STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
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: January 28, 2014

TO: Group Insurance Board

FROM: Emily Loman, Manager, Alternate Health Plans
Mary Statz, Director, Health Benefits and Insurance Plans Bureau

SUBJECT: GUIDELINES and Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2015

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

In the past, a staff discussion group 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, and representatives from the Wisconsin Association of Health Plans and the Alliance of Health Insurers have also participated. Staff plans to continue this process for contract year 2015. We are providing the following information on a variety of expected issues and timelines for the development of the GUIDELINES. This "Study Group" plans to convene three times before the end of April. The anticipated timeline for the 2015 contract is as follows:

- **February 11, 2014** – Health plans may submit written recommendations to the Department of Employee Trust Funds (ETF) by this date, identifying issues that warrant clarification or change in the GUIDELINES or Uniform Benefits. Throughout January and February, staff will draft preliminary recommendations for changes/clarifications for the 2015 contract year, with input from the Board's actuary.

- **February 19, 2014** – GIB meeting. The Board will review ETF's memo outlining certain anticipated issues for the 2015 contract.

- **February 25, 2014** - *Study Group meeting #1* - On or around this date, the Study Group will meet to identify issues to be included in the first draft of the GUIDELINES/Uniform Benefits.

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

Lisa Ellinger

Electronically Signed: 02/06/2014

Board	Mtg Date	Item #
GIB	2.19.14	4A

- **March 7, 2014** - On or around this date, ETF will send health plans a draft of the 2015 GUIDELINES/Uniform Benefits.

- **March 14, 2014** – Health plans have until this date to return comments on the draft Guidelines/Uniform Benefit changes.

- **March 25, 2014** - *Study Group meeting #2* - On or around this date, the Study Group will meet to discuss health plan comments and identify issues to be included in the final draft of the GUIDELINES/Administrative Provisions and Uniform Benefits.

- **April 11, 2014** – *Study Group meeting #3* - the Study Group will meet to finalize recommendations to the Board.

- **May 21, 2014** – GIB meeting. Recommended changes to the 2015 GUIDELINES/Uniform Benefits are set for review and approval at this meeting.

Changes Under Consideration for the Alternate Group Health Insurance Plan-2015
The following provides a brief summary of some of the contract issues that may be reviewed and discussed for inclusion during this process. Participants, health plans and/or staff members have raised these issues over the course of the past year. We also welcome comments or suggestions from the Board.

Some items may have associated costs, while others may be clarifications of existing practice (with no expected cost). Cost factors, if any, will be identified by the study group and presented to the Board in the final recommendation. Changes under consideration include:

- **Federal law**:
  - Current federal law allows for separate maximum out-of-pocket limits for medical, pharmacy, and dental expenses under a safe-harbor provision for large group health plans until the end of 2014. Beginning January 1, 2015, combined expenses must not exceed the annual limitation under federal rule. The Department of Health and Human Services (HHS) has proposed a maximum limit of $6,750 for single coverage and $13,500 for family coverage for 2015.

    Therefore, we will consider whether to structure a benefit design using separate out-of-pocket limits for medical, pharmacy, and dental benefits, provided that the combined amount of any separate out-of-pocket limits applicable to all Essential Health Benefits (EHB) under the plan does not

exceed the annual limitation on out-of-pocket maximums for that year under section 1302(c) of the Affordable Care Act.

Another option would be to require all service providers (medical, pharmacy, and dental) to routinely track and communicate members' out-of-pocket expenses with one another other to ensure that the combined expenses do not exceed the annual limit.

We will also research and apply relevant rules for out-of-pocket limits to plan design for the Health Savings Account (HSA) and High Deductible Health Plan option required by statute.

  - Provide 100% coverage of routine preventive vision exams for all children under age 18 as required under federal law. The current age limit requires 100% coverage for children under age 5.

- **Disease Management**:
  - Expand the Shared Decision Making (SDM) program by requiring plans to provide members with the opportunity to discuss a particular intervention with their provider, a caregiver, or a vendor who is trained to have such a discussion.

  - Expand the SDM program to require clinicians to engage in shared decision making with women who are at increased risk for breast cancer about medications to reduce their risk pursuant to United States Preventive Services Task Force (USPSTF) guidelines. Also, group health plans, such as ours, will be required to cover such medications for applicable women without cost sharing subject to reasonable medical management.

  - Improve End of Life (EOL) care by contractually requiring a credible Advanced Care Planning (ACP) program to include palliative care consultation, and hospice care according to a variety of approaches approved by ETF.

- **Pharmacy Benefits**:
  - Require members to obtain specialty medications through use of the state's mail-order specialty pharmacy vendor.

  - Review co-pay and/or co-insurance levels and out-of-pocket limits for prescription medications.

  - Discuss limiting the use of certain specialty medications to specific FDA-approved indications.

- **Wellness Program**:
    - Discuss the concept of providing a wellness program through a Third Party Administrator (TPA), as is done with the pharmacy benefits program.
    - Discuss the concept of providing different premium levels based on an employee's annual completion of both a Health Risk Assessment (HRA) and biometric screening test.
- **Dental Benefits**:
    - Discuss the concept (with both the Study Group and GIB Strategic Planning Workgroup) of removing the uniform dental benefit from the health insurance contract and to provide the dental benefit through a TPA similar to the pharmacy benefits program. Implemention target would be no sooner than 1/1/2016.
    - Consider adding coverage for crowns and basic endodontic services.
- **Medical Benefits**
    - Review the status of the existing 90%/10% coinsurance cost-sharing measure to decide if a co-pay arrangement would be preferable in some circumstances.
    - Review whether to adjust the out-of-pocket limit for inflation.
    - Discuss coverage of tele-health services. Tele-health services use telecommunication and information technologies in order to provide clinical health care to patients at a distance, which can be beneficial to patients living in rural or isolated areas. Tele-health is not designed to prevent or interfere with communication between providers concerning a patient's treatment or condition.
- **Administration**
    - Clarify that a subscriber's sick leave conversion credits can be split between multiple eligible surviving dependents under applicable Administrative Rule.
    - Consider whether to allow an employer to perform a retroactive premium adjustment beyond the current two month retroactive limit. This would allow an employer that had failed to properly terminate an employee's health insurance coverage upon termination of employment to correct a mistake in enrollment beyond the current limit, and, thus, collect further

back premium. This would not apply if prohibited by federal anti-rescission rules or if claims have been properly paid under the coverage.

- Clarify enrollment opportunities for employees returning from Leave of Absence (LOA).

- Health Savings Accounts: staff expects there to be administrative requirements associated with implementation of the statutorily-required HSA and HDHP option.

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