



STATE OF WISCONSIN
Department of Employee Trust Funds
 Robert J. Conlin
 SECRETARY

Wisconsin Department
 of Employee Trust Funds
 PO Box 7931
 Madison WI 53707-7931
 1-877-533-5020 (toll free)
 Fax 608-267-4549
 etf.wi.gov

Correspondence Memorandum

Date: April 14, 2019
To: Group Insurance Board
From: Renee Walk, Strategic Health Policy Advisor
 Office of Strategic Health Policy
Subject: 2020 Benefit Changes


The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) approve the following benefit change options for the 2020 plan year:

1. Medical Benefit Options M3.2, M4, and M6.2;
2. Pharmacy Benefit Options P1.1 and P2; and
3. Dental Benefit Options D2, D3, and D4.

See Table 1 below for reference.

Table 1. Recommendation Summary

Reference Number	Summary of Change	Summary of Current Benefit
Medical Benefit Recommendations		
<u>M3.2</u>	25 initial therapy visits of each type, followed by 25 authorized therapy visits of each type	50 initial therapy visits (combined across physical, occupational or speech therapy), followed by a possible 50 authorized therapy visits of each type
<u>M4</u>	Coverage of Congenital Defects – remove the requirement that the covered individual must have been covered continuously by the Board’s program	Requires the covered individual to have been covered continuously by the Board’s program
<u>M6.2</u>	Cover surgery and weight loss services for members with body mass index (BMI) of 35 or greater	Bariatric surgery and weight loss services except for certain nutritional counseling are excluded

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
 Electronically Signed 5/3/19

Board	Mtg Date	Item #
GIB	5.15.19	8C

<i>Pharmacy Benefit Recommendations</i>		
<u>P1.1</u>	Combine out-of-pocket limit (OOPL) for Levels 1, 2, and 3 to \$1200 individual and \$2400 family for non-HDHPs	Levels 1 and 2 have the same out-of-pocket limit, but Level 3 prescriptions accumulate all the way to the federal maximum out-of-pocket limit. Current Level 1 and 2 OOPLs are \$600 individual and \$1200 family
<u>P2</u>	Cover vaccines at retail pharmacies under the pharmacy benefit	Vaccines are only covered at pharmacies if the health plan lists the pharmacy in their network
<i>Dental Benefit Recommendations</i>		
<u>D2</u>	Cover periodontal maintenance at 100%	Currently cover 80%
<u>D3</u>	Cover Pulp Vitality Tests	Not covered
<u>D4</u>	Cover Caries Assessment and Sealant Restorations	Not covered

Background

The Board makes annual adjustments to the benefits provided by its insured products based upon state budget targets, legal requirements, member utilization and need, and industry standards. For changes that are not required by law or legal ruling, the annual benefit change process begins with proposals by the Board's participating health plan vendors, pharmacy benefit vendor and dental benefit vendor. Those proposed changes, along with issues submitted to the Board and ETF throughout the year, are researched by ETF and Segal Consulting (Segal), the Board's consulting actuary, and recommended changes to coverage are then brought to the Board for review and consideration. Current utilization data specific to the Group Health Insurance Program (GHIP) population is also provided through ETF's data warehouse resource and is discussed below.

This memo presents the changes reviewed by ETF along with analysis and options for coverage. A summary of the estimated cost impact of recommended changes is in Table 4 on page 18 of the memo.

Current Population and Utilization Trends

The release of the IBM Watson data warehouse resource, Data, Analytics and Insights (DAISI), in 2018 has allowed ETF to examine cost, utilization and population risk data to analyze benefit change recommendations. This section provides a summary of the referenced data from the most recent IBM Watson Health March 2019 DAISI Dashboard. It includes data from the most recent, complete 12-month period of claims and enrollment data, November 2017 to October 2018.

The Group Health Insurance Program (GHIP) provided coverage for approximately 260,000 unique members in the most recent rolling year of available data. The average

age of GHIP subscribers is 51, and the average age of members, including dependents, is 39.3.

Table 2. Current Enrollment Statistics, Nov 2017 – Oct 2018 (Previous 11/16-10/17)

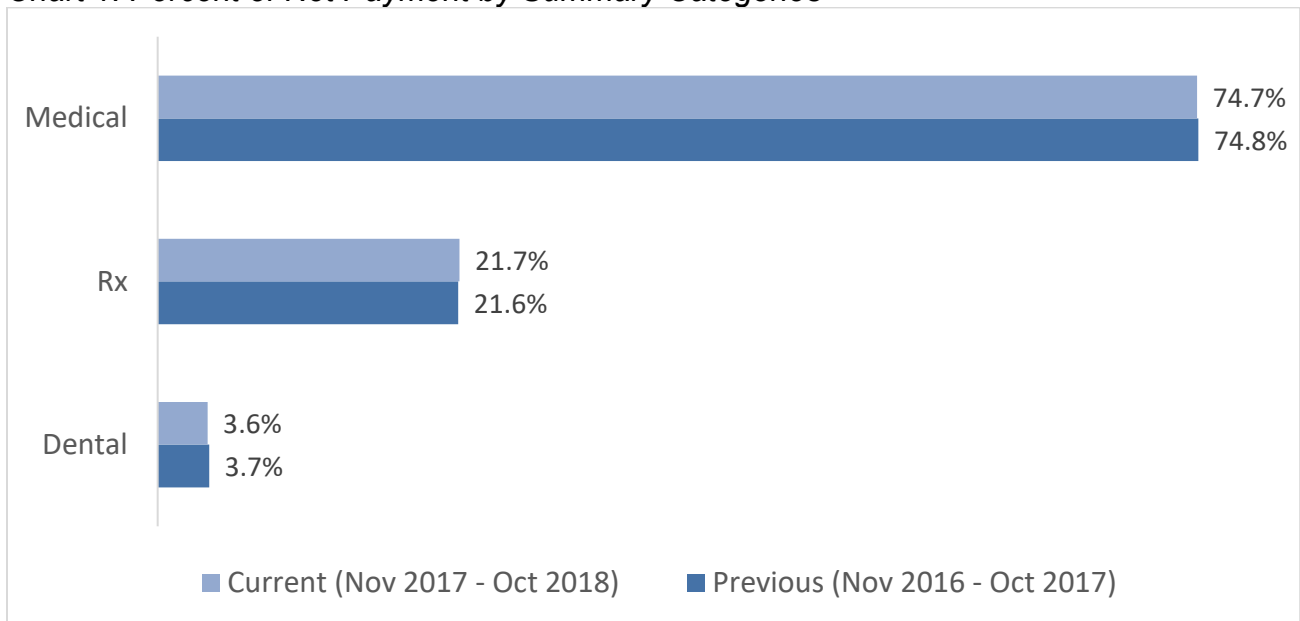
	Enrollment			Average Age		
	Previous	Current	% Change	Previous	Current	% Change
Subscribers	121,926	120,432	-1.2%	51.0	51.0	0.0%
Members	269,515	263,754	-2.1%	39.3	39.3	0.2%
Average Family Size	2.2	2.2	-1.0%			

