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Correspondence Memorandum

Date: April 12, 2021

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
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Office of Strategic Health Policy

Subject: 2022 Health, Pharmacy and Dental Benefit Changes

The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) approve the following changes to the Health, Pharmacy, and Dental benefits:

- **Health benefits:**
  - **Adding coverage of medically necessary orthognathic surgeries,**
  - **Updating the maximum out-of-pocket (MOOP) to follow the annual federal maximum updated values,**
  - **Applying all benefits to the MOOP,**
  - **Removing the explicit exclusion of acupuncture,**
  - **Removing the timeframe requirement for extractions/dental repairs due to accidents,**
  - **Updating and specifying telehealth coverage, and**
  - **Making other minor changes for benefit clarification or to fix typographical errors.**
- **Pharmacy benefits:**
  - **Removing Level 4 out of pocket limits (OOPLs).**
- **Uniform Dental Benefit (UDB):**
  - **Adding coverage of composite/resin fillings for back teeth.**

ETF also requests the Board's consideration of options regarding medical and pharmacy benefit coverage of continuous glucose monitors (CGMs).

Background

ETF presented initial change concepts to the Board for benefit year 2022 (Ref. GIB | 02.17.21 | 7D) at the February 2021 Board meeting. This initial review is intended to provide ample opportunity for stakeholder input and Board consideration.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy

Eileen K Mallow Electronically Signed 5/3/21

Board	Mtg Date	Item #
GIB	5.12.21	8F

Following the February meeting, ETF reviewed potential program changes with health plans and the Board's actuary, Segal. Through this process, ETF developed a final set of proposed contract and benefit language revisions for the Board to review.

This memo presents a series of recommended changes to the health, pharmacy, and uniform dental benefits, as well as some discussion points and options for the Board to consider.

Health Benefit Change Recommendations

ETF considered 29 proposed changes to the health benefits that are provided by Uniform Benefits (UB). Changes were proposed by health plans, requested by members, and identified by ETF staff as opportunities for clarity or program improvement. Following is a list of changes that ETF recommends moving forward with, as well as brief statement of the expected impacts in terms of the Healthcare Triple Aim:

- **Increase coverage of orthognathic surgery:** Orthognathic surgery is a surgery of the jaw, where a surgeon breaks and realigns the bones of the face in order to correct bite. These surgeries can correct severe deformities, where patients are unable to chew food or speak easily due to dental malformation. Requests for surgeries for major deformity are not common, but ETF Ombudsperson Services receives several requests per year and they are currently being denied under UB. Per Segal, these services are generally covered by medical certificates in the case of medical necessity and increasing coverage to allow in select cases should not have a material impact on rates.
    - *Health Impact: High for treated individuals*
    - *Quality Impact: Moderate, due to increased industry consistency*
    - *Cost Impact: Minimal, due to limited utilization*

- **Update federal MOOP values:** Maximum out-of-pocket limit or MOOP is a plan parameter established by the Affordable Care Act (ACA) to ensure that members of an insurance plan are never responsible for spending more than a certain dollar amount each year for services that ACA defines as "essential health benefits" (EHB). MOOP values increase slightly each year, as set by the federal government. The Board added MOOP to UB during the implementation of ACA in addition to the OOPLs already in the plan. Currently, few services have costs that extend beyond the OOPL (primarily Level 3 drugs) and very few members in any given year reach the MOOP. The total members in 2020 who had $6,850 out of pocket reported per the Data, Analytics, and InSIghts (DAISI) tool was 106, and 105 in the prior year. The Board has not increased the MOOP to align with the federal values since 2016, and the current UB MOOP values are not significantly less than the federal MOOP. UB MOOP is still communicated as being related to the ACA values, which can lead to confusion regarding what the limits are and the function they serve. Updating the MOOP to the 2022 proposed values would have minimal impact to plan and member costs, and automatically updating to the current federal values will simplify program administration.

  - *Health Impact: Minimal, very few members seeking this volume of services*
  - *Quality Impact: Moderate, due to increased consistency in benefit communication*
  - *Cost Impact: Minimal, due to few members reaching MOOP*

- **Apply all covered benefits to MOOP**: As mentioned above, currently only EHBs apply toward MOOP. The non-EHB benefits included in the Board's plans are adult hearing aids, adult cochlear implants, dental implants, and temporo-mandibular joint disorder treatments. These benefits all have benefit maximums, as well as coinsurance that applies to surgical treatments and durable medical equipment. Utilization of these benefits is minimal and counting the member out-of-pocket costs toward MOOP is estimated to have no effect on the overall costs of the plan. Further, including these payments in the MOOP would simplify benefit communication.
  - *Health Impact: Minimal, due to low utilization of services that incur costs beyond OOPLs*
  - *Quality Impact: Minimal, due to minor simplification of benefit*
  - *Cost Impact: Minimal, due to low utilization*

- **Remove explicit exclusion of acupuncture**: As a step toward considering acupuncture as a covered benefit in 2023, ETF recommends removing the explicit exclusion for acupuncture from the plan's exclusions and limitations. The Alternate Care Provision of UB allows plans to approve services that might not otherwise be covered if there is evidence the service will be less expensive and as effective as a covered treatment, and the Alternate Care Provision lists acupuncture as an example of such a service. This can cause confusion when compared with the specific exclusion for acupuncture in UB. Removing the exclusion should simplify plans' ability to consider covering acupuncture under the Alternate Care Provision in appropriate cases.
  - *Health Impact: Indeterminate; additional research on outcomes is needed*
  - *Quality Impact: Moderate, due to benefit clarification and expanded access to low-risk alternative care*
  - *Cost Impact: Minimal, due to low utilization and provider availability*

