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Correspondence Memorandum

Date: August 1, 2016

To: Group Insurance Board

From: Tara Pray, Alternate Health Plans Manager
Joan Steele, Manager of Performance Measurement
Office of Strategic Health Policy

Subject: Potential 2018 Health Benefit Program Contract Changes

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

Background

The recently-released self-insurance/regionalization Request for Proposals (RFP) includes required specifications that are largely based on the current contract between the Group Insurance Board (Board) and the health plans. However, to accommodate a self-insured program structure, a number of current program specifications would need to be modified. Staff deconstructed the current contract and developed a new State of Wisconsin Health Benefit Program Agreement (Agreement) that captures all specifications required under a self-insurance model, and could be awarded as a result of the RFP process, if the Group Insurance Board (Board) decides to self-insure the program.

The Department of Employee Trust Funds provides this information to ensure the Board is informed about the changes incorporated into the new contract.

Every part of the current contract was analyzed and the new Agreement was built to ensure that expectations related to administering the program were clear to proposing vendors and that participants would maintain current contractual protections. In addition, much of the new Agreement was reworded and restructured to make the document easier to navigate.

If a self-insured model is adopted, the state will take on the financial risk of claims. This means that some of the provisions in the current contract intended to spread risk across the health plans were no longer necessary or appropriate. In addition, this revision process provided an opportunity to enhance protections for quality, program integrity, customer service and the ability to hold vendor partners accountable.

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

Lisa Ellinger Electronically Signed 8/15/16

Board	Mtg Date	Item #
GIB	8.16.16	8C

Finally, the new Agreement was written to be flexible. This means that regardless of whether the Board moves forward with a self-insured model, maintains a fully-insured model, or chooses a hybrid approach, staff can easily modify the new Agreement accordingly.

While there may be additional changes to the Agreement before it is executed with contractors, the bulk of the contract work is complete. In addition to the Agreement itself, any contracts awarded will include the vendor's proposal submitted as part of the RFP process.

Below is a summary of the key components of the new Agreement, which was released with the RFP:

- Areas of No Change
- Summary of Changes
- New Provisions

Areas of No Change

Enrollment and Eligibility

There were no changes made to enrollment and eligibility specifications, and the annual open enrollment process. The only exception is a minor change to re-enrollment in the rare case of participant fraud, which is described in the next section.

Benefits

Uniform Benefits remain the same, except for minor changes highlighted in the next section. The program will continue to comply with state and federal laws and regulations pertaining to mandated or minimum benefits. While the Board would not be required to comply with certain laws and regulations under a self-insured model, staff did not change requirements that provide participant protections, such as provider access and grievance and appeal rights. In addition, while self-insurance provides some flexibility on benefit design, most of the federal and state laws on benefit design will still apply, such as coverage for mammograms or oral and injected chemotherapy.

Contract/Administrative

Contract requirements and administrative processes largely remain the same. Certain contract provisions that pertain to employers – not contractors – were removed from the Agreement and will be covered in the employer administration manual.

Grievances

There were no significant changes to the participant grievance process. A minor change to the independent/external review process is described in the next section.

Other
Medicare requirements are included in the Agreement. If a Medicare Advantage procurement is executed for 2018, as recommended by Segal, certain Medicare provisions may be removed.

Summary of Changes
Program Name and Terminology
The program name has changed from the State of Wisconsin Group Health Insurance Program, to the State of Wisconsin Health Benefit Program since the state would no longer be purchasing "insurance policies," but rather, purchasing administrative services to provide benefits to participants in a self-insured structure. Additionally, definitions and other references to "insurance" were changed to "benefits."

Improved Structure and Navigation
The new Agreement is structured differently than the current contract. The Agreement has been reorganized for improved readability, is easier to reference and eliminates redundancies between the state and local programs. Hyperlinks are provided both to external laws and regulations as well as to navigate to related sections within the document.

Benefit Changes
Benefit changes are listed in the table below.

Benefit	Current 2017 Contract	Changes Under a Self-Insured Model
Mid-Year Plan Transfers	Annual medical benefit maximums and accumulations to the deductible or out-of-pocket limits start over at $0 when a member changes plans during a benefit period, such as a change in residence. [In the current fully-insured model, premium bids do not account for having deductibles or out-of-pocket limits waived and there are not processes to transfer accumulations from another insurer.]	Annual benefit maximums and accumulations to the deductible or out-of-pocket limits will continue to accumulate when a member changes plans during a benefit period. [This is consistent with the approach used in our other self-insured benefits, such as the pharmacy benefit, where there is no need for accumulations to start over.]

Benefit	Current 2017 Contract	Changes Under a Self-Insured Model
Organ Retrans-plantation Benefit	Benefit is limited to one transplant per organ per plan during the lifetime of the policy, except as required for treatment of kidney disease. [In the current fully-insured model, our benefit is designed to spread risk of high-cost claims.]	Limitation is removed. [In a self-insured model, there is no longer the need to spread the risk among the plans.]

