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Correspondence Memorandum

Date: January 21, 2022

To: Group Insurance Board

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

Subject: 2023 Preliminary Agreement and 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 health plans provide to ETF, the Group Insurance Board (Board), and its members. Each health plan offers the same standard medical Uniform Benefits (UB) to GHIP members. UB coverage is summarized in the Certificates of Coverage (Certificates) and the Schedules of Benefits (Schedules). Navitus Health Solutions, LLC (Navitus), 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 Certificates.

ETF began the 2023 Agreement and Certificate review process in November 2021 by soliciting change ideas from contracted health plans. Plans returned their proposals to ETF in December 2021, and the summary of these changes was 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 2021. This memo provides a brief overview of the general change concepts ETF will review for the 2023 Agreement, Certificates, and UPB.

Proposed Changes to the Agreement

Following a major restructuring of the Agreement for program year 2022, few substantial changes were proposed to the Agreement by health plans. The proposed changes detailed below could modify the current administration of the Agreement.

<u>Preliminary Provider Network Submission Review</u>

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 01/28/2022

Eileen K Mallow

Board	Mtg Date	Item #
GIB	2.16.22	7D

One health plan requested that the Board include in the Agreement that ETF return a preliminary network access analysis to health plans once initial provider network data is submitted, as a way for plans and ETF to verify the intended health plan network is mutually understood. Currently, ETF and Segal, the Board's actuary, only provide final network outputs to health plans. Adding this step could help identify any errors in plan submissions earlier in the bidding process. ETF is also updating instructions for how plans should submit provider data to help clarify what should be imputed and how that information is used by Segal.

Removing Prior Authorization for Chronic Low Back Diagnoses
One plan suggested the Board revise the agreement to indicate that chronic back diagnoses not require prior authorization for low back surgery. The rationale is that all such surgeries are approved, and so the requirement is administratively burdensome.

Further Describing ETF Due Dates
Several recommendations involved ETF clarifying when it will deliver contract documents to the health plans, including the Agreement itself, Certificates, or data specifications. ETF's document, the Key Dates & Deliverables memo, already includes much of this information, but ETF will review whether this document should be more formally included in the Agreement.

Detailed change proposals are included in Attachment A of this memo.

Proposed Changes to Medical Benefits
The new Certificate document is a more member-focused document; the 2022 revisions included moving relevant sections of the Agreement into the Certificates, such as eligibility and premium payments, as well as creating new Schedules. The Schedules detail how much a member pays out of pocket for a service. The new Schedules include more detailed breakdowns of member costs. Many of the requested revisions submitted by plans for 2023 were requests to clarify language in the Schedules to make them more consistent with how benefits work.

What follows are the more notable changes to the Certificates proposed by plans, members, and ETF.

Revise Definition of "Usual and Customary Charges"
The current language has been misinterpreted by plans to allow charges to members beyond what the plan has paid and what their benefits allow in certain circumstances. Following the implementation of the No Surprises Act (Ref. GIB | 2.16.22 | 6), plans must consistently not charge members for services received in certain out-of-network circumstances. This is not a change to the actual benefits of the plan as originally intended.

Add Separate Definition of "Hold Harmless"

The Usual and Customary Charges definition includes the concept of holding a member harmless, but in order to further clarify expectation, it may help to create a separate definition.

Limiting Member Movement to Other Plans

The Board's current program allows members who have a "qualifying life event" (marriage, new child, move, etc.) to both change coverage types and to change health plans. One plan requested that the Board only allow members with these events to move coverage types within a plan, not to change plans. ETF has concerns about the legality of this restriction under HIPAA, as well as the impact of this on the quality of a member's experience.

Requiring Medicare Members to Only Seek Care From Providers Who Accept Medicare

One plan requested that ETF require Medicare members to only seek care from Medicare providers. The request cited the costs of plans having to assume the Medicare portion of payments in cases where members are not seen by a provider that accepts Medicare. ETF will review this request to see how frequently it occurs and evaluate what impact this would have on member access to care.

Excluding Coverage of Bariatric Surgery

One plan requested the Board remove coverage of bariatric surgery due to costs. "2020 Benefit Change Review: Bariatric Surgery" provides a review of what is known about bariatric surgery utilization and costs to date (Ref. GIB | 2.16.22 | 7A).