- **Remove the timeframe requirement for extractions/dental repairs due to accidents**: UB covers certain extractions and dental repairs following an accident. The current language states that members must seek such care within 18 months of the accident. One of the Board's contracted health plans raised concerns following their own audit that this could potentially be considered a pre-existing limitation, which are not allowed following the implementation of ACA. Segal noted in its review that the cost of removing this language would be negligible because most people in need of restoration services after a traumatic injury would probably seek those services within the 18-month time frame.
  - *Health Impact: Minimal, access and care habits not likely to change*

  - *Quality Impact: Moderate, improves member experience and reduces barriers*
  - *Cost Impact: Minimal, utilization expected to be low and would not change based on this change*

- **Updating and specifying telemedicine coverage and copays**: Telemedicine use increased dramatically in 2020, from a largely unused service to replacing a substantial proportion of services provided to members during the statewide "Safer at Home" order. This raised many questions about which services were covered as telehealth, acceptable modalities, and what member out-of-pocket costs would be. ETF has worked with health plans to create specific coverage language for telehealth, telephone visits, digital visits, and remote monitoring. This language is included in Attachment B of this memo.

- **Making other minor changes for clarification or to fix typographical errors**: Additional changes for benefit clarity are also included in Attachment A of this memo. None of the changes marked as recommended to improve clarity are intended to change how benefits are administered currently.

Health Benefit Changes Not Recommended or for Future Consideration
Attachment A of this memo also includes details on other options that ETF does not recommend the Board pursue at this time. The Attachment includes details on the proposals, as well as the reasons to hold on these changes. Several, such as acupuncture, emergency room and urgent care copay changes, and adult hearing aid benefit expansion, are areas that ETF intends to explore in future years to determine whether there are more innovative opportunities to enhance benefits while controlling program costs.

Pharmacy Benefit Change Recommendations
At the February 2021 Board meeting, ETF presented a series of administrative service changes or additions to the pharmacy benefit. After further review, ETF recommends moving forward with the following change:

- **Remove Level 4 OOPLs**: At this time there is a separate OOPL for Level 4 drug coverage, which is $1,200 for an individual and $2,400 for a family. According to Navitus, the Board's pharmacy benefit manager (PBM), no members have met the OOPL for a Level 4 drug in past three years (2018 through 2020). Given the $50 copay, a member would have to take more than two specialty drugs for an entire year in order to even meet the OOPL, which is very rare. Segal analysis of this benefit change found it to be cost neutral.
  - *Health impact: Minimal; with no change to the benefit except the removal of the OOPL members health will not be affected*
  - *Quality impact: Moderate, positive impact on member experience and understanding of the pharmacy benefit; removing Level 4 OOPL will cut down on confusion with the Level 1 & 2 OOPL and the Level 3 OOPL*

- *Cost impact: Minimal, no members have reached the Level 4 OOPL in the past three years and Segal indicates cost neutral*

Pharmacy Benefit Change for Board Discussion: CGM Devices
Currently, most CGMs are covered under the Group Health Insurance Program (GHIP) medical insurance benefit as durable medical equipment. CGMs are covered at 20% coinsurance after the deductible is met. When asked for 2022 plan year changes, numerous health insurance vendors suggested removing CGMs from the medical benefit and placing the devices and supplies on the pharmacy benefit for coverage.

Some clients in Navitus' book of business provide CGM coverage through their pharmacy benefit at Level 3. Several health plans also noted that many of their other clients have switched CGM coverage from the medical benefit to the pharmacy benefit. This has led to some member confusion when our health vendors have sent mailings and information to all of their clients about CGM coverage through their pharmacy benefit. When members have contacted ETF or Navitus about this information ETF has gone back to the health plan and asked them to contact the members to explain that their CGMs are covered under the medical benefit.

As discussed at the February 2021 Board meeting, companies are launching new CGMs onto the market and only allowing coverage of the new devices under the pharmacy benefit. At the end of the 2020, ETF was notified by a member that his GHIP coverage could not cover his dependent's new Omnipod Dash because the manufacturer would only allow coverage under the pharmacy benefit. The decision was made to cover the Omnipod Dash and supplies under on Tier 3 of the pharmacy benefit beginning March 1, 2021. Currently the manufacturer is providing the CGMs for free and only Omnipod Dash supplies are covered under the pharmacy benefit. Whenever the manufacturer stops providing the Omnipod Dash for free, they too will be covered on Tier 3 of the pharmacy benefit.

In order to better understand the potential disruption if the Board were to move CGM coverage from the health benefit to the pharmacy benefit, ETF surveyed health plans regarding which CGMs they currently cover. The top three brands provided to the GHIP members were the Freestyle Libre, Dexcom, and Medtronic Guardian. Two health plans stated that they cover all CGMs ordered on a member's behalf. According to DAISI, the Board's data warehouse, approximately 669 CGMs were paid for between October 2019 and January 2021 for the Board's members. DAISI does not have information on which CGM brands were covered because the specific product information is not included in data submissions.

The Freestyle Libre and Dexcom are both on Navitus's formulary and would be covered on Level 3 of the pharmacy benefit. However, the Medtronic Guardian CGM is not on Navitus's formulary. Navitus reports that Medtronic units are one of the mostly costly on the market and are not considered therapeutic CGMs as they require constant

calibration compared to other CGMs. Navitus reports they have no plans to add the Medtronic Guardian CGM to their formulary.