Contract/Administrative Changes

Certain changes are necessary because of the new contracting and payment processes required in a self-insured model. For example, because the contract will be a minimum of three years, a review of the financial stability of proposing vendors has been added to the procurement process. The Agreement outlines areas in which the contractor(s) would be required to work with ETF to establish banking and other financial processes during the implementation process.

Topic	Current 2017 Contract	Changes Under a Self-Insured Model
Proposal Process	Non-participating health plans must submit required documents by April 15 each year to participate for the next benefit year. Participation is approved as long as all requirements are met.	These requirements were removed, as they do not apply under the new procurement process.
Primary Care Provider (PCP) Required	PCPs are strongly encouraged.	Each participant must select (or be assigned) a PCP. [This change is related to the data warehouse and strategic goals related to population health.]
Provider Guarantee	Providers listed in the plan's submission for determining qualification status or in the plan's provider directory are available for the remainder of the benefit year. Exceptions include a provider's retirement, move from the service area, death, or disciplinary action relating to quality of care.	Require Contractors to provide continuity of care in accordance with Wis. Stat. § 609.24, which allows for continued access to: • Primary care physicians until the end of the benefit year. • Providers who are not primary care physicians and who are treating members in a course of treatment, for the remainder of the course of treatment or

		for 90 days after the provider terminates, whichever is shorter. • Maternity care for members in their second or third trimester of pregnancy until the completion of postpartum care for the member and infant. Exceptions include providers no longer practicing in the plan's service area and termination due to provider misconduct.
Rate-making Process	Rates are derived from the annual premium bid process.	The Board's actuaries will determine premium rates based on claims experience and other financial data.
Plan Qualification Status	Plans must meet minimum provider availability requirements to be "qualified" in a county. The minimum provider availability requirements are five primary care providers, a hospital if one exists in the county, and a chiropractor.	Remove references to qualification status because Contractors must meet the minimum provider availability requirements in all counties in the region in which it is offered.
Independent / External Review	Currently, health plans can choose a federally accredited vendor.	Contractors will be required to use the federal process and vendor to handle external reviews.
Re-enrollment Rights Due to Member Fraud	When disenrollment occurs due to fraudulent attempts to obtain benefits, the subscriber can re-enroll for coverage in the Standard Plan with the option to change plans during the It's Your Choice enrollment period that occurs at least twelve months after the disenrollment date.	The Board has the authority to limit re-enrollment. [In a self-insured model, there is no longer the need to spread the risk among the plans.]

<u>Other</u>
The Local Annuitant Health Program (LAHP) is a program that provides group health insurance for a very small number of retirees of non-participating local public employers whose group health insurance with their former employer does not meet their needs or is not permanently available after retirement. LAHP provides two policy options (Medicare supplement and Preferred Provider Organization (PPO)) that have a unique

set of benefits and member materials. For 2018, staff plans to recommend the LAHP benefits be aligned with the benefits of the local program for ease of administration, but rated independently to account for the increased risk of this group.

New Provisions
The following is a general list of provisions that were added to the new Agreement:

- Objectives, outlining areas of importance to the Board
- Expectations related to data sharing and integration
- Implementation plan requirements
- Administrative fee and financial administration guidelines
- Information technology protocols and technical requirements
- Requirements for continued provider negotiations to strategically realize cost savings to the benefit program and reporting the results annually
- Provider review requirements regarding fraud and abuse
- Reporting and deliverable requirements
- Performance standards and penalties
- Hospital bill audits
- Federally required nondiscrimination testing
- Plan outlining transition to a succeeding vendor

Conclusion
Regardless of whether the Board moves forward with a self-insured model, stays with a fully-insured model, or chooses a hybrid approach, the Agreement is intended to ensure consistent contract requirements for all selected vendors so that participants receive the same level of service irrespective of their benefit plan choice.

As a result of the RFP process under way, the Board will have a number of decisions to make for 2018 beyond self-insuring, such as selecting vendors, regionalization and provider networks. In addition, the Board will also need to consider other topics pertaining to the Board's strategic priorities and Segal's recommendations as part of a program redesign, including:

- Plan design options and any changes to participant cost sharing or covered benefits
- Wellness incentives related to the benefit plan design
- Premium tiering structure
- Provider network structure, and whether any non-emergency out-of-network services will be covered (such as a PPO model), and the associated participant cost-sharing
- Pharmacy networks
- Changes to the local program options
- Medicare program offerings

The current version of the new Agreement is included in the RFP as Exhibit 1 – Pro Forma State of Wisconsin Contract and is available on ETF's Extranet at https://etfonline.wi.gov/etf/internet/RFP/HealthBeneAdminRFP1/index.html.

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