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CORRESPONDENCE MEMORANDUM

DATE: May 14, 2015

TO: Group Insurance Board

FROM: Tara Pray, Manager, Alternate Health Plans

SUBJECT: Guidelines & Uniform Benefits for the 2016 plan year

This memo presents a variety of options for health insurance plan design changes for the 2016 plan year and several technical or administrative changes to the Guidelines contract.

The Department of Employee Trust Funds (ETF) staff requests the following of the Group Insurance Board (Board).

1. **Approve one of the benefit options presented in this memo. Staff recommends Option 2.**

2. **Approve the technical changes to the Guidelines contract that are detailed in this memo and grant ETF staff the authority to make additional technical changes as necessary.**

Background

Segal Consulting (Segal) presented initial recommendations for 2016 benefit changes at the March 25, 2015 Board meeting. The recommendations aim to achieve cost savings that meet the requirements of the Governor's 2015-2017 Biennial Budget (detailed below). Segal and ETF recommendations also take into consideration the impending Affordable Care Act (ACA) "Cadillac Tax" set to go into effect in 2018 -- the program is in danger of meeting the thresholds that would trigger the tax at current benefit levels.

In addition to biennial budget provisions and Segal's recommendations, ETF staff collected benefit change suggestions from its regular sources over the past year: health plans, members, employers, and ETF Ombudsperson Services staff. These suggestions have been discussed with Segal and those that are supported by both Segal and ETF staff are recommended in the options included in this memo.

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy
Lisa Ellinger
Electronically signed: 05/15/15

Board	Mtg Date	Item #
GIB	5.19.15	3C

Every year, ETF convenes a "study group" to discuss potential benefit changes in order to provide the Board with feedback from the member, employer and health plan perspectives. The Study Group convened on April 28 to review the 2016 recommendations. ETF staff answered the group's questions and collected feedback which is summarized in this memo.

The Study Group was comprised of ETF staff, eight representatives from other state agencies and two representatives from Wisconsin health plan professional associations. Participants included: Jennifer Kraus and Mickie Waterman, Department of Administration (DOA); Jason Levine, Office of the Commissioner of Insurance (OCI); Danielle Carne and Paul Ostrowski, Office of State Employment Relations (OSER); Nicole Zimm, STAR Project (DOA); Zoua Vang and Deanna DeSlover, University of Wisconsin System and University of Wisconsin – Madison; Beth Ritchie, University of Wisconsin Hospital and Clinics; Phil Dougherty, Wisconsin Association of Health Plans (WAHP); RJ Pirlot, Alliance of Health Insurers (AHI); and the following ETF staff: Lisa Ellinger, Bill Kox, Mike Bormett, Sarah Bradley, Sherry Etes, Roni Harper, Arlene Larson, Tara Pray, John Alexander, Allen Angel, Vickie Baker, Liz Doss-Anderson, Brian Shah, Korbey White, and Tarna Hunter.

Biennial Budget Changes

The 2015-2017 state budget currently includes a provision requiring the Board to work with Segal to identify $25 million (General Purpose Revenue funds) in cost savings over the next two years. This amount equates to a needed savings of **$54 million** in all funds over the 2015-2017 biennium.
Note: Due to the health insurance program operating on a calendar year, versus the State Budget operating on a state fiscal year (July 1 – June 30), required program cost savings will begin one quarter of the way into the biennium.

The state budget also calls for an employee opt-out incentive, where those who opt out of the state employee health insurance plan will receive an annual $2,000 stipend. Based on previous analysis, the state budget accounted for **$27 million** in savings over the biennium for this provision. However, Segal's recent analysis of the opt-out provision concluded that there will be a negligible financial impact overall on the program.

Therefore, the total program savings required by the 2015-2017 State Budget is $81 million in all funds over the 18 months from January 1, 2016 – June 30, 2017. To achieve the targeted savings over the 18-month timeframe would require the implementation of cost-containment strategies equal to $54 million in savings for 2016.

Segal Recommendations

The following recommendations are essentially the same as those presented by Segal at the March Board meeting, with minor adjustments. Segal is not recommending an

increase in the employee percentage share of premium contributions. Employee premiums are established by OSER.