Home Birth and Fertility Coverage

Coverage for home birth and fertility services are two of the most frequently requested service sets that ETF hears about. In the marketplace, employers can often purchase fertility coverage riders for health policies. There was also legislation introduced in 2021 related to group health plan coverage of fertility services. Home birth remains somewhat controversial in the health insurance coverage space, with advocates noting the potential for cost savings and better birth experiences, and detractors citing safety concerns. ETF will review available literature in addition to stakeholder feedback and cost information as a part of its final recommendation.

Limits For Cranial Helmets/Banding For Infants

The medical benefits of cranial banding for infants appears to be limited but can result in substantial program costs. ETF will review opportunities for limiting low-value use.

Removing Separate Out of Pocket Limit in Program Option 4/14

One plan noted that the separate $500 per-person out of pocket limit for durable medical equipment in Program Option 4/14 for locals can be a source of confusion; the plan recommended its removal and that these charges fall to the general medical deductible. ETF will review the change with Segal to determine whether this would have a negative cost impact.

Disease Management Promotion Incentives

One health plan requested the Board incentivize members to participate in disease management programming by implementing a higher/lower premium based on participation. ETF has brought this to the Board in prior meetings and the Board has approved this approach; however, ETF's current administration systems limit differential premiums. This change may be re-broached with the Board once the new Insurance Administration System is implemented.

Medicare Supplemental Benefits
Two plans raised the possibility of offering services like meals after surgery, transportation, or other non-medical benefits to Medicare members; ETF has begun to explore these benefits as well. Currently these benefits are most common in Medicare Advantage plans, and the Board's Medicare Advantage plan does offer some of these programs. The request would extend these benefits to all Medicare-enrolled retirees.

Additional Changes to Improve Specificity
Various plans requested clarifications including provider types allowable as primary care providers; clarification on lens coverage following cataract surgeries; timeline for assigning primary care providers; and other changes that would not materially impact benefits.

Specific Coverage Requests From Members
Several members who have written to ETF or the Board have specifically requested consideration of coverage for spinal decompression therapy, iontophoresis for drug delivery, and removing the limit on orthoptics coverage.

In addition to the changes described above, changes may be recommended as a part of the Board's initiatives on specialty drugs (Ref. GIB | 11.17.21 | 5A), mental health (Ref. GIB | 2.16.22 | 9A), and the high-deductible health plan (Ref. GIB | 2.16.22 | 9B). A summary of the above recommendations is included in Attachment B.

Proposed Changes to Pharmacy Benefits
ETF is also considering several proposed changes to the Board's pharmacy benefit program. The following items will continue to be investigated by staff, Navitus, and other stakeholders (when applicable):

- Changing coverage of Continuous Glucose Monitoring (CGM) devices, which are currently covered under both the pharmacy benefit and medical benefit, to solely be covered under the pharmacy benefit in 2023.
- Add weight loss drugs to the Commercial pharmacy formulary.
- Allow a drug that is granted a lifetime exception through the grievance and appeals process to be exempt from any future formulary.

Staff is also continuing to investigate the approaches presented to the Board at the November 17, 2021 meeting on the initiative related to specialty drugs and site of care (Ref. GIB | 11.17.21 | 5A). Since November, staff have met with representatives from

the Wisconsin Hospital Association, the Pharmacy Society of Wisconsin, Rural Wisconsin Health Cooperative, Wisconsin Association of Health Plans, and the University of Wisconsin Specialty Pharmacy, and are waiting for a response to a request from the Wisconsin Medical Society for a meeting date. Staff plan to meet with internal and external stakeholders and present to the Board any proposed changes for 2023 at the May 2022 meeting.

Next Steps
ETF will continue its review of the proposed changes and will consult with stakeholder groups, the Board's vendors, and Segal before presenting final changes to the Board in May 2022.

