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
etf.wi.gov

CORRESPONDENCE MEMORANDUM

DATE: August 4, 2015

TO: Group Insurance Board

FROM: Tara Pray, Manager, Alternate Health Plans

SUBJECT: Uniform Benefits update for the 2016 plan year

Staff requests that the Group Insurance Board (Board) approve the combined medical out-of-pocket limit proposed in Item 1. The remainder of the memo is for informational purposes.

Background

At the May 19, 2015 meeting the Board approved technical changes to the 2016 Uniform Benefits/Guidelines contract and also granted Employee Trust Funds staff the ability to make additional technical changes as necessary. This memo outlines additional technical changes for 2016 that were not listed in the memo presented on May 19.

Additionally, it was determined that the out-of-pocket limits as originally proposed by Segal Consulting (Segal) may be confusing for members and administratively burdensome for the health plans. The original proposal was to maintain separate medical out-of-pocket limits for both copayments and coinsurance member costs. This new proposal combines the medical out-of-pocket limits into one new out-of-pocket limit per individual or family contract. The proposed out-of-pocket limits were calculated by Segal, and will have a neutral cost impact to the program.

2016 Uniform Benefits Updates

Specific contract language for the Uniform Benefits that was approved in concept by the Board in May, as well as the changes listed below, are included in the attachment to this memo.

Item 1: Staff recommends the Board approve the revised combined Medical Out-of-Pocket Limits of $1,250 Individual/$2,500 Family.

Here is an illustration:

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Electronically signed: 8/10/15

Board	Mtg Date	Item #
GIB	8.25.15	3A

	Original Proposal		Revised Proposal
	Office Visit **Copayments**	**Coinsurance**	**Combined** Office Visit Copayments and Coinsurance
Medical Out-of-Pocket Limits	$1,000 Individual / $2,000 Family	$1,000 Individual / $2,000 Family	$1,250 Individual / $2,500 Family

Item 2: Update the names of the plan designs as follows:

Current Name	New Name	New Shortened Name for benefit tables, etc.
Coinsurance Uniform Benefits	It's Your Choice Health Plan	IYC Health Plan
High Deductible Health Plan	It's Your Choice High Deductible Health Plan	IYC HDHP
Standard Plan	It's Your Choice Access Health Plan	IYC Access Health Plan
HDHP Standard Plan	It's Your Choice Access High Deductible Health Plan	IYC Access HDHP

Item 3: Update the names of the local program options as follows:

Program Option (PO) #	Current Name	New Name	New Shortened Name for benefit tables, etc.
PO2	Traditional HMO – Standard PPO	It's Your Choice Local Traditional – with Dental Option	IYC Local Traditional – w/ Dental Option
PO4	Deductible HMO – Standard PPO	It's Your Choice Local Deductible – with Dental Option	IYC Local Deductible – w/ Dental Option
PO6	Coinsurance HMO – Standard PPO	It's Your Choice Local Health Plan – with Dental Option	IYC Local Health Plan – w/ Dental Option
PO7	High Deductible Health Plan HMO – Standard PPO	It's Your Choice Local High Deductible Health Plan – with Dental Option	IYC Local HDHP – w/ Dental Option
PO12	N/A	It's Your Choice Local Traditional	IYC Local Traditional
PO14	N/A	It's Your Choice Local Deductible	IYC Local Deductible

Program Option (PO) #	Current Name	New Name	New Shortened Name for benefit tables, etc.
PO16	N/A	It's Your Choice Local Health Plan	IYC Local Health Plan
PO17	N/A	It's Your Choice Local High Deductible Health Plan	IYC Local HDHP

Item 4: Changes to accommodate the State Transforming Agency Resources (STAR) system. The following scenarios will change as follows:

Coverage Scenario	Current Policy	New Policy
Timing of ETF's monthly payment to the health plans	Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.	The DEPARTMENT shall transmit to the HEALTH PLAN that month's PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD by the end of the month of coverage.
Clarification that employers' monthly payment to ETF applies to the current month's coverage vs. the following month's	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the following month's coverage.	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the current month's coverage.
New hire	Insurance effective on the first day of the month following the receipt of the application by the EMPLOYER (when application is submitted within 30 days of hire).	Insurance effective on the first day of the month that first occurs during the 30-day period, or by electing coverage prior to becoming eligible for the EMPLOYER contribution… (Meaning "on or following the hire date" when

Coverage Scenario	Current Policy	New Policy
		application is submitted within 30 days of hire).
New eligibility for employer contribution	Insurance effective on the first day of the month following the receipt of the application by the EMPLOYER (when application is submitted within 30 days of date of hire which resulted in the increase in employer contribution).	Insurance effective on the first day of the month following the date in which the EMPLOYEE becomes eligible for the increase in employer contribution (when application is submitted within 30 days of date of hire which resulted in the increase in EMPLOYER contribution).
Coverage end date in the case of employee death	Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT for which PREMIUMS have not already been deducted, and shall remain in effect until such time as the DEPENDENT coverage would normally cease.	Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT, and shall remain in effect until such time as the DEPENDENT coverage would normally cease had the death not occurred.

