorization or referral for women.

- Emergency care must be available both in- and out-of-network, and cannot require prior-authorization.

- Specific appeal procedures including external review must be provided.

Traditional uniform benefits offered to state and local employers (not deductible Uniform Benefits) currently cover most of these provisions. The provision that is of concern is the first dollar coverage for preventive benefits described above, where the federal list of preventive care services is not identical to those that are currently covered.

The Standard Plan, offered to state and local employers, and the deductible Uniform Benefits plan do not offer first dollar coverage for preventive services. Therefore, the loss of grandfathering for these programs could likely have a material impact on their rates. Overall, we believe that the rate impact would be negligible for the local program as relatively few employers and subscribers choose the deductible or Standard Plan. The impact on the Standard Plan is likely to be more material for the state program.

Staff recommends option B, above, where the Board eliminates grandfathering for the local program, but retains it for the state program. This recommendation continues to allow local governments flexibility in enrollment plan design. It also avoids benefit offsets that we believe would be required to the state Standard Plan due to the required increase in first dollar coverage for preventive care should grandfather status be removed.

AMENDMENTS FOR 2011:

Regardless of grandfather status, all plans must conform to the following provisions, as required by PPACA.

1. **Enrollment Opportunities for the Standard Plan:** Currently, members can elect the Standard plan at any time. However, if there is no enrollment opportunity, members are subject to a six-month waiting period for pre-existing conditions. PPACA prohibits a waiting period for pre-existing conditions for members under age 19. The waiting period would also be prohibited for adult members by 2014.

2. **Lifetime Maximum Benefit Limits:** PPACA prohibits group health plans from placing lifetime limits on coverage. This impacts the lifetime and transplant maximum benefits currently on the policy, which have been removed. Based upon this change, we will be renaming the Medicare Plus $1,000,000 plan to Medicare Plus.

3. **Dependents:** PPACA requires coverage for dependent children (married or unmarried; student or not) to age 26. Currently, unmarried dependents are covered up to the end of the month in which they turn 27. This provision expands coverage to married dependent children through the month in which they turn 26 years of age. The provision requires a 30-day open enrollment period be made available for these members to begin coverage under their parent's plan effective January 1, 2011. It does not allow for coverage of the

dependent's spouse or child(ren).

4. **Early Retiree Reinsurance Program:** Language has been added to require health plans to assist the Board in complying with any necessary requirements of this program.

In addition to the Federal requirements, two recent state laws require changes to the plan language:

5. **Autism Spectrum Disorders:** 2009 Wisconsin Act 282 adds behavior analysts to the list of providers that may provide physician prescribed services for the treatment of autism spectrum disorders.

6. **Colorectal Cancer:** 2009 Wisconsin Act 346 requires coverage for diagnostic or surgical procedures to cover colorectal cancer examinations and laboratory tests.

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

Attachments

Amendments to the 2011 Guidelines, State and Local Contracts and Uniform Benefits for Alternate Health Plans

Section	Language Change	Rationale
Guidelines *Section II., G., m.*	~~Upon request of the Department or the participant, the plan must provide the total dollar amount of claims paid by the plan that has been applied towards the participant's lifetime benefit maximum.~~	Refer to amendment #2 on page 4 of the memo
State & Local Contract *Article 1.7* Uniform Benefits *Section II.* (Definitions Section)	**DEPENDENT:** Means the Subscriber's: • Spouse. • Domestic Partner, if elected. • Unmarried child, except those under age 26 pursuant to the Federal Patient Protection and Affordable Care Act. • Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward. • Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896. • Stepchild • Child of the Domestic Partner insured on the policy. • Grandchild if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.	Refer to amendment #3 on page 4 of the memo
State & Local Contract *Article 3.4 (5)*	~~As required by Federal law, an EMPLOYEE or CONTINUANT may change HEALTH PLANS if a claim is incurred by an individual covered under the policy that would meet or exceed the lifetime maximum BENEFITS. This also applies to ANNUITANTS as if Federal law required it. An application must be filed during the 30-day period after a claim is denied due to the operation of a lifetime limit on all BENEFITS with coverage effective on the first day of the month on or following receipt of the application.~~	Refer to amendment #2 on page 4 of the memo
Local Contract *Article 3.7*	. . . Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions for PARTICIPANTS 19 years of age and older.	Refer to amendment #1 on page 4 of the memo