Note: The recommended changes to the medical deductibles, copayments and coinsurance would not apply to the Medicare population or the Wisconsin Public Employers (WPE) program options, except as stated.

A. Medical Benefits - Projected 2016 savings: $50 million ($75 million (M) over biennium)

1. Coinsurance Uniform Benefits Plan

a. Modify deductible and out-of-pocket limits.

	Single		Family	
	Current	Proposed	Current	Proposed
Deductible	$0	$250	$0	$500
Out-of-Pocket Limit (OOPL)	$500	$1,000	$1,000	$2,000

Savings: This change will generate an average program savings of $34M in 2016 ($20M deductible and $14M OOPL, respectively), and $52M over the biennium.

b. Replace coinsurance with copays for office visits. The deductible would not need to be met for the copay amounts to apply for office visits.

	Current	Proposed
Primary Care Physician (PCP) Office Visit*	10%	$15
Specialist Office Visits	10%	$25

**copay will also apply to visits for chiropractic and therapy services*

Savings: This change will generate an average program savings of $16M in 2016, and $24M over the biennium.

2. Standard Plan

	Single		Family	
	Current	Proposed	Current	Proposed
Deductible (Preferred Provider)	$200	$250	$400	$500
Out-of-Pocket Limit	$800	$1000	$1,600	$2,000

Savings: This change will generate an average program savings of $300,000 in 2016, and $450,000 over the biennium.

3. High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

	Single		Family	
	Current	Proposed	Current	Proposed
HSA Employer Contribution*	$170	$750	$340	$1,500

**HSA Employer Contribution amounts are established by OSER*

Cost: This change will generate an average program cost of $300,000 in 2016, and $450,000 over the biennium.

B. Pharmacy Benefits – Projected 2016 savings: $8 million ($12M over biennium)

Convert to a coinsurance structure for cost sharing for prescription drug levels 2-4 and increase the out-of-pocket limits.

Level	Current	Proposed
Member Costs		
Level 1	$5	$5
Level 2	$15	20% ($50 max)
Level 3	$35[1]	40% ($150 max)[1]
Level 4 • Preferred • Non-preferred	 $15[2] $50	 $50[2] 40% ($200 max)
Member Out-of-Pocket Limits (OOPL)		
Levels 1 & 2[1]	$410 S[3] / $820 F[3]	$600 S / $1,200 F
Level 4	$1,000 S / $2,000 F	$1,200 S / $2,400 F

[1]Level 3 copays do not apply toward out-of-pocket limits
[2]Reduced copay applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy
[3] Single (S), Family (F)

Savings: This change will generate an average program savings of $8M in 2016 ($7M coinsurance and $1M OOPL, respectively), and $12M over the biennium.

Benefit Recommendations Generated From Other Sources

The following recommendations were generated from the suggestions ETF collected from sources other than Segal (e.g., members, employers, health plans, etc.). Segal has reviewed the recommendations with ETF staff and the associated costs and savings are listed below each.

C. Members with serious disease and a likely survival of less than six months will be offered Advanced Care Planning (ACP) and/or a palliative care consultation. When appropriate, such individuals will receive multidisciplinary palliative care in their homes.

Rationale: ETF supports the expansion of ACP to ensure that members facing serious illness are informed of care options and are able to make treatment decisions based on their individual values and goals of care.

Savings: This change will generate an average program savings of $195,000 in 2016, and $292,500 over the biennium.

D. Add coverage for therapies associated with habilitative services

Rationale: Therapy services related to habilitative care (to "gain or maintain a new function") are not currently covered. The program only covers therapy services for rehabilitative care (to "regain or maintain a lost function"). The coverage for habilitative services is being considered this year to align the program with the coverage offered by many other plans in the state. This is currently the only ACA-required federal Essential Health Benefit that the program does not cover, although large employers are not required to cover Essential Health Benefits. If this benefit is added, the coverage will be offered in parity with the rehabilitation benefit; must be medically necessary; and visit limits and specialty copayments will apply.
Note: If the Board does not approve this benefit, staff will consider adding clarification that therapies for developmental delay (not just disabilities) are also excluded. This clarification was suggested by a health plan this year. The current language states the therapies are excluded for "developmental disabilities," but not specifically "developmental delays". This would be a clarification, not a benefit change.