Source: IBM Watson Health March 2019 DAISI Dashboard, Created April 16, 2019, Page 6.

The total net payment for claims during this period was \$1.48 billion, an increase of 5.9% over the previous year. 74.7% of dollars paid were classified as medical services, which are currently fully-insured benefits provided by 11 contracted health plans.

The self-insured pharmacy and dental programs represented 21.7% and 3.6% of costs, respectively. Changes in the proportion of costs in each of these categories remained essentially the same as the prior reference period.

Chart 1. Percent of Net Payment by Summary Categories



Source: IBM Watson Health March 2019 DAISI Dashboard, Created April 16, 2019, Page 1

Within the medical service category, the percentage of costs incurred as physician or other individual provider claims was 46.3%, roughly the same as during the prior year period (November 2017 to October 2018). Facility outpatient costs were a slightly larger portion of total costs, at 32.3% in the current period versus 31.1% in the prior year

2020 Benefit Changes

April 14, 2019

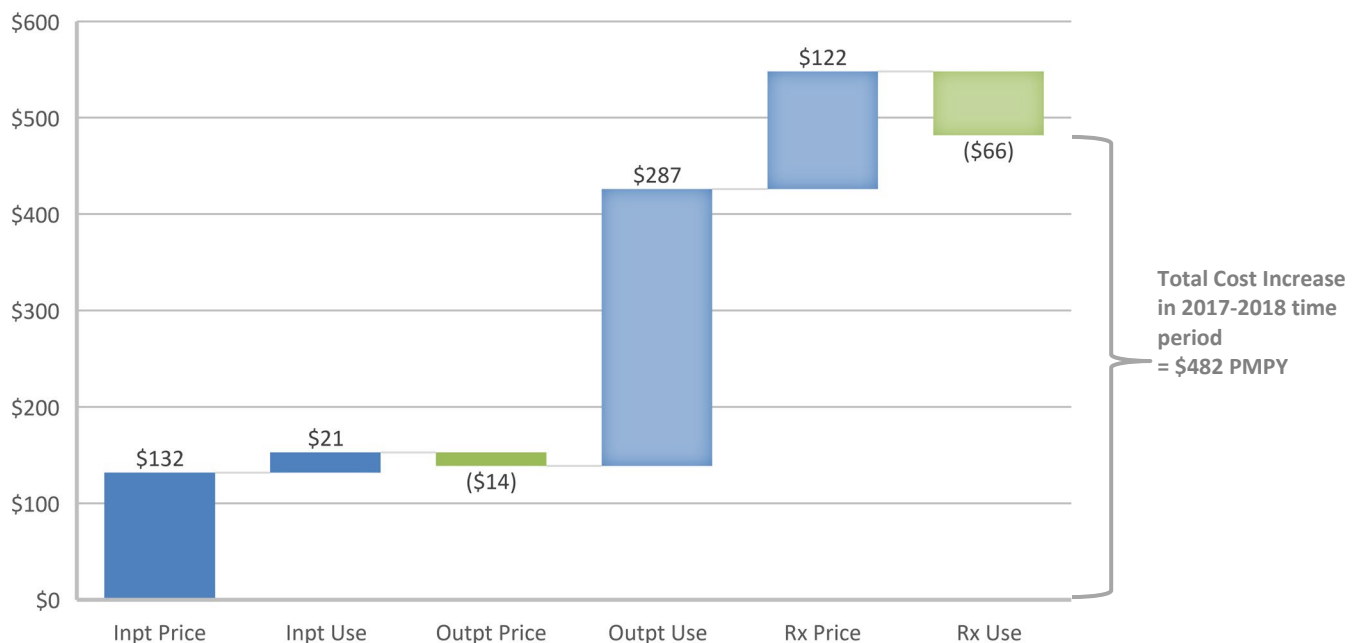
Page 4

period. Concurrently, facility inpatient costs were a slightly smaller percentage of total costs, reducing from 21.2% to 20.4% of total costs.

The overall costs per member per year (PMPY) in the GHIP increased \$482 in the current period. The largest factor in this change was outpatient use, which accounted for more than half of the increase (see Chart 2). Despite the reduction in percentage of overall costs, inpatient use and price also contributed to increasing costs. While the GHIP is protected within a benefit year from directly experiencing medical cost increases because the medical benefit is fully-insured, PMPY costs may drive future premium increases for subsequent benefit years.

