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CORRESPONDENCE MEMORANDUM

DATE: April 29, 2013

TO: Group Insurance Board

FROM: Bill Kox, Deputy Administrator
Emily Loman, Manager, Alternate Health Plans

SUBJECT: Guidelines and Uniform Benefits for the 2014 Benefit Year (DRAFT)

The Department of Employee Trust Funds (ETF) recommends 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.* These guidelines establish participation requirements for health plans for the upcoming benefit year (2014) as well as establish employer and employee eligibility and certificates of coverage for insured health plans.

On February 13, 27, March 20, and April 11, 2013, an advisory study group, comprised of fifteen ETF staff, six representatives from other state agencies, and two representatives from Wisconsin health plan professional associations, met to review and offer comments on a list of potential benefit adjustments and guideline changes compiled by ETF. The study group did not vote on recommendations but rather offered thoughts on the issues for the ETF's consideration. Study group member feedback and the ETF's final recommendations are 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.

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GIB-SPW	5.7.13	6

Participants of the study group meetings included: Jennifer Stegall, Office of Commissioner of Insurance (OCI); Roger Frings, (OCI); Mickie Waterman, Department of Administration (DOA); Paul Ostrowski, Office of State Employment Relations (OSER); Beth Ritchie, University of Wisconsin (UW); Nicole Zimm (UW); Katrina Rupert (UW Hospital and Clinics), Phil Dougherty, Wisconsin Association of Health Plans (WAHP), Rebecca Larson, Alliance of Health Insurers, U.A. (AHI), and the following ETF staff: Lisa Ellinger, Bill Kox, Mary Statz, Emily Loman, Arlene Larson, Jeff Bogardus, Roni Harper, Holly Klawitter, John Bott, Brian Shah, Brian Schroeder, Dan Hayes, Allen Angel, Liz Doss-Anderson, Vickie Baker.

Attached are the following:*

- **Attachment A** – Explains the basis for any notable changes to the Guidelines, Addendum, and State and Local Contracts.
- **Attachment B1** – Excerpts from the Guidelines and Addendum with recommended cost-neutral modifications for 2014.
- **Attachment B2** – Excerpts from the State and Local Contracts with recommended cost-neutral modifications for 2014.
- **Attachment C** – Explains the basis for any notable changes to Uniform Benefits.
- **Attachment D** – Excerpts from Uniform Benefits, with recommended modifications for contract year 2014.

Staff previously advised the Board at its February meeting to expect few benefit changes for 2014 unless required by federal law. For the 2014 Benefit Year, the Department recommends no material benefit changes, with the exception of the change to a cost-neutral, optional uniform dental benefit, which is addressed in a separate memo. However, note that there are several recommended administrative and program changes. Since there are no material medical benefit changes for 2014, the overall benefit level of the Group Health Insurance program remains essentially cost neutral.

The impetus for these proposals comes from the Board, participants, health plans and staff. On January 11, 2013, ETF solicited recommendations from incumbent health plans concerning benefit and administrative changes. On March 8, 2013, ETF provided health plans with draft contract language based on their recommendations. 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 in Attachment B (Guidelines/Addendums/Contracts)* and D (Uniform Benefits)* that are not described on the table or discussed below. We consider these to be minor modifications or clarifications of current practice.

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Please note that as staff continues to refine Uniform Benefits, 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 or compliance with federal requirements.

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

SECTION 1: RECOMMENDED BENEFIT CHANGES

As stated above, ETF does not recommend any material changes to medical benefits for 2014. However, ETF recommends removing dollar limits on four benefits in order to be in compliance with federal law.

Under the Affordable Care Act (ACA), large-group plans are not required to provide Essential Health Benefits (EHB). However, if they do provide EHB, large-group plans must remove annual dollar limits from those benefits. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits in order to maintain the cost neutrality of the benefit.

According to the Department of Health and Human Services, both the state and local group insurance plans are considered large-group plans. Therefore, dollar limits must be removed from the existing hearing aid benefit, the benefit for temporomandibular disorders, dental implants, and possibly for pediatric dental services.