Cost: This change will generate an average program cost of $1.75 million in 2016, and $2.625 million over the biennium.

E. Bariatric surgery with strict treatment protocols.

Rationale: Certain surgical procedures are proven in adults for the treatment of clinically-severe obesity. Technology in this area has improved and the majority of the procedures are performed laparoscopically. Successful outcomes include reduction of excess weight, improvement of quality of life and longevity and a decreased risk of weight-related conditions, including cardiovascular disease and cancer.

Cost: This change will generate an average program cost of $1.5 million in 2016, and $2.25 million over the biennium.

Study Group, Health Plan, Public Feedback

The following were key areas of concern:

- **Specialty office visit copay:** Some Study Group members said the proposed specialty office visit copayment was high, especially for those who see multiple specialists. ETF staff relayed that the average current coinsurance cost was close to the proposed $25 copayment amount.

- **Prescription drug cost share:** There was some concern that increasing the member share of Level 2 – 4 prescription drug costs did not equitably affect the program's population, and that an across-the-board increase to all levels would be more appropriate. ETF staff responded that there was a desire to keep drugs affordable whenever possible, particularly with Level 1 generic drugs that impact the vast majority of members in the health insurance program.

- **Cost shifting:** There was a general concern about cost shifting to members and the effect this could potentially have on employers' recruitment and retention efforts.

- **Education/communications needed:** The Study Group agreed that if the recommendations are adopted, a significant educational effort will be needed for both employers and members.

  Study Group participants emphasized the importance of the Board understanding how each proposed change would affect members, individually and as a group.

- **Offering ACP and/or palliative care with less than six months life expectancy:** Some health plans have indicated they can identify members with serious illnesses, but are unable to identify those with a less than six month life expectancy.

- **Coverage for habilitative services:** The Study Group concurred this would be a positive change for the program. Health plans suggested establishing clear medical necessity criteria at the health plan's discretion as well as a set limit on the benefit. Families who have been denied services feel that the current exclusion is discriminatory.

- **Bariatric surgery:** Health plans said that such coverage is not a common market benefit and adding coverage does not seem to align with reducing costs and increasing the focus on wellness. They also acknowledged that technology has greatly improved in this area. If this becomes a covered benefit, health plans

want ETF to define the specific types of bariatric surgery covered and coverage protocols so that plans can administer consistently.

Note: The Study Group feedback has been shared with Segal.

Since Segal's recommendations have become public, ETF has experienced an increase in calls and emails from members and employers expressing concerns over the proposed changes. The overarching concern is health care costs being shifted to members. There is concern about affordability, as most members are experiencing a net decrease in take-home pay due to minimal salary adjustments and increases in employee contributions for benefits.

Benefit and Contract Change Options – to be voted on by the Board

The following options are for the Board's consideration. Staff recommends Option 2. The total cost savings for 2016 associated with Option 2 are in line with the savings required as a part of the biennial budget, and they also add benefits that will round out the program, covering all of the federal Essential Health Benefits as well as progressing the end of life initiatives that are part of the ETF strategic plan. Staff recognizes that the projected savings correlated with Option 2 are slightly above the required budget target, however this figure helps to address the need to reduce program costs to avoid the impending ACA "Cadillac Tax."

Note: The Coinsurance Wisconsin Public Employers (WPE) Group Health Insurance Program mirrors the State Coinsurance Uniform Benefits plan design and will incorporate changes approved by the Board. Other WPE options will maintain different deductibles and coinsurance.