Item 5: The $75 emergency room (ER) copayment will now accumulate towards the out-of-pocket limit. If the Board approves Item 1, above, all medical copayments will count towards the new, higher out-of-pocket limits. Making this change to have the ER copayment will result in consistent treatment of all medical copayments. The copayment will still be waived if the patient is admitted to the hospital in an inpatient status.

Item 6: Expand the requirement that health plans offer Advance Care Planning (ACP) and/or a palliative care consultation to members with a serious disease and/or a likely survival of less than twelve months, rather than six months or less.

ETF has received feedback from health plans about limitations in the accuracy of a “six months to live” prognoses and the need for ACP to be offered earlier for terminally ill patients.

In addition, under the existing hospice benefit, ACP would be covered for any member with a terminal diagnosis regardless of the life expectancy. It is estimated that these minor changes to ACP coverage will have an immaterial cost impact.

Item 7: Slightly revised hospice care benefit for clarification that both inpatient and home-based care is covered. There is no benefit change with this clarification.

Item 8: Remove references to health plans' dental coverage. This does not include medically appropriate oral surgery that is covered by the medical benefit.

Item 9: Remove obsolete preexisting condition language as current federal law prohibits this for our program.

Item 10: Add clarification that the Health Savings Account application must be accepted, not just submitted, in order to be eligible for the High Deductible Health Plan. This was recommended by the Board late in 2014, after the 2015 Guidelines had been finalized.

Item 11: Change the name of the reference to the Office of State Employment Relations (OSER) to the Division of Personnel Management in the Department of Administration.

In Progress
Staff is currently analyzing whether the current coverage for transitional residential treatment complies with federal mental health parity regulations. The actuaries have reviewed the addition of this benefit and have determined the cost to be immaterial. If it is determined that an expansion of this benefit is required under the law, staff will provide further information at the November 17 Board meeting.

Notes on Attachment A: Uniform Benefits/Guidelines contract language for 2016
The guidelines contract changes are detailed in the attached Excel workbook. The workbook is divided into three worksheets (*see tabs*):

- Benefit changes
- Technical/administrative changes
- Dental changes

Here are a few more explanatory notes:

- Changes that apply to both state and local participants have no highlights/background color.
- Changes that apply to state only are highlighted light blue.
- Changes that apply to local only are highlighted light green.
- New or removed text is in dark red font.
- Removed text is presented, but stricken with a red line.

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

Attachment A: Uniform Benefits/Guidelines contract language for 2016

BLUE: 2016

TRACKING SHEET

BENEFIT CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Provide state Employee opt-out incentive	Guidelines: I. OBJECTIVES (page 1-2)	Add opt-out provision	None	EMPLOYEES also have the option to opt-out of Group Health Insurance coverage. An EMPLOYEE who opts out of State Group Health Insurance, and is also not a covered DEPENDENT of the State Group Health Insurance Program, is eligible for a $2,000 opt-out payment from their EMPLOYER. Graduate assistants and craftworkers are not eligible for the opt-out incentive and nor are EMPLOYEES who opted out in 2015.	
Modify deductible and out-of-pocket limits (OOPLs)	Guidelines: I. (page 1-3)	Add copay to description of benefit structures that may be offered by the Board.	The BOARD also may offer an optional deductible benefit and/or coinsurance benefit structure that mirrors the State program for local governments.	The BOARD also may offer an optional deductible benefit and/or copayment and coinsurance benefit structure that mirrors the State program for local governments.	
Modify deductible and OOPLs	Guidelines: I. (page 1-3)	Expand reference of local program options to be broader.	Plans shall provide rates for both the regular and deductible options for the local group.	Plans shall provide rates for each of the ~~both the regular and deductible~~ program options for the local group.	
Health plans must offer Advance Care Planning and/or a palliative care consultation to members with a serious disease and a likely survival of less than six months. When appropriate, such individuals will receive multidisciplinary palliative care in their homes.	Guidelines: II. D. 13. (page 1-10)	Add requirement to offer to all members with a likely survival of less than six months.	3. HEALTH PLANS and their contracting providers must provide a credible Advanced Care Planning (ACP) program that includes hospice care and a palliative care consultation in a manner that is consistent with the Disease Management initiatives of the DEPARTMENT.	3. HEALTH PLANS and their contracting providers must provide a credible ADVANCE CARE PLANNING ~~Advanced Care Planning (ACP)~~ program that includes hospice care and a palliative care consultation in a manner that is consistent with the Disease Management initiatives of the DEPARTMENT. HEALTH PLANS must offer ACP and/or a palliative care consultation to members with a serious disease and/or a likely survival of less than twelve ~~six~~ months.	