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

Attachment A: 2023 Program Agreement Requested Changes
Attachment B: 2023 Certificate of Coverage Requested Changes

Attachment A: 2023 Program Agreement Requested Changes

2022 Program Agreement Reference	Description of Requested Change	Proposed Language
III. (new)	Suggesting to add a "Department Accountabilities" section to the agreement. This section to include items that the Department is accountable for, including the proposed language.	The DEPARTMENT will send all final agreement and benefit documents (i.e. Group Health Insurance Program Agreement, Department Terms & Conditions, Certificate of Coverage, Schedule of Benefits, Summary of Benefits and Coverage, etc) to the CONTRACTOR no later than September 15th.
III. D. 4. Data Integration and Use	Adding language to ensure that a six month lead time to any specification changes is needed.	i. Pharmacy Claims Data – The CONTRACTOR must be able to accept and accommodate a daily file from the DEPARTMENT'S PBM for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The file shall be in a file format compliant with the most recent Pharmacy Data Specifications provided by the DEPARTMENT in consultation with the PBM. If directed by the DEPARTMENT, the CONTRACTOR shall establish a data transfer process to retrieve pharmacy claims data from the DEPARTMENT'S data warehouse for the CONTRACTOR'S PARTICIPANTS and integrate the data as required later in this section. The pharmacy claims data is based on data provided by the PBM to the DEPARTMENT'S data warehouse. All changes to file specifications will be communicated to the CONTRACTOR at least six months before the change implementation is required.
III. D. 4. Data Integration and Use	Adding language to ensure that a six month lead time to any specification changes is needed.	Wellness and Disease Management Data – The CONTRACTOR must be able to accept and accommodate a weekly file from the DEPARTMENT's wellness and disease management vendor that includes data for the CONTRACTOR'S PARTICIPANTS and integrate that data into the CONTRACTOR'S medical management program. This data may include results from biometric screenings, health risk assessments, and unique PARTICIPANT information regarding enrollment in wellness health coaching and/or disease management programs. The file format must comply with the most recent Wellness Data Specifications as provided by the DEPARTMENT. All changes to file specifications will be communicated to the CONTRACTOR at least six months before the change implementation is required.

III. D. 5. Data Warehouse File Requirements	Adding language to ensure that a six month lead time to any specification changes is needed.	a) The CONTRACTOR shall comply with the DEPARTMENT'S specifications for submission of the required data in the formats attached to this AGREEMENT, and as updated by the DEPARTMENT. To comply with the data submission requirements, the CONTRACTOR shall follow the specified data file layout and formatting of all data elements within the specified data file layout and the DEPARTMENT'S specifications for data filtering and extraction. All file formats are subject to change, as determined by the DEPARTMENT, to better serve the needs of the HEALTH BENEFIT PROGRAM. All changes to file specifications will be communicated to the CONTRACTOR at least six months before the change implementation is required.
III. F. 1. Provider Access Standards	Requesting that the department share results of preliminary access submission with all health plans.	The CONTRACTOR must also meet the provider access standards as described in the Provider Network Submission Tool actuary. The DEPARTMENT will use this data to determine the counties in which the that is collected by the DEPARTMENT annually via the DEPARTMENT'S CONTRACTOR is qualified. CONTRACTORS are determined to be qualified on a county-by-county basis by meeting the provider access standards in this section and the operating experience required for CONTRACTORS. The DEPARTMENT will inform the CONTRACTOR after the preliminary network access and final network access submission which counties will be considered qualified.
III. G. 1. Department Initiatives	Suggesting that prior authorizations not be required for diagnosis of chronic diagnoses, example: Scoliosis.	Low Back Surgery – The CONTRACTOR must have prior authorization procedures for referrals to orthopedists or neurosurgeons for PARTICIPANTS with a diagnosis of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses or scenarios that require immediate or expedited orthopedic, neurosurgical, other specialty referrals or with chronic diagnoses (i.e. scoliosis).