Option 1: $54,945,000 Projected 2016 Savings ($82,417,500 Savings Over Biennium)				
A. Segal medical benefit changes **$50M savings**	B. Segal pharmacy benefit changes **$8M savings**	C. ACP & palliative care **$195,000 savings**	D. Habilitative services **$1.75M cost**	E. Bariatric surgery **$1.5 cost**
+ Deductible $20M ↑ Max Out-of-Pocket $14M Office Visit Copays $10M Therapy Copays $6M Standard Plan $.3M ↑ HSA Deposit ($.3M)	Coinsurance Rx Levels 2-4 $7M ↑ Max Out-of-Pocket $1M	Average 2016 savings $195,000	Average 2016 cost $1.75M	Average 2016 cost $1.5M

Option 2: $56,445,000 Projected 2016 Savings ($84,667,500 Savings Over Biennium)

A. Segal medical benefit changes **$50M savings**		B. Segal pharmacy benefit changes **$8M savings**		C. ACP & palliative care **$195,000 savings**	D. Habilitative services **$1.75M cost**
+ Deductible	$20M	Coinsurance Rx Levels 2-4	$7M	Average 2016 savings $195,000	Average 2016 cost $1.75M
↑ Max Out-of-Pocket	$14M	↑ Max Out-of-Pocket	$1M		
Office Visit Copays	$10M				
Therapy Copays	$6M				
Standard Plan	$.3M				
↑ HSA Deposit	($.3M)				

Option 3: $58,195,000 Projected 2016 Savings ($87,292,500 Savings Over Biennium)

A. Segal medical benefit changes **$50M savings**		B. Segal pharmacy benefit changes **$8M savings**		C. ACP & palliative care **$195,000 savings**
+ Deductible	$20M	Coinsurance Rx Levels 2-4	$7M	Average 2016 savings $195,000
↑ Max Out-of-Pocket	$14M	↑ Max Out-of-Pocket	$1M	
Office Visit Copays	$10M			
Therapy Copays	$6M			
Standard Plan	$.3M			
↑ HSA Deposit	($.3M)			

Option 4: $58M Projected 2016 Savings ($87,000,000 Savings Over Biennium)			
A. Segal medical benefit changes **$50M savings**		B. Segal pharmacy benefit changes **$8M savings**	
+ Deductible	$20M	Coinsurance Rx Levels 2-4	$7M
↑ Max Out-of-Pocket	$14M	↑ Max Out-of-Pocket	$1M
Office Visit Copays	$10M		
Therapy Copays	$6M		
Standard Plan	$.3M		
↑ HSA Deposit	($.3M)		

Option 5: 2016 Savings to be Determined
Other options as selected by the Board

Recommended Technical/Administrative Changes

This section explains minor contract and Guidelines updates. These recommendations were also generated from the suggestions ETF collected from sources other than Segal (e.g., members, employers, health plans, etc.). Staff will be at the meeting if the Board has questions about any of the following changes.

1. Health plans may offer a conversion policy or a Marketplace plan in the event of exhaustion of COBRA coverage. Current Guidelines require a conversion policy only. The Office of the Commissioner of Insurance (OCI) interprets Marketplace plans to meet state law (§632.897).
2. Add a due date for Summary of Benefits & Coverage (SBC) documents required by the ACA to the timeline in the Guidelines.
3. Clarify that the Standard Plan and the HDHP Standard Plan are two separate plans.
4. Require employers to pay the ETF invoice amount and adjust for discrepancies prospectively.
5. Allow WPE to offer opt-out incentives, as provided for state employees in the biennial budget proposal.
6. Clarify that ETF allows retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely.
7. Clarify that ETF allows participants to enroll within 30 days of *notice* of loss of eligibility for coverage.

8. Clarify that new hires must file an application for the HDHP at the same time as creating an HSA account. This is implied, but not specifically stated.
9. Align WPE language with that in the state contract for consistency as appropriate.
10. Add "employer paid local annuitants" to the 2016 contract clarification requiring all Medicare eligible annuitants to enroll when first eligible. This is a clarification of current policy.
11. Clarify that an implanted special lens, such as a multi-focal lens, is not medically necessary for cataract surgery.
12. Clarify that the autism benefit limits are adjusted annually by OCI based on inflation. This is confusing now because the stated limits are $50,000/$25,000 and the related statute regarding inflationary increases is also referenced.
13. Update the surgical exclusion language from "sex transformation" to "gender reassignment".
14. Allow subscribers who move from a county to change to any health plan, not limited to the health plans offered in the new county.
15. Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.
16. Limit coverage of minor dependents to only be covered once within the program.
17. Change language in the Wellness Guidelines from "The BOARD ***will*** reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS….", to "The BOARD ***may*** reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS…."
18. Add expired prescription drugs to the exclusions for covering/replacing prescription drugs.
19. Plans/providers will administer a patient satisfaction survey to all ETF members participating in a SDM program.