BLUE: 2016

TRACKING SHEET

BENEFIT CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Modify deductible and OOPLs	Uniform Benefits: I. (start page 4-5)	Update Schedule of Benefits to reflect changes	Contained in Schedule of Benefits	Schedule of Benefits will be updated based on Board action and will be provided to the Board in November.	
Replace coinsurance with copays for office visits	Uniform Benefits: I. (start page 4-5)	Update Schedule of Benefits to reflect changes	Contained in Schedule of Benefits	Schedule of Benefits will be updated based on Board action and will be provided to the Board in November.	
Convert Rx Levels 2-4 to coinsurance; raise OOPLs	Uniform Benefits: I. (start page 4-5)	Update Schedule of Benefits to reflect changes	Contained in Schedule of Benefits	Schedule of Benefits will be updated based on Board action and will be provided to the Board in November.	
Health plans must offer Advance Care Planning and/or a palliative care consultation to members with a serious disease and a likely survival of less than six months. When appropriate, such individuals will receive multidisciplinary palliative care in their homes.	Uniform Benefits: II. DEFINITIONS (page 4-17)	Add definition for Advance Care Planning	None	**ADVANCE CARE PLANNING:** A process across time of understanding, reflecting on and discussing future medical decisions, including end-of-life preferences. Advance care planning includes: · Understanding your health care treatment options · Clarifying your health care goals · Weighing your options about what kind of care and treatment you would want or not want · Making decisions about whether you want to appoint a health care agent and/or complete an advance directive · Communicating your wishes and any documents with your family, friends, clergy, other advisors and physician and other health care professionals	

BLUE: 2016
TRACKING SHEET
BENEFIT CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Add coverage for therapies associated with habilitative services	Uniform Benefits: II. Definitions (page 4-20)	Take out exclusion language	**HABILITATION SERVICES:** Means excluded health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services 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.	**HABILITATION SERVICES:** Means ~~excluded~~ health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services 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.	
Add coverage for therapies associated with habilitative services	Uniform Benefits: III. Benefits and Services, A. Medical/Surgical Services, 11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy (page 4-32)	Add habilitation services	***11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy*** Medically Necessary Rehabilitation services and treatment as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.	***11. Outpatient Rehabilitation, Physical, Speech and Occupation Therapy*** Medically Necessary Habilitation or Rehabilitation services and treatment as a result of Illness or Injury, provided by a Plan Provider. Therapists must be registered and must not live in the patient's home or be a family member. Limited to the benefit limit described in the Schedule of Benefits, although up to 50 additional visits per therapy per calendar year may be Prior Authorized by the Health Plan if the therapy continues to be Medically Necessary and is not otherwise excluded.	

BLUE: 2016
TRACKING SHEET
BENEFIT CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Add coverage for therapies associated with habilitative services	Uniform Benefits: IV. 4. b.	Remove exclusion for habilitation services	Therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein. These therapies that are excluded may be used to treat conditions such as learning/developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) limit this exclusion.)	Except for services covered under the HABILITATION SERVICES therapies benefit, therapies, as determined by the Health Plan, for the evaluation, diagnosis or treatment of educational problems. Some examples of the type of assessments and therapies that are not covered are: educational programs, developmental and neuro-educational testing and treatment, second opinions on school or educational assessments of any kind, including physical therapy, speech therapy, occupational therapy and all hearing treatments for the conditions listed herein. These therapies that are excluded may be used to treat conditions such as learning/ developmental disabilities, communication delays, perceptual disorders, mental retardation, behavioral disorders, hyperactivity, attention deficit disorders, minimal brain dysfunction, sensory deficits, multiple handicaps, and motor dysfunction. (Note: Mandated benefits for autism spectrum disorders under Wis. Stat. § 632.895 (12m) limit this exclusion.)	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
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…."	Guidelines: II. GENERAL REQUIREMENTS D. 6. (pg. 1-8)	update language	The BOARD will reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS described above by crediting the plan's composite score during annual negotiation.	The BOARD ~~will~~ may reward HEALTH PLANS that administer HRAs and biometric screenings to more than 50% of the PARTICIPANTS described above by crediting the plan's composite score during annual negotiation.	
Plans/providers will administer a patient satisfaction survey to all ETF members participating in a SDM program.	Guidelines: II. GENERAL REQUIREMENTS D. 12. (pg. 1-10)	add survey requirement	Plans must provide a credible Shared Decision Making (SDM) program for low back pain surgery consistent with the prior authorization requirement to all PARTICIPANTS and may collaborate with providers or a vendor to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). The SDM process must also include an opportunity for members to discuss a particular intervention with their primary care provider, care manager, health educator or a vendor who is trained to have a discussion after the member has reviewed the PDA. Upon request by the DEPARTMENT, plans must report annual patient utilization rates and program impacts in accordance with DEPARTMENT guidance.	Plans must provide a credible Shared Decision Making (SDM) program for low back pain surgery consistent with the prior authorization requirement to all PARTICIPANTS and may collaborate with providers or a vendor to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). The SDM process must also include an opportunity for members to discuss a particular intervention with their primary care provider, care manager, health educator or a vendor who is trained to have a discussion after the member has reviewed the PDA. Upon request by the DEPARTMENT, plans must report annual patient utilization rates and program impacts in accordance with DEPARTMENT guidance. Plans are required to administer a patient satisfaction survey to all SDM participants, based on requirements provided by the DEPARTMENT. Upon request by the DEPARTMENT, plans must report the number of surveys administered as well as the results of the survey, including verbatim comments/feedback as applicable.	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
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).	Guidelines: II. D. 16. (pg. 1-11)	Add language that a Marketplace plan meets the requirement	Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion right shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the State of Wisconsin Group Health Benefit Program as a result of such termination of employment. (See Wis. Stat. § 632.897)	Plans must permit enrolled employees the opportunity to convert coverage in the event of termination of employment. Such conversion rights shall pertain to those employees who terminate employment and move out of the service area, and to those employees who remain in the service area but are unable to continue under the State of Wisconsin Group Health Benefit Program as a result of such termination of employment. ~~(See Wis. Stat. § 632.897)~~ Marketplace plans meet the requirements of a conversion policy set forth in Wis. Stat. § 632.897.	
Add a due date for Summary of Benefits & Coverage (SBC) documents required by the ACA to the timeline in the Guidelines.	Guidelines: II. J. (pg. 1-23)	Add SBC due date	See current Time Table - no current SBC language	Summary of Benefits and Coverage (SBC) due and must be completed in accordance with federal guidance.	
Change Standard Plan definition to make more clear and to differentiate from the Standard High Deductible Health Plan	State Contract: Definitions 1.20	add reference to 40.52 (1) to Standard Plan definition	"STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.	"STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD as provided by § 40.52 (1).	
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	State Contract: 2.6 (pg. 3-10)	ETF will pay health plans at end of month instead of beginning	Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.	~~Prior to the beginning~~ By the end of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.	

