STATE OF WISCONSIN
Department of Employee Trust Funds
David A. Stella
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
http://etf.wi.gov

CORRESPONDENCE MEMORANDUM

DATE: June 24, 2011

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Division of Insurance Services

SUBJECT: Benefit Changes Relating to Act 10

Staff recommends that the Group Insurance Board (Board) adopt the benefit changes for State employees and annuitants as described in Option 2a (Attachment 1) for Uniform Benefits, and separate modifications for Standard Plan members as described in Option 2 (Attachment 2). In addition, staff recommends that the Board grant staff the authority to make additional technical changes as necessary.

On June 13, 2011, the Wisconsin Supreme Court upheld the validity of 2011 Wisconsin Act 10. The law requires a 5% reduction in the cost of health insurance described under Section 9115 (4), and the change in employer contributions required under Section 77 for 40.05 (4) (ag) 2. At the Board meeting on June 7, 2011, the Board reviewed several options to meet this reduction and requested further information. This memo responds to those requests. The pertinent language reads under Section 9115, Nonstatutory provisions; Employee Trust Funds (4):

> *"REDUCTIONS IN HEALTH CARE PREMIUM COSTS FOR HEALTH CARE COVERAGE DURING 2012 CALENDAR YEAR. The group insurance board shall design health care coverage plans for the 2012 calendar year that, after adjusting for any inflationary increase in health benefit costs, as determined by the group insurance board, reduces the average premium cost of plans offered in the tier with the lowest employee premium cost under section 40.51 (6) of the statutes by at least 5 percent from the cost of such plans offered during the 2011 calendar year. The group insurance board shall include copayments in the health care coverage plans for the 2012 calendar year and may require health risk assessments for state employees and participation in wellness or disease management programs."*

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

Lisa Ellinger — Signature

6/24/11 — Date

Board	Mtg Date	Item #
GIB	6.28.11	2

The options discussed below are based upon the interpretation that the law gives the Board flexibility in applying the reductions to benefits and other program changes to develop the 5% average actuarial cost reduction. Further, although the law specifically addresses health plans that are in the lowest-cost Tier 1, that is, plans that offer Uniform Benefits, staff is recommending a comparable benefit reduction in the Tier 3 Standard Plan. This is consistent with Board authority under 40.03 (6) (c), allowing the Board to modify the Standard Plan to establish a more cost-effective benefit design.

Alternatives include Copayment, Coinsurance, or Deductible Approach

Based on the Board discussion at the June 7, 2011, meeting, staff has developed separate approaches to medical benefit options that would utilize one of three primary member cost-sharing approaches common in the insurance industry. (See Attachment 1.) These include:

- Copayments (Options 1a and 1b), or
- Coinsurance (Options 2a and 2b), or
- Deductible (Options 3a and 3b).

Each type of member cost-sharing could be applied with or without prescription drug and plan administrative changes to achieve the 5% reduction. Under each of the three options you will find the benefit option and the per member per month (PMPM) cost savings. All of the "a" options include lesser changes to the medical benefits, changes to the prescription drug benefit, and administrative changes that affect members who are no longer employed. The "b" options differ in that they do not contain the prescription drug benefit changes. Therefore, the "b" options require greater cost sharing for the medical benefits.

These options apply to the Uniform Benefits insurance certificate that all fully insured health plans offer, as well as the State Maintenance Plan (SMP), and may be applied to only non-Medicare contracts or could include Medicare contracts. The Board will need to make this determination.

For Standard Plan options, see Attachment 2.

Discussion:

- Uniform Benefits for Medicare Program: The benefit options in Attachment 1 will likely have a different impact on retirees who are covered by Medicare. Commercially-available Medicare supplement policies typically have no cost-sharing on medical services. However, staff recommends applying the same changes to the Medicare contracts as the non-Medicare members. This will greatly increase ease of understanding and administration, especially for retired members whose Medicare status changes during the year. During the annual renewal process later this summer, Deloitte will determine whether the benefits changes cause a decrease of more than 5% in the Medicare rates. If so, the difference will be applied to reduce the final premium rates for our Medicare members.