To be in compliance with federal law, ETF recommends removing the annual and lifetime dollar limits from benefits for hearing aids, diagnostic procedures and non-surgical treatment benefit for temporomandibular disorders, dental implants following accident or injury, and pediatric dental services.

1. **Hearing Aids**: the current benefit for participants age eighteen and over limits hearing aids to one hearing aid per ear no more than once every three years and applies a maximum health plan payment of $1,000 per hearing aid. There is no dollar limit for participants under age eighteen.

   ETF recommends removing the $1,000 limit from the hearing aid benefit and requiring that hearing aids be provided once per ear per member per lifetime. This would be in compliance with federal law.

   The Board's actuary estimates that this recommendation is essentially actuarially equivalent to the existing benefit.

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2. **Temporomandibular Disorders (TMJ)**: the current benefit for TMJ disorders is limited to $1,250 per participant per calendar year for diagnostic procedures and non-surgical treatment. Intraoral splints are subject to the Durable Medical Equipment (DME) coinsurance and apply to the non-surgical treatment benefit maximum.

   The Board's actuary has determined that diagnostic and non-surgical TMJ procedures currently have costs at or below the $1,250 annual maximum per participant. Further, given the relatively low frequency of such procedures, the Board's actuary expects that the elimination of this annual maximum to produce an increase in PMPM costs of less than $0.01 PMPM.

   ETF recommends removing the $1,250 annual limit on diagnostic procedures and non-surgical treatment for TMJ. This will be in compliance with federal law. No actuarially equivalent substitute is necessary.

3. **Dental Implants:** the current benefit for dental implants following accident or injury is limited to a maximum payment of $1,000 per tooth.

   ETF recommends removing the $1,000 per tooth limit on dental implants following accident or injury to be in compliance with federal law. ETF also recommends implementing a 50% coinsurance as an actuarially equivalent substitute.

4. **Pediatric Dental Services**: Under the optional Uniform Dental Benefit Plan recommended for 2014, dental services are limited to an annual maximum payment of $1,000. Absent federal law, this limit would apply to dental services for children. However, under EHB requirements, annual dollar limits must be removed from pediatric dental services. Federal law defines pediatric services for EHB purposes as individuals who are nineteen years of age or younger. ETF is waiting for further guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) on specifically what services are required under pediatric dental services. With this guidance, ETF also hopes to gain a more complete understanding of the scope of the benefit and the cost implications of removing the dollar limit.

   ETF recommends removing the $1,000 limit for pediatric dental services under the recommended optional Uniform Dental Benefit plan. This will be in compliance with federal law.

SECTION 2: RECOMMENDED ADMINISTRATIVE CHANGES

1. Shared Decision Making (SDM): Shared Decision Making (SDM) is a process in which relevant risk and benefit information on treatment alternatives is shared with the patient and the patient discusses with the provider relevant personal information that might make one treatment or side effect more or less tolerable. Both parties use this information to come to a mutual medical decision. For many medical and surgical interventions, ETF believes that the SDM model represents the best blending of physician expertise and patient choice for members and their families to be able to make well-informed preference and value-sensitive treatment decisions.

Independent of the study group process this year, ETF was able to meet with all but one of the medical directors and/or representatives from each health plan to discuss the parameters of a SDM program.

Similar to the prior authorization requirement for certain listed procedures, the SDM program requirement appears in both the Guidelines and Uniform Benefits sections of the contract so that both participants and health plans are advised of the requirement.

ETF and the study group had considered allowing health plans to choose the medical intervention(s) for which they would provide SDM. However, after health plans reported that they would have difficulty fulfilling specific reporting requirements for SDM, ETF developed the recommendation that health plans provide an SDM program only for surgery for low back pain (LBP) in 2014. ETF thinks that SDM for LBP surgery will support the disease management program's strategy of conservative care that is currently in place for LBP. SDM for LBP surgery also supports the existing prior authorization requirement for LBP surgery.