Segal's analysis of moving CGMs from the medical benefit to the pharmacy benefit estimated that cost of each CGM was about $1,000 and there could be a shift of about $0.5 million from the medical to the pharmacy benefit. Segal also stated they had seen some group health plans move CGM coverage from the medical to the pharmacy benefit but most of their employers still cover CGMs under the medical benefit.

ETF offers the Board the following three options for how to approach coverage of CGMs within its benefit plans:

- **Option 1: Remove all CGM coverage from the medical benefit and place the coverage solely under the pharmacy benefit.**
  - *Pros:*
    - Coverage under the same benefit may cut down on member and health insurance vendor confusion.
    - Rebates through the pharmacy benefit on CGMs will be passed back through to the Board. Currently, the Board sees no rebates on CGMs from the medical insurance vendors.
  - *Cons:*
    - The Medtronic Guardian CGM will no longer be covered. This could lead to member confusion and complaints.
    - Currently, members can get their CGMs in their medical providers office and having it inserted all in one visit. With this change members will have to have a medical provider write a prescription for the CGM, go to the pharmacy pick up the CGM and take the CGM to the medical providers office for insertion.
    - With a higher coinsurance and OOPL, members will pay more for the CGM under the pharmacy benefit than what they pay under the medical benefit.

- **Option 2: Allow for CGM coverage on both the pharmacy benefit and medical benefit.**
  - *Pros:*
    - Would allow the Board to realize rebate savings on CGMs through the pharmacy benefit.
    - Allows members to stay with their current CGM brand.
    - ETF's data warehouse will see more robust data on CGM brands through the pharmacy data right away.
    - Provides the data warehouse team more time to work with health insurance vendors to be able to see NDC and HCPCS numbers on medical claims data.
  - *Cons:*

- Could create member and vendor confusion.
- Would be overlapping of coverage with Dexcom and Freestyle Libre covered on both medical and pharmacy benefit.

- **Option 3: Make no change (status quo).**
  - *Pros:*
    - Allows members to stay with their current CGM brand.
    - Provides the data warehouse team more time to work with health insurance vendors to be able to see NDC and HCPCS numbers on medical claims data.
    - No increase to coinsurance or OOPL for members.
    - ETF staff would monitor the market and may come back to the Board in the future with a recommendation for the change.
  - *Cons:*
    - According the GHIP's health insurance vendors, ETF would be an outlier in their book of business by not moving to pharmacy coverage creating vendor and member confusion.
    - The Board would continue to not realize any rebates on CGMs

Pharmacy Administrative Changes Not Being Recommended
At the February 2021 Board Meeting there seven administrative services changes/additions that were discussed as options for 2022. After working with Navitus, frontline ETF staff members, health plan vendors and examining data from our data warehouse ETF staff is not recommending moving forward in 2022 with these proposals.

- **Removing individual OOPLs for level 1 and 2 drugs**: The current OOPL for Levels 1 and 2 drugs is $600 for an individual and $1,200 for a family. In 2020, 6,124 individual members and 593 families met that OOPL. Removing this OOPL would have a detrimental financial effect on members.

- **Implementing Navitus' Copay-Max program**: The Copay-Max program takes advantage of drug manufacturer coupons and copay assistance programs applied to many high-cost drugs to help maximize savings. For every program-eligible paid claim the Board would pay a $75 fee. For example, if a member was registered in the program for a drug that had to be filled monthly over a year the Board would pay Navitus $900 in fees for one member. ETF staff feels any savings the Board may realize through the Co-Pay Max program would be significantly decreased and possibly eliminated by the fee.

- **Enacting Navitus' Copay True program**: Currently high deductible health plans (HDHPs) have accumulators that track how much each member pays in out-of-pocket costs. These accumulators do not consider whether a member receives

any kind of copay assistance. Navitus' Copay True Program will track if a member does receive any kind of assistance when paying for a drug and make sure the HDHP accumulator reflects the true cost the member pays. ETF staff believe that those on HDP could view this program as a cost increase as it would take members longer to reach their HDHP deductible if this program was implemented. There is currently legislation, Senate Bill 215 (SB 215) and companion bill Assembly Bill 184 (AB 184) that would end Navitus's Copay True Program.

- **Implementing Navitus' Medication Therapy Management program:** In this program, clinical pharmacists would review commercial members' medication profiles and contact them via telephone. During these phone calls the pharmacist would work with the member to increase adherence to medication therapy, give instructions on how manage side effects, and work to improve overall health literacy. ETF recommends tabling this proposal until the Board's Specialty Drug Site of Care Initiative is fully studied and presented to the Board at a future Board Meeting

- **Enrollment into a Pharmacogenomics program:** Pharmacogenomics testing uses a person's genetic make-up and ability to metabolize medications to provide personalized drug recommendations. This program has the potential to optimize a member's drug therapy, avoid adverse drug events, reduce overall costs by avoiding trial and error prescribing. With the addition of more medications and disease states that are able to be studied through pharmacogenomics, ETF is hopeful the price of the program will drop in the future and be something the Board could offer members.

- **Blanket enrollment for all members into Navitus' texting program:** Navitus' program sends to members text messages members such as general education and reminders about flu vaccine and the mail order drug program. After soliciting internal feedback on the best way to enroll members in the texting program, the decision was made to work with Navitus to set up a web-based portal opt-in and a keywork opt-in option. These opt-in options allow the members to make the choice to enroll without sharing members' contact information with the vendor. This action does not require board action.

