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To: Members of ETF's Group Insurance Board December 15, 2016

ETF's Group Insurance Board is in the midst of restructuring its Group Health Insurance Program (GHIP). Segal Consulting, ETF staff and members of the Group Insurance Board appear to agree that the new systems will (1) safeguard the confidentiality of personal health information being collected on all participants and insured family members and (2) will result in a high-level of cost savings.

The attached document, titled TABLE 13, REQUIRED DATA FORMAT, reveals the depth of private, personal medical and pharmaceutical information Segal Consulting has been gathering on the 98% of program participants enrolled in one of the "fully insured" HMO plans. This TABLE forms part of Segal's "revised" Application Addendums, introduced during CY2015 and connected to the Annual (HMO) Premium Rate Application and Approval Process overseen by ETF's Group Insurance Board. Segal's introduction of TABLE 13 marks the first time that HMO plans were required to disclose individually-disaggregated, protected health information, or PHI, on their members by ETF.

I urge you to review the attached TABLE and judge for yourself whether or not the PHI information Segal Consulting demanded is individually "identified" (see lines 8 through 13). ETF staff claim that all private, personal health information collected by Segal is "de-identified," although they have not specified what that means. Federal Privacy and Security Regulations, however, are clear on this matter. Any individually-disaggregated medical or pharmaceutical data disclosed in conjunction with Subscriber identification numbers, Member IDs, full dates of service, etc. is, by definition, "identified or readily re-identifiable" per HIPAA and HITECH. More recently, Segal, ETF staff and the Group Insurance Board have expanded their PHI data demands from the HMOs. In August 2016, Segal "deemed," and ETF's Group Insurance Board "mandated" that any HMO to be "considered" for continued inclusion in ETF's GHIP during CY2018 must commit "in advance" to releasing three years of encounter-level, medical PHI on individual plan members dating all the way back to January 2014! This information is scheduled to be released to Segal in January 2017. These issues of privacy and personal health information are subject to Federal and State laws with may make policy board members and related staff personally liable for decisions that contravene those regulations on privacy and data handling.

I also urge you to review the attached TABLE to see how medical "costs" are assessed. Basically, the TABLE curtails collection of ANY information about shifting member "cost share" obligations created by increasing individual premium, deductible, co-pays and co-insurance charges (lines 41-43). The massive financial contributions of Medicare reimbursement payments to plans and Program are likewise buried (line 44) and "discounts" on medical treatment costs generated internally by the HMOs (lines 36 and 37) are ignored. The result is an artificially inflated and inaccurate assessment of the GHIP "costs" borne by myriad employers, the State of Wisconsin and "Wisconsin taxpayers" because cost are equated with gross amounts "billed" (line 38) instead of net amounts "paid" (line 46) and the financial contributions of individual members, Medicare and HMO discounts are suppressed. Moreover, all retirees pay 100% of their monthly premium costs and associated medical fees with their own money: no state or local government monies are involved.

Bottom line: Group Insurance Board members lack some of the most critical actuarial information necessary to develop ANY valid risk/cost/benefit evaluation of Segal's recommended shift away from GHIP's present structure, in which 98% of participants are enrolled in "pre-paid, comprehensive, fully-insured, group health insurance plans (HMOs), toward a model in which the State and Wisconsin taxpayers would be the program's insurers. This is because Segal has decided NOT to collect any information about the rapidly expanding "cost share" contributions made by individual members, retirees, Medicare and in-house HMO "allowed" service discounts. I urge GIB members to request and review this information independently before taking any of Segal's "cost avoidance/savings" projections at face value. Whereas 85% of the 41 million dollars in Segal-projected "cost savings" are linked to avoiding projected ACA fees and taxes that have not and mostly likely, will not materialize, the added financial risks of a self-insurance model for the State and Wisconsin taxpayers are very real, as ETF discovered in the early 1980s.