BLUE: 2016

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
1. Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans. 2. Require employers to pay the ETF invoice amount and adjust for discrepancies prospectively.	State Contract: 2.8 (1) (pg. 3-10)	1. Employers will be paying ETF for the current month's coverage. 2. Add sentence requiring employers to pay the ETF invoice amount and adjust for discrepancies prospectively.	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the following month's coverage.	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the ~~following~~ current month's coverage. The remittance by the EMPLOYER shall be the amount invoiced by the DEPARTMENT.	
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	State Contract: 3.3 (2) (a) & (b)	Make STAR change where coverage begins 1st day of month following hire instead of the 1st of the month following the receipt of the application.	(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution... (b) ...An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.	(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective ~~on~~ as of the first day of the month that first occurs during the 30-day period, or by electing coverage ~~following receipt of the application by the EMPLOYER, or~~ prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution... (b) ...An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following the date in which the EMPLOYEE becomes eligible for the increase in EMPLOYER contribution ~~receipt of the application by the EMPLOYER~~.	Based on changes to 40.51 (2)

BLUE: 2016

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Clarify that ETF allows retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely.	State Contract: 3.3 (7) (b) (pg. 3-15)	Add sentence clarifying retroactive effective date	If permitted by state or Federal law, an eligible EMPLOYEE may defer or disenroll from coverage if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care.	If permitted by state or Federal law, as determined by the DEPARTMENT, an eligible EMPLOYEE may defer or disenroll from coverage for themselves or a DEPENDENT if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care. Termination may be retroactive to the effective date of the other coverage upon request by the subscriber.	We are handling these case-by-case with Medicaid/ DHS.
Clarify that ETF allows participants to enroll within 30 days of notice of loss of eligibility for coverage.	State Contract: 3.3 (9) (c) (pg. 3-16)	Add language confirming OK to enroll within 30 days of notice of loss of eligibility	PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility.	PARTICIPANTS losing eligibility for other coverage or the EMPLOYER'S contribution towards the other coverage ceases, may elect coverage under any plan by filing an application with the DEPARTMENT within 30 days of the loss of eligibility, or notice of loss of eligibility, and by providing evidence satisfactory to the DEPARTMENT of the loss of eligibility.	
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.	State Contract: 3.3 (13) (pg. 3-17)	Add clarification language	For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission and acceptance of a Health Savings Account application to the third party administrator.	For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission and acceptance of a Health Savings Account application to the third party administrator. The Health Savings Account application must be submitted concurrently with the HIGH DEDUCTIBLE HEALTH PLAN application.	
Allow subscribers who move from a county to change to any health plan, not limited to the health plans offered in the new county.	State Contract: 3.4 (4) (pg.3-17)	Remove language prohibiting selection of plan without in network providers in new county	An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual dual-choice enrollment materials.	An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. ~~The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual dual-choice enrollment materials.~~	