Dental Benefit Change for Board Discussion
ETF recommends changing the coverage for dental fillings to allow coverage for composite/resin fillings for both anterior and posterior teeth for plan year 2022.

Currently, composite/resin fillings are covered at 100% for front teeth only. If a member has a composite/resin filling in back teeth, the UDB reimburses at the current amalgam

filling rate, which is generally lower than the full cost of the resin filling. Members are then responsible for the difference in cost.

In September 2020, the FDA issued updated recommendations concerning dental amalgam fillings and potential risks to certain high-risk individuals that may be associated with these fillings. FDA recommends certain groups, including, women who are pregnant, planning to become pregnant, or nursing; children younger than six years old; individuals with pre-existing neurological diseases; individuals with impaired kidney function; and individuals with known heightened sensitivity to mercury avoid getting dental amalgam whenever possible and appropriate (United States Food and Drug Administration, 2020).

Composite/resin fillings are made of ceramic and plastic compounds and look more like a healthy tooth because of the white color and are more aesthetically pleasing to most individuals. Some dentists claim a composite/resin filling requires less drilling and fewer follow up appointments. Composite fillings bond to the tooth structure better, providing more support than amalgam fillings. Disadvantages to composite fillings include that they are less durable and wear out sooner than amalgam fillings. Typically, composite fillings last five to seven years, which is half the lifetime of an amalgam filling. The process of placing a composite filling is more involved, so it takes more time at the dentist office.

Member requests for composite/resin filling coverage for all teeth have increased over the past three years due to the fillings being white and closer in color to the surrounding teeth. A small number of members have voiced concern over having even a trace amount of mercury in their teeth. Under the current UDB, if a member requests a composite/resin filling in posterior teeth, they must pay the difference between the amalgam and composite/resin filling. The average additional cost that a member paid for a composite filling in 2020 was $46.84.

Table 1 shows the number of claims for posterior teeth fillings filed in CY 2019 and 2020. It was noted during the Uniform Dental Benefit Request for Proposals (RFP) process by all three potential vendors that an increasing number of dentists are no longer offering amalgam fillings. This could lead to reduced access for members who cannot find a dentist willing to use amalgam and would lead to an increase in out-of-pocket costs for the member.

Table 1 – Posterior Teeth Fillings Claims

	Composite	Amalgam	Total
CY 2019	46,135	7,372	53,507
CY 2020	39,330	4,985	44,315

The increase in premium for this benefit change is 4.5% to the UDB Plan. This has been reviewed by Segal. Typically, the Board is limited under

Wis. Stats. §40.03(6)(c) from changing benefits in a way that cause an increase to overall program costs. However, the information provided to ETF as a part of the UDB RFP and updated FDA safety guidance create a situation where the existing benefit is effectively no longer accessible. The intent when creating the UDB was to provide for filling coverage, and so it would keep with that intent to modify coverage to allow full coverage of resin fillings.

