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CORRESPONDENCE MEMORANDUM

DATE: October 18, 2013

TO: Group Insurance Board

FROM: Emily Loman, Manager, Alternate Health Plans
Shayna Gobel, Manager, Self-insured Benefit Plans
Mary Statz, Director, Health Benefits and Insurance Plans Bureau

SUBJECT: 2014 Guidelines and Uniform Benefits Technical Changes
2014 Standard Plan Technical Changes

This memo is for informational purposes only. No Board action is required.

At the May 21, 2013 Group Insurance Board (Board) meeting, staff received Board approval to proceed with necessary technical changes relating to the Alternate and Standard Plan contracts. This memo highlights the changes for the Board's reference.

1. Uniform Wellness Incentive

In 2012, the Board approved a Wellness program for 2013. Health plans were required to provide Biometric Screenings and Health Risk Assessments (HRAs) to 30% of their adult members; health plans were allowed to provide incentives *up to* $150 to encourage participation; no penalty was imposed on health plans that failed to achieve 30% participation.

While plan year 2013 has not yet concluded, participation rates among the health plans are expected to fall well below the 30% threshold. In order to address low participation and increase access to screening events, the Board approved the procurement of a third party administrator to conduct Biometric Screening and Health Risk Assessments (HRAs), coordinate screening events and report results. At the May 21, 2013 meeting, the Board moved to have a uniform wellness incentive of $150.

In order to implement the Board's decision to standardize wellness incentives, staff found it necessary to revise section II.D.5 of the 2014 Guidelines to clarify the requirement that health plans provide a uniform $150 incentive to eligible members who complete both a biometric screening and an HRA. The language below also clarifies that members may submit screening results that are obtained through the State's

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

Lisa Ellinger

Electronically Signed
10/28/2013

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biometric screening vendor to their health plans.

No changes were made to the participation rate thresholds for 2014. ETF sent the revised language to health plans for their signature in October 2013.

Guidelines II.D.5 Excerpt

Plans must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult members including members whose biometric screening results are obtained through the State's biometric screening vendor. Plans ~~may~~ must provide incentives ~~up to~~ of $150.00 in value to members who complete an HRA and biometric screening to encourage participation. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. Members may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The Board will reward health plans that administer HRAs and biometric tests to more than 50% of the Participants described above by crediting the plan's composite score during annual negotiation. Plans must demonstrate, upon request by the Department, their efforts in utilizing the results to improve the health of members of the group health insurance program.

2. Coverage of Spouse or Domestic Partner

Article 3.11 State and Local Contract

At the May 21, 2013 meeting, staff recommended, and the Board approved, technical changes to Article 3.11 of the State and Local contract that were designed to allow married couples and Domestic Partners (DP) where one individual is a state employee and the other is a local employee to each elect individual or family coverage. Previously, these participants had only been allowed to elect individual coverage. It has since come to staff's attention that the relevant contract revisions were made to the wrong section of Article 3.11. The language below correctly states the change to allow individual or family coverage where one spouse or DP is a state member and the other is a local member.

3.11 (1), (2) State Contract Excerpt

(1) If both spouses are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one spouse elects family coverage, the other eligible spouse may be covered as a DEPENDENT but may not have any other coverage. If both spouses are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage.

(2) If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and both are eligible for coverage, each may elect individual coverage, but if one DOMESTIC PARTNER elects family coverage, the other eligible DOMESTIC PARTNER may be covered as a DEPENDENT but may not have any other coverage except if necessary to avoid imputed income. If both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin and a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage.

3.11 Local Contract Excerpt

If both spouses or both DOMESTIC PARTNERS are ANNUITANTS or employed through the State of Wisconsin or a participating Wisconsin Public EMPLOYER and both are eligible for coverage, each may elect individual or family coverage.

3. Standard Plan Technical Changes

The current Standard Plan contract with WPS Health Insurance provides benefits for some services that require prior authorization. As a procedural matter, genetic testing for cystic fibrosis and trigger point injections for pain management no longer require prior authorization. In contrast, prior authorization is newly required to receive pharmacogenetics testing. Contract language has been updated to reflect this change.

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