Pharmacy prices continued to increase in step with national trends; however, the average allowed amount per prescription is still 7.5% lower than the IBM Watson reference data. Prescription utilization trends also resulted in a \$66 per member per year reduction in costs.

Chart 2. Cost Drivers Per Member Per Year Versus Prior Year

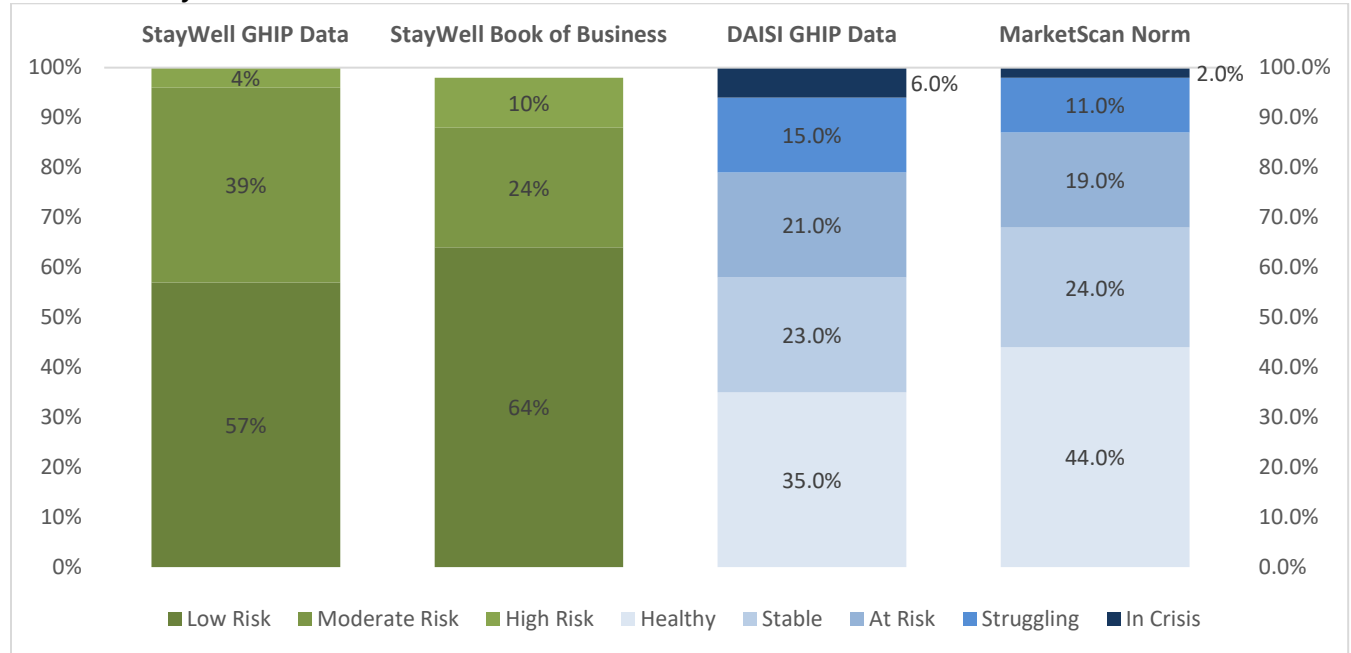


Source: IBM Watson Health March 2019 DAISI Dashboard, Created April 19, 2019, Page 2.

To get a sense of the overall population health and risk levels of GHIP participants, ETF reviews both the data available in DAISI as well as reports provided by StayWell, the Board's wellness program vendor. As reported by both StayWell and DAISI, approximately 58% of members fall into the Low Risk or Healthy/Stable Risk ranges. StayWell reports 39% of members in their Moderate Risk range, as compared with DAISI's 36% of members in the IBM Watson At Risk/Struggling range. StayWell reports 4% of members participating in the wellness program fall into the High Risk range; DAISI reports a similar 6% of members who are considered In Crisis. The GHIP

population’s risk prevalence is generally higher than both the StayWell book of business data and the IBM Watson Health MarketScan norms.

Chart 3. StayWell and IBM Watson Health Risks and Norms



Sources: StayWell Annual Key Findings Report, January 16, 2019; IBM Watson Health March 2019 Dashboard, Page 4.

Note: StayWell data as appears in Key Findings Report; percentages may not sum due to rounding.

Medical Benefit Cost Sharing Changes

Health plans proposed several changes to the benefit plan cost sharing design that would align the GHIP benefits with industry standards. These included the following:

- Option M1: Moving to a coinsurance-only structure in the high-deductible health plan (HDHP).** When the Board’s HDHP was established, the Board opted to keep the cost sharing structure post-deductible the same as members in the non-HDHP experience—that is, a combination of copays for office visits and coinsurance for other services and equipment – to help participants compare the two plan designs. This configuration, however, is uncommon in the commercial insurance market. It is more common for only coinsurance to apply to any services or supplies received after the deductible and before the OOP/L is met. Moving to coinsurance only would affect both the state employee HDHP option and the local employer HDHP program option (7/17). This change would simplify the benefit configuration and align with industry standard but would result in an estimated premium increase of \$3.50 - \$5.50 per employee per month (PEPM) for HDHP members and would increase the actuarial value of the plan by 0.4%, per Segal.

- Unifying coinsurance rates within existing plan structures (Options M2.1 and M2.2). Both the HDHP and non-HDHP plan designs for state employees, as well as local program options 6/16 and 7/17, have two different coinsurance rates within the plans. The benefit plans cover 90% of non-office visit services such as laboratory tests, x-rays and home health services, with the member responsible for the remaining 10% until the OOPPL is met.