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

Attachment A: 2022 Benefit Changes
Attachment B: Telehealth Coverage

Attachment A

Description of Change Requested	Rationale for Requested Change	Cost Impact	Quality Impact	Health Impact	ETF Recommendation
Orthognathic surgery	Consider change in coverage to allow for orthognathic surgery for cases where functional ability is severely limited	Minimal due to small number of cases included; individual cases can be very expensive, however.	Moderate -- Segal indicates that most of the plans in their book cover in cases of severe deformity; aligns program with industry norms.	High -- improved functioning for eating and speaking in treated individuals	Recommend adding for medically-necessary cases, in order to correct life-limiting deformities. Plans will develop specific clinical coverage criteria, and must provide to members, member advocates, and ETF upon request.
Update federal Maximum Out Of Pocket (MOOP) values	Update to the 2022 MOOP values; values have not been updated for several years	Minimal, since few members currently meet the existing maximum out of pocket limits	Minimal -- will reduce some confusion for members and plans reading plan documents, given current reference to outdated federal MOOP values	Minimal -- few members reach the current MOOPs	Recommend updating MOOP language to reflect that MOOP will adjust annually based on federal values. 2022 Values are proposed by HHS as $9,100 for self-only coverage, and $18,200 for family coverage
MOOP - have ALL covered medical services apply toward the MOOP. **<u>Examples</u>** Hearing Aids - One hearing aid per ear no more than once every three years. Adults: Payable at 80% after deductible, up to a maximum payment of $1,000 per hearing aid. 20% coinsurance **does not apply** towards OOPL or MOOP. Children (under 18 years of age): 10% coinsurance after deductible **applies toward** the OOPL and MOOP. Cochlear Implants - Adults payable at 80% after deductible. 20% coinsurance **does not apply** to OOPL or MOOP. Hospital charges for the surgery are covered at 90%. 10% coinsurance after deductible **does apply** to OOPL and MOOP. Cochlear implants and related services for Participants under 18 years of age are payable at 90%. 10% coinsurance **applies to** the OOPL and MOOP. Dental Implants - Following accident or injury, up to a maximum payment of $1,000 per tooth. **Does not apply** to MOOP.	Removes the member confusion of what services apply to the OOPL, but not the MOOP, or to the MOOP, but not the OOPL by having ALL covered medical services applying toward the MOOP. Additionally, simplifies benefit build/administration. Member satisfaction and cost-share transparency.	Minimal -- small utilization and few people reaching MOOP otherwise. Requesting plan projected 0% increase	Minimal -- simplifies benefit for the cohort utilizing these services and reaching higher dollar medical claims in a year	Minimal -- low utilization of these benefits and few members meeting MOOP currently; access to services not expected to change as a result given the benefits themselves are still capped	Recommend changing in conjunction with federal MOOP adjustment; simplifies benefits and cost is negligible.
Remove acupuncture from the list of services within the Exclusions and Limitations. Add coverage for acupuncture services.	Remove the acupuncture exclusion to remove conflict with Alternate Care Provision language that lists acupuncture as an alternative that may be cost-effective	Minimal -- will have limited experience under Alternate Care Provision, also due to limited available providers and low cost of services	Moderate -- benefit limited by Alternate Care application, but could create opportunities to expand access	Indeterminate -- additional research and monitoring will be needed to determine whether this positively impacts member health and experience	Recommend removing exclusion to allow easier consideration/remove conflict with Alternate Care Provision. Hold on adding benefit per Acupuncture item above.
Clarify services included in a routine eye exam	Many members ask plans to define routine eye exam. Clarifying the services included in a routine eye exam will increase member satisfaction	Minimal -- change would codify current service expectations	Moderate -- benefit is an area of confusion and member calls for both plans and ETF	Minimal -- change would codify current services provided	Change recommended to help clarify benefits
Modify "Urgent Care" definition as follows: URGENT CARE: Means care for an accident or ILLNESS which is needed sooner than a routine doctor's visit. If the accident or INJURY occurs when the PARTICIPANT is out of the SERVICE AREA, this does not include follow-up care unless such care is necessary to prevent his/her health from getting seriously worse before he/she can reach his/her PRIMARY CARE PROVIDER. The convenience of the PARTICIPANT may not be the reason for not returning to the SERVICE AREA for follow-up care. It also does not include care that can be safely postponed until the PARTICIPANT returns to the SERVICE AREA to receive such care from an IN-NETWORK PROVIDER. Urgent services from an OUT-OFNETWORK PROVIDER may be subject to USUAL AND CUSTOMARY CHARGES. However, the HEALTH PLAN must hold the PARTICIPANT harmless from any effort(s) by third parties to collect from the PARTICIPANT the amount above the USUAL AND CUSTOMARY CHARGES for medical/HOSPITAL services.	This provides clarity to members, thus improving their experience. Controls costs for minimizing unnecessary out of network care. Reduces administrative time spent addressing complaints. And ensures that the members are receiving care from the appropriately credentialed and high quality providers within the health plan network.	Minimal -- currently how the plan is administered	Moderate -- may provide some administrative simplification if members better understand when out of network care is covered	Minimal -- may help members with lower-level urgent services obtain those in their primary networks which would facilitate any follow up	Change recommended to help clarify benefits
Add Exclusion for Continuous Passive Motion and Continuous Cold Therapy devices	Continuous passive motion devices or Continuous Cold Therapy devices	Minimal -- administrative cost and burden of addressing these claims following the denial for medical necessity would be relieved. There are less costly alternatives to the use of these devices, which are primarily for the members or caregivers convenience.	Minimal -- low demand, but services are not typically medically necessary or better than other, less expensive services	Minimal -- other, less expensive and better evidenced services are available	Change recommended given limited evidence of utility

Clarifty DME Coverage language : MEDICAL SUPPLIES (rendered outside of a hospital setting) AND DURABLE MEDICAL EQUIPMENT : Means items which are, as determined by the HEALTH PLAN: 1) Used primarily to treat an ILLNESS or INJURY, and 2) generally not useful to a person in the absence of an ILLNESS or INJURY, and 3) the most appropriate item that can be safely provided to a PARTICIPANT and accomplish the desired end result in the most economical manner, and 4) prescribed by a PROVIDER.	Clarify language for members as well as claims adjudicators	Minimal -- could prevent some incorrect claims processing which may add cost	Minimal -- can help in cases of confusion where supplies are unbundled from hospital-provided services	Indeterminate -- no estimate provided	Change recommended as part of UB/Certificate of Coverage clarifications
Vision Services - clarifying language for member cost-share on these services.	Often a question to customer service departments	Minimal -- simplifies plan internal processes but should not change plan administration	Minimal -- provides clarification and better quality member experience	None -- does not change plan administration	Change recommended as part of UB/Certificate of Coverage clarifications
Extracton of Natural Teeth - remove time frame for when the treatment must commence. 16) Extraction of NATURAL TEETH and/or Replacement with Artificial Teeth Because of Accidental Injury Total extraction and/or total replacement (limited to bridge, denture or implant) of NATURAL TEETH by an IN-NETWORK PROVIDER when necessitated by an INJURY. ~~The treatment must commence within 18 months of the accident.~~ As an alternative, crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by the HEALTH PLAN before the service is performed. Coverage of one retainer or mouth guard shall be provided when MEDICALLY NECESSARY as part of prep work provided prior to accidental INJURY tooth repair. INJURIES caused by chewing or biting are not considered to be accidental INJURIES for the purpose of this provision. Dental implants and associated supplies and services are limited to $1,000 per tooth.	Plan review with CMS indicated that the 18 month pre-accident time period could be considered a pre-existing condition limit	Minimal -- instances of use are not expected to be many, and Segal anticipates that the majority of people using would use not long after an accident anyway	Moderate -- improves member experience	Minimal -- may improve the outcomes for some members who are more able to access needed services without barriers	Change recommended
Language change due to typo	Continuous glucose monitoring devices.				Change recommended--typo.
Language modification to clarify benefit coverage, remove "may" from the definition. A PROVIDER who does not have a signed participating provider agreement and is not listed on the most current edition of the HEALTH PLAN'S professional directory of providers. Care from an OUT-OF-NETWORK PROVIDER requires PRIOR AUTHORIZATION from the HEALTH PLAN unless it is EMERGENCY or URGENT CARE.	Proposed language will provide clarity, reducing confusion and improving the member and provider experience.				Change recommended for additional clarity.
100% coverage subject to benefit maximum for resin (composite) fillings on both anterior and posterior teeth for the Dental UDB beginning calendar year 2021.	Current benefit covers 100% coverage subject to benefit maximum. Benefit covers amalgam (silver) for posterior teeth and resin on anterior teeth. Member requests for composite/resin filling coverage for all teeth has increased over the past three years, due to the fillings being white and closer in color to the surrounding teeth. A small number of members voiced concern over having even a trace amount of mercury in their teeth. Under the current UDB benefit, if a member requests a composite/resin filling in posterior teeth, they must pay the difference between the amalgam and composite/resin filling. This difference is between $40 – $60 per filing.	An addition increase of 3-6% in premium to UDB. Delta Dental, our current administrator, has an increase of 4.5%.	Utilization would not be expected to be impacted.	Moderate -- new FDA guidance urges against amalgam fillings for certain populations, and members have voiced concern about the mercury in amalgam fillings	Coverage change recommended due to present industry norms, as well as minor concerns related to health of some members who may be recommended not to have amalgam fillings.
Remove Tier 4 Prescription Out-of-Pocket Limit (OOPL) $1,200 individual/ $2,400 family	Removing the OOPL will help to simplify the benefit	According to Navitus no members have meet the tier 4 OOPL in 2018, 2019 or 2020	No impact	No impact	Recommended; improves benefit clarity

