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Correspondence Memorandum

Date: January 14, 2021

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
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Subject: Preliminary 2022 Program Agreement and Uniform Benefit Changes

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

Background

The Department of Employee Trust Funds (ETF) annually reviews the contract documents signed by health plans offered under the Group Health Insurance Program (GHIP). The Program Agreement (Agreement) outlines the administrative services plans provide to ETF, the Group Insurance Board (Board), and its members. Uniform Benefits (UB) summarizes benefits coverage provided by the plans; each health plan offers the same UB to members of the GHIP. The Board's Pharmacy Benefit Manager (PBM) has a separate contract for services, and a separate Uniform Pharmacy Benefit (UPB), but these benefits are closely coordinated with the Agreement and UB.

ETF began the 2022 Agreement and UB review process in November 2020 by soliciting change ideas from its contracted health plans. Plans returned their proposals to ETF in December 2020, and the summary of these changes were reviewed at the January ETF Council on Health Program Improvement (CHPI) meeting. The Board's PBM also provided options for UPB and administrative service changes to ETF in December 2020. This memo provides a brief overview of the concepts presented to ETF by the health plans, as well as legislative changes that may impact 2022 programs and proposed benefit changes for the 2022 pharmacy benefit program.

Proposed Changes to the Agreement

The most substantial change to the Agreement in 2022 will be a general restructuring of the document. ETF rewrote the Agreement in 2017 as a part of the request for proposals (RFP) for self-insurance. When self-insurance was rejected by the Joint Committee on Finance, ETF had to quickly retool the document to convert self-insurance concepts back to accommodate the fully-insured structure of the program. While the document in its current state represents a significant improvement over its prior version, there are still opportunities to streamline the document, remove

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Eileen K Mallow Electronically Signed 2/2/21

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unnecessary language, and create additional sections that are more tailored to suit the program's needs.

A complete version of the updated agreement, as well as a crosswalk document to track where sections are relocated, will be provided to the Board in May.

Legislative Changes Impacting the Agreement & UB

ETF is analyzing the impact of several changes stemming from the Consolidated Appropriations Act of 2021 (CAA). The first provision that may impact the Agreement is referred to in the CAA as the No Surprises Act (Division BB, Title I of the CAA). The Act requires group health plans to hold patients harmless from surprise medical bills and apply in-network cost sharing for any out-of-network emergency care, ancillary services provided by out-of-network providers at in-network facilities, and any out-of-network care provided at an in-network facility without the patient's prior informed consent. The bill requires the Health and Human Services (HHS) Secretary to define payment methodologies for health plans by July 1, 2021 for out-of-network services and to create an independent dispute resolution (IDR) process for providers and plans to settle out-of-network claims. The Act specifically addresses surprise air ambulance billing, requires in-network cost sharing for these services, and applies a similar IDR process. The Act is intended to be effective for plans on January 1, 2022. ETF will continue to monitor the specific elements of this bill as it develops and will work with the Board's contracted health plans and Segal to determine what the cost impact might be.

In addition to cost sharing requirements, the No Surprises Act and Title II of Division BB of the CAA impose several price transparency requirements on health plans. The Act requires that, starting in January 2022, plans provide Advance Explanation of Benefits for scheduled services no less than three days ahead of the service's scheduled date. The Advance Explanation of Benefits must include detail on which providers will be performing which services, the network status of the providers, and the expected cost of those services. Providers and facilities must also verify the type of coverage a patient has no later than one day after scheduling a service and provide a good faith estimate of coverage to the payer or patient. Health plans will be required to offer price comparison tools and guidance for consumers

Title II adds several other transparency mandates for health plans, including restrictions on pricing and quality gag clauses in contracts between providers and plans, and reporting on pharmacy benefits and drug costs. There are further transparency requirements specific to ensuring parity of mental health benefits that will be discussed in the Mental Health Parity and Access Report in Item 6 of this meeting (Ref. GIB | 2.17.21 | 6B).

Proposed Changes to UB

As a part of the general restructuring of the Agreement mentioned earlier in this memo, ETF intends to update UB to resemble a commercial insurance certificate of coverage. ETF will review the document for plain language, update definitions as appropriate, and

relocate elements in the current Agreement to UB such as eligibility and enrollment criteria that are important for members to easily access. Following requests from health plans, ETF also intends to create a separate document based upon the schedules of benefits in the existing UB that clarifies cost sharing for each program option. This will assist health plans in their annual configuration of benefits in their claims processing systems.

Beyond the restructuring of UB, there are only a few recommended benefit changes that ETF and the health plans have offered for consideration this year:

- Adding acupuncture coverage;
- Allowing orthognathic surgery in cases of severe deformity;
- Updating Maximum Out of Pocket (MOOP) values to match the current federal threshold;
- Expanding vision screenings for children under age 19;
- Removing exclusions for skin tags and orthoptics;
- Further clarifying coverage for biofeedback;
- Explicitly excluding coverage of continuous passive motion devices and continuous cold therapy machines; and
- Moving coverage of continuous glucose monitors to the pharmacy benefit program.

ETF also intends to continue working with health plans to define guidelines for telehealth coverage. ETF discussed a proposed set of guidelines with health plans at the December 2020 CHPI meeting attended by plan medical directors. Plans were invited to submit written follow up suggestions, and ETF will provide a second draft of guidelines for their review in April before bringing a final version to the Board in May.

ETF will review the above changes with plans and Segal consulting to determine the impact such changes will have to plan cost, quality, and member health. A full review of these changes will be provided at the May Board meeting.

Proposed Changes to UPB

ETF is also considering several proposed changes to the Board's pharmacy benefit program. The following items will continue to be investigated by staff and the Board's PBM, Navitus Health Solutions, LLC (Navitus):

- Removing individual out-of-pocket limits (OOPLs) for level 1, 2, and 4 drugs.
- Removing the Level 4 OOPL of $600 for an individual and $1,200 for a family.
- Moving coverage of Continuous Glucose Monitoring (CGM) devices from the medical benefit to the pharmacy benefit.
- Implementing Navitus's Copay-Max program. The Copay-Max program takes advantage of drug manufacturer coupons and copay assistance programs applied to many high cost drugs in order to maximize the amount of savings for the member and the GHIP.

- Enacting Navitus's Copay True program for members on high deductible health plans (HDHP). The proposed program adjusts accumulators to the true out-of-pocket amount based on a member's benefit design after copay assistance is applied.
- Implementing Navitus's Medication Therapy Management (MTM) program for members who are not on Medicare, known as Commercial members.
- Enrollment into a Pharmacogenomics program for targeted members in specific disease states or taking specific mediations.
- Blanket enrollment for all members into Navitus's texting program.

ETF staff continues to work with the PBM and is gathering information on each option for final recommendation of 2022 changes at the Board's May 12, 2021, meeting.

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