Section	Language Change	Rationale
State & Local Contract *Article 3.18 (5)*	No person other than a PARTICIPANT is eligible for health insurance BENEFITS. The SUBSCRIBER'S rights to group health insurance coverage is forfeited if a PARTICIPANT assigns or transfers such rights, or aids any other person in obtaining BENEFITS to which they are not entitled, or otherwise fraudulently attempts to obtain BENEFITS. Coverage terminates the beginning of the month following action of the BOARD. Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions for PARTICIPANTS 19 years of age and older.	Refer to amendment #1 on page 4 of the memo
State & Local Contract *Article 3.20 (3)*	~~The HEALTH PLAN shall give reasonable notice to the PARTICIPANT when the PARTICIPANT has reached approximately 75% of their BENEFIT maximum (e.g. lifetime maximum)~~. The HEALTH PLAN shall provide the PARTCIPANT with BENEFIT accumulations upon request. This requirement can be satisfied through mailing of a plan explanation of benefits.	Refer to amendment #2 on page 4 of the memo
Uniform Benefits *Section I.* (Schedule of Benefits)	. . . A change to another Health Plan will result in all benefit maximums restarting at $0 with the exception of the prescription annual out-of-pocket maximum. This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits. ~~This also does not include Your lifetime maximum benefit if You were previously covered by the Health Plan, as Your lifetime maximum benefit may include any benefits paid during all periods of coverage with the same Health Plan under this program.~~ . . . • ~~Lifetime Maximum Benefit On All Medical and Pharmacy Benefits: $2,000,000 per Participant.~~ . . . • Transplants: Limited to transplants listed in Benefits and Services section~~, subject to a lifetime benefit of $1,000,000 for transplants, including Preoperative and Postoperative Care~~.	Refer to amendment #2 on page 4 of the memo

Section	Language Change	Rationale
Uniform Benefits *Section III., A., 5., d.* (Benefits and Services Section)	Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).	Refer to amendment #5 on page 4 of the memo
Uniform Benefits *Section III., A., 18.* (Benefits and Services Section)	The following transplantations are covered, however, all services, including transplant work-ups, must be Prior Authorized by the Health Plan in order to be a covered transplant. Donor expenses are covered when included as part of the Participant's (as the transplant recipient) bill. ~~All transplant-related expenses, including Preoperative and Postoperative Care, are applied to the $1,000,000 maximum lifetime benefit for transplants.~~	Refer to amendment #2 on page 4 of the memo
Uniform Benefits *Section III., C., 6.* (Benefits and Services Section)	. . . Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following Plan Providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those ~~three~~ four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist.	Refer to amendment #4 on page 4 of the memo
Uniform Benefits *Section IV., B., 8. & 9.* (Exclusions and Limitations Section)	8. ~~Lifetime policy maximum for transplant benefits: $1,000,000.~~ Only one transplant per organ per Participant per Health Plan is covered during the lifetime of the policy, except as required for treatment of kidney disease. 9. ~~Lifetime maximum benefits under this policy for charges paid by the Health Plan and PBM: $2,000,000 (includes transplant benefits) per Health Plan.~~	Refer to amendment #2 on page 4 of the memo

Section	Language Change	Rationale
Uniform Benefits *Section VI., D.* (Miscellaneous Provisions)	No person other than a Participant is eligible for health insurance benefits. The Subscriber's rights to group health insurance coverage is forfeited if a Participant assigns or transfers such rights, or aids any other person in obtaining benefits to which they are not entitled, or otherwise fraudulently attempts to obtain benefits. Coverage terminates the beginning of the month following action of the Board. Re-enrollment is possible only if the person is employed by an employer where the coverage is available and is limited to the Standard Plan with a 180-day waiting period for preexisting conditions for Participants 19 years of age and older.	Refer to amendment #1 on page 4 of the memo

