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CORRESPONDENCE MEMORANDUM

DATE: May 1, 2012

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits and Insurance Plans
Arlene Larson, Manager of Federal Health Programs & Policy

SUBJECT: Wisconsin Public Employer Standard Plan, Wisconsin Public Employer State Maintenance Plan, and State and Wisconsin Public Employer Medicare Plus Modernization

Staff recommends the Board adopt the Wisconsin Public Employer (WPE) Standard Plan, WPE State Maintenance Plan (SMP), State and WPE Medicare Plus and hospitalization notification changes outlined below.

BACKGROUND

Staff recommends modifications to the WPE Standard Plan, including the SMP and the State's Medicare Plus Plan, in order to simplify administration and modernize the Plans. This is being presented, due to two bidder responses to the WPE Standard Plan's request for proposals that occurred during 2011, when the vendors declined to bid due to the antiquated nature of these plans. The proposed changes are generally minor and will not materially change the overall value of the programs.

The WPE Group Health Insurance Program was authorized pursuant to Wis. Stat. 40.51(7) in 1987 and offered benefits that were based on the State Plan design. The program offers two types of health insurance products to employees, annuitants (retirees), and their dependents for local governments (Wisconsin Public Employers) that have filed a resolution to participate. Among the plans offered are the Standard and SMP Plans, two self-insured plans administered by Wisconsin Physicians Service (WPS). The Standard and SMP benefits have remained largely unchanged since inception. Enrollment in these plans is very low. Of 15,321 WPE subscribers, only 277 are covered under the WPE Standard or SMP Plans. Staff has discussed modernization with a number of large employers, and they are supportive of the concept.

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

Lisa Ellinger
Signature

5/7/12
Date

Board	Mtg Date	Item #
GIB	5.22.12	5B

1. Staff recommends that the WPE Standard and SMP benefit provisions be updated to match the State Standard Plan that became effective January 1, 2012. This will not include deductibles and coinsurance that shall remain consistent with the three program options detailed in Item 5C.

2. Staff further recommends that the Medicare Plus Plan be changed to fully supplement Medicare. In addition, this State Plan would replace the WPE Standard Plan for annuitants and their dependents who are Medicare-eligible.

3. Finally, staff recommends a change to the State's emergency hospitalization certification requirement following an emergency hospital admission to replace the criteria that a call must be made to the administrator within two days of admission. Instead, the language will state that contact should be made as soon as reasonably possible. Staff also recommends that notification requirements be implemented in the WPE Plan for consistent administration.

Please note that as staff continues to refine the Standard Plans, further contract changes may be necessary. Staff will bring any notable changes before the Board but also requests authority to proceed with any needed technical clarifications.

DISCUSSION

1. WPE Standard Plan and SMP changes: Staff recommends implementing benefit changes that are described in Attachment A. While some of the changes described are either increases or decreases in the value of benefits, overall the results of these changes make the plan more cost-effective, and the overall difference has been determined by Deloitte Consulting (Deloitte) to be non-material. The modifications are designed to align the contract with current commercial insurance practices.

2. Medicare Plus changes: Medicare supplement plans cover Medicare deductibles and coinsurance to make the member whole when Medicare allows for the service. Medicare Plus is a self-insured plan for Medicare primary participants. It is based on an older WPS supplemental policy originally named Medicare Plus $22,500. Over the years, it incorporated some features of the Standard Plan. For example, it has followed the Standard Plan organ transplant benefit, without updating these benefits as Medicare incorporated them. Thus it no longer supplements 100% of the Medicare benefits.

In cases where Medicare excludes payment for the service, the supplement also denies coverage. However, Medicare Plus covers some services not required by

Medicare. For example, it pays for more skilled nursing facility services than the Medicare requirement.

These differences are generally minor. The actuarial staff of WPS estimates that the change in benefits would result in a savings of .5% to .7% for the overall medical and prescription drug package. This estimate is based upon:

- Allowing for payment of all Medicare deductibles and coinsurance;
- Allowing for stays in certain skilled nursing facilities up to 120 days to align with Uniform Benefits;
- Including a foreign travel rider for members who travel or temporarily reside out of the country; and
- Providing protections from usual, customary, and reasonable fees if the member uses a provider who does not have an affiliation with Medicare.

Examples of services that are not allowable under both programs are listed in Attachment B. Thus, although some members will see an increase in benefits and others see a decrease, the program will not change materially in overall value. In the future, the benefits should be more understandable to our members and manageable for prospective vendors.

3. Regarding notification following an emergency admission into a hospital, currently in cases when a subscriber or a personal representative does not contact the administrator within two days of admission, a $100 penalty is assessed. This provision exists to manage costs by eliminating unnecessary hospital days prior to incurral. It allows WPS to come to an agreement about the length of a stay with the provider. As such, it reduces appeals of denied claims. Employee Trust Funds legal counsel has advised staff the provision is unenforceable, as a matter of contract law, in cases where the subscriber is incapacitated and unable to provide such notice. Therefore, staff recommends modifying the two-day requirement such that the member be required to contact the administrator within two business days after admission or, if that is not reasonably possible, then as soon as reasonably possible thereafter.

Staff will be available at the Board meeting to answer any questions you may have.

Attachments: Attachment A – Benefits Changes Summary
Attachment B – Unallowable Examples of Services

Reduce WPE Standard Plan & SMP benefits and modernize:

- Implement an emergency room co-payment that aligns with Uniform Benefits.

- Reduce the home care benefit to align with Uniform Benefits, a limit of 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.

- Remove fourth quarter carry-over and common accident deductible provisions. These are now uncommon in the insurance industry.

- 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.

- Eliminate the benefit for home attendance care. This $1,500 lifetime benefit is rarely used and is unique to our program.

- 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.

- 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 WPE Standard Plan & SMP 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.

- Modernize inpatient hospital occupancy requirement from a semi-private room or lesser accommodations and remove the private room limitation since a number of hospitals no longer have two-bed rooms.

- 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.

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

- Implement a hospital pre-certification requirement that mirrors the State's criteria.

- 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.

- 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 the administrator 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 the administrator 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 issues 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 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 the contract regarding diabetic supplies. This Plan will pay if 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.

Some significant benefits allowed under Medicare Plus but denied entirely by Medicare:

- Medicare Plus pays for an additional 20 allowable days in a Medicare approved skilled nursing facility after a member reaches Medicare's 100 day limit.

- For an allowable stay when a member is admitted within 24 hours of a hospitalization to a non-Medicare approved skilled nursing facility, Medicare Plus pays for the first 30 days, then pays $50 a day for the next 70 days up to day 100, and finally pays for all services up to day 120. Note, if the individual is admitted more than 24 hours after a hospitalization, but within 14 days of discharge, the first 30 days are allowed at $50 per day.

- Certain physical, speech, and occupational therapy is allowable under Medicare Plus and not under Medicare.

Some significant benefits allowed under Medicare but denied and not supplemented by Medicare Plus:

- Heart or lung transplants specifically excluded by Medicare Plus.

- The charge assessed for a physician's development of documentation for certification or re-certification of Medicare covered home health services when the patient is not present is excluded under Medicare Plus.