Increase ER copayment to $150 for all plans	The $75 is well below industry norms and does little to discourage non-emergent trips to the ER.	If raising co-pays has the effect of reducing ETF non-emergent ER utilization to the non-ETF rate, per the proposing plan we would expect to see: O A reduction of 884 ETF 2020 ER visits, from 2,289 to 1,408 visits O Annualized, the estimate would be 1,061 fewer ER visits O Using an average allowed cost of $795 per Non-Emergent ER visit. This would equate to savings of $843,500 annually	Moderate -- members may be steered toward more appropriate sites of care with an additional financial disincentive.	Minimal -- it is possible that members could avoid needed ER care if the financial barrier is perceived to be too high. That said, this copay does align with industry norms.	Requesting GIB input on this as a possible package of other changes related to ER diversion projects.
Urgent Care Copay - Align with PCP Copay	Common in the market for some of our participating plans as a way to encourage UC use instead of ER	Moderate -- 0.1%-0.3% pricing increase estimated by proposing plan	Moderate -- could support steering members to lower-acuity sites of care	Minimal -- may not change member outcomes, but could help simplify encounters for care if members are seen in lower-acuity settings	Requesting GIB input on this as a possible package of other changes related to ER diversion projects.
Continuous Glucose Monitors (CGM) - Move from medical benefit to pharmacy benefit.	Move coverage from DME benefit to pharmacy benefit. Navitus Formulary is able to include meters covered at $0 copay (i.e. Accu-Chek products) up to tier 3 for Continuous Glucose monitoring equipment (i.e. Dexcom and Freestyle Libre products). Accu-Chek Guide Care Meter - $0 Copay (Expanded Preventive Care) Continuous Glucose Monitoring Equipment – Tier 3 (Non-preferred brands and select generics).	Minimal -- estimated decrease to medical benefit is small; per Segal could shift roughly $0.5M from medical to pharmacy	Moderate -- Segal indicates that most plans in their book of business keep this in the medical benefit, but the Board's plans say that more are moving it to the pharmacy benefit. While the population of members using these devices is small, disruption may be likely depending upon the difference in covered/preferred devices	Moderate -- may standardize this benefit and access, which would promote regular use, but disruption or issues with transition may have negative effects on member adherence	Requesting GIB input, considering costs and current market norms, potential member disruption
Coinsurance - have all medical services that apply to coinsurance have the same level of coinsurance applied (i.e. all 10% or all 20% - not a combination of both)	Member satisfaction, ease of understanding expected out-of-pocket cost-share, removes layer of potential error for claims processing from both provider and carrier.	Moderate -- somewhat significant savings anticipated by Segal ($3M to $15M) for reducing all coinsurance to 80/20; conversely, somewhat significant increase in costs associated with moving all coinsurance to 90/10	Moderate -- simplifies benefit, but depending on change would create greater cost sharing for many members and push people to their medical OOPLs faster	Minimal -- possible that increase coinsurance could deter members from seeking care; not expected that 90/10 increase in benefis would increase care given the limited service set that would be impacted.	Do not recommend 90/10 due to increased costs to plan. Board may consider aligning with 80/20 if seeking savings to expand other benefits.
Add acupuncture as a Uniform Benefit	Potential to improve services as well as create non-pharmaceutical options for pain management	Indeterminate	Indeterminate -- current available providers may not be adequate to meet need or demand based on plan input	Moderate	Do not add: while savings are possible, there are substantial complications in setting up a network and methods of payment, since many providers are not traditional billers. Also, limited evidence available at the time of decision-making. Recommendation: use 2021 as a time to evaluate evidence and method of network setup, and to monitor acupuncture pilots as the pandemic shifts, and reconsider for 2023.
Consider increasing coverage cap for adult hearing aids from $1,000 per ear to $2,000 per ear	Current benefit limits can be substantially lower than the market cost of hearing aids; change requested by member in letter to Governor's Office	Moderate -- per Segal, increasing to $2,000 per ear would cost $1.0 - $2.5M 2020 spending by members = $304k, plan spending = $782k;	Moderate -- members would be able to defray more out of pocket costs for hearing aids	Minimal -- use by GHIP members is small and has been declining over the past four years.	Do not recommend due to cost and lack of other options to offset; bound by Wis. Stats. 40.03(6)(c). Recommend considering other options to enhance hearing aid benefit such as sole-source purchasing or member shared savings, possibly for 2023-2024
OOPL - Consistently apply covered Medical services toward OOPL (i.e. ALL medical services that apply deductible, coinsurance and/or Medical copay). See above examples under MOOP.	Removes the member confusion of what services apply to the OOPL, but not the MOOP, or to the MOOP, but not the OOPL by having ALL covered medical services applying toward the MOOP. Additionally, simplifies benefit build/administration. Member satisfaction and cost-share transparency.	Moderate -- 0.1% - 0.2% pricing impact. This impacts such a small cohort of members, the change would have a marginal impact on premium. Somewhat substantial increase to plan benefits	Minimal -- simplifies benefit for the cohort utilizing these services and reaching higher dollar medical claims in a year	Minimal -- low utilization of these benefits and access to services not expected to change as a result given the benefits themselves are still capped	Do not recommend due to increase costs to plan
Follow WI benchmark plan - align EHB across the community	Aligning would address issues like the dollar limit on hearing aids and TMD. Both are defined as an Essential Health Benefits under the WI benchmark plan; therefore, when this benefit is offered it must not have any dollar limits. By removing the dollar limits, these benefit will be compliant with the Affordable Care Act (ACA). (Under WI benchmark.)	Minimal -- requesting health plan indicated it could increase costs	Minimal -- would align with other plans that adhere to WI Benchmark, potentially simplifying comparisons for people new to the plan or considering changing. Could be another method of addressing hearing aid coverage	Minimal -- the changes in benefits would likely be modest, but those with greater service access may benefit	Do not recommend in 2022 due to ETF staff workload and other priorities; can consider for future years if Board is interested.
HDHP Plan Only - Remove copays and structure with a straight deductible/coinsurance plan design.	Not industry standard to blend copays and coinsurance in a HDHP; simplifies benefit	Moderate -- 0.3% increase in premium	Minimal -- would simplify for those HDHP members who meet deductible, but overall HDHP enrollment remains low, and current design aligns with traditional plan	Minimal -- not expected to change care seeking behaviors or outcomes	Do not recommend due to increase costs to plan