- Optional Dental Benefits: The Board requested information regarding the impact of eliminating the dental benefits that health plans optionally provide. Deloitte has determined that this benefit is valued at $19.76 PMPM based on the 2012 estimated bids. Staff has investigated the potential impact of reductions in preventive dental care and does not recommend this change. Staff does not believe that the employee-pay-all optional dental plans offered through Anthem DentalBlue and EPIC Dental Wisconsin are sufficient to ensure broad participation. In addition, evidence suggests that the lack of regular dental care can have a significant negative effect on overall health, especially for individuals with diabetes, pregnancy, cardiovascular disease, osteoporosis and Alzheimer's disease.

- Health Plan Administration: On balance, health plans prefer a copayment approach (options 1a/1b). This approach would be more consistent with their existing administrative capabilities. Copayments would be collected by the providers at the point of service, as is now done for prescription drugs. Health plans have more difficulty administering coinsurance and deductible arrangements, and express significant concerns with a mixed copayment, deductible or coinsurance arrangement that includes a uniform out-of-pocket annual maximum (OOPM) for the member.

- Communication: Several Board members at the June 7, 2011, meeting expressed a preference for keeping the benefit change as simple as possible. Staff feels that the deductible option would likely be the easiest for members to understand.

  Due to the timing and lack of clarity around the passage of Act 10, staff did not think it would be productive to actively solicit input from employee or retiree groups regarding the proposed benefit changes. At the last meeting staff shared correspondence that was received on the topic from a provider group and a member.

  Following Board action, staff will work with employers to provide a comprehensive communication plan describing the benefit changes for our members. For example, we expect to provide information in the September *It's Your Benefit* newsletter, the annual *It's Your Choice* booklets, the Employee Reimbursement Account materials, the Department of Employee Trust Funds (Department's) website, Employer Bulletins and ETF staff will attend as many health fairs as possible upon employers' request.

- Equity and Utilization: The deductible option will impact more members than other options but typically results in a lower out-of-pocket cost per member. Thus, the cost-sharing provisions of the plan are spread out among greater numbers of individuals. Note that in the deductible option, the current durable medical equipment coinsurance of 80% / 20% up to a $500 single / $1,000 family OOPM does not change.

  Coinsurance affects members who utilize care more frequently to a greater extent than the deductible option, because OOPMs tend to be higher. This is illustrated in Attachment 1 with a single coinsurance OOPM of $225 compared to the deductible option OOPM of $190 single (not including durable medical equipment).

Coinsurance also provides automatic inflation adjustments to the value of the coinsurance amount since it is based on a percent of charges. However, the OOPM would need to be adjusted annually to maintain the 5% relative value going forward.

Deloitte notes that coinsurance has a greater impact on health care utilization as members weigh the costs versus the necessity of care, however, this benefit is more difficult for employees to estimate their out-of-pocket costs in order to utilize Employee Reimbursement Accounts. In theory, coinsurance would be appropriate if care was found to be unnecessary or excessive, however, studies have not been able to exactly determine what out-of-pocket expense becomes a barrier to a member and results in the avoidance of medically necessary care.

Deloitte estimates that at the recommended levels, approximately 60% of members will reach a deductible cap, whereas approximately 25% of members would reach a coinsurance OOPM.

Finally, copayments are relatively easy for members to understand, but they will not have any OOPM associated with them as discussed above. Therefore, the highest utilizing members will have the greatest cost share. Both the health plans and Dr. Tom Hirsch, the Department's medical advisor, suggest that targeted copayments, such as those recommended for radiology, are more likely to decrease unnecessary utilization.