Later this year, ETF will work with health plans to develop guidance outlining how plans should report patient utilization rates and program impacts experienced by the implementation of an SDM program for LBP surgery in 2014. In this guidance, ETF also expects to inform plans that SDM will be required for multiple medical interventions in 2015.

ETF recommends requiring health plans provide a credible SDM program for participants who are considering surgery for Low Back Pain (LBP). Plans must also provide Patient Decision Aids, or specific informational literature, that meets certain international standards to members who are participating in the SDM program. Upon request by ETF, health plans will report annual patient utilization rates and program impacts based on guidance issued by ETF. Participants are required to complete the SDM program for LBP surgery before they can obtain prior authorization for LBP surgery. ETF expects to expand the SDM program requirement to multiple medical interventions in 2015.

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2. Biometric Screenings: For 2013, the Board approved a requirement that health plans offer a wellness program designed to engage 30% to 50% of their adult members to participate in taking a Health Risk Assessment (HRA) and biometric screening. As part of this requirement, health plans may provide incentives (up to $150.00 in value) to adult participants who complete the HRA and biometric screening. Biometric screening is required to test glucose level, body mass index, cholesterol level, and blood pressure.

During the first year of implementation, several health plans asked for guidance on whether glucose and cholesterol level tests should be administered as fasting or non-fasting. ETF recommends that health plans should administer glucose and cholesterol screenings as non-fasting. Biometric screenings are not diagnostic tests, and as such, these tests do not need to be as accurate diagnostic tests, which are designed to detect a problem and its severity. If a problem is detected through a non-fasting screening but the severity of the problem is unknown, the patient should undergo the more accurate fasting diagnostic test. Non-fasting tests are easier to administer and will likely generate higher participation rates than fasting tests because participants will not be turned away for failing to properly fast.

ETF recommends health plans shall administer glucose and cholesterol screenings as non-fasting tests according to current U.S. Preventive Services Task Force (USPSTF) guidelines and that the frequency of these tests shall be determined by the same guidelines.

3. CAHPS Survey: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures participants' perceptions of certain interpersonal aspects of healthcare, such as their satisfaction with their health plan and the health care they receive. Currently, ETF, with the assistance of a third-party vendor, administers an annual CAHPS survey to Group Health Insurance program participants. Each participating health plan receives a CAHPS composite score based on results from this survey. A rating chart comparing health plan performance based on CAHPS results is updated annually and appears in each edition of the It's Your Choice Decision Guide provided to employees prior to Open Enrollment. The CAHPS quality composite rating chart is one of many health plan comparison tools in the Decision Guide designed to aid participants in deciding which health plan to choose.

The CAHPS survey includes questions about participant experiences such as getting needed care, getting care quickly, health plan customer service, ease of finding and understanding information, and how claims were processed.

Currently, ETF expends significant staff work time and financial resources paid to the third-party vendor to coordinate the administration of the survey to Group Health Insurance program participants and to produce the Quality Composite Rating Chart. All of the Alternate Health Plans, even those that are not accredited by the National Committee for Quality Assurance (NCQA), already capture CAHPS results based on responses from their commercial populations.

By eliminating the administration of the CAHPS survey to Group Health Insurance program participants and replacing it with CAHPS results that are based on a health plan's commercial population, ETF can reallocate the financial and staff resources that it currently spends on administering a CAHPS survey to program participants to the development and reporting of other important health care performance measures. As health plans already capture CAHPS results based on their commercial populations, ETF will be able to publish these CAHPS results instead. And since these results are based on a uniform set of questions and provided in the same format that the current survey uses, ETF is confident that participants will continue to receive nearly the same helpful and accurate information concerning consumer satisfaction and experiences that they receive today.