Suggestions Deferred to Future Plan Years

The following proposed changes are not recommended for 2016, based on discussions between ETF and Segal staff. Consideration of these changes will be deferred as possibly part of a broader program redesign for 2017 or beyond.

1. Create a member incentive to participate in SDM.
2. Modify hospice care language to expand to include those who have less than 1 year life expectancy, rather than 6 months.
3. Increase the emergency room copay to a market standard of $150-$200.
4. Implement an urgent care visit copay.
5. Align all coinsurances at either 10% or 20% (member responsibility).
6. Add coverage for 3D mammography.
7. Add coverage for tooth root removal (D7250) under oral surgery benefits.
8. Add specific contract language on coverage for telemedicine.
9. Add coverage for gender reassignment benefits with strict protocols.

10. Modify current exclusion language on genetic testing to exclude genetic testing that is not proven to affect medical management.
11. Administer the Well Wisconsin Program through a Third Party Administrator.
12. Add a “Tier 0” where health plans could offer a narrow “value based” network built on an Accountable Care Organization or a Patient-Centered Medical Home.
13. ETF creates SBC documents instead of the health plans.
14. Codify in contract that members have up to one year to add a child due to birth per Wis. §632.895.
15. Exemption from participation in Wisconsin Health Information Organization (WHIO).
16. Create a lower prescription drug copay to incent members to participate in disease management programs.
17. Modify the Miscellaneous Hospital Expense definition to specifically exclude convenience items. This would be duplicative of an existing exclusion.
18. Include shingles vaccine coverage for individuals as early as age 50. Not recommended for this group per the Centers for Disease Control.
19. Add 50% coverage for out-of-area care that is medically necessary, non-emergent, non-urgent follow up care. It would require prior authorization and be subject to the usual, customary and reasonable health plan charges.
20. Shift SDM requirements to the providers instead of the health plans.
21. Shift End of Life Care and ACP requirements to providers instead of the health plans.
22. Add a spousal surcharge.
23. Limit hearing aid replacement to every three years, counted even if member changes health plans.
24. Remove the $1,000 maximum health plan hearing aid payment for members ages 18 and older (covering 90% with the limit of one aid per ear no more than once every 3 years).
25. Limit the number of cardiac rehabilitation visits covered per calendar year.
26. Remove the authorization requirement for standard corneal transplants (prior authorization will still be necessary for artificial corneal transplant or keratoprosthesis).
27. Limit chiropractic visits to 15 per year and allow additional visits only when prior authorized by the health plan, up to a maximum of additional 15 visits.
28. Allow transgender people to change their gender in the ETF system with or without surgery.
29. Allow members to select a gender other than male or female on their health insurance application.
30. Add an exclusion for the additional cost of robotic surgery.
31. Add an exclusion for the removal of skin tags.
32. Add an exclusion for the routine foot care.
33. Add an exclusion for hair removal.
34. Add “unproven” to the experimental exclusion (alternative – add “unproven” to the definition of “Experimental”).
35. Remove the “hold harmless” provision.

36. WPE Deductible Program Option (PO) 4 for Medicare eligible & enrolled. Deductible is applied. Most Medicare retiree plans would have $0 deductible apply.
37. Add contract language regarding Suboxone and related detoxification maintenance exclusion.
38. Add coverage for transitional residential services for patient needs beyond Alcohol and Other Drug Abuse (AODA) treatment (e.g. treatment of an eating disorder).
39. Clarify that exclusion for out of area prior authorized maternity services also applies to births that take place after the due date.

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