- Comparability: Board members asked to know how the proposed benefits compare to other state public employers. Below is a brief comparison of benefits, based on input from Deloitte and information collected from benefit booklets that are available online. Please note that these options focus on the state's most generous offerings, not all of the available plans. The office visit (OV) copays do not apply to preventive care in Minnesota and Illinois.

Employer	Medical				Pharmacy	
	Deductible (ded)	Co-insurance	Copays	OOP	Copays	OOP
Minnesota HMO Plan Cost Level 1	$50 / $100	95%	After ded $17 or $22* – OV $75 – ER $85 – Hosp Inpt $55 – Hosp Outpt	$1100 / $2200	$10 / $16 / $36	$800 / $1600
Iowa HMO Plan	$0	100%	$10 – OV $50 - ER	$750 / $1500	$5 / $15 / Or greater of $30 or 25%	None
Illinois HMO Plan	$0	100%	$15 – OV $200 – ER $275 – Hosp Inpt $175 – Hosp Outpt	None	$50 ded, then $10 / $24 / $48	None
Michigan HMO Plan	$0	100%	$10 – OV $50 - ER	None	$10 / $20 / $40	None

*Level of copay varies based upon completion of Health Risk Assessment.

- Employee Reimbursement Account (ERA): Employees must estimate their health expenses for the next calendar year for their enrollment in the ERA Medical Expense Account. An accurate estimate is important because the money elected to be contributed to a medical expense account cannot be changed during the next plan year unless the employee experiences a permitted change in status event as described in Federal regulations governing Internal Revenue Code Section 125 plans. Money left in the account at the end of the year cannot be refunded.

  Accurate estimates of future plan year expenses are easier to predict when copayments, deductibles, and OOPMs are clearly established. Health plans that include coinsurance are harder to predict because the employee's out-of-pocket expenses depend on the cost of the service which is difficult at best to determine prior to the service being rendered.

Standard Plan:

Attachment 2 provides two options for achieving a 5% reduction to the Standard Plan, the Board's self-insured Preferred Provider Plan (PPP). This plan offers different benefits than the HMOs and allows freedom of choice of providers, however, the member incurs larger out-of-pocket costs if a non-Preferred provider is utilized. The current PPP benefit includes an in-network deductible of $100 single / $200 family with 100% coinsurance thereafter. The out-of-network benefit is a $500 single / $1,000 family deductible and a coinsurance of 80% / 20% with an annual OOPM (including deductible) of $2,000 single / $4,000 family.

In addition to alternatives for a 5% benefit reduction, staff from ETF and the plan administrator, WPS Health Insurance (WPS), have been working to modernize and clarify various plan provisions, including some of the oldest provisions, to align the contract with current insurance practices. Changes are also recommended which will lessen ambiguity in the contract, consistent with the audit findings presented to the Board at the November 9, 2010, meeting. With a new three-year ASO (administrative service only) contract with WPS to begin January 1, 2012, this is an appropriate time to consider modifying the benefit plan. The changes are described in Attachment 3. Overall, the results of these changes make the plan more cost-effective; however, the decrease in the value of benefits of the plan has been determined by Deloitte to be non-material.

Following Board action on Attachment 3, staff will provide specific Standard Plan contract language at the Board's August meeting.

Conclusion and Recommendation

We recognize that regardless of the option chosen by the Board, a 5% reduction in benefit costs represents a significant change for our members. Combined with similar increases in the cost-sharing formula for monthly premium contributions, these changes make it incumbent on staff and the Board to balance principles of insurance design with the need for clear communication with our members.

On balance, staff believes that the coinsurance and deductible options are the better choices and either could be chosen. However, staff believes that the coinsurance option comingled with prescription drug changes represent the best blend of responses to design, administrative, and member concerns.