In ETF's opinion there are some negative implications with using CAHPS survey results based on commercial populations that are worth mentioning. These include that the Standard Plan would no longer have CAHPS results. However, since only a single health plan administers the Standard Plan, a comparison tool for only one vendor that provides a unique program may not be as useful as it is for the multiple Alternate Health Plans. Also worth mentioning is that health plans with multiple service areas would have combined results rather than separate results for a CAHPS score that is based on a health plan's commercial population. By using the Health Plans' commercial surveys, ETF will not be able to ask unique questions. In the past, for example, we have asked about BMI and tobacco usage.

On balance, ETF thinks that the benefits of being able to continue to provide substantially similar CAHPS results combined with having extra resources to use to develop and report on other important health care performance measures justify the decision to eliminate the current CAHPS survey model and replace it with a CAHPS survey that is based on responses from health plans' commercial population in Wisconsin.

ETF recommends health plans be required to provide the results of their annual CAPHS survey that is based on the health plan's commercial population in Wisconsin to ETF according to specific technical requirements as outlined in the Guidelines. ETF also recommends discontinuing the administration of the current CAHPS survey that is based on results from members enrolled in the Group Health Insurance program.

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4. Appeals Related to Cases of Medical Necessity: Last year, the Board decided to stop providing administrative review of disputes, including medical necessity disputes, that are eligible for review under Wis. Stats. § 632.895 and corresponding regulations mainly because the Board lacks the necessary medical expertise to sufficiently review these types of disputes. As part of that decision, effective January 1, 2014, members who seek review of their health plan's final grievance decision will be required to have their cases decided by an Independent Review Organization (IRO).

ETF recommends the Board approve specific changes in the State and Local contracts and Uniform Benefits that support the previously adopted change in policy to have appeals that are eligible for Independent Review to be reviewed only by an IRO rather than giving members the choice of appealing to the Board or an IRO.

5. Rate-Making Process: Currently, the Board reserves the right to reject the bid of any health plan when the Board believes that it is not in the best interests of the group health insurance program. This provision delineates the fundamental contract principle that prior to acceptance the offeree may reject any offer made by the offeror. This provision protects the health insurance program and its participants by not binding the Board to accept a bid merely because it was submitted by a qualified health plan.

ETF now recommends that the Board also reserve the right to reopen the bid process after final bids are submitted when the Board determines that the bid is not in the best interests of the group health insurance program. The provision would give the Board flexibility and authority to renegotiate with all health plans if it determines that a bid is unreasonably high and that to accept such a bid would jeopardize the integrity of the program. The provision would also give the Board the ability to make changes if necessary. Therefore, ETF thinks that the Board should be equipped to reopen the negotiation process as it believes necessary prior to finalizing the process.

ETF recommends the Board reserve the right to reopen the bid process after final bids are submitted when the Board determines that the bids are not in the best interests of the group health insurance program.

6. Deferred Coverage Enrollment: In 2011, the Board approved a change to require employees who are uninsured and who retire with an immediate annuity to enroll in the Standard Plan for 30 days prior to retirement in order to escrow sick leave. Employees under this scenario are eligible for employer contribution toward premium for the Standard Plan. Currently, the contract is silent as to how uninsured employees on leave of absence (LOA) under Wis. Stats. § 40.02 (40) who want to escrow their sick leave credits upon retirement without returning to work should be treated.

ETF recommends aligning the requirement for uninsured employees on LOA under Wis. Stats. § 40.02 (40) with the requirement for active employees. However, employees on LOA are not eligible for employer contribution toward premium like active employees. Despite this, ETF thinks that requiring employees on LOA to pay at least one month of full premium is not unreasonable to be able to escrow their sick leave credits to pay for health insurance after retirement.

ETF recommends clarifying uninsured employees on LOA under Wis. Stats. § 40.02 (40) who want to escrow their sick leave credits without returning to work enroll in the Standard plan for at least 30 days prior to retirement.