Durable medical equipment (DME) is paid at 80%, with members responsible for 20% of the remaining costs until the OOPPL is met. This adds a level of complexity to the benefit plan, which can be challenging for both the members and the health plans. Segal reviewed two different scenarios to align coinsurances: moving all benefits to the 90%/10% coinsurance rate or moving all benefits to the 80%/20% coinsurance rate.

- **Option M2.1: Moving all coinsurance benefit levels to 90%/10% in the state plan designs and local program options 6/16 and 7/17.**
 - *Pros:*
 - Simplifies benefit configuration, making the program easier to communicate.
 - *Cons:*
 - Minimal estimated cost increase to the non-HDHP of \$1M to \$2M or \$1.00 - \$3.00 PEPM; 0.14% increase in actuarial value of the plan.
 - Very minimal cost estimated for HDHP is \$10K to \$30K or \$0.15 - \$0.45 PEPM, 0.01% increase in actuarial value.
- **Option M2.2: Moving all coinsurance benefit levels to 80%/20% in the state program options and local program options 6/16 and 7/17.**
 - *Pros:*
 - Simplifies benefit configuration, making the program easier to communicate.
 - Estimated cost decrease of \$5.00 to \$18.00 PEPM in the non-HDHP, or 0.48% decrease in actuarial value of the plan.
 - Estimated cost decrease of \$3.50 to \$7.50 PEPM in the HDHP, or a 0.46% decrease in actuarial value.
 - *Cons:*
 - More substantial cost to members could lead to care disruption.

Medical Cost Sharing Change Recommendation: No Changes.

- ETF *does not recommend* Option M1, or M2.1 at this time, given the costs to the program.
- ETF *does not recommend* Option M2.2 at this time given the substantial increase in costs to members and concerns regarding disruption.

Medical Therapy Limit Changes

The GHIP's benefit design includes limits on the number of therapy visits members may receive in a given benefit year. Currently, members may receive a total of 50 physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services before the benefit requires plans to prior authorize services. Once the initial 50 visit limit has been reached, members may receive authorization for an additional 50 visits of each service type, which are aggregated separately. The current design is challenging for health plans to administer; therefore, plans have requested the Board consider aligning the benefits to either have a common limit or separate limits for each benefit type before and after prior authorization.

ETF reviewed DAISI data to determine the number of members utilizing each type of therapy in a given year and how many visits members are using (see Table 3). Utilization of therapy services decreased in all categories from 2017 to 2018. For each type of therapy analyzed, the majority of members required 10 or fewer therapy visits during the benefit period. Only 2% of OT patients, 6% of ST patients and less than 1% of PT patients in 2018 needed more than 40 therapy visits during the benefit period. Visits were analyzed independently to determine the total numbers received; it is therefore possible that members who received multiple types of therapies will be counted in each table.

Table 3. Therapy Visits by Type, Patient and Visit Count, by Incurred Year

Number of Visits	Physical Therapy Patients		Occupational Therapy Patients		Speech Therapy Patients	
	2017	2018	2017	2018	2017	2018
0 – 10	13,039	11,412	2,556	2,348	771	678
11 – 20	2,459	1,897	294	303	89	72
21 – 30	612	442	86	89	39	64
31 – 40	189	133	58	54	43	34
41 – 50	70	37	35	18	24	26
over 50	36	20	134	37	31	26
Totals	16,405	13,941	3,163	2,849	997	900

Source: IBM Watson Health Advantage Suite query, claims through 10/30/2018

- **Option M3.1: Change the Number of Therapies Prior Authorized to 100 Total.** This option would aggregate therapy limits both before prior authorization and for which authorization is required. The total number of visits possible per member per year would be 150.
 - *Pros:*
 - Simplifies benefit configuration, making the program easier to communicate.
 - Allows for members who might need a high number of a certain type of therapy to receive more of that therapy without needing to appeal for coverage.

- *Cons:*
 - Would result in a cost increase to the medical benefit. Segal estimates \$100K to \$200K based on current therapy utilization.
 - Therapy use may increase for some more extensive utilizers.
- **Option M3.2: Provide 25 Initial Visits of Each Type, Followed by 25 Authorized Visits of Each Type.** This option would count the total number of approved therapies for each of PT, OT and ST separately both before prior authorization is needed and after authorization. The total number of visits possible per member per year would be 150.
 - *Pros:*
 - Simplifies benefit configuration, making the program easier to communicate.
 - Aligns the benefit with use needs of most members. Plans could approve additional therapy if needed based upon the cost effectiveness and medical necessity provisions of the health plan.
 - Would result in a cost savings of \$350K to \$500K.
 - *Cons:*
 - May reduce access to therapies for some members who use larger numbers of a particular type of therapy visit.

Medical Therapy Limit Changes Recommendation: Option M3.2.

- This change represents a GHIP cost savings opportunity that should have minimal disruption to members. It also results in greater simplicity in benefit configuration and communication.
- Members who would need more than the potential 50 visits per therapy per year could be approved by plans for additional therapy visits based upon medical need and the cost-effective care provisions of the contract.

Medical Benefit Additions

ETF reviewed three new medical benefits for coverage in 2020, following correspondence to the Board and reviewing grievances received in 2018 and early 2019.

- **Option M4: Coverage of Congenital Defects.** Uniform Benefits (UB) currently provides coverage as follows for congenital defects under section III. Benefits and Services, A. Medical/Surgical Services, 6) Coverage of Newborn Infants with CONGENITAL Defects and Birth Abnormalities:
“As required by Wis. Stat. [§632.895 \(5\)](#) and [Wis. Adm. Code § INS 3.38 \(2\)\(d\)](#), if a DEPENDENT is continuously covered under any HEALTH PLAN under this health benefits program from birth, coverage includes treatment for the functional repair or restoration of any body part when necessary to achieve normal functioning. If required by Wis. Statute, this provision includes orthodontia and dental procedures if necessary as a secondary aspect of restoration of normal

functioning or in preparation for surgery to restore function for treatment of cleft palate.”

