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CORRESPONDENCE MEMORANDUM

DATE: January 14, 2011

TO: Group Insurance Board

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

SUBJECT: GUIDELINES and Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2012

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

In the past, a staff discussion group has developed recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year. Recently, Group Insurance Board (Board) members, or their designated staff, have also participated. Should the Board wish to continue this process for contract year 2012, we are providing the following information on the expected issues and timelines for the development of the GUIDELINES.

The anticipated timeline for the 2012 contract is as follows:

- With the Board's actuary input, staff established preliminary recommendations for changes/clarifications for the 2012 contract year. The health plans were asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits by January 5, 2011.

- On or around February 23, 2011, an Employee Trust Funds (ETF) staff discussion group will meet to identify issues to be included in the first draft of the GUIDELINES.

- On or around February 25, 2011, ETF will send health plans a draft of the 2012 GUIDELINES/Administrative Provisions and Uniform Benefits. Health plans will have until March 4, 2011, to return their comments on the draft.

- On or around March 9, 2011, the discussion group will meet to finalize recommendations to the Board. The discussion group's deadline for finalizing its recommendations is March 18, 2011.

Reviewed and approved by Lisa Ellinger, Division of Insurance Services.

Lisa Ellinger 1/19/11
Signature Date

Board	Mtg Date	Item #
GIB	2.8.11	4B

- ➢ The recommendations are set for review and approval at the Board's April 12, 2011, meeting.

Board members may recall that Wisconsin Statute §40.03 (6)(c) prevents the Board from modifying or expanding the health insurance program in a manner that materially changes the level of benefits or the premium unless required by law to provide the benefit. The Board is also required by statute and collective bargaining agreements to keep benefits substantially equivalent to those offered under the Standard Plan. Traditionally, this results in a benefit cost calculation whereby any benefit increase is offset by a similar decrease.

<u>The following briefly summarizes several 2012 contract issues that may be reviewed during this process</u>. Participants, health plans or staff members have raised these issues over the course of the past year. We also welcome comments or suggestions from the Board.

In addition, some items may have associated costs, while others are simply clarifications of existing practice (with no expected cost). Cost factors, if any, will be identified by the discussion group and presented to the Board in the final recommendation.

Possible Changes to Administration:

- Review the Medicare ratio with the Board's actuary to determine if the 50% ratio for the Medicare-reduced rate is an appropriate limit. We will review whether the average rate may be lowered based on experience. The challenge in the past has been attaching credibility to the experience.
- Consider revising the provider qualification criteria by including "hospitalists" when there are not the minimum number of required primary care providers that have admitting privileges to the hospitals in the county. Hospitalists generally care for patients only when they are in the hospital and communicate the information back to the patient's primary care physician.
- Update eligibility information as needed due to recent guidance from the federal government indicating that when a subscriber voluntarily cancels coverage or changes from family to single coverage, it results in an involuntary loss of eligibility for coverage for the insured dependents. The insured dependents then are entitled to an enrollment opportunity pursuant to the federal Health Insurance Portability and Accountability Act (HIPAA) if they previously deferred coverage and the right to elect continuation coverage pursuant to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) through the group health plan for which the involuntary loss of eligibility occurred.
- Consider revising the requirement for health plans to contact the employer of a subscriber that lists on the application a primary care physician or clinic that is not in the health plan's provider network so that it only applies to Health Maintenance Organizations, not preferred provider plans (PPPs).

- Determine what changes are needed due to the Centers for Medicare and Medicaid Services (CMS) change, which goes into effect in 2012, prohibiting a member in a group Medicare Advantage (MA) plan to select a prescription drug plan (PDP) administered through a different entity. CMS believes this is inconsistent with congressional intent to coordinate care between the prescription coverage under Medicare Part D with the medical coverage. Humana is the only plan that currently offers a MA plan in this program. This will affect local retirees enrolled in Humana and Medicare because they are required to enroll in the PDP available through DeanCare Rx.
- Review for updates needed to specify the conditions that coverage can be rescinded retroactively pursuant to the Patient Protection and Affordable Care Act (PPACA) and any other healthcare reform provisions that may be required in 2012.
- Eliminate the late enrollment opportunity into the Standard Plan throughout the year, due to the elimination of the 180-day waiting period for pre-existing conditions for participants under age 19. Consider making the *It's Your Choice* enrollment period an open enrollment for coverage effective the following January 1.

Possible Change to the Local Contract:

- Consider a request from an employer to provide for health reimbursement accounts (HRA) for use in funding the deductible when the employer has elected the deductible option coverage for its employees. Currently, the contract limits employers to Section 125 plans for funding the deductible.

Possible Changes to Benefits:

- Update as needed if "grandfathering" status is lost for the state program under PPACA.
- Consider the following benefit changes:
  - Providing coverage for hearing aids at 100% up to $1,000 per aid every three years.
  - Providing coverage for dental implants.
  - Providing coverage for bariatric surgery.
  - Providing coverage for acupuncture.
  - Providing coverage for massage therapy.
- Suggestions for ways to free-up dollars if needed to offset benefit additions:
  - Implement mandatory mail order for prescriptions.
  - Increase copayment for emergency room visits.
  - Implement copayments for office visits.

We will be at the February 8, 2011, meeting to answer any questions you may have.