BLUE: 2016

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Clarify that the Standard Plan and the HDHP Standard Plan are two separate plans.	State Contract: 3.10 (5) (pg. 3-19)	Add sentence stating that the Standard HDHP is not included in the definition of STANDARD PLAN for the purposes of enrolling 30 days prior to retirement for the purpose of delaying initiation of post-retirement employer premium contribution.	An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of delaying initiation of post-retirement EMPLOYER premium contribution per Wis. Stat. § 40.05 (4) (b).	An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of delaying initiation of post-retirement EMPLOYER premium contribution per Wis. Stat. § 40.05 (4) (b). An EMPLOYEE is not allowed to enroll in the High Deductible Health Plan option as part of this provision.	
Limit coverage of minor dependents to only be covered once within the program.	State Contract: 3.11 (3) *new Article* (pg. 3-20)	Revise title of Article to include "DEPENDENT", and add a Article 3 explaining limitation	Current title: 3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER	New title: 3.11 COVERAGE OF SPOUSE, ~~OR~~ DOMESTIC PARTNER, OR DEPENDENT (3) A DEPENDENT cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	State Contract: 3.14 (2)	Change related to STAR taking out language referring to premiums having not yet been paid.	Coverage under this Article shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT for which PREMIUMS have not already been deducted, and shall remain in effect until such time as the DEPENDENT coverage would normally cease.	Coverage under this Article shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT ~~for which PREMIUMS have not already been deducted,~~ and shall remain in effect until such time as the DEPENDENT coverage would normally cease had the death not occurred.	
Align WPE language with that in the state contract for consistency as appropriate.	State Contract: 3.16 (3) (pg. 3-24)	Add sentence for alignment.	In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV., A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively.	In the event that a PARTICIPANT is enrolled in regular coverage, the DEPARTMENT will direct the HEALTH PLAN to refund any PREMIUM paid in excess of the Medicare reduced PREMIUM for any months for which BENEFITS are reduced in accordance with Uniform Benefits IV,. A., 12., b. In such cases, the HEALTH PLAN will make claims adjustments prospectively. However, PREMIUM refunds for retroactive enrollment on a Medicare reduced contract will correspond with the retroactive enrollment limits and requirements established by Medicare for medical and/or prescription drug coverage. This may limit the amount of PREMIUM refund for the SUBSCRIBER.	
1. Clarify that ETF allows retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely. 2. Remove obsolete preexisting condition language.	State Contract: 3.18 (1) (g) (pg. 3-26)	Add sentence clarifying retroactive effective date and also strike obsolete preexisting condition language.	The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under paragraph (4) below.	The effective date of coverage obtained with another employer group health plan ~~which coverage does not contain any exclusion or limitation with respect to any preexisting condition~~ of PARTICIPANT who continues under paragraph (4) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care may be retroactive to the effective date of coverage upon request by the subscriber and determination by the DEPARTMENT.	We are handling these case-by-case with Medicaid/ DHS.
Change Standard Plan definition to make more clear and to differentiate from the Standard High Deductible Health Plan	Local Contract: Definitions 1.20	add reference to 40.52 (1) to Standard Plan definition	"STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD.	"STANDARD PLAN" means the fee-for-service health care plan offered by the BOARD as provided by § 40.52 (1).	

BLUE: 2016

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	Local Contract: 2.6	ETF will pay health plans at end of month instead of beginning	Prior to the beginning of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.	~~Prior to the beginning~~ By the end of any calendar month, the DEPARTMENT shall transmit to the HEALTH PLAN that month's estimated PREMIUM for SUBSCRIBERS who are properly enrolled less the pharmacy premium and administration fees required by the BOARD.	
1. Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans. 2. Require employers to pay the ETF invoice amount and adjust for discrepancies prospectively.	Local Contract: 2.8 (1) (pg. 3-43)	1. Employers will be paying ETF for the current month's coverage. 2. Add sentence requiring employers to pay the ETF invoice amount and adjust for discrepancies prospectively.	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the following month's coverage.	Reports and remittances from EMPLOYERS required in the administration of the group health insurance program shall be submitted to the DEPARTMENT no later than the 24th day of the calendar month for the ~~following~~ current month's coverage. The remittance by the EMPLOYER shall be the amount invoiced by the DEPARTMENT.	
Allow WPE to offer opt-out incentives, as provided for state employees in the biennial budget proposal.	Local Contract: 3.1 (4) (pg. 3-48)	Remove language prohibiting payments in lieu of coverage.	The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD nor provide payments to or on behalf of EMPLOYEES in lieu of coverage under this program. EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical.	The EMPLOYER may not offer group health insurance coverage to eligible EMPLOYEES from any health insurance carrier not participating in the health insurance program of the BOARD ~~nor provide payments to or on behalf of EMPLOYEES in lieu of coverage under this program~~. ~~EMPLOYERS providing payments in lieu of coverage must make a good faith effort to end the practice as soon as practical~~.	

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	State Contract: 3.3 (2) (a) & (b)	Make STAR change where coverage begins 1st day of month following hire instead of the 1st of the month following the receipt of the application.	(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective on the first day of the month following receipt of the application by the EMPLOYER, or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution... (b) ...An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following receipt of the application by the EMPLOYER.	(a) An EMPLOYEE shall be insured if a completed DEPARTMENT application form is received by the EMPLOYER within 30 days of hire, coverage to be effective ~~on~~ as of the first day of the month that first occurs during the 30-day period, or by electing coverage ~~following receipt of the application by the EMPLOYER,~~ or prior to becoming eligible for the EMPLOYER contribution toward the PREMIUM coverage to be effective upon becoming eligible for EMPLOYER contribution... (b) ...An EMPLOYEE who does not file an application at this time but who files within 30 days after the date of hire which resulted in the increase in EMPLOYER contribution shall have coverage effective on the first day of the month following the date in which the EMPLOYEE becomes eligible for the increase in EMPLOYER contribution ~~receipt of the application by the EMPLOYER~~.	Based on changes to 40.51 (2)
1. Clarify that ETF allows retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely. 2. Remove obsolete preexisting condition language.	Local Contract: 3.18 (1) (g) (pg. 3-61)	Add sentence clarifying retroactive effective date and also strike obsolete preexisting condition language.	The effective date of coverage obtained with another employer group health plan which coverage does not contain any exclusion or limitation with respect to any preexisting condition of PARTICIPANT who continues under paragraph (4) below.	The effective date of coverage obtained with another employer group health plan ~~which coverage does not contain any exclusion or limitation with respect to any preexisting condition~~ of PARTICIPANT who continues under paragraph (4) below. Terminations due to enrollment in medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care may be retroactive to the effective date of coverage upon request by the subscriber and determination by the DEPARTMENT.	We are handling these case-by-case with Medicaid/ DHS.

