2019 Health & Pharmacy Program Changes

GIB Item 5A

ETF staff recommends the Board approve the following:

- Changes to the Health Program Agreement, Uniform Benefits, and pharmacy benefits for 2019
- Pilot programs for further development and implementation in 2018 and 2019
- Changes to the 2018 program agreement to remove self-funded program requirements

Background

2019 Change Process to Date

February 2018

- Initial proposed changes brought to Board

March 2018

- Changes reviewed with stakeholder groups
- Analysis by health plans & pharmacy benefit manager

April 2018

- Pricing by Segal
- Final list of proposed changes compiled

May 2018

- Final proposed changes for Board review

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Cost savings requirements

- No additional changes needed due to cost savings requirements

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Recent Legislative Changes

- WI Act 191: abortion services
  - Staff recommends updating language to include statute requirements
- WI Act 305: prescription eye drops
  - Staff recommends no change to Uniform Benefits language
- Additional analysis in GIB Item 10 I.

Memo page 2, GIB Item 10I

Health Program Agreement Changes

Agreement Changes

- Staff recommends pursuing all agreement changes proposed in February
- Complete list of changes is in Attachment A to GIB Item 4A
- Additional changes recommended following review

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Security Updates & Paper Reduction

Password security requirements

- Updated following Medicare Advantage Negotiations
- Approved by ETF Security Team

Reduce paper submissions

- Currently new proposers submit 15 hard copies
- Reduces number to 5

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New Department Initiative

- Monitoring Potentially Low-Value Services
  - Based on University of Michigan Value Based Insurance Design (VBID) Center work
  - Plans would monitor a list of 4-6 services considered “low value”
  - Report annually on service utilization, cost, and potential clinical impact of changing coverage
- Any changes to benefits derived from this item would be brought to the Board through the annual review process.

Memo page 3

Fraud Monitoring & Onboarding

Fraud and abuse monitoring

Plans attest to fraud and abuse plans	Required to report any material findings	Must provide plans on request

Annual onboarding process

Replacement for SOC-1, Type 2 reporting	Staff will develop a process to verify claims system setup annually	Staff will also develop a process to validate provider credentialing

Memo page 3

Double Coverage Limitations

- Correction to allow staff to assign coverage
  - Current contract does not allow double enrollment
  - Does not specify staff remedy for members found to have double enrollment
  - Correction would allow staff to assign coverage after 30 days
  - Staff would develop a policy and procedure for selecting plans.

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Health Benefit Changes

Net Cost Impact of Changes

Benefit Change	Cost (Savings)
Telehealth	$0
Contact lenses for keratoconus	$200,000
Home sleep studies	($400,000 - $800,000)
Returning Local retiree eligibility	$0
Removal of skin tags	($50,000 - $150,000)
Foot orthotics	$0
Removal of erupted teeth	$0
Transplants	$0
Total	**($250,000 - $450,000)**

Proposed Benefit Changes

- Reviewed by plans, stakeholders, and Segal
- List of recommendations narrowed from February memo
- Goal of changes is to align with industry, modernize where possible
- Full description of changes available in Attachment B

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Additions

Add telehealth benefit category

- $0 copay for non-HDHP
- Full cost until deductible met for HDHP/Local Deductible/Local HDHP
  - *Fiscal Impact: none*
  - *Member impact: unavailable, but currently covered by plans*

Contact lenses for keratoconus

- Allows one (1) set of hard lenses under medical benefit
  - *Fiscal Impact: minimal cost, <$200,000*
  - *Member Impact: 83 members w/ diagnosis known*

Memo page 3

Additions

Add coverage of home sleep studies

- Can be less expensive and more effective than lab studies in some cases
  - *Fiscal Impact: minimal savings, $400,000 - $800,000*
  - *Member Impact: estimated 1,350 members could be diverted to home*

