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Correspondence Memorandum

Date: August 9, 2018

To: Group Insurance Board

From: Arlene Larson, Manager of Federal Health Programs & Policy
Renee Walk, Strategic Health Policy Advisor

Subject: 2019 Uniform Benefits Changes & Updates

The Department of Employee Trust Funds (ETF) provides the following policy clarifications to the Group Insurance Board (Board) for informational purposes only. No Board action is required on these items:

- **Federally required benefits in the Medicare Advantage program;**
- **Changed requirements for dependent eligibility verification for single parents; and**
- **Clarifying special enrollment eligibility for the Access Plan for retirees preserving sick leave.**

ETF further requests the Board approve the following program changes:

- **Adding a benefit and revising an administrative requirement for the Medicare Advantage Program;**
- **Revising the retiree benefit for Medicare-eligible retirees in Program Option (PO) 4/14 to align with other Medicare-eligible state and local program retirees;**
- **Adding two new Medicare Plus benefits;**
- **Adding a diabetes value-based program pilot from Dean Health Plan (Dean); and**
- **Finally, in response to a request from UW-Madison and several other UW System institutions, ETF will research and bring back to the Board information concerning potential options for adding coverage for domestic partners.**

Background

Since the March and May 2018 Board meetings, several benefit and agreement-related changes have come to light related to the Medicare Advantage implementation with UnitedHealthcare (UHC). Some of these changes are required to provide a Centers for Medicare and Medicaid Services (CMS)-compliant Medicare Advantage Program; a few

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changes are best practices recommended by UHC. In addition, the Medicare Advantage implementation raised questions related to other retiree programs, including benefit options available to certain local retiree groups; Medicare Plus benefit offerings; and the policies surrounding enrollment in the Access Plan as a means to preserve accumulated sick leave credits immediately prior to retirement. A discussion of these changes follows.

Also, at the May 2018 Board meeting ETF requested approval for health program pilots for low back pain and diabetes management. ETF has since received and reviewed one additional pilot proposal for 2019 from Dean Health Plan and brings a brief description of that program to the Board for approval.

ETF has reviewed member questions related to the dependent eligibility verification requirements for a change from single to family coverage for single parents. This memo includes a clarification of the requirements for documentation for these members.

Coverage Clarifications: Medicare Advantage
At its March 21 meeting the Board approved contracting with UHC for a Medicare Advantage product to be offered during It's Your Choice and effective January 1, 2019. During implementation of the program, UHC provided an analysis of Uniform Benefits versus their CMS-approved certificate of coverage. UHC identified a few benefits that Medicare Advantage plans are required by CMS to offer that vary from Uniform Benefits. This memo informs the Board of these required benefits, and in a later section requests the Board approve two additional agreement variations that were included in the agreed-upon rate for the plan.

Mandated Benefits: CMS requires Medicare Advantage plans to provide coverage for federally required services, including Medicare deductibles and coinsurance. When federal law, state law and/or program contracts conflict, federal law supersedes. Adding these benefits to the Medicare Advantage program will not increase costs to members.

These mandated benefits are:

1. **Bariatric surgery for the treatment of morbid obesity**: CMS issued a National Coverage Determination (NCD) specifying allowable surgical procedures and limitations. This document codifies Medicare's medical policy for coverage. CMS policy is substantially the same as the policy followed by the Access Plan when bariatric surgery was allowable. In fact, WPS Health Insurance had referred to it when developing medical policy for the Access Plan in previous years. Uniform Benefit specifically excludes this coverage.

2. **Speech, occupational and physical therapies may not have visit limits**: Medicare requires that medically necessary therapies be payable and does not permit visit limits. Uniform Benefits provides coverage for up to 50 visits per member for all therapies, combined with an additional 50 visits per therapy type available as authorized by the health plan. When polled on the subject as a part

of 2019 benefit changes, six of the Board's health plans responding provided data showing that a total of 127 members for ETF's entire population had more than 50 visits, and only nine (9) had more than 100 visits. UHC has management procedures in place to monitor service use, and ETF would not expect excessive use under this benefit change.

3. **Home health care may not have visit limits:** Medicare requires that medically necessary home health care be payable and does not permit visit limits. Uniform Benefits provides for a maximum 50 visits per member per calendar year. 50 additional medically necessary visits may be authorized by the health plan per year. UHC monitors usage for medical necessity.

4. **Temporomandibular Joint (TMJ) treatment may not have a dollar limit**: Uniform Benefits follows state mandated benefits for TMJ treatment. Benefits for diagnostic procedures and non-surgical treatment, including intraoral splints, are allowable up to $1,250 per calendar year. UHC reviews services for medical necessity.

UHC has also raised the possibility that the Board's Medicare Advantage program through UHC will need to cover treatments for gender dysphoria. Further discussion of this issue is in the supporting memorandum for Item 6A1.

Policy Clarification: Dependent Eligibility Verification
The ETF *Health Insurance Application/Change Form* (ET-2301) includes a question about the reason for a coverage change (e.g., from single to family coverage). Single male employees have been required to produce documentary evidence to add a dependent child in addition to the narrative question response on the application. Acceptable forms of verification include a birth certificate, paternity support order, or a similar document that may have been issued by another state. Single females have not been required to provide similar documentation upon adding a dependent child. Employers and members have questioned whether this practice is fair. As a result, ETF recommends changing this policy to require documentary evidence from both single males and single females to add a dependent child.

