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Correspondence Memorandum

Date: April 21, 2016

To: Group Insurance Board

From: Tara Pray, Alternate Health Plans Manager
Office of Strategic Health Policy

Subject: Guidelines Contract & Uniform Benefits for the 2017 Plan Year

The Department of Employee Trust Funds (ETF) staff requests that the Group Insurance Board (Board) approve the 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

At the February 17, 2016 meeting, the Board approved the recommendation to make limited benefit changes for the 2017 program year, with the exceptions of changes related to the wellness benefit and issues pertaining to compliance with state and federal law.

The following recommendations are technical or administrative in nature and either aim to achieve Board goals relating to the 2016 procurements underway, or are clarifications or minor changes that have been identified since the 2016 Guidelines Contract was finalized.

Key Recommended Changes

Wellness and Disease Management Vendor

The Request for Proposals process is underway for a single vendor to administer wellness and disease management programs for the group health insurance program. Therefore, the Guidelines Contract will be updated to remove the provisions that required the health plans to administer a Health Risk Assessment and the $150 Well Wisconsin incentive.

Data Warehousing and Business Intelligence Vendor: Health Plan Requirement to Submit Claims Data

In Segal Consulting's (Segal) November 2015 report to the Board, it recommended requiring "vendors to provide complete and comprehensive data and to engage the technology necessary to perform data analysis and health risk modeling of the covered

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

Lisa Ellinger

Electronically Signed 5/6/16

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population." ETF is currently in the process of procuring a data warehouse/business intelligence solution to be implemented in early 2017. ETF will be adding requirements for the 2017 Guidelines Contract to include the submission of claims data from 2014 to the present, in order to adequately perform baseline analytics and data modeling.

Additional Technical Changes/Clarifications (Attachment A)

Attachment A details the proposed additional changes or clarifications that are technical in nature. The purpose of making these changes is to make the intent of certain provisions of the Guidelines Contract and/or the Uniform Benefits clearer. Certain provisions have been added as placeholders and comprehensive contract language will be provided to the Board at the August 2016 Board meeting.

Other minor improvements are underway, such as:

- Aligning the timetable of deliverables with the contract year
- Making improvements to the Schedule of Benefits to make the benefit clearer as related to the deductible
- Hyperlinking statutes and rules for easy reference
- Updating the addenda as revised by Segal

Staff will bring the final contract language to the Board for approval at the August 16, 2016 meeting.