Given the language in the passage above, members who have not been continuously covered by the Board’s plan may not be covered for correction of congenital conditions. In one 2018 example, the Group Insurance Board received correspondence from a member who adopted a non-infant child in need of corrective surgery. The plan was not able to cover medically necessary services for that child under the current benefit, resulting in substantial out of pocket costs for the family. If a child were to change health plan vendors before a congenital defect has been corrected, this also may not be covered under a strict reading of the above language.

The current contract language is also in conflict with both the pre-existing condition and essential health benefits requirements of the Affordable Care Act (ACA). Under the ACA, state-mandated benefits are essential health benefits. The statutory language referenced in the contract language above requires that congenital defects be covered in the same way that illnesses or injuries are covered by the plan; it does not include any language related to continuous coverage. The Wisconsin Statutory language notwithstanding, the ACA further prohibits the exclusion of a service related to a pre-existing condition.

Segal estimates that extending this coverage by removing the “continuously covered” requirement will result in a \$100K to \$200K increase in costs to the plan. Several participating plans indicated that these services would already be covered due to their coverage policies related to medical necessity and ACA requirements, so the actual increase may be smaller.

- **Option M5: Coverage of Severe Malocclusion.** Malocclusion is a misalignment of the jaw and teeth. It is a common condition that does not always require treatment and can be the result of a variety of factors, including genetics, thumb-sucking and persistent pacifier use in childhood. However, in some severe cases, malocclusion can cause patients to be unable to chew food adequately or close their jaws. Treatment may require as little as basic braces to full orthognathic surgery to correct.

Currently, treatment of malocclusion is explicitly excluded in UB; there is limited coverage of orthodontia in the Uniform Dental Benefit (UDB). The health plans participating in the GHIP vary in terms of which cover any type of severe malocclusion treatment in their other commercial business, and to what severity. The Wisconsin Medicaid and Children’s Health Insurance Program (CHIP) does cover some severe malocclusion correction. Medicaid employs dental consultants (directly and via managed care plans) that review the severity of cases and make recommendations for coverage. The Board does not require that health plans employ dental consultants for this type of review.

ETF has received grievances related to severe malocclusion treatment coverage in the past. The most recent cases were regarding children who were not covered due to the continuous coverage requirement for congenital defect treatment.

Segal estimates adding this benefit would cost an additional \$300K to \$500K in costs to the plan.

- Coverage of Bariatric Surgery (Options M6.1 – M6.3). “Bariatric surgery” describes a group of procedures that modify the digestive system to help patients lose weight. Bariatric surgeries are becoming more common worldwide, though recent research seems to indicate the rate in the United States has plateaued at approximately 200,000 procedures per year.¹ The most common procedures performed in the United States today are the gastric bypass, sleeve gastrectomy and biliopancreatic diversion with or without duodenal switch.² Less commonly performed are gastric banding or the insertion of a gastric balloon.

History. Prior to 2018 bariatric surgery was covered by the GHIP only under the Access Plan. The Board elected in 2017 to apply UB to the Access Plan for benefit year 2018, and thereby removed coverage for bariatric surgery. At the time of this change, utilization of bariatric surgery in the GHIP population was very low: Between 2007 and 2012, fewer than 30 members sought bariatric surgery in each year. The low volume is likely due less to low demand than to the small population in the Access Plan and the high cost of that plan. In each year examined by Segal of that same period, between 48% and 75% of members who received the surgery in a given plan year moved to the lower-cost IYC Health Plan the following year. Since that time, the Board has received several pieces of correspondence from members requesting coverage of this service.

Nearby States’ Employee Plan Coverage. Employee benefit plans in Minnesota, Michigan, Iowa, and some carriers for Illinois’ plan all cover bariatric surgery for members. Wisconsin’s Medicaid program covers bariatric surgery, and Medicare also requires coverage, which means that some retirees in the GHIP also have access through the Medicare Advantage product offered by UnitedHealthcare®.

Mechanism of Weight Loss. Bariatric surgeries typically assist patients in losing weight via two means—restriction and malabsorption. Restrictive procedures limit the volume that the stomach can hold, thereby limiting the amount of food that a

¹ Lim, R. B. (2018, September 27). Bariatric procedures for the management of severe obesity: Descriptions. Retrieved March 15, 2019, from <https://www.uptodate.com/contents/bariatric-procedures-for-the-management-of-severe-obesity-descriptions>

² Institute for Clinical and Economic Review. (2015). Bariatric Surgery: Final Evidence Report. *Bariatric Surgery: Final Evidence Report*, ES-1. Retrieved March 26, 2019, from https://icer-review.org/wp-content/uploads/2016/02/bariatric_final_rpt_040315.pdf.

patient can eat. Malabsorptive procedures limit the amount of nutrients that a patient's body can absorb from food by shortening or bypassing part of the small intestine. The most common procedures currently performed are both restrictive and malabsorptive, and this combination tends to yield larger weight loss and sustained results over time.

Other Associated Services. Bariatric surgery is one part of a larger protocol involving multi-disciplinary care teams that address patient behaviors, diet, and comorbid physical and psychological health concerns. Many health plans require an initial protocol where a member must attempt to lose weight by other means for a period of time before a surgery will be covered. These additional programs and services may or may not be covered by the medical benefit, depending upon the health plan.