Out-of-Area Dependent Coverage - Expand coverage beyond emergency and/or urgent care only.	Based on contract language, almost all follow up care is denied; as it is not considered "urgent".	Moderate -- 0.3% increase in premium	Moderate -- for people with dependents regularly needing care out of state, this could provide additional access. However, there could be concurrent negative impacts on the Access Plan if younger dependents out of state (e.g., college students) leave the plan	Minimal -- there may be some services that plans are not currently approving out of state that, if received in the dependent's state of residence, would be better managed	Do not recommend due to selection issues associated with the Access Plan and maintaining that program's stability.
Expand vision screening coverage to age 18 or age 21	Requesting plan covers vision screenings as part of well child exams under preventive care through the age of 21 with no member cost share. This is beyond the USPSTF mandate of covering through age 5	Minimal -- Segal projects a cost increase of $300 - $600K	Moderate -- would expan coverage/reduce cost sharing for services already being provided. Also would reduce benefit confusion for parents.	Minimal -- no evidence presented that $15 copay is a barrier to these services being provided beyond age 6; per DAISI data, screening utilization remains steady in members age 0 to 18, with a marked decrease for members age 19-21; this is consistent with other healthcare use behaviors and not likely due to cost	Not recommended due to increased costs to plan
Remove skin tag removal from exclusions	All other lines of business at Network allow this benefit.	Minimal -- change would result in up to $150k increase in costs	Minimal -- inconsistent with general plan approach to not cover cosmetic services	Minimal -- no evidence provided that services are not cosmetic	Change not recommended due to cost and conflict with general plan tenets that cosmetic services are not covered. Support not provided by the requesting plan that skin tags have an effect on health that is not cosmetic.
Update definition of ILLNESS	This definition update will help clarify the types of services covered under Outpatient Rehabilitation, Physical, Speech and Occupation Therapy as a result ot Illness or Injury.	Indeterminate -- no language change offered	Indeterminate -- no language change offered	Indeterminate -- no language change offered	Change not recommended since requesting plan indicates that it will not change administration to change language; no language offered.
Remove orthoptics exclusion	Included in some plans' standard benefits; would simplify their administration	Minimal -- expected $1,000 per service per Segal, but unable to determine frequency of use	Minimal -- Segal indicated that services are still rare and controversial	Indeterminate -- may help some members but number of potential users and the change in outcomes not detailed in change request	Change not recommended due to cost and uncertain evidence base and outcomes.
Expand on the determination of coverage statement: Eligible services are covered only when medically necessary for the proper treatment of a PARTICIPANT. The HEALTH PLAN and/or PBM medical directors, or their designees, make coverage determinations of medical necessity, restrictions on access and appropriateness of treatment, and they make final authorization for covered services. Coverage determinations are based on established medical policies, which are subject to periodic review and modification by the medical directors.	Requesting plan would like the Board to incorporate their own language into definition	Indeterminate -- none provided	Minimal -- supports proposing plan in using their definition to adjudicate services	Indeterminate -- no estimate provided	Change not recommended--unclear from the proposal how this would improve the general administration of the program.
Define Essential Health Benefits	Define what services are considered Essential Health Benefits (EHB) and what types of services are not EHB. Provides clarity to both member and carrier.	Indeterminate -- no estimate provided	Minimal -- could clarify for some members in some years, but is not a static definition per se, or one controlled by ETF, and would require regular maintenance to not cause additional confusion	Indeterminate -- no estimate provided	Change not recommended
Additional language to clarify benefit coverage EMERGENCY or URGENT CARE. Non-urgent follow up care out of the SERVICE AREA must be PRIOR AUTHORIZED or it will not be covered (approval of services is at the discretion of the HEALTH PLAN), and	Per requesting plan, members frequently have the misperception that they just have to contact the health plan to "put the authorization in", not that the health plan can determine if services aren't covered. Members are then surprised when services are denied.	Minimal -- would reduce some plan administrative costs	Minimal -- would add some support to plans in reviewing claims, but won't necessarily ease member experience	Minimal -- should not substantially change what is approved or denied	Change not recommended--language is already included in other parts of Uniform Benefits. ETF will look for other, more specific ways to clarify the prior authorization requirements