Sincerely, Dr. S. E. Hutchinson

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TABLE 13
REQUIRED DATA FORMAT
Based on April 1, 2014 Through March 31, 2015 Incurrals

	Field Name	Field Description	Examples/Notes
1	HealthPlanCode	Two-digit plan code	
2	HealthPlanName	Health Plan Name	
3	Group	State or Local	State (S) or Local (L)
4	Plan	Plan Design	Uniform Benefits (U) or HDHP (H)
5	EligibilityStatus	Active Employee, Non-Medicare Retiree, Medicare Retiree, Grad Assistant	Active Employee (1); Non-Medicare Retiree (2); Medicare Retiree (3); Grad Assistant (4)
6	ServiceCategory	Service Category Code	See Service Category Codes in Table 14 for complete listing
7	Capitated	Yes or No	Y, N. Specifies whether a claim is capitated (Y) or not (N)
8	ClaimNumber	Medical claim number	ClaimNumber is an assigned number that identifies a claim
9	ClaimLineNumber	Line number of the claim	ClaimLineNumber identifies the line item detail for each service provided
10	SubscriberID	Subscriber identification number	Navitus Subscriber ID
11	MemberID	Member identification number	Navitus Member ID
12	Relationship	Self, Spouse or Child	Self (1); Spouse (2); Child (3)
13	ProviderID	Provider identification number	National Provider Identification number (NPI); if unable to provide then populate this field with Provider TIN
14	ProviderName	Name of provider	
15	ProviderAddress	Address of provider	
16	ProviderCity	City of Provider	
17	ProviderState	State of Provider	
18	ProviderZipCode	Zip code of Provider	
19	ProviderSpecialty	Specialty description	Use CMS Standard Coding
20	NetworkFlag	In or out of network	Y, N. Specifies whether a claim is in (Y) or out (N) of network.
21	OutOfAreaFlag	Claim is out of area	(1) if out of area
22	PlaceOfServCode	Place of service code	Use CMS Standard Coding
23	ProcTypeFlag	Procedure code type	Code which indicates what types of codes are in the procCode field CPT4 (C), HCPCS (H), revenue codes (R), and DRG, ICD9Proc codes (D)
24	ProcCode	Procedure code	Code for the medical procedure performed. Types of codes include CPT4, HCPCS, revenue codes, etc. If non-standard codes are used, code descriptions are required.
25	ModifierCode	Modifier code for procedure	Used to further define the medical procedure code
26	PrimaryDiagCode	ICD-9 code or ICD10 if applicable	
27	Diag2Code	Additional ICD-9 code or ICD10 if applicable	
28	Diag3Code	Additional ICD-9 code or ICD10 if applicable	
29	Diag4Code	Additional ICD-9 code or ICD10 if applicable	
30	DRG	DRG Code	
31	ServiceFromDate	Date of service start	
32	ServiceToDate	Date of service end	
33	Service Units	Number of units	
34	Discharge Status		Use CMS Standard Coding
35	ClaimPaidDate	Date claim paid	
36	SubmittedAmount	Amount Submitted	Not required for 2015
37	NotCoveredAmount	Amount not covered	Not required for 2015
38	BilledAmount	Amount billed	Totals must tie to Addendum 1
39	SavingsAmount	Amount of savings as generated by network	Not required for 2015
40	AllowedAmount	Amount allowed under contract	Not required for 2015
41	DeductibleAmount	Amount of deductible	Not required for 2015
42	CoinsuranceAmount	Amount of coinsurance	Not required for 2015
43	CoPayAmount	Amount of copay	Not required for 2015
44	MedicarePaid	Amount paid by Medicare	Not required for 2015
45	COBAmount	Coordination of Benefits amount other than Medicare	Not required for 2015
46	PaidAmount	Amount paid	Not required for 2015

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2017 Guidelines Contract and Uniform Benefits Changes

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Ref #	Color key:	State contract specific change = blue	Local contract specific change = green
	Topic	Contract/ Uniform Benefits Reference	Description of change
1	Wellness	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 6.	Removes requirement to administer the HRA and provide the $150 incentive. Clarifies that any other wellness-related offerings must be approved by the department, and also that plans still need to provide biometric screenings.
2	Claims data submission requirements	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 11.	New: Add requirement regarding claims submittal.
3	Disease management	Guidelines: II. General Requirements, D. Comprehensive Health Benefit Plans Eligible for Consideration, 11, bullet 8. [Note: Item will become #12 after renumbering due to new #11, above.]	New: Adds requirement to coordinate with the new wellness and disease management vendor.