7. Therapy Benefit: The current therapy benefit covers up to 50 visits per participant for all therapies, speech, physical, and occupational, combined per calendar year. An additional 50 speech, 50 physical, and 50 occupational medically necessary visits per participant per calendar year may be available when prior authorized by the health plan. Unless specifically mandated for coverage under state law, speech, physical, and occupational therapies that are intended to treat learning, behavioral, or developmental problems are excluded. Speech, physical, and occupational therapies are available only for treatment of those conditions which the patient's doctor believes will yield significant improvement within two months of beginning treatment.

A description of the therapy benefit, the pertinent exclusion and limitation are currently listed in multiple sections of Uniform Benefits. As a result, some health plans have had difficulty administering and explaining the limitations of the benefit to participants who were seeking what is commonly referred to as "habilitative" therapy. Some issues over interpretation of the therapy benefit have resulted in participants filing grievances with health plans.

ETF recommends adding definitions to Uniform Benefits:

- **Habilitation Services** under federal law are those which help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age and may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- **Rehabilitation Services** under federal law are those which help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

The current therapy benefit is intended to cover only "rehabilitative" therapy, or that which is aimed at restoring a functional ability that was once achieved but has been diminished or lost because of an illness or injury. However, in some circumstances, certain state mandated benefits, such as coverage of newborn infants, treatment for autism spectrum disorders, hearing aids, cochlear implants, and related treatment for infants and children could require coverage of therapies that would otherwise be considered excludable habilitation services.

ETF recommends clarifying the therapy benefit by adding the federal definitions for habilitation and rehabilitation services in Uniform Benefits and clarifying that habilitation services are not covered, except when required by state law coverage mandates, including Wis. Stats. § 632.895 (5), (12m), and (16).

8. Coordination of Dental Benefits: The coordination of benefits (COB) provisions of stand-alone or wrap-around dental policies that are approved by the Board state that the benefits of a medical or health policy are determined before the benefits of the optional dental policy. Dental benefits under the Group Health Insurance medical policy are generally considered basic and preventive, whereas the stand-alone/employee-pay-all policies are considered complimentary, and are therefore not considered to be duplicate policies.

Wis. Admin. Code INS 3.40 (9)(d) provides that "a contract holder's coverage that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder."

By adding an express provision to the Group Health Insurance coordination of benefits section that provides that the dental benefits of the medical plan are considered to be primary over the dental benefits of stand-alone policies, the order of dental benefits will be unambiguous and will not rely solely on the interpretation of administrative code for proper coordination of dental benefits.

ETF recommends adding a provision in the Coordination of Benefits section of the Uniform Benefits certificate which makes explicit that the dental benefits of a Plan provided under Uniform Benefits are considered to be primary with regards to stand-alone or wrap-around dental plans that are approved by the Group Insurance Board and held by employees, annuitants, and continuants pursuant to Wis. Admin. Code INS 3.40 (9)(d).

9. ACA's Maximum Out-of-Pocket (MOOP) Requirement: Under ACA, effective January 1, 2014, an individual or family's out-of-pocket expenses for medical benefits are limited to $6,400 or $12,800 respectively. Currently, the Group Health Insurance program imposes an out-of-pocket limit (OOPL) for coinsurance expenses of $500 for individual policies and $1,000 for family policies. However, there are several other benefits which impose other cost-sharing methods, which could cause a participant's out-of pocket expenses to exceed the coinsurance OOPL, such as the emergency room co-pay, cochlear implants, hearing aids and prescription drug co-pays.

Federal rules at this time indicate that MOOP limits will likely be relaxed for 2014 allowing for separate out-of-pocket maximums for medical and prescription drug expenses. However, the MOOP limits may be combined in subsequent years, which would have the effect of lowering those limits.

In order to assist health plans with the proper administration of federal MOOP limits, ETF recommends adding provisions to Guidelines and the state and local sections of the contract requiring that health plans apply all applicable state or federal maximum out-of-pocket limits. Because it is very unlikely that participants would exceed the federal MOOP limit under the current cost-sharing structure, ETF does not anticipate any material change in cost as a result of this requirement.