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Clarify that ETF allows retroactive terminations of coverage in cases where a dependent was enrolled in Medicaid but the employer was not notified timely.	Local Contract: 3.3 (7) (b) (pg. 3-52)	Add sentence clarifying retroactive effective date	If permitted by state or Federal law, an eligible EMPLOYEE may defer or disenroll from coverage if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care.	If permitted by state or Federal law, as determined by the DEPARTMENT, an eligible EMPLOYEE may defer or disenroll from coverage for themselves or a DEPENDENT if he/she is covered under medical assistance (Medicaid), the Children's Health Insurance Program (CHIP), or Tri-Care. Termination may be retroactive to the effective date of the other coverage upon request by the subscriber.	We are handling these case-by-case with Medicaid/ DHS.
Align WPE language with that in the state contract for consistency as appropriate.	Local Contract: 3.4 (1) (pg. 3-53)	Change word for alignment - does not change meaning.	The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES and currently covered ANNUITANTS and CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51 (7).	The BOARD shall establish enrollment periods, which shall permit eligible EMPLOYEES and currently ~~covered~~ insured ANNUITANTS and CONTINUANTS to enroll for or transfer coverage to any plan offered by the BOARD as required by Wis. Stat. § 40.51 (7).	
Allow subscribers who move from a county to change to any health plan, not limited to the health plans offered in the new county.	Local Contract: 3.4 (4) (pg. 3-53)	Remove language prohibiting selection of plan without in network providers in new county	An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual dual-choice enrollment materials.	An EMPLOYEE, ANNUITANT or CONTINUANT may also change plans if the SUBSCRIBER moves from his/her residence across county lines for a minimum of three months. ~~The newly selected plan must have in-network providers in the county to which the SUBSCRIBER moved, as shown in the annual dual-choice enrollment materials.~~	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Clarify that the Standard Plan and the HDHP Standard Plan are two separate plans.	Local Contract: 3.10 (4) (pg. 3-55)	Add sentence stating that the Standard HDHP is not included in the definition of STANDARD PLAN for the purposes of enrolling 30 days prior to retirement for the purpose of delaying initiation of post-retirement ER premium contribution.	An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40)who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of using post-retirement EMPLOYER premium contribution.	An eligible EMPLOYEE or EMPLOYEE on leave of absence under Wis. Stat. § 40.02 (40) who is not enrolled for coverage, may enroll in the STANDARD PLAN 30 days prior to retirement for the purpose of using post-retirement EMPLOYER premium contribution. An EMPLOYEE is not allowed to enroll in the High Deductible Health Plan option as part of this provision.	
Limit coverage of minor dependents to only be covered once within the program.	Local Contract: 3.11 (3) *new Article* (pg. 3-56)	Revise title of Article to include "DEPENDENT", and add a Article 3 explaining limitation	Current title: 3.11 COVERAGE OF SPOUSE OR DOMESTIC PARTNER	New title: 3.11 COVERAGE OF SPOUSE, ~~OR~~ DOMESTIC PARTNER, OR DEPENDENT (3) A DEPENDENT cannot be covered at the same time by two separate SUBSCRIBERS of the State Group Health Insurance Program (including the Wisconsin Public Employers State Group Health Insurance Program). In the event it is determined that a DEPENDENT is covered by two separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have 30 days to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Make technical enrollment changes as needed to accommodate STAR including regarding the timing of premium payments to health plans.	Local Contract: 3.14 (2)	Change related to STAR taking out language referring to premiums having not yet been paid.	Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT unless the EMPLOYER provides for additional months of PREMIUM payment after the date of death, and shall remain in effect until such time as the DEPENDENT coverage would normally cease.	Coverage under this section shall be effective on the first day of the calendar month following the date of death of the insured EMPLOYEE or ANNUITANT ~~unless the EMPLOYER provides for additional months of PREMIUM payment after the date of death~~, and shall remain in effect until such time as the DEPENDENT coverage would normally cease had the death not occurred.	
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.	Local Contract: 3.16 (2) (pg. 3-58)	Add clarification language	The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) as the primary payor and coverage is provided under an annuitant group number.	The reduction in PREMIUM shall be effective on the first day of the calendar month, which begins on or after the date the PARTICIPANT is eligible for the Medicare hospital and medical insurance benefits (Parts A and B) as the primary payor and coverage is provided under an annuitant group number, or, under an employer goup number in the case of an employer paid annuitant.	
Clarify that an implanted special lens, such as a multi-focal lens, is not medically necessary for cataract surgery.	Uniform Benefits: III. Benefits & Services, C. 3. (pg. 4-38)	Add word "external"	An initial lens per surgical eye directly related to cataract surgery (contact lens or framed lens).	An initial external lens per surgical eye directly related to cataract surgery (contact lens or framed lens).	
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.	Uniform Benefits: III. Benefits & Services, C. 6. (pg. 4-40)	Add clarification language	Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. The therapy limit does not apply to this benefit.	Care up to $50,000 per year for intensive-level and up to $25,000 per calendar year for nonintensive-level services is not subject to policy exclusions and limitations. These minimum coverage monetary amounts shall be adjusted annually beginning in 2011 as determined by the Office of Commissioner of Insurance. The therapy limit does not apply to this benefit.	