Memo page 4

Additions

Returning local retiree eligibility

- Allows local employers to mirror state health program
- Local program retirees could return after leaving program
  - *Fiscal Impact: none (employers/retirees assume cost)*
  - *Member Impact: Estimated 254 local retirees eligible to return in a year*

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Modifications

Exclude removal of skin tags

- Nearly always cosmetic, but lack of language causes administrative challenges
  - *Fiscal Impact: minimal savings, $50,000 - $150,000*
  - *Member Impact: 850 claims paid in the last year*

Annual limit for foot orthotics

- One pair per member per year as authorized
  - *Fiscal Impact: expected minimal*
  - *Member Impact: unavailable*

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Modifications

Move extraction of erupted teeth to dental benefit

- Follows industry standard of coverage
  - *Fiscal Impact: none, assumed by Uniform Dental*
  - *Member Impact: unavailable*

Modifications

Transplant coverage language revision

- Removes clinically-specific language from Uniform Benefits
- Removes prior authorization for cochlear implants
- Removes per member, per organ, per plan limit
- Goal: rely on health plan medical expertise, support care continuity, align with industry
  - *Fiscal Impact: None*
  - *Member Impact: Unavailable, but not expected to impact utilization*

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Changes Not Recommended

- List included in Attachment B
- Review by plans and Segal indicated high cost and/or member impact

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Pharmacy Benefit Changes

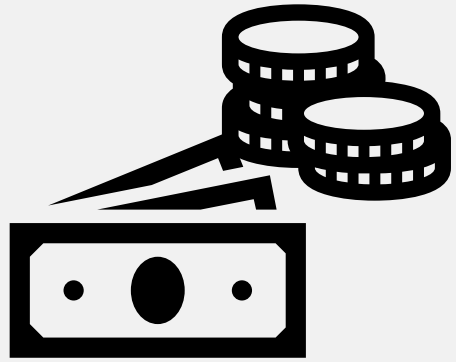
Non-Substantive Changes

- Carve out Uniform Pharmacy Benefit language
  - Mirrors how program has been administered for 15+ years
  - Simplifies contract maintenance
  - Clarifies coverage responsibility between vendors
  - No impact to benefits received

Memo page 5-6

Cost Sharing Change

- Level 3 “DAW-1” drugs
  - Dispense As Written, Code 1 (DAW-1)
  - Physician indicates that brand name must be dispensed
  - Current cost sharing = 40% up to $150



- **Recommendation: change cost sharing to include the difference between the cost of the generic and the brand name drug**

Member Cost Share = Coinsurance + Differential

Memo page 5-6

Cost Sharing Change: Example

- Non-Preferred Brand cost = $3,000

  Level 3 Drug on Formulary with 40% Coinsurance ($150 maximum)

- Preferred Generic alternative cost = $500

- Member cost share:
  - 40% COINSURANCE x $3,000 BRAND COST = $1,200, reduced to $150 Maximum
  - $3,000 BRAND COST - $500 GENERIC COST = $2,500 Differential
  - Total Cost to Member = $150 + $2,500 = $2,650 Member Cost

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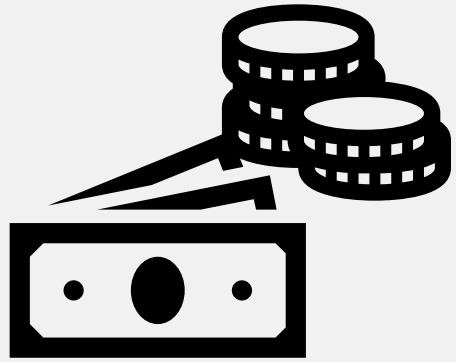
Cost Sharing Change

- $1.6M in savings estimated over a six-month period
- The cost to the member will never exceed the total cost of the non-preferred brand drug



- Members who need non-preferred brand drugs for medically necessary reasons can have their doctor submit a FDA MedWatch form to Navitus to have cost sharing lowered to just the coinsurance