ETF recommends adding provisions that would require health plans to apply all applicable state or federal maximum out-of-pocket limits to benefits.

SECTION 3: PROPOSED CHANGES STILL UNDER CONSIDERATION

1. Standardized Wellness Incentive: The study group considered a proposal to standardize wellness program incentives awarded to members who complete Health Risk Assessments (HRAs) and biometric screening tests provided by their health plan. As mentioned above, in 2012, the Board approved a change that allows health plans to provide cash or cash-equivalent incentives to adult participants who complete the HRA and biometric screening in an amount not to exceed $150.00. The Board also grand-fathered the $225 incentive that one health plan began providing in 2012 under its pilot wellness program. Health plans are currently providing a broad range of incentives that differ significantly in value. Health plans appreciate the opportunity to differentiate their services by having the flexibility to set their own incentive levels within prescribed parameters. Staff are involved in ongoing discussions with the administration and plan to present a final recommendation to the Board at its May 21, 2013 meeting.

SECTION 4: PROPOSED CHANGES NOT RECOMMENDED

ETF presented other issues listed below to the study group, which did not result in recommended changes. The most notable issues are summarized below. Staff will provide additional information upon request.

1. Tobacco Cessation Benefit: This year the study group and a special subcommittee of the Group Insurance Board Strategic Planning Workgroup examined whether to increase the current smoking cessation benefit based on the Governor's proposed budget to create a tobacco use surcharge under Wis. Stats. 40.03 (6)(cm). At this time, ETF does not recommend increasing the tobacco cessation benefit. However, depending upon the final determination of the impact that federal rules may have on the surcharge, the Uniform Benefits certificate may need to be modified after the May 2013 GIB meeting.

2. Nurse Midwife Feasibility Study: The 2011-2013 State Budget Bill required the Board to study the feasibility of mandating state employee health plan coverage for nurse midwife services to assist in births at home or at stand-alone birth centers. As part of this study, in 2012 and 2013, ETF asked health plans, the Wisconsin Association of Health Plans (WAHP), the Wisconsin Guild of Midwives for assistance in compiling factual information about the availability, safety, cost and quality of nurse midwife services in Wisconsin. On these topics, ETF found the following:

Availability: There are significant coverage gaps for out-of-hospital midwife services outside Wisconsin's major metropolitan areas.

Demand: Demand for this service is projected to be relatively low.

Safety: Risk of mother's death is about the same for home birth as in hospital. Risk of child's death during home birth is about three times higher than in hospital.

Quality of Care: Several health plans cited concerns that nurse midwife services outside hospitals do not work closely enough with physicians to ensure quality of care despite the requirement that they maintain written collaborative agreements with at least one OB-GYN.

Cost: Low demand combined with high fixed costs tends to drive costs up for this service.

ETF concludes that providing nurse-midwife services would not be a cost-effective benefit to add to our program at this time. Concerns over safety, quality and access must also be addressed before this service becomes part of standard health care coverage under the Group Health Insurance Program.

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3. Bariatric Surgery Benefits: The study group considered a proposal for the inclusion of bariatric surgery benefits prepared by UW Health. The proposal recommended that bariatric surgery services be provided by a Bariatric Surgery Center of Excellence as a covered benefit for a defined period of time that will allow utilization and outcomes within the Group Health Insurance Program to be studied further. The Standard Plan currently covers bariatric surgery.

Feedback from health plans was generally opposed. Plans cited high cost, mixed outcomes and the risks of complications as reasons for their opposition. In addition, bariatric surgery is not currently covered or administrated by all health plans. For these reasons, ETF does not recommend adding bariatric surgery as a covered benefit.

4. Coinsurance Waiver for Biometric Screening Services: The study group considered a proposal to waive the 10% coinsurance charges for services, including office visit charges, associated with obtaining biometric screening tests and other specific preventive services. Under federal law, cost-sharing may not be applied to certain defined preventive services.