Clinical Criteria for Coverage. Per the Institute for Clinical and Economic Review (ICER) and Washington State Healthcare Authority Health Technology Assessment of Bariatric Surgery completed in 2015, there are certain patient populations where evidence of effectiveness is stronger than others. In particular, adults with a BMI of 35 or greater and patients with a BMI between 30 and 35 who also have Type 2 Diabetes tend to consistently see greater clinical effectiveness at a comparable value over non-surgical weight management.³ Wisconsin's Medicaid criteria requires that members meet a minimum BMI with comorbid conditions, be 18 years of age or older, have had a BMI of 30 or greater for at least five years, have failed other weight loss attempts, have abstained for six months from any drug or alcohol use, and undergone a 12-month, multi-disciplinary team evaluation.⁴ The Centers for Medicare and Medicaid Services have issued a national coverage determination that specifies protocols for patients with specific clinical needs, and are similar to the Wisconsin Medicaid criteria.⁵

Safety and Effectiveness. As with any surgery, bariatric surgery can result in complications, but immediate complication rates are relatively low. Rates of complications tend to be inversely correlated with the experience of the medical center in which the surgery is performed. The American Society for Bariatric Surgery and the American College of Surgeons each certify facilities to verify they have adequate experience in performing these procedures. Somewhat unique to bariatric surgeries, however, is the occurrence of delayed late

³ Institute for Clinical and Economic Review, ES-54.

⁴ ForwardHealth Provider Portal. *Topic #12177 Bariatric Surgery*. Retrieved April 23, 2019, from <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=50&s=3&c=11&nt=Bariatric%20Surgery&adv=Y>

⁵ Centers for Medicare and Medicaid Services. *Decision Memo for Bariatric Surgery for the Treatment of Morbid Obesity (CAG-00250R)*. Retrieved April 23, 2019, from <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=160&NcaName=Bariatric+Surgery+for+the+Treatment+of+Morbid+Obesity+%281st+Recon%29&bc=ACAAAAAAEAAA&>

complications. Late complications can be defined as occurring 30 or more days after the surgery but may still occur several years after the initial surgery. These complications include marginal ulcers and other problems with the surgical site, hernias, metabolic and nutritional challenges, and weight regain. The later that complications occur, the more challenging they are to report in clinical research. The Washington State Healthcare Authority/ICER review found that overall complication rates for the most common procedures were 17.9% to 19.4%, and reoperation rates were 6.2% to 14.8% in adults.⁶ Despite complications or sequelae, bariatric surgery has also been shown to have substantial positive impacts on comorbid conditions, specifically Type 2 Diabetes. 16 of the 21 studies reviewed by ICER showed improvement or resolution of comorbidities. For Type 2 diabetes, bariatric surgery was “associated with a substantial increase in the likelihood of full resolution.”⁷

Estimated Eligible GHIP Population. As noted in the StayWell presentation (GIB Item 7B), obesity is the most prevalent health condition in the ETF population. According to DAISI data, 5.9% of the GHIP population, or about 15,512 members, has a BMI of 35 or greater. 2.9% of the population has a BMI of 35 or greater with a related comorbid condition. Not all members with BMIs in the obese range will want to undertake bariatric surgery or will meet all the prior authorization criteria established by a plan to receive the surgery. A reference population reviewed by IBM Watson Health showed that in a demographically-similar population with 93,157 members, 701 members had a bariatric surgery during the one-year review period. This group saw an initial spike in individuals who sought surgery, followed by an overall decline in the number of patients over the following 12-month period.

Cost and Return on Investment. Calculating return on investment for bariatric surgery is challenging, due to the complexity of obesity as a medical condition. Several studies indicate that bariatric surgery is cost effective. One study estimated that the cost of a bariatric surgery could be recovered in full in approximately 30 months.⁸ ICER estimated that at 10 years, bariatric surgery resulted in an additional 0.5 quality-adjusted life years (QALYs); the cost per QALY gained ranged per surgery from \$29,000 to \$47,000.⁹ Segal estimates adding coverage for bariatric surgery will cost \$1M to \$3M in additional claims.

Options for Board Coverage. The Board would have a few options to add coverage for bariatric surgery should they so choose. Evidence-based coverage criteria is available for these services, and they are no longer considered

⁶ Institute for Clinical and Economic Review, ES-28.

⁷ Ibid. ES-16.

⁸ Klein, Samuel, Ghosh, Arindam, Cremieux, Pierre, Eapen, Sara, & McGavock, Tamara. *Economic Impact of Bariatric Surgery in Diabetes Patients With BMI \geq kg/m²*. First Published: September 6, 2012. Retrieved April 23, 2019. DOI: [10.1038/oby.2010.199](https://doi.org/10.1038/oby.2010.199)

⁹ Institute for Clinical and Economic Review, ES-51.

experimental. There is evidence that coverage can result in improved member health and quality of life, as well as cost recoupment through comorbid disease improvement. Specifically, the Board may consider coverage in one of the following ways:

- **Option M6.1: Cover only surgery for members with BMI of 35 or greater.** Other services related to nutrition or weight loss may not be covered by the plan. ETF would work with plans to allow appropriate StayWell services to meet coverage criteria. Services would require prior authorization, with criteria determined by the health plans.
 - *Pros:*
 - Would route members through existing wellness resources to help manage weight pre and post-surgery.
 - May manage marginal additional costs associated with weight management.
 - *Cons:*
 - Nutritional counseling services that may be required for surgery preparation and are necessary for post-surgical success would not be covered. This could limit members from seeking services and diminish the return on investment of coverage.
 - IBM Watson cost estimates indicate that weight management services are of negligible cost and have essentially no impact on cost projections.
 - Setting the BMI limit may prevent plans from approving cases with lower BMIs that are otherwise appropriate for treatment.
 - Cost to the plan of adding surgery is between \$1M and \$3M in claims, though costs are expected to be recovered in approximately 30 months.