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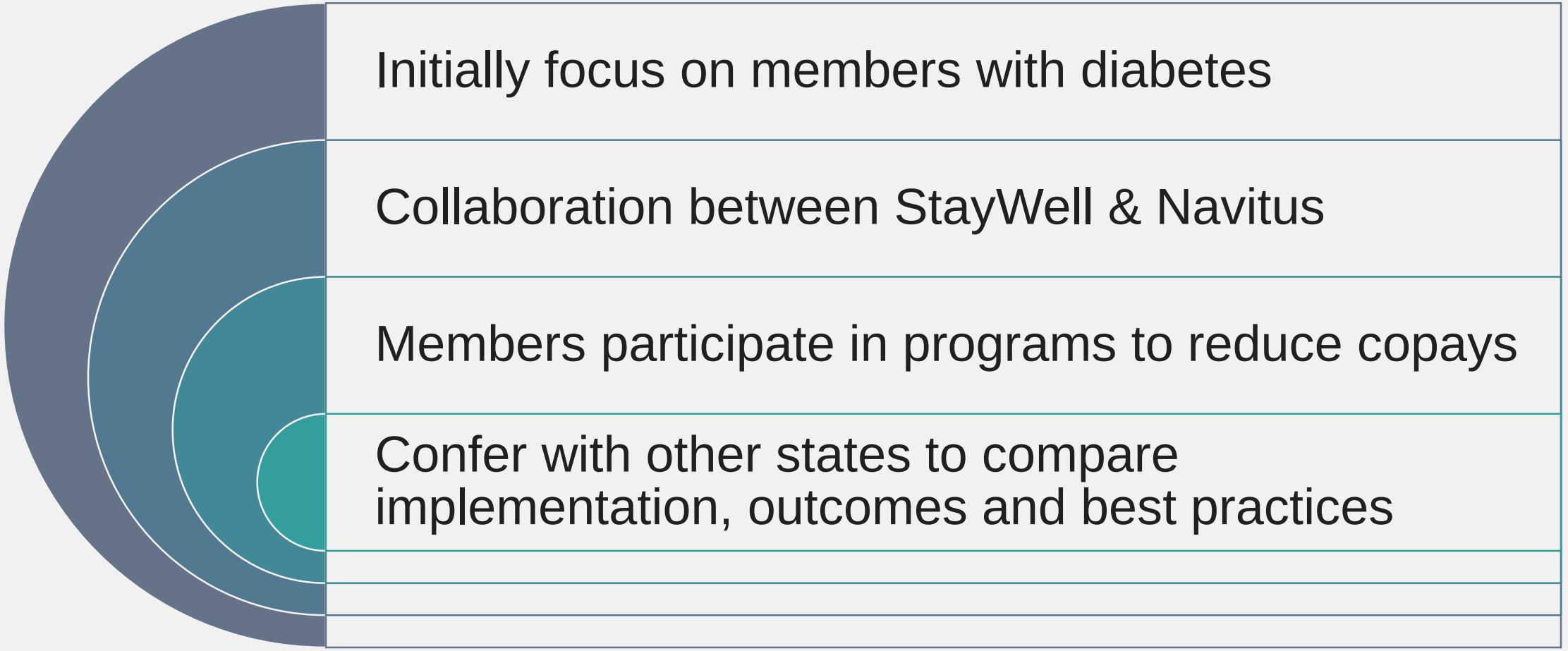
Value-Based Plan Design



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Health Plan Pilot Programs

Pilot Program Proposals

2018: Kiio / Mobile Back Program

- Offered by Quartz and WEA Trust
- Self-guided exercise program through mobile app
- Goal: mitigate low back pain

2019: Livongo for Diabetes

- Offered by WEA Trust
- Smart diabetes meter, strips, and diabetes coaching
- Goal: management assistance for diabetic members

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2018 Agreement Changes

Recommended Changes

- Remove:
  - Non-discrimination testing
  - Quarterly out-of-network claims report
  - Hospital bill audit
  - SOC I, Type 2 reporting

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Questions?

Thank you

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ETF E-mail Updates

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