ETF does not recommend waving coinsurance for biometric screening services because office visits could include other services or tests that are not required to be covered at 100% making the benefit extremely difficult for health plans to administer. In addition, on-site biometric screening is generally available at no charge.

5. Coinsurance: The study group considered a proposal to remove the existing 90%/10% coinsurance cost-sharing measure, which has been in place for two years, and to replace it with an actuarially equivalent co-pay arrangement. ETF does not recommend replacing coinsurance with co-pays because participants are more aware of associated health care costs with coinsurance and therefore tend not to over-utilize services. Coinsurance is also preferable because co-pays do not automatically adjust for inflation. Health plans also cited an overwhelming preference for coinsurance.

6. Co-pay Differential for Specialty Medications: The study group considered a proposal to remove the co-pay reduction for Level 4 specialty medication prescriptions that are filled through the Pharmacy Benefit Manager's specialty vendor. Currently specialty prescriptions filled through the mail-order specialty vendor are subject to a $15 co-pay, whereas those same prescriptions filled at a non-preferred participating pharmacy are subject to a $50 co-pay. Both co-pay levels apply to an out-of-pocket limit for specialty medications of $1,000 for individuals and $2,000 for families.

ETF does not recommend removing the co-pay reduction for Level 4 specialty medication prescriptions that are filled through the specialty vendor because the current specialty vendor system is operating in an efficient manner.

7. Pharmacy and Medical Out-of-Pocket Limit (OOPL): The study group considered raising the pharmacy and medical OOPL as a means to offset any increased benefits. Because there are no recommended benefit increases for this year, ETF does not recommend raising the pharmacy and medical OOPL.

8. Subrogation: The study group considered a proposal from a health plan that would allow the health plan to deny a member's claim if the member failed to adequately respond to the health plan's request to provide all pertinent information in order to process the claim. ETF does not recommend a change of this nature because ETF thinks that the current contract language concerning a member's responsibility to provide information to a health plan is sufficient.

The study group also considered a proposal from a health plan that would exclude health services for injury or illness for which there is other non-group insurance providing medical expense coverage, regardless of whether the other coverage is primary, excess or contingent to the plan. The intent of the provision is to help support the subrogation method where liability is determined in advance of payment as opposed to the traditional method commonly referred to as "pay and chase." ETF does not recommend a change of this nature because only two health plans currently determine liability in advance of payment. In addition, ETF thinks that current contract language adequately supports either subrogation method.

9. In-Network Benefits for Students: The study group considered a proposal to offer in-network benefits to students who attend school outside of the service area. The study group also considered a proposal to offer routine allergy shots as in-network benefits to students who attend school outside the service area. Many health plans opposed this recommendation for a variety of reasons: the proposals potentially interfere with the managed care systems of health plans' designed to control cost and ensure quality; the proposals potentially interfere with the coordination of care by primary in-network providers; health plans will have difficulty determining student status since federal law no longer requires the identification of student status. For these reasons, ETF does not recommend offering in-network benefits, including routine allergy shots, as in-network benefits to students who attend school outside the service area.

10. Contact Lenses for Keratoconus: The study group considered a proposal to provide coverage for contact lenses and lens fitting for the treatment of keratoconus. Currently, corneal transplants are covered to treat keratoconus only when the condition is not correctible with a contact lens. In 2007, the Board clarified the exclusion for contact lenses to cover an initial lens per surgical eye only when directly related to *cataract* surgery. ETF does not recommend covering contact lenses for the treatment of keratocunus because the Uniform Benefit certificate currently covers an adequate alternative treatment for the condition.

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11. Infertility Treatment: The study group considered a proposal to provide a benefit for infertility treatment of up to $15,000 for treatment, surgeries, or medications. The proposal also suggested that up to $15,000 could alternatively be used to cover the costs of adoption services or the cost of providing paid time off from employment. ETF does not recommend adding infertility treatment for two reasons. First, providing cash to a participant for adoption services and paid time off is not a medical benefit, and as such, has no place in a health insurance policy. Second, Assisted Reproductive Technology (ART), standard treatment for infertility, costs between $12,500 and $15,000 per procedure and most patients pursue multiple procedures as only 31% of ART procedures result in births.