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Update the surgical exclusion language from "sex transformation" to "gender reassignment".	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, A. 1. a. (pg. 4-44)	update language	a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.	a. Procedures, services, and supplies related to ~~sex transformation~~ surgery and sex hormones associated with gender reassignment ~~related to such treatments~~.	
Add expired prescription drugs to the exclusions for covering/replacing prescription drugs.	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, A. 11. n. (pg. 4-47)	add exclusion	Charges for spilled, stolen or lost prescription drugs.	Charges to replace ~~for~~ expired, spilled, stolen or lost prescription drugs.	
Clarify that an implanted special lens, such as a multi-focal lens, is not medically necessary for cataract surgery.	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, A. 12. q. (pg. 4-48)	Add language to the exclusion	q. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery.	q. Eyeglasses or corrective contact lenses, fitting of contact lenses, except for the initial lens per surgical eye directly related to cataract surgery. The incremental cost of a non-standard intraocular lens (e.g., multifocal and toric lenses) compared to a standard monofocal intraocular lens is not covered.	
New Technical changes - Not included in May 2015 Board memo					
Update contract language to use new name for Office of State Employment Relations (OSER)	Guidelines: I. OBJECTIVES	Replace OSER with Division of Personnel Management	Under the tiered structure, the Office of State Employment Relations...	Under the tiered structure, the Division of Personnel Management in the Department of Administration... ~~Office of State Employment Relations...~~	2015 Wisconsin Act 55

BLUE: 2016
TRACKING SHEET
TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Remove obsolete preexisting condition language.	State Contract: 2.10 (2)	Remove obsolete preexisting condition language.	In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.	In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding ~~a preexisting condition exclusion denial or~~ the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.	
Add clarification that the Health Savings account application must be accepted (not just submitted) to be eligible for the HDHP	State Contract: 3.3 (13)	Add clarification language	For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission of a Health Savings Account application to the third party administrator.	For the purposes of selecting a HIGH DEDUCTIBLE HEALTH PLAN, a completed application requires the submission and acceptance of a Health Savings Account application to the third party administrator.	Recommended by Board late in 2014.
Remove obsolete preexisting condition language.	Local Contract: 2.10 (2)	Remove obsolete preexisting condition language.	In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding a preexisting condition exclusion denial or the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.	In accordance with Wis. Stat. § 632.835 and Wis. Adm. Code § INS 18.11 any decision by an Independent Review Organization is final and binding except for any decision regarding ~~a preexisting condition exclusion denial or~~ the rescission of a policy or certificate. Apart from these two exceptions, PARTICIPANTS have no further right to administrative review by the DEPARTMENT or BOARD once the Independent Review Organization decision is rendered. Within 14 days of the Independent Review Organization rendering its determination, the HEALTH PLAN must notify the DEPARTMENT of the outcome and the Independent Review Organization's fee for the review.	

BLUE: 2016

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES

Color key:	State = blue	Local = green	Guidelines/Uniform Benefits = white

Benefit change	Guidelines/ Contract Article	Description of language change	Current language	Proposed language	Reference/ comments
Update hospice care benefit language just to clarify the benefit - no changes beyond ACP listed on Substantive Ben Changes tab	Uniform Benefits: III. A. 13	Minor clarifications	Hospice Care is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. Hospice Care is available to a Participant who is Confined. Hospice Care includes, but is not limited to, Medical Supplies and services, counseling, bereavement counseling for one year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a six-month period if authorized by the Health Plan. Covers a one-time in-home palliative consult after the Participant receives a terminal diagnosis regardless of whether his or her life expectancy is six months or less. Inpatient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility. When benefits are payable under both this Hospice Care benefit and the Home Care Benefits, benefits payable under this subArticle shall not reduce any benefits payable under the home care subArticle.	Hospice Care, which may be inpatient or home-based care, is provided by an inter-disciplinary team, consisting of but not limited to, registered nurses, home health or hospice aides, LPNs, and counselors. ~~Hospice Care is available to a Participant who is Confined.~~ Hospice Care includes, but is not limited to, Medical Supplies and services, counseling, bereavement counseling for one year after the Participant's death, Durable Medical Equipment rental, home visits, and Emergency transportation. Coverage may be continued beyond a six-month period if authorized by the Health Plan. Covers Advance Care Planning after the Participant receives a terminal diagnosis regardless of life expectancy. Covers a one-time in-home palliative consult after the Participant receives a terminal diagnosis regardless of whether his or her life expectancy is six months or less. Hospice Care is available to a Participant who is Confined. Inpatient charges are payable for up to a total lifetime maximum of 30 days of confinement in a Health Plan-approved or Medicare-certified Hospice Care facility. When benefits are payable under both this Hospice Care benefit and the Home Care Benefits, benefits payable under this subArticle shall not reduce any benefits payable under the home care subArticle.	