- **Option M6.2: Cover surgery and weight loss services for members with BMI of 35 or greater.** This option would cover weight loss services under the health plan for members with a BMI of 35 or greater. Members with lower BMI would not have services covered but would still be eligible for offerings through StayWell. Services would require prior authorization, with criteria determined by the health plans.
 - *Pros:*
 - Coverage of weight loss services as well as surgery may encourage members to follow protocols pre-surgery. Members who see success through those protocols may ultimately not progress to surgery.
 - Would reduce coverage confusion if plans require members to receive weight loss services as a part of the surgery prior authorization process.

- *Cons:*
 - May marginally increase the cost of the medical benefit, though analysis from IBM Watson indicates that the increase will not impact premium.
 - Setting the BMI limit may prevent plans from approving cases with lower BMIs that are otherwise appropriate for treatment.
 - Cost to the plan of adding surgery is between \$1M and \$3M in claims, though costs are expected to be recovered in approximately 30 months.
- **Option M6.3: Cover weight loss services and bariatric surgery as approved by the health plans.** This option would defer coverage of weight loss services and the BMI for surgery eligibility to the health plans to determine in addition to prior authorization criteria.
 - *Pros:*
 - Would remove ETF and the Board from medical decision-making. The appropriateness of services would be determined by the health plans.
 - *Cons:*
 - Benefits would be less likely to be uniformly applied.
 - Variance in benefit applications may result in more cost uncertainty.

Medical Benefit Addition Recommendations: Options M4 and M6.2.

- ETF recommends changing the coverage criteria to allow coverage of congenital defects without continuous coverage under a health plan.
- Given that many of the severe malocclusion cases raised could have been addressed under revised congenital defects coverage language, ETF *does not recommend* removing the malocclusion exclusion or adding specific coverage requirements at this time. Should need persist, ETF would reexamine the issue.
- ETF also recommends adding coverage of bariatric surgery and required precursor weight management and nutrition services for members with BMI of 35 or greater. Adding the BMI limit increases the likelihood that benefits will be administered uniformly and adding the associated service coverage will help members who are preparing for bariatric surgeries to succeed post-surgery. The costs of a successful bariatric surgery are estimated to be recovered by the plan in 30 months, due in large part to improved comorbid conditions. The GHIP's relatively stable membership lends particularly well to being able to recoup these costs.

Pharmacy Benefit Cost Sharing Changes

To ready the GHIP pharmacy benefits for additional value-based plan design initiatives, ETF reviewed opportunities to simplify the Uniform Pharmacy Benefit (UPB) design.

ETF recommends combining the current OOP levels into fewer categories. All service costs would aggregate to a single OOP; none would separately aggregate toward the much higher federal maximum out of pocket (MOOP).

- **Option P1.1: Combine OOP for Levels 1, 2, and 3.** This option would keep the separate specialty drug OOP and create a single OOP for all covered non-specialty drugs. The individual copay or coinsurance for Levels 1, 2 and 3 would remain the same. Segal recommends the new non-specialty OOP be \$1,200 for an individual and \$2,400 for a family to remain cost-neutral.
 - *Pros:*
 - Simplifies OOPs, making benefits easier to communicate and understand.
 - Preserves the separate specialty and non-specialty OOPs, which allows for more cost sharing options specific to specialty medications.
 - *Cons:*
 - May result in additional cost sharing exposure for approximately 3,500 members who currently meet the substantially lower Level 1 and 2 OOPs (\$600 individual/\$1,200 family).

- **Option P1.2: Combine Levels 1-4 into a Single OOP.** This option would combine all OOPs. Copays and coinsurance for each of the individual levels would remain the same. Segal recommends \$1,300 individual and \$2,600 family OOP to remain cost-neutral.
 - *Pros:*
 - Even greater simplicity for the out of pocket limits, making benefits easier to communicate and understand.
 - Members have single OOP to track for all medications.
 - *Cons:*
 - May result in additional cost sharing exposure for approximately 3,500 members who currently meet the substantially lower Level 1 and 2 OOPs of \$600 individual and \$1200 family.
 - Future changes to manage specialty drug costs may require cost sharing changes for specialty medications, which will require the single OOP to be increased or specialty medications to be separated again.

Pharmacy Benefit Cost Sharing Recommendation: Option P1.1.

- Moving to a single non-specialty OOP while keeping the separate specialty OOP achieves benefit simplicity without limiting future cost sharing adjustments needed to manage high cost specialty medications.

Pharmacy Benefit Additions

ETF reviewed one addition to coverage under the UPB: vaccines administered at pharmacies. Currently, members may be able to receive vaccines at pharmacies under

their medical benefit if the pharmacy they go to is in their health plan's network. However, the Board's carved-out pharmacy benefit and new narrow pharmacy network coupled with current vaccine supply shortages have resulted in some members receiving vaccines outside of their health plan's network. Currently in Wisconsin, pharmacists cannot vaccinate anyone under the age of 6. Individual pharmacies may have additional limits on patient age.

- **Option P2: Vaccines at Pharmacies.** This option would add coverage at pharmacies, while maintaining coverage at clinics and employer onsite clinics through the medical benefit. Segal estimates this change to be cost neutral to the health plan; Navitus expects costs to be minimal. In some cases, pharmacies will be a less expensive site of care than physician offices. Pending a law change, this benefit would be limited both to patients age 6 and older (or the age limit set by the individual pharmacy, if greater) and to vaccinations carried at pharmacies and appropriate for provision outside of a regular primary care encounter, such as flu and shingles vaccines. Navitus Health Solutions (Navitus), the Board's pharmacy benefit manager, estimates the average vaccine costs \$15 when received at a pharmacy, and that 9% of eligible members could be expected to take advantage of the service.

Pharmacy Benefit Addition Recommendation: Option P2.