12. Non-Surgical Weight Loss Services: As an alternative to bariatric surgery, the study group considered a proposal to expand the current non-surgical weight-loss services to include weight-loss medications and an expansion of existing nutritional counseling services. The nutritional counseling benefit currently covers: 1) a nutritional assessment by a physician; 2) a re-assessment and intervention; 3) diabetes outpatient self-management training services; 4) dietitian visit.

Common weight management services covered include:

- Initial assessment of eating and activity habits
- Counseling on diet and physical activity
- Education on how to improve diet and changes that promote weight loss and improve health
- Follow-up visits to monitor diet and weight loss progress

Offering the following weight management benefit would result in the following costs (the range of the estimated cost the Group Health Insurance program is based on assumed utilization of services by overweight members from 10% - 30%):

$250 Annual Benefit - $1.06 - $3.19 PMPM
$500 Annual Benefit - $2.13 - $6.38 PMPM
$1000 Annual Benefit - $4.25 – $12.76 PMPM

ETF does not recommend expanding weight loss services beyond the current nutritional counseling benefit because ETF regards the existing benefit as sufficient.

13. Therapy Benefit Limitation: The study group considered a proposal to limit the existing therapy benefit. The current therapy benefit covers up to 50 visits per participant for all therapies, speech, physical, and occupational, combined per calendar year. Up to a maximum of 50 additional medically necessary visits per therapy per participant per calendar year may be available when prior authorized by the health plan. In theory, a participant could receive up to 200 therapy visits if prior authorized by the health plan. However, feedback from health plans indicates that the prior authorization requirement currently in place is adequate to control over-utilization of this benefit. Therefore, ETF does not recommend lowering the therapy visit limit.

14. Renal Disease Treatment: The study group considered a proposal to limit coverage of renal (kidney) disease treatment to $30,000 annually. Wis. Stats. § 632.895 (4) requires a minimum coverage amount of $30,000 annually for renal disease treatment. The current kidney disease treatment benefit provides coverage for inpatient and outpatient treatment, limited to all services and supplies directly related to kidney disease, including but not limited to dialysis, transplantation, donor-related services, and related physician charges.

Beginning January 1, 2014, all state mandated benefits, including renal disease treatment, are by federal regulation included as an Essential Health Benefit (EHB) under Wisconsin's proposed default benchmark plan. Federal law also prohibits annual dollar limit on EHBs. Both rules go into effect January 1, 2014. Since renal disease treatment is considered an EHB under the proposed default benchmark plan for Wisconsin, it is ETF's interpretation that federal rule would prohibit the imposition of annual dollar limits on renal disease treatment. Accordingly, ETF does not recommend limiting coverage of renal disease treatment to $30,000 annually.

15. Screening, Brief Intervention, and Referral to Treatment (SBIRT): SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment for persons with substance abuse disorder, as well as those who are at risk of developing these disorders. Primary care centers and emergency rooms equipped with SBIRT programs can provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

As of February 2009, SBIRT (a federally-funded program) had been implemented in 17 states and more than 658,000 patients nationwide had been screened through SBIRT. SBIRT implementation costs are not typically great. For instance, the training can be done in-house with public resources that are available at no cost on the Internet. State block grants are also available, and costs are offset by the program's billability.

While studies have indicated that healthcare costs savings that range from $3.80 to $5.60 for each $1.00 spent can be realized, the actual quantification of such savings is often more difficult. An analysis performed by the Board's actuary for one organization based on employee "readiness to change" attitudes indicated that savings resulting from drug and tobacco screening were relatively minor, while savings from depression screening were possible.

Although ETF does not recommend implementing SBIRT in 2014, ETF feels that this type of program merits further analysis for possible implementation in future years.

Staff will be at the Board meeting to answer any questions.