BLUE: 2016

TRACKING SHEET

REMOVAL OF DENTAL REFERENCES

Color key:	State = blue	Local = green	Guidelines/ Uniform Benefits = white

Article	Removed language	Reference/comments
Guidelines: II. GENERAL REQUIREMENTS, D. 27.	~~Optional Dental Coverage. Plans may offer optional Uniform Dental coverage. The eligibility and enrollment provisions will be the same as the medical coverage provisions as specified by the Guidelines. If a plan offers dental coverage, it will be offered to all PARTICIPANTS who enroll for medical coverage with the plan. However, a plan may offer dental coverage under the state employee's plan only, the local employer's plan only or both plans. If a plan offers dental coverage, the plan must independently review all adverse grievance decisions issued by a third-party dental administrator and provide to affected PARTICIPANTS notification of such a review and appeal rights to the DEPARTMENT in accordance with the CONTRACT.~~ ~~A PARTICIPANT'S level of benefit, after commencing a treatment for orthodontia, will not be adversely impacted by a subsequent change in benefit level made by the plan. If a PARTICIPANT is in a course of orthodontic treatment and changes plans while covered under this program, and both the prior and succeeding plans provide orthodontic coverage, the succeeding plan must continue to cover the course of orthodontic treatment. The PARTICIPANT must use plan providers of the succeeding plan. Benefit accumulations from the prior plan will carry over and will be applied to the new benefit level.~~	

BLUE: 2016

TRACKING SHEET

REMOVAL OF DENTAL REFERENCES

Color key:	State = blue	Local = green	Guidelines/ Uniform Benefits = white

Article	Removed language	Reference/comments
Guidelines: II. GENERAL REQUIREMENTS, J. TIME TABLE	~~• If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit.~~ ~~• Draft of dental benefit description that will be provided to PARTICIPANTS if the plan offers dental coverage. This must include the exclusions and limitations. DEPARTMENT approval, prior to September 12, is required.~~ ~~• Draft of letter the plan will mail to current SUBSCRIBERS summarizing dental benefit, accessing the plan's health risk assessment tool, and medical and dental provider network changes for the new calendar year, including a description of referral requirements, and, for dental providers, identify specific providers that are categorized as "designated in-network". Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the DEPARTMENT. DEPARTMENT approval, prior to September 12, is required. THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 26, WITH FORWARDING REQUESTED.~~ • Put a PDF copy of your plan's medical ~~and dental~~ provider directory for the upcoming benefit year on your plan's web site and provide DEPARTMENT with the location. The PDF must remain on your plan's web site through the benefit year. • ~~Final dental benefit description that will be provided to PARTICIPANTS if the plan offers dental coverage.~~	
Article 2: Addendum 1		Need to remove Dental from Addendum 1
State Contract: 2.5 (1)	The HEALTH PLAN shall provide the SUBSCRIBER with identification cards indicating the EFFECTIVE DATE of coverage, a listing of all available providers and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization and referral requirements. ~~If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.~~	
State Contract: 2.10 (3)	The HEALTH PLAN'S grievance procedure must be included as Attachment E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., ~~dental,~~ chiropractic, mental health).	

BLUE: 2016

TRACKING SHEET

REMOVAL OF DENTAL REFERENCES

Color key:	State = blue	Local = green	Guidelines/ Uniform Benefits = white

Article	Removed language	Reference/comments
State Contract: Attachment C		Update Best and Final - remove dental
Local Contract: 2.5 (1)	The HEALTH PLAN shall provide the SUBSCRIBER with identification cards indicating the EFFECTIVE DATE of coverage, a listing of all available providers and their available locations, information on accessing and completing the Health Risk Assessment tool, and pre-authorization and referral requirements. ~~If the HEALTH PLAN offers dental coverage, it must provide the PARTICIPANT a description of the dental network BENEFITS, limitations and exclusions.~~	
Local Contract: 2.10 (3)	The HEALTH PLAN'S grievance procedure must be included as Attachment E. At a minimum, the grievance process must comply with Wis. Adm. Code § INS 18.03 or any other statutes or administrative codes that relate to managed care grievances. This extends to any "carve-out" services (e.g., ~~dental,~~ chiropractic, mental health).	
State Contract: Attachment C		Update Best and Final - remove dental
Uniform Benefits: I.	All benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. Uniform Benefits and this Schedule of Benefits are wholly incorporated in the Master Contract. The Schedule of Benefits describes certain essential dollar or visit limits of Your coverage and certain rules, if any, You must follow to obtain covered services. In some situations (for example, Emergency services received from a Non- Plan Provider), benefits will be determined according to the Usual and Customary Charge. A change to another Health Plan will result in all benefit maximums restarting at $0 with the exception of the prescription annual Out-Of-Pocket Limit. ~~This does not include dental and orthodontia benefits that Health Plans may offer that are not a part of Uniform Benefits.~~	
Uniform Benefits: V. COORDINATION OF BENEFITS AND SERVICES, C. 3.	~~Coordination of Dental Benefits~~ ~~The dental benefits under Uniform Benefits provided by a Health Plan 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. Adm. Code Ins. 3.40 (9) (d).~~	

BLUE: 2016

TRACKING SHEET

REMOVAL OF DENTAL REFERENCES

Color key:	State = blue	Local = green	Guidelines/ Uniform Benefits = white

Article	Removed language	Reference/comments
Bullets under Schedule of Benefits		