Amendments to the 2011 Standard Plan Contracts Administered by WPS

Section	*Language Change*	Rationale
All Standard Plans *Article I (Definitions section)*	**BENEFITS** mean payments for HOSPITAL SERVICES, PROFESSIONAL SERVICES and OTHER SERVICES under the HEALTH BENEFIT PLAN. ~~For purposes of the lifetime maximum benefit limit, BENEFITS shall include all payments made under the prescription legend drug program.~~	Refer to amendment #2 on page 4 of the memo
All Standard Plans *Article I and PASA* (Definitions sections)	**DEPENDENT:** Means the Subscriber's: • Spouse. • Domestic Partner, if elected. • Unmarried child, except those under age 26 pursuant to the Federal Patient Protection and Affordable Care Act. • Legal ward who becomes a legal ward of the Subscriber prior to age 19, but not a temporary ward. • Adopted child when placed in the custody of the parent as provided by Wis. Stat. § 632.896. • Stepchild • Child of the Domestic Partner insured on the policy. • Grandchild if the parent is a Dependent child. The Dependent grandchild will be covered until the end of the month in which the Dependent child turns age 18.	Refer to amendment #3 on page 4 of the memo
All Standard Plans *Article II., C., 5.*	~~As required by federal law, an EMPLOYEE, ANNUITANT, or CONTINUANT may change plans if a claim is incurred by a PARTICIPANT that would meet or exceed the lifetime maximum BENEFITS. An application must be filed during the 30-day period after a claim is denied due to the operation of a lifetime limit on all BENEFITS with coverage effective on the first day of the month on or following receipt of the application.~~	Refer to amendment #2 on page 4 of the memo
All Standard Plans *Article II., Q., 6.*	... Re-enrollment is possible only if the person is employed by an EMPLOYER where coverage is available and is limited to the STANDARD PLAN with a 180-day waiting period for pre-existing conditions for PARTICIPANTS 19 years of age and older.	Refer to amendment #1 on page 4 of the memo

Section	*Language Change*	Rationale
All Standard Plans *Article II., S., 3.*	~~The PLAN shall give reasonable notice to the PARTICIPANT when the PARTICIPANT has reached approximately 75% of their benefit maximum (e.g., lifetime maximum).~~ The PLAN shall provide the PARTICIPANT with BENEFIT accumulations upon request. This requirement can be satisfied through mailing of a plan explanation of benefits.	Refer to amendment #2 on page 4 of the memo
State & Local Standard Plans *Articles III., C., 1., and 2.,* and *VI., D., 1., c., (1),and (2)* and *VI., E., 1., c., (1),and (2)*	After the applicable annual out-of-pocket limit is reached, BENEFITS are payable at 100% of the CHARGES for covered expenses, unless specifically stated otherwise in the PLAN, incurred by the PARTICIPANT during the remainder of the CALENDAR YEAR, subject to ~~the lifetime maximum benefit limit and~~ all other terms, conditions and provisions of the PLAN.	Refer to amendment #2 on page 4 of the memo
State & Local Standard Plan *Articles III., D.* and *VI., D., 1., d.* and *VI., E., 1., d.* and *VI., G., 2., c..*	~~**LIFETIME MAXIMUM BENEFITS**~~ ~~The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.~~	Refer to amendment #2 on page 4 of the memo

Section	*Language Change*	Rationale
All Standard Plans *Articles IV., C., 31.,* and *VI., B., 4., c., (18)*	Treatment of autism spectrum disorders is covered as required by Wis. Stat. §632.895 (12m). Autism spectrum disorder means any of the following: autism disorder, Asperger's syndrome or pervasive developmental disorder not otherwise specified. Treatment of autism spectrum disorders is covered when the treatment is prescribed by a physician and provided by any of the following plan providers: psychiatrist, psychologist, social worker, behavior analyst, paraprofessional working under the supervision of any of those ~~three~~ four types of providers, professional working under the supervision of an outpatient mental health clinic, speech-language pathologist, or occupational therapist. Benefits are payable up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services. The therapy limit does not apply to this benefit.	Refer to amendment #4 on page 4 of the memo
All Standard Plan *Articles IV., C., 31.,* and and *VI., B., 4., c., (19)*	Colorectal cancer examinations and laboratory tests as required by Wis. Stat. § 632.895 (16m).	Refer to amendment #5 on page 4 of the memo
Local Standard Plan *Article VI., B., 4., b.*	~~**PARTICIPANT Lifetime Maximum Benefit Limit.**~~ ~~The PARTICIPANT lifetime maximum BENEFIT limit for all covered major medical CHARGES for each PARTICIPANT is $250,000.00.~~ ~~The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered major medical expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under this CONTRACT. However, after a PARTICIPANT has received major medical BENEFITS of $30,000.00, the remaining portion of the PARTICIPANT lifetime maximum BENEFIT limit will be increased the beginning of each succeeding CALENDAR YEAR by the lesser of $10,000.00 or the amount necessary to restore the PARTICIPANT lifetime maximum BENEFIT limit to $250,000.00.~~	Refer to amendment #2 on page 4 of the memo