Attachment B: Telemedicine & Remote Care Coverage Language

The following language will be inserted into the Uniform Benefits/Certificate of Coverage provided to ETF members and appended to the Program Agreement.

Definitions

E-Visit is an evaluation and treatment by a provider using a patient portal, preferred or vended portal, email, or secure messaging which can include text, images, or videos. Services must address an issue that would typically require an office visit and be patient-initiated. An **E-Visit** is also called a digital visit or a virtual visit.

Telehealth is a service delivered via real-time audio and video. **Telehealth** may also be called telemedicine, online or virtual evaluation and management, or a video visit.

Telephone Visit is an evaluation and treatment by a provider using audio-only. Services must address an issue that would typically require an office visit and be patient-initiated.

Remote Patient Monitoring is the collection and interpretation of a person's physiologic data that is sent digitally to a health care provider to support treatment and management of medical conditions.

Virtual Check-In is a brief discussion either by telephone or real-time audio and video between a provider and an established patient to manage a medical condition. These are services separate from and less intensive than **Telehealth, Telephone Visits, or E-Visits**.

Schedule of Benefits

Service Category	Non-HDHP Plans (PO1, PO 6/16)	HDHP Plans (PO1 and PO 7/17)
E-Visit	$0	Deductible, then $0
Telehealth	$15 or $25, depending upon provider specialty	Deductible, then $15 or $25, depending upon provider specialty
Telephone Visit	$15 or $25, depending upon provider specialty	Deductible, then $15 or $25, depending upon provider specialty
Remote Patient Monitoring	$15 for each 30-day period of monitoring	Deductible, then $15 for each 30-day period of monitoring

Benefits & Coverage

Telemedicine and Remote Care

The below telehealth and remote care service types are covered when provided by an in-network provider and when using telehealth or remote care results in no reduction in quality, safety, or effectiveness. Health plans may create a review process to ensure that services provided by any of these methodologies meet quality, safety, and effectiveness standards.

- **E-Visits** are covered by your plan. An **E-Visit** must be initiated by the member seeking services, not the provider, in order to be covered. **E-Visits** are covered when the same service would be covered if provide in person when performed by:

- A doctor
- A nurse practitioner
- A physician assistant
- Licensed clinical social workers
- Clinical psychologists or psychiatrists
- Physical therapists
- Occupational therapists
- Speech language pathologists

Because **E-Visits** are completed via messaging services, they may happen over several hours or even days.

- **Remote Patient Monitoring** is covered by your plan under certain circumstances. The remote monitoring device that is used for services must be a home-use medical device as defined by the Food and Drug Administration (FDA), and must be provided as a part of the monitoring services, not billed separately. Devices are provided as a lease to you, and cannot be lease-to-own, purchased to own, or already owned by you. **Remote Patient Monitoring** is intended for long term conditions for which regular measurements need to be taken and must take place for a minimum of 16 days for the service to be covered; monitoring for shorter time periods will not be covered.

- **Telehealth** services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by a doctor or other health care provider who is located elsewhere using interactive 2-way, real-time audio and video technology. **Telehealth** can be provided in your home, as well as at a health care facility.

- **Telehealth** will be covered by your health plan if those services are delivered:
  - Outside of your physical presence (e.g., remotely),
  - When both audio and video elements are present, and
  - When there is no reduction in the quality, safety, or effectiveness of the service.

  If you and your provider determine that you cannot successfully complete a **Telehealth** visit with full audio and video, you may opt to change to a **Telephone Visit**.

  Any service that is currently covered by your **Benefit Plan** and that can be administered remotely with no reduction in quality, safety, or effectiveness is covered when provided via **Telehealth**.

- **Telephone Visits** will be covered if the provider can successfully provide the service without a reduction in quality, safety, or effectiveness. ETF encourages members and providers to determine the best technology solutions to fit their care needs. Health plans may create review processes to ensure that services provided by audio only meet quality, safety, and effectiveness standards.

- **Virtual Check-ins** will be covered on their own as long as they are not related to a medical visit within the past seven (7) days, and as long as they do not lead to a medical visit within the next twenty-four (24) hours or the next available appointment.