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

Attachment A: Guidelines Contract Updates – Tracking Sheet 2017

Guideline Contract Uniform Benefits: 2017

TRACKING SHEET

TECHNICAL / ADMINISTRATIVE CHANGES				
Color key:	**State = blue**	**Local = green**	**Guidelines/Uniform Benefits = white**	
Change topic	**Guidelines/ Contract Article**	**Description of language change**	**Current language**	**Proposed language**
Placeholder for data transmissions				
Placeholder for security/privacy breach updates				
Placeholder for wellness due to new contract				
Placeholder for disease management due to new contract				
Remove conversion policy requirement	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 16.	After going back-and-forth with health plans last year, we determined this is not necessary due to the Marketplace.	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. Marketplace plans meet the requirements of a conversion policy set forth in Wis. Stat. §632.897.	Plans must provide SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. §632.897 and/or Marketplace plan in the event of termination of employment.
Transitional Care description in Addendum 1 to include mental health parity, services beyond substance abuse	Addendums: Addendum 1, Table 3A, B. Hospital Outpatient, 8. Other Facility, b. Transitional Care	Add clarification that services are not limited to substance abuse due to mental health parity	Transitional Care -This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be outpatient or day care setting and charges would include professional and facility charges.	Transitional Care -This benefit includes substance abuse rehabilitation services , or other mental health services as required by the Federal Mental Health Parity Act, provided in a transitional care program. Services may be outpatient or day care setting and charges would include professional and facility charges.
Disabled adult dependent when subscriber deceases	State and Local Contracts: ARTICLE 1 DEFINITIONS, 1.7 DEPENDENT, (3) (a) Uniform Benefits: II. DEFINITIONS: DEPENDENT	Revise "support test" language for situations where adult disabled dependent's parent, the subscriber, is deceased.	An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The HEALTH PLAN will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. The Health Plan will monitor eligibility annually, notifying the employer and Department when terminating coverage prospectively upon determining the Dependent is no longer so disabled and/or meets the support requirement. The Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.	An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible DEPENDENT, regardless of age, as long as the child remains so disabled and he or she is dependent on the SUBSCRIBER (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER deceases, the disabled adult must still meet the remaining disabled criteria and be incapable of self-support. The HEALTH PLAN will monitor eligibility annually, notifying the EMPLOYER and DEPARTMENT when terminating coverage prospectively upon determining the DEPENDENT is no longer so disabled and/or meets the support requirement. The HEALTH PLAN will assist the DEPARTMENT in making a final determination if the SUBSCRIBER disagrees with the HEALTH PLAN determination. An unmarried dependent child who is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration of at least one year is an eligible Dependent, regardless of age, as long as the child remains so disabled and he or she is dependent on the Subscriber (or the other parent) for at least 50% of the child's support and maintenance as demonstrated by the support test for federal income tax purposes, whether or not the child is claimed. If the SUBSCRIBER deceases, the disabled adult must still meet the remaining disabled criteria and be incapable of self-support. The Health Plan will monitor eligibility annually, notifying the employer and Department when terminating coverage prospectively upon determining the Dependent is no longer so disabled and/or meets the support requirement. The Health Plan will assist the Department in making a final determination if the Subscriber disagrees with the Health Plan determination.

Guideline Contract Uniform Benefits: 2017

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Allow dependents to move under either contract even if one parent has family and one has single?	State Contract: 3.11 COVERAGE OF SPOUSE, DOMESTIC PARTNER, OR DEPENDENT (3)	If there is double coverage found and one parent has family coverage and one has single. Allows either SUBSCRIBER to cover the DEPENDENT(S). Clarification that no one can be double covered, even if they are only a subscriber on one contract.	(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.	(3) A DEPENDENT or SUBSCRIBER 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. If the DEPENDENT(S) is to be newly covered by a SUBSCRIBER that has single coverage, the contract may be converted to a family contract. The effective date will be the first of the month following receipt of the application. The health plan(s) will be notified.
Correction	State and Local Contract: 3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE (3)	Should refer to #11 in UB, not #12	(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., 12., b... 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...	(3) Except in cases of fraud which shall be subject to section 3.18 (5), coverage for any PARTICIPANT enrolled in Medicare coordinated coverage who does not enroll in Medicare Part B when it is first available as the primary payor or who subsequently cancels Medicare coverage shall be limited in accordance with Uniform Benefits IV., A., ~~12~~11., b... 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~~11., b...
Death	New: State and Local Contract: 3.18 INDIVIDUAL TERMINATION OF COVERAGE (1) (j)	Add provision for coverage termination when subscriber dies.	N/A	(j) Upon date of death. No refund of PREMIUM may be granted for the month in which the coverage ends. If deceased subscriber has covered dependents, see 3.14 CONTINUED COVERAGE OF SURVIVING DEPENDENTS.
Correction	Local Contract: 3.16 COVERAGE OF EMPLOYEES, ANNUITANTS, SURVIVING DEPENDENTS AND CONTINUANTS ELIGIBLE FOR MEDICARE (1)	Remove CONTINUANT - local only, Board approved in 2013, was not removed previously	(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS, or CONTINUANT who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.	(1) Each insured ANNUITANT, their DEPENDENTS or surviving DEPENDENTS~~, or CONTINUANT~~ who becomes insured under federal plans for hospital and medical care for the aged (Medicare) may continue to be insured, but at reduced PREMIUM rates as specified by the BOARD.