Section	*Language Change*	Rationale
Local Standard Plan *Article VI., C., 4., c.*	**ANNUAL OUT-OF-POCKET LIMIT** The annual OUT-OF-POCKET limit is $2,000 per PARTICIPANT ($500 per MEDICARE PARTICIPANT), not to exceed $4,000 per family ($1,000 for MEDICARE PARTICIPANTS). This total is made up of the DEDUCTIBLE and COINSURANCE amounts a PARTICIPANT pays for covered expenses in one CALENDAR YEAR. No benefits are payable for CHARGES used to satisfy a PARTICIPANT'S annual DEDUCTIBLE amount and COINSURANCE amounts. After the annual OUT-OF-POCKET limit is satisfied, BENEFITS are payable at 100% of the CHARGES for covered expenses unless specifically stated otherwise in this section, incurred by a PARTICIPANT during the remainder of the CALENDAR YEAR~~, subject to the PARTICIPANT'S lifetime maximum benefit limit~~.	Refer to amendment #2 on page 4 of the memo
Local Standard Plan *Article VI., C., 4., d.*	~~**Lifetime Maximum Limit.** The PARTICIPANT lifetime maximum BENEFIT limit is the total amount of BENEFITS payable for all covered ILLNESSES and INJURIES for each PARTICIPANT and is $2,000,000. The PARTICIPANT lifetime maximum BENEFIT limit applies to all covered expenses incurred during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under the PLAN. No benefits are payable for expenses incurred for HEALTH CARE SERVICES provided to a PARTICIPANT either before that PARTICIPANT'S EFFECTIVE DATE of coverage under the PLAN or after that PARTICIPANT'S coverage has terminated under the PLAN. In no event will the PLAN pay more than the PARTICIPANT lifetime maximum BENEFIT limit.~~	Refer to amendment #2 on page 4 of the memo
Medicare + $1 Million Plan *Article VII., B., 7.*	~~**Aggregate Lifetime Maximum Benefit Limit.**~~ ~~The aggregate lifetime maximum BENEFIT limit for BENEFITS paid for CHARGES for HEALTH CARE SERVICES covered under this Section VII. is $1,000,000 during the lifetime of the PARTICIPANT while that PARTICIPANT is covered under this CONTRACT.~~	Refer to amendment #2 on page 4 of the memo

Section	*Language Change*	Rationale
All Standard Plans *Article XI.*	*WAITING PERIODS FOR PRE-EXISTING CONDITIONS* This section only applies to Section III., IV., VI., VII., VIII., and IX. for late enrollees only. Within six months prior to a PARTICIPANT'S enrollment date of coverage under the PLAN, he/she may have: (1) had an ILLNESS or INJURY diagnosed; (2) received care, MEDICAL SERVICES or TREATMENT for an ILLNESS or INJURY; or (3) received medical advice for an ILLNESS or INJURY; or (4) had care, MEDICAL SERVICES or TREATMENT recommended for an ILLNESS or INJURY. If so, BENEFITS are not payable for expenses incurred as a result of that ILLNESS or INJURY and any complications of any such ILLNESS or INJURY until the PARTICIPANT has been covered under the PLAN for 180 days in a row. No BENEFITS are payable for CHARGES for HEALTH CARE SERVICES incurred during the waiting period for any such ILLNESS or INJURY and any complications of any such ILLNESS or INJURY. CHARGES for covered expenses for treatment of a pre-existing ILLNESS or INJURY and any complications of any such ILLNESS or INJURY which are incurred after the expiration of the waiting period for it are eligible for BENEFITS as provided under the PLAN. If a dependent child is born or is legally adopted by a SUBSCRIBER while he/she has FAMILY COVERAGE under the PLAN, the child doesn't have a waiting period for any such ILLNESS or INJURY. The waiting periods for pre-existing conditions described above do not apply to HEALTH CARE SERVICES in connection with pregnancy. This provision does not apply to PARTICIPANTS under age 19.	Refer to amendment #1 on page 4 of the memo
PASA *Article XII. 7.*	Upon request of the DEPARTMENT or the PARTICIPANT, the HEALTH BENEFIT PLAN shall provide the total dollar amount of claims paid by the HEALTH BENEFIT PLAN ~~that have been applied toward the PARTICIPANT'S lifetime benefit maximum~~.	Refer to amendment #2 on page 4 of the memo