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

Attachments (3)

2012 Benefit Options achieving 5% Reduction in Estimated 2012 Premium

	Copayment Option				Coinsurance Option				Deductible Option			
	UNIFORM BENEFITS (Savings PMPM)											
	Option 1 (a)		Option 1 (b)		Option 2 (a)		Option 2 (b)		Option 3 (a)		Option 3 (b)	
MEDICAL	Benefit Plan	Savings PMPM	Benefit Plan	Savings PMPM	Benefit Plan	Savings PMPM	Benefit Plan	Savings PMPM	Benefit Plan	Savings PMPM	Benefit Plan	Savings PMPM
Deductible S/F with Member OOP Max S/F[1]	OOP Max $500/$1000	No Change	OOP Max $500/$1000	No Change	OOP Max $225/$450		OOP Max $500/$1000	No Change	$190/$380 with OOP Max $500/$1000	$20.99	$275/$550 with OOP Max $500/$1000	$30.64
Coinsurance	DME and Hearing Aids[5] 80%/20%	No Change	DME and Hearing Aids[5] 80%/20%	No Change	90%/10% and DME and Hearing Aids[5] 80%/20%	$21.56	90%/10% and DME and Hearing Aids[5] 80%/20%		DME and Hearing Aids[5] 80%/20%	No Change	DME and Hearing Aids[5] 80%/20%	No Change
Office Visit Copay	$15	$15.89	$20	$18.15	90%/10%		90%/10%	$30.64	N/A		N/A	
IP Admit Copay	$125	$0.57	$250	$1.70	90%/10%		90%/10%		N/A	No Change	N/A	No Change
OP Surgery Copay	$50	$1.70	$150	$5.67	90%/10%		90%/10%		N/A		N/A	
Radiology Copay	$50	$2.84	$80	$4.54	90%/10%		90%/10%		N/A		N/A	
ER Copay	$75	$0.57	$75	$0.57	$75	$0.57	$75	$0.57	$75	$0.57	$75	$0.57
SAVINGS PMPM (a)	$21.56		$30.64		$22.13		$31.20		$21.56		$31.20	
PHARMACY												
RX Copays	$5/$20/$40		$5/$15/$35		$5/$20/$40		$5/$15/$35		$5/$20/$40		$5/$15/$35	
RX Member OOP Max S/F[2]	$1,000/$2,000		$410/$820		$1,000/$2,000		$410/$820		$1,000/$2,000		$410/$820	
SAVINGS PMPM (b)	**$2.96**		**$0.00**		**$2.96**		**$0.00**		**$2.96**		**$0.00**	
Eliminate PPIs & NSAs coverage	$1.20		No Change		$1.20		No Change		$1.20		No Change	
Mandatory 90-day retail or mail order[3]	$3.71		No Change		$3.71		No Change		$3.71		No Change	
Mandatory tablet-splitting w/opt out[4]	$1.00		No Change		$1.00		No Change		$1.00		No Change	
SAVINGS PMPM (c)	**$5.91**		**$0.00**		**$5.91**		**$0.00**		**$5.91**		**$0.00**	
CONTRACTUAL/ADMINISTRATIVE												
Eliminate 2-mo run-out for	YES		YES		YES		YES		YES		YES	
18 mo max for COBRA	YES		YES		YES		YES		YES		YES	
SAVINGS PMPM (d)	**$3.00**		**$3.00**		**$3.00**		**$3.00**		**$3.00**		**$3.00**	
BENEFIT ADDITIONS												
Palliative Care Consult PMPM	$0.05-$0.10		$0.05-$0.10		$0.05-$0.10		$0.05-$0.10		$0.05-$0.10		$0.05-$0.10	
Dental Implant PMPM	$0.24		$0.24		$0.24		$0.24		$0.24		$0.24	
COSTS PMPM (e)	**$0.32**		**$0.32**		**$0.32**		**$0.32**		**$0.32**		**$0.32**	
TOTAL												
TOTAL SAVINGS PMPM (a)+(b)+(c)+(d)-(e)	**$33.12**		**$33.33**		**$33.68**		**$33.89**		**$33.12**		**$33.89**	
Savings %	**5.11%**		**5.14%**		**5.20%**		**5.23%**		**5.11%**		**5.23%**	