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Make necessary clarification Re: Rx OOPL for HDHP	Uniform Benefits: I. SCHEDULE OF BENEFITS, Prescription Drugs and Insulin (Except Specialty Medications): (after the SOB matrices)	Need explanation of how HDHP OOPL works.	**Prescription Drug Copayments:** Level 1 Copayment: $5.00 The Level 1 Copayment applies to Preferred Generic Drugs and certain lower-cost Preferred Brand Name Drugs. Level 1 Copayments accumulate toward the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 Drugs for that benefit year. **Prescription Drug Coinsurance:** Level 2 Coinsurance: 20% ($50 max) The Level 2 Coinsurance applies to Preferred Brand Name Drugs, and certain higher-cost Preferred Generic Drugs. Level 2 Coinsurance accumulate toward the Level 1/Level 2 annual OOPL until the Level 1/Level 2 OOPL is met after which You pay no more out-of-pocket expenses for Level 2 Drugs for that benefit year. Level 3 Coinsurance: 40% ($150 max) The Level 3 Coinsurance applies to Non-Preferred Brand Name Drugs and certain high-cost, Generic Drugs for which alternative and/or equivalent Preferred Generic Drugs and Preferred Brand Name Drugs are available and covered. Level 3 Coinsurance does not accumulate toward an annual OOPL. You must continue to pay Level 3 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP. **Level 1/Level 2 Annual Out-of-Pocket Limit (OOPL)** (The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin): $600 per individual or $1,200 per family for all Participants, except: $1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.	**Prescription Drug Copayments:** Level 1 Copayment: $5.00 The Level 1 Copayment applies to Preferred Generic Drugs and certain lower-cost Preferred Brand Name Drugs. ~~Level 1 Copayments accumulate the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 1 Drugs for that benefit year.~~ **Prescription Drug Coinsurance:** Level 2 Coinsurance: 20% ($50 max) The Level 2 Coinsurance applies to Preferred Brand Name Drugs, and certain higher-cost Preferred Generic Drugs. ~~Level 2 Coinsurance accumulate the Level 1/Level 2 annual Out-of Pocket Limit (OOPL) until the Level 1/Level 2 OOPL is met after which, You pay no more out-of-pocket expenses for Level 2 Drugs for that benefit year.~~ Level 3 Coinsurance: 40% ($150 max) The Level 3 Coinsurance applies to Non-Preferred Brand Name Drugs and certain high-cost, Generic Drugs for which alternative and/or equivalent Preferred Generic Drugs and Preferred Brand Name Drugs are available and covered. ~~Level 3 Coinsurance does not accumulate toward an annual OOPL. You must continue to pay Level 3 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP.~~ **Level 1/Level 2 Annual ~~Out-of-Pocket Limit (OOPL)~~** ~~(The amount You pay for Your Level 1 and Level 2 prescription drugs and insulin):~~ Level 1/Level 2 out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): $600 per individual or $1,200 per family for all Participants. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs.~~, except:~~ ~~$1,000 per individual or $2,000 per family for State and Wisconsin Public Employer Participants enrolled in the Standard Plan.~~ **Level 3 Annual OOPL** Level 3 out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): **no annual OOPL**. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs.