Policy Clarification: Special Enrollment in Access Plan for Employees Planning to Retire, in Order to Preserve Sick Leave
If a state employee is not enrolled in the Group Health Insurance Program as they near retirement and wishes to escrow their sick leave credits for use in retirement, the employee must enroll in the Access Plan 30 days prior to the month in which they retire. If the member submits an escrow application and their coverage is found to be comparable by ETF, they are asked to then cancel their enrollment in the Access Plan after 30 days. Staff had found that federal law does not permit short term policies such as this 30-day offering. Thus, the current practice of requesting that a retiree cancel the coverage is not permissible. Therefore, retirees will be permitted to remain on the

Access Plan until the next It's Your Choice open enrollment period if preferred or may still cancel and escrow if they wish.

Request for Coverage & Administrative Changes to Medicare Advantage
ETF and UHC request Board approval of two variations to the agreement for Medicare Advantage, as described below. If approved, these changes will have no material effect on the final rate.

1. **Routine foot care:** UHC offers a non-mandated preventive foot care benefit and states that this benefit addresses a significant need with their Medicare Advantage population. UHC has found that by including the following services, illness and injury care of feet is reduced, which results in cost savings over the long term. The following services covered by this benefit are not covered under Medicare. They are:
    - Preventive treatment of the foot
    - Removal of corns and calluses
    - Trimming, cutting, and clipping of nails
    - Wart care

   UHC offers this benefit in all Medicare Advantage products. It was a part of the original bid and final approved rate for this program. Allowing this will create a difference in benefits between the Medicare Advantage plan and the Medicare coordinated products currently offered by other vendors. However, it is unlikely that this benefit alone would create a competitive advantage for a member to choose Medicare Advantage rather than another plan.

2. **Date printed on ID cards**: UHC requested that its ID cards list the date the card is printed, rather than effective date of coverage. They are currently unable to print both dates and state that since CMS requires UHC to print ID cards every year, members find the printed date less confusing than the effective date. Staff supports this request.

Request for Revision of the PO4/14 Medicare Retiree Benefit
When local program retirees become Medicare-eligible, most receive the lowest cost-sharing benefit option with no deductibles, a $60 emergency room copay, and coinsurance on a very limited set of services. This is the same benefit offered to state retirees. Medicare-eligible retirees in the Local Deductible Plan, Program Option (PO) 4/14, however, continue to have a $500 individual / $1,000 family deductible. This structure is challenging for health plans to administer, causes retiree complaints and results in ongoing education and support from staff. For administrative simplicity, staff recommends changing this retiree option to match the option offered to all state and other local retirees.

ETF requested input from employers who had selected the PO4/14 benefit and from retiree groups with members enrolled in this option. ETF asked whether, regardless of which vendor they select at open enrollment, retirees would be willing to pay a small

premium increase per month if the deductibles were removed. The amount of premium increase was estimated by the Board's actuary, Segal Consulting, to be less than the cost of the deductibles. All parties indicated that they saw no issue in changing to the non-deductible benefit.

During implementation meetings UHC informed ETF that the approved 2019 premium rates would not vary between PO4/14 and the more comprehensive benefit offered to other local and state retirees. This is due to the fact that these rates had been approved by CMS and the Board for the program as a whole and reopening the rates with CMS is seen as burdensome. UHC would administer the deductibles if this benefit remains in place for 2019. Other health plans would be compensated at their approved rates, submitted for the more comprehensive benefit.

Request to Add Telehealth and Silver Sneakers Benefits to Medicare Plus
Following the Board's approval of Uniform Benefits for 2019, WEA Trust (WEA) approached ETF to request adding telehealth to the benefits provided under Medicare Plus. WEA indicated that Medicare does not currently pay for telehealth benefits. However, CMS publications in recent months have indicated it is likely Medicare will begin reimbursement for telehealth in the future. Telehealth benefits are also traditionally inexpensive, ranging from $20 to $50 for a primary care visit, and even though the benefit may be valued by customers its utilization tends to be low in the retiree population. WEA will not increase Medicare Plus rates to add this benefit for retirees. ETF recommends adding telehealth to the benefits covered by Medicare Plus.

WEA requested approval to offer Silver Sneakers, a gym membership benefit, to the Medicare Plus plan. Members have repeatedly requested this benefit of WEA and ETF staff. The medical-only increase in state rates without the benefit is 4% over 2018 individual and Medicare family rates. The increase with the new benefit is approximately 7%. Retirees pay the full amount of premium for this plan. Staff agrees with the vendor's recommendation to include this benefit.

Request to Add Diabetic Services Pilot Program
Dean has proposed including the Board's member population in a diabetes value-based insurance design pilot program. This program will allow members to receive additional programming for diabetes management, and these members may be eligible for cost sharing reductions on medications. The program is similar to what ETF will be implementing with StayWell and Navitus in 2019 and would serve as a comparison population for that program. If approved, ETF will provide additional details to the Board in November.

Further Research: Request to Add Domestic Partner Coverage
The University of Wisconsin has written a letter to the Board requesting the return of coverage of domestic partners to the health program (See GIB Item 10C). They state that the lack of coverage impacts their ability to recruit and retain staff. ETF recommends further research and will bring options to the Board at a future meeting.

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