Footnotes:
1. Medical copays do not apply to the Member OOP Max
2. Tier 3 prescription drugs do not count towards the Member OOP Max
3. Based on Navitus Cost Saving Exploration analysis, proposed savings option - Mandatory 90-day retail or mail order Option C
4. Preliminary estimate
5. Coverage for hearing aids has the same plan limit as provided in 2011

Attachment 1

2012 Benefit Options achieving 5% Reduction in Estimated 2012 Premium

	Copayment Option				Coinsurance Option			
	STANDARD PLAN BENEFITS (Savings PMPM)							
	Option 1				Option 2			
	In Network		Out of Network		In Network		Out of Network	
Medical	**Benefit Plan**	**Savings PMPM**	**Benefit Plan**	**Savings PMPM**	**Benefit Plan**	**Savings PMPM**	**Benefit Plan**	**Savings PMPM**
Deductible S/F	$200/$400	$8.68	$500/$1,000	No Change	$200/$400	$8.68	$500/$1,000	No Change
OOP Max S/F[1]	None	No Change	$2,000/$4,000	No Change	$800/$1,600	$27.82	$2,000/$4,000	No Change
Coinsurance	None	No Change	80%/20%	No Change	95%/5%		80%/20%	No Change
Office Visit Copay	$15	$18.94	80%/20%	No Change	95%/5%		80%/20%	No Change
IP Admit Copay	$125	$2.37	80%/20%	No Change	95%/5%		80%/20%	No Change
OP Surgery Copay	$50	$3.16	80%/20%	No Change	95%/5%		80%/20%	No Change
Radiology Copay	$50	$3.95	80%/20%	No Change	95%/5%		80%/20%	No Change
ER Copay	$75	$4.74	$75	$1.18	$75	$4.74	$75	$1.18
SAVINGS PMPM (a)	**$41.83**		**$1.18**		**$41.24**		**$1.18**	
Pharmacy								
RX Copays	$5/$20/$40				$5/$20/$40			
RX Member OOP Max S/F[2]	$1,000/$2,000				$1,000/$2,000			
SAVINGS PMPM (b)	**$3.36**				**$3.36**			
Eliminate PPIs & NSAs coverage	$1.20				$1.20			
Mandatory 90-day retail or mail order[3]	$3.71				$3.71			
Mandatory tablet-splitting w/opt out[4]	$1.00				$1.00			
SAVINGS PMPM (c)	**$5.91**				**$5.91**			
Contractual/Administrative								
Eliminate 2-mo run-out for termed EE	YES				YES			
18 mo max for COBRA	YES				YES			
SAVINGS PMPM (d)	**$4.62**				**$4.62**			
TOTAL								
TOTAL SAVINGS PMPM (a)+(b)+(c)+(d)	**$56.91**				**$56.32**			
SAVINGS %	**5.04%**				**4.98%**			

Footnotes:
1. Medical copays do not apply to the Member OOP Max
2. Tier 3 prescription drugs do not count towards the Member OOP Max
3. Based on Navitus Cost Saving Exploration analysis, proposed savings option
   - Mandatory 90-day retail or mail order Option C
4. Preliminary estimate

Attachment 2

Reduce Standard Plan benefits and modernize:

- Reduce the home care benefit to align with Uniform Benefits, that is, limit it to 50 visits per year. Currently the benefit is two-pronged, with mandated and coordinated benefits available. This change would eliminate the coordinated benefit for coverage up to 365 days. This change will result in savings of $90,000

- Remove fourth quarter carry-over and common accident deductible provisions. These are now uncommon in the insurance industry. This change will result in savings of $50,000

- Reduce the benefit for physical, speech and occupational therapies to match Uniform Benefits at 50 combined with an additional 50 per calendar year as approved by the plan. The current benefit has no visit limit and is subject only to medical necessity. This would result in a savings of approximately $3,500.