- Adding this benefit to the UPB is not estimated to add costs to the plan and ensures members are able to access important preventive services. ETF and Navitus would partner to create clear marketing materials explaining age limits for vaccinations and which vaccines can or cannot be received at a pharmacy.

Dental Benefit Cost Sharing Changes

ETF reviewed two changes to the benefit plan design of the UDB:

- **Option D1: Increase the Annual Dental Benefit Maximum to \$1,500 Per Member.** The current UDB has a \$1,000 per member benefit maximum. In each of the past two years, approximately 2,400 or 1%-2% of members have reached the maximum benefit during the benefit year. The largest drivers of reaching the maximum are fillings, followed by sealants, anesthesia, and x-rays. According to the National Association of Dental Plans, maximum dental benefits in the commercial market average between \$1,000 and \$2,000 per member. Delta Dental of Wisconsin (Delta), the UDB administrator, estimates that this will increase claim costs from \$796K to \$1.1M.
- **Option D2: Coverage of Periodontal Maintenance at 100%.** Lack of follow-up care after periodontal scaling and root planing can result in the return of serious gum disease and ultimately tooth loss. Periodontal maintenance is similar to a regular preventive dental cleaning. While regular cleanings are covered at 100% by UDB, periodontal maintenance is currently subject to the 80% coverage to

which other periodontal services are subject. These charges to members can be unexpected and may be a financial barrier to continuing maintenance care. More than 2,229 members over the age of 20 are known to have some level of periodontal disease according to Delta. Increasing the coverage for periodontal maintenance from 80% to 100% could help members continue necessary preventive services. Delta estimates a \$398K to \$663K increase in claims cost as a result of changing this coverage.

Dental Benefit Cost Sharing Recommendation: Option D2.

- Increasing coverage by the plan for periodontal maintenance is consistent with the purpose of the UDB to provide preventive-focused coverage, and increased use may help to avoid future retreatment costs. The costs per Delta are also expected to be minimal.
- ETF *does not recommend* Option D1 at this time due to additional costs incurred to the plan that may not be offset by future savings.

Dental Benefit Coverage Changes

Following the advice of Delta, ETF has investigated adding two service sets to the UDB for plan year 2020.

- **Option D3: Coverage of Pulp Vitality Tests.** Dental pulp vitality tests aid dentists in establishing the health of the dental pulp in the pulp chamber and root canals of a tooth. The test is generally associated with emergency services. From January 2017 until October 2018, 666 pulp tests were sent to Delta for coverage, making it the 32nd most denied code sent to the UDB. The other 31 denied codes for that time period are covered under the supplemental dental plan. This service is diagnostic, fitting the basic benefit covered by the rest of the UDB. Costs per Delta are around \$60 per procedure.
- **Option D4: Coverage of Caries Assessment and Sealant Restorations.** These services are standard aspect of preventive protocol for dentists to maintain existing preventive work and monitor the status of dental decay in patients. Delta estimates this will have little to no cost to the benefit due to the low cost of these services.

Dental Benefit Coverage Recommendation: Options D3 and D4.

- Each of these services is of negligible cost to the plan and consistent with the preventive focus of the UDB.

Program Cost Requirements

Under Wis. Stats. 40.03(6)(c), the Board cannot expand benefits under a group insurance plan unless, “the modification or expansion is required by law or would

maintain or reduce premium costs for the state or its employees in the current or any future year. A reduction in premium costs in future years includes a reduction in any increase in premium costs that would have otherwise occurred without the modification or expansion.”

Two of the changes recommended in this memo may result in a premium increase in the initial period after benefit changes. However, bariatric surgery is anticipated to recover its own cost over 2.5 years and to continue to save costs and potentially reduce premium in future years. The GHIP population is particularly likely to achieve these savings due to the long tenure of members in the GHIP. Periodontal cleanings are a low-cost means of maintaining members at an improved state of oral health; similar to bariatric surgery, the near-term costs of prevention are designed to stem more costly treatments in future. These future savings may meet the above-referenced statutory requirements.

Should the Board not wish to incur these initial costs, however, additional options are available to offset program costs more immediately, such as increasing member coinsurance (see Option M2.2 above) or increasing the OOPs. Staff would bring a further analysis of these offset options to the Board at the August meeting; however, it should be noted that these changes in cost to membership would be immediate and would outlast the savings recovery period of bariatric surgery and periodontal maintenance, resulting in a long-term benefit reduction that the above statute would prevent the Board from rescinding.

Summary of Recommendations

Based on the above review and cost containment requirements, ETF recommends the changes captured in Table 4 below for benefit year 2020.

Table 4. Summary Cost Impact of Recommended Changes

Recommended Change	Estimated Cost	Notes on Impact
M3.2: Modifying therapy limits to 25 of each before authorization and 25 of each after authorization	Savings of \$350K - \$500K	
M4: Increasing coverage of congenital defects	Cost of \$100K - \$200K	Compliance with federal mandate; offset not required.
M6.2: Adding coverage of bariatric surgery	Cost of \$1M - \$3M	Cost recovery estimated in 30 months; cost savings opportunity following due to chronic disease control
Medical Benefit Change Total Cost	\$750K - \$2.7M cost	
P1.1: Combine Level 1, 2, and 3 OOP	No cost to plan	

2020 Benefit Changes

April 14, 2019

Page 19

P2: Adding vaccine coverage to pharmacy benefit at pharmacies	No cost to plan	
Pharmacy Benefit Change Total Cost	No change in costs	
D2: Increasing coverage of periodontal maintenance to 100%	Cost of \$398K to \$663K	Initial costs intended to divert members from more costly future procedures
D3: Pulp Vitality Tests coverage	No/limited cost	
D4: Caries Assessment and sealant restoration coverage	No/limited cost	
Dental Benefit Change Total Cost	\$398K - \$663K cost	

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