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Revised 6/22/16

Guidelines/Uniform Benefits = white

Text key:
Bold items = new changes since the May Board meeting
Red text = the new 2017 language
Blue text = references that will be added at a later date

Current language	Proposed language
HEALTH PLANS must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult PARTICIPANTS including PARTICIPANTS whose biometric results are obtained through the State's biometric screening vendor. Plans must provide a screening tool to participants in the annual Health Risk Assessment that includes screening for substance abuse, tobacco use, and depression. Participants who are identified as at-risk for substance abuse, depression, tobacco, diet, exercise, and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services. Plans must provide incentives of $150.00 in value to PARTICIPANTS who complete an HRA and biometric screening to encourage participation. HEALTH PLANS must provide information as specified by the DEPARTMENT for payroll tax purposes. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. PARTICIPANTS may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The BOARD 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 must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the results to improve the health of PARTICIPANTS of the State of Wisconsin Group Health Benefit Program.	~~HEALTH PLANS must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult PARTICIPANTS including PARTICIPANTS whose biometric results are obtained through the State's biometric screening vendor. Plans must provide a screening tool to participants in the annual Health Risk Assessment that includes screening for substance abuse, tobacco use, and depression. Participants who are identified as at-risk for substance abuse, depression, tobacco, diet, exercise, and obesity must be offered the opportunity for health coaching and, if appropriate, information on intervention and treatment services. Plans must provide incentives of $150.00 in value to PARTICIPANTS who complete an HRA and biometric screening to encourage participation.~~ HEALTH PLANS must receive written approval from the DEPARTMENT prior to offering any financial incentive or discount programs to PARTICIPANTS. HEALTH PLANS must participate in collaboration efforts between the DEPARTMENT, its wellness and disease management vendor and the HEALTH PLANS. HEALTH PLANS must accept PARTICIPANT level data transfers from the DEPARTMENT'S wellness and disease management vendor. HEALTH PLAN must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data from DEPARTMENT'S wellness and disease management vendor to identify PARTICIPANTS appropriate for complex/chronic case management and enroll PARTICIPANTS in such HEALTH PLAN programs. HEALTH PLANS must provide incentive payment information as specified by the DEPARTMENT for payroll tax purposes. Provider obtained biometric ~~Biometric~~ screenings as required by the DEPARTMENT'S wellness program shall ~~still~~ be provided by the HEALTH PLAN~~plan~~ at the PARTICIPANT'S request, for no cost to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may ~~shall~~ be administered as non-fasting and in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. ~~PARTICIPANTS may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results for the four tests listed above and the results were obtained within the timeframe allowed by current USPSTF guidelines. The BOARD 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 must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the results to improve the health of PARTICIPANTS of the State of Wisconsin Group Health Benefit Program.~~
N/A	HEALTH PLANS must submit claims data for all PARTICIPANTS, for all claims processed for dates of service from January 1, 2014 through December 31, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Claims Data Specifications document (Appendix X). HEALTH PLANS must also submit provider data for providers under contract anytime from January, 2014 through December, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Provider Data Specifications document (Appendix Y).
If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the plan, have a process to enroll the participants into the appropriate wellness and/or disease management programs.	If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the HEALTH PLAN, have a process to enroll the PARTICIPANTS ~~participants~~ into the appropriate wellness, ~~and/or~~ disease management, or chronic care management programs. The HEALTH PLAN must coordinate this effort with the program(s) offered by the DEPARTMENT'S wellness and disease management vendor.

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Appendix X + Y

an important safeguard to consider

It would be "prudent" for GIB members to request to see Appendix X + Y BEFORE * assuming that * the PHI information being requested meets all Federal + State privacy requirements

Since any lapse could make Bd. members legally liable for any failure to respect these requirements