- Eliminate the benefit for home attendance care. This $1,500 lifetime benefit is rarely used and is unique to our program. In 2010 one member utilized it up to the maximum allowable amount.

- Limit the extended care facility (skilled nursing facility) benefit to align with Uniform Benefits and eliminate the provision that states days are limited to double the number of unused hospital days, that is, up to 730 days. Staff recommends limiting this benefit to 120 days per benefit period as medically necessary. Since most care is rarely medically necessary after 120 days, WPS states that in 2010 this change would have saved the plan $600.

- Clarify the benefits for office visits to allow for payment of services rendered in a convenient care clinic. The contract is silent on this, and the potential for such claims is growing as these types of clinics expand into Wisconsin. This should result in a small savings as the cost of care in these clinics is usually less than a regular physician's office.

Increase Standard Plan benefits and modernize:

- Modernize the contract to include a list of payable genetic services. The contract is silent and this creates barriers to authorizing medically necessary services. If made in 2010, this change would have resulted in an additional cost of $40,000.

- Modernize inpatient hospital occupancy requirement from a semiprivate room or lesser accommodations and remove the private room limitation since a number of hospitals no longer have two-bed rooms. In 2010 the current language saved the state $1,000, but required additional system manipulation by the administrator that lessened efficiency.

- Modernize the plan by allowing for payment of dental claims related to cancer. These are: (a) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (b) sealants on existing teeth to prepare the jaw for chemotherapy

treatment of neoplastic disease. This would add to the cost of the program by approximately $400 per incidence.

Modernization of Standard Plan items that have no impact on rates:

- Staff recommends eliminating the 365 day hospital inpatient limit, and replacing it with language to align with Uniform Benefits, that is simply subject to medical necessity.

- Modernize the list of payable implants. The current list is out-of-date and creates barriers to authorizing medically necessary implants. This language would clarify existing practice.

- Clarify the contract to permit WPS to allow additional savings from a third party network for surgical assistants, bilateral surgical procedures, and multiple procedures when they are greater than those stated in the contract. This language would clarify existing practice.

- Eliminate the private duty nursing services language. The plan could authorize the care as alternate care if it was found to be more cost effective than other covered services, but the benefit would not explicitly be available.

- Clarify the contract to permit WPS to allow for payment of outpatient cardiac rehabilitation services following hospital outpatient cardiac treatment. Currently, the contract states these services are payable only if the participant begins them immediately following a hospital confinement. Outpatient care is less costly, and this is becoming the standard of care. This language would clarify existing practice.

- Clarify the contract to permit WPS to allow for payment of health and behavior assessments and neuropsychological testing provided by a psychologist to treat a physical illness or injury. These types of services are to treat specific issue such as a head injury, and are almost always performed only by psychologists. The current contract does not allow for a psychologist to bill such services with a medical diagnosis. It requires billing by a physician. This language would clarify existing practice.

- Clarify the contract to exclude infertility services that are not for the treatment of illness or injury, and align with Uniform Benefits. The contract is currently silent and this was an issue identified in the audit for clarification. This language would clarify existing practice.

- Clarify the transplant benefit to state that procurement and donor charges are included. This codifies existing practice.

- Clarify the benefit for pain management to assist members in understanding the benefit. The contract is currently silent and this benefit is payable if it meets the administrator's medical policy.

- Clarify that refractive surgery is allowable if medically necessary to treat an illness or injury. Retain the exclusion for all other refractive surgery.

- Clarify the contract regarding medically necessary treatment for sexual dysfunction. The contract is currently silent and this benefit was identified as unclear in the audit.

- Clarify the contract regarding diabetic supplies. This plan will pay if they are received from a durable medical equipment vendor. The pharmacy benefits manager pays for those provided by a pharmacy. The contract is currently silent and this was an issue identified in the audit for clarification.