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Rx detail in Schedule of Benefits last year did not adequately cover HDHP.	Uniform Benefits: I. SCHEDULE OF BENEFITS, Specialty Medications (after the SOB matrices)	Need explanation of how HDHP OOPL works.	**Copayments:** Level 4 Copayment and Coinsurance: Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy: $50 Copayment The Level 4 Copayment applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. Level 4 copayments for Preferred Specialty Medications accumulate toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year. Preferred Specialty and Non-Preferred Specialty Medications Obtained From a Participating Pharmacy other than a Preferred Specialty Pharmacy AND Non-Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy: 40% Coinsurance ($200 max) The Level 4 Coinsurance applies when any Specialty Medication is obtained from a Participating Pharmacy other than a Preferred Specialty Pharmacy and when Non-Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. Level 4 Coinsurance for only Preferred Specialty Medications accumulates toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year. Level 4 Coinsurance for Non-Preferred Specialty Medications do not accumulate toward an annual OOPL. You must continue to pay Level 4 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP **Level 4 Annual** Out-of-Pocket **Limit (OOPL)** (The amount You pay for Your Level 4 Preferred Specialty Medications.) $1,200 per individual or $2,400 per family for all Participants.	**Specialty Drug Cost Share ~~Copayments~~:** Level 4 Copayment: $50 ~~and Coinsurance:~~ ~~Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy: $50 Copayment~~ The Level 4 Copayment applies when Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. ~~Level 4 copayments for Preferred Specialty Medications accumulate toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year.~~ Level 4 Coinsurance: 40% ($200 max) ~~Preferred Specialty and Non-Preferred Specialty Medications Obtained From a Participating Pharmacy other than a Preferred Specialty Pharmacy~~ ~~AND~~ ~~Non-Preferred Specialty Medications Obtained From a Preferred Specialty Pharmacy: 40% Coinsurance ($200 max)~~ The Level 4 Coinsurance applies when any Specialty Medication is obtained from a Participating Pharmacy other than a Preferred Specialty Pharmacy AND~~and~~ when Non-Preferred Specialty Medications are obtained from a Preferred Specialty Pharmacy. ~~Level 4 Coinsurance for only Preferred Specialty Medications accumulates toward the Level 4 annual OOPL until the Level 4 annual OOPL is met after which You pay no more out-of-pocket expenses for Preferred Specialty Medications for that benefit year.~~ ~~Level 4 Coinsurance for Non-Preferred Specialty Medications do not accumulate toward an annual OOPL. You must continue to pay Level 4 Coinsurance even after other annual OOPLs have been met, up to the Federal MOOP~~ **Level 4 Annual** ~~Out-of-Pocket **Limit (OOPL)**~~ **There is no OOPL for Non-Preferred Specialty Medications.** You must continue to pay Level 4 Coinsurance for Non-Preferred Specialty Medications ~~even after other annual OOPLs have been met, up to~~ until You meet the Federal MOOP of $7,150 individual / $14,300 family . ~~(~~The maximum annual amount You pay for Your Level 4 Preferred Specialty Medications.~~)~~ Level 4 Preferred Specialty Medications out-of-pocket costs accumulate toward OOPLs as follows: - IYC Health Plan, IYC Medicare, Medicare Advantage, Medicare Plus, IYC Local Traditional (PO2/12), IYC Local Deductible (PO4/14), IYC Local Health Plan (PO6/16): $1,200 per individual or $2,400 per family ~~for all Participants~~. - IYC HDHP, IYC Local HDHP (PO7/17): all medical and prescription drug out-of-pocket costs combined count towards meeting the combined OOPL of $1,500 for single coverage, or $3,000 for family coverage. When the OOPL is met, You pay no more out-of-pocket expenses for covered medical services or prescription drugs.
Therapies exclusion is still a bit contradicting with the new Habilitation Therapies benefit.	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 2. Medical, b. Therapies	Revise exclusion to be clearer.	Except for services covered under the HABILITATION SERVICES therapy 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.)	Except for services covered under the HABILITATION SERVICES therapy benefit, and mandated benefits for autism spectrum disorders under Wis. Stat. §632.895 (12m) 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.)~~

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Expand exclusion on marriage counseling to couples/family counseling	Uniform Benefits: IV. EXCLUSIONS AND LIMITATIONS, 11. General, ak. Marriage counseling	We received a question about couples counseling for domestic partners and non-married couples. Expanding exclusion to beyond just "marriage."	ak. Marriage counseling.	ak. Marriage/couples/family counseling.