Attachment B: 2023 Certificate of Coverage
Requested Changes

2022 Certificate of Coverage Reference	Description of Requested Change	Proposed Language
1. Glossary of Terms	Definition of Usual & Customary Charge. Review in conjunction with provision 4.F. on coverage for Ancillary Services (specifically, if OON pay as in-network). Take hold harmless into account.	Usual and Customary Charge: an amount for a treatment, service or supply provided by an Out-of-Network Provider that is reasonable, as determined by the Health Plan, when taking into consideration, among other factors determined by the Health Plan, amounts charged by health care Providers for similar treatment, services and supplies when provided in the same general area under similar or comparable circumstances and amounts accepted by the health care Provider as full payment for similar treatment, services and supplies. In some cases, the amount the Health Plan determines as reasonable may be less than the amount billed. In these situations ~~where the service is provided by an In-Network Provider or an approved Out-of-Network Provider,~~ the Participant is held harmless for the difference between the billed and paid Charge(s), other than the Copayments, Coinsurance, or Deductibles specified on the Schedule of Benefits, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related Charges) prior to receiving services. Health Plan approved Referrals or Prior Authorizations to Out-of-Network Providers are not subject to Usual and Customary Charges; Participants may be responsible for costs beyond Usual and Customary Charges for services obtained from Out-of-Network Providers for services that are non-Emergency or non-Urgent and which are not previously approved for In-Network reimbursement by the Health Plan. Emergency~~, or~~ Urgent Care or ancillary services from an Out-of-Network 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/dental services. For more information about ancillary service coverage, see 4.F. Covered Services.
1. Glossary of Terms	Add definition of Hold Harmless	TBD -- create separate definition based on U&C
2. H. Qualifying Life Events	Updating life events language to limit opportunity to change to a different health plan	
3. C. Medicare Participant Premiums	Add Language Concerning Utilization of Medicare Approved Providers	…As discussed in Section 2. F. Medicare Enrollment, you must enroll in Medicare Part and Part B if you are continuing your health insurance coverage when you retire. If you don't it could affect your health insurance Premiums and your overall benefits coverage. When you are enrolled in a Medicare coordinated benefit plan, you must seek care from providers that accept Medicare. If Medicare is your primary payer and you seek care from a provider that does not accept Medicare, your plan will estimate what Medicare would have paid and reduce its coverage accordingly. ...

4. F. Covered Services	Add clarifying language to indicate lens coverage only after initial cataract surgery, differentiating initial surgery versus revision surgery.	An initial external lens per eye directly related to initial cataract surgery (contact lens or framed lens) or …….
4. F. Covered Services	Exclude coverage of bariatric surgery	Place bariatric surgery in excluded services category
4. F. Covered Services	Recommend removing the separate DME $500 OOPL in Program Option 4/14	
4. F. Covered Services	Diabetic Education - recommendation to remove member cost-share.	
4. F. Covered Services	Add Remote Patient Monitoring provision to 2023 contract to recommend edit to state	"Devices *may require* Prior Authorization by your Health Plan in order to be covered
4. F. Covered Services	Add language of which types of providers are considered PCPs.	2021 language: A PCP may be any one of the following types of providers: i. Family Practice ii. General Practice III. Internal Medicine iv. Gynecology/Obstetrics v. Pediatrics vi. Midwives (if HEALTH PLAN offers) vii. Nurse Practitioners viii. Physician Assistants ix. Chiropractors x. Mental Health xi. Physical Therapy xii. Occupational Therapy xiii. Speech Therapy
4. F. Covered Services	Strike language regarding timeline of PCP assignment.	Your Health Plan is required by ETF to ensure you have an assigned, In-Network PCP or PCC ~~at all times~~. If you do not choose a PCP or PCC, or your PCP or PCC is no longer available, your Health Plan will assign a PCP or PCC, notify you in writing, and provide instructions for changing the assigned PCP or PCC if you are not satisfied with their selection.
4. F. Covered Services	Adding a surchase or financial penalty for members that are eligible to participate in Disease Management programs, and elect not to	
4. F. Covered Services	Allow plans to offer transportation to and from critical services for Health Plan Medicare members with End State Renal Disease (ESRD)	
4. F. Covered Services	Allow plans to offer a fitness benefit to Health Plan Medicare members	

4. F. Covered Services	Allow plans to offer home-delivered meals to Health Plan Medicare members following an inpatient or SNF stay	
4. F. Covered Services	**Pulmonary Rehabilitation Therapy** is absent from the Certificate of Coverage and Schedule of Benefits. GHC-SCW has inquired about this benefit in the past and was told ETF's intention is that we cover it. Due to this, we have been covering this Benefit. Based on the most recent 2022 update that included a new section regarding Cardiac Rehabilitation, we recommend an additional section for Pulmonary Rehabilitation Therapy be added. Since we are considering this a clarification and not a new benefit, and since there is no mention of this benefit in the Certificate of Coverage, it was unclear to us where in the documentation given (Changes Spreadsheet and marked up SOBs) where this should go. Please advise if this needs to go somewhere in the 2023 changes document.	
4. F. Covered Services	Adding coverage/services for home delivery/childbirth.	TBD
4. F. Covered Services	Adding coverage for infertility services	TBD
4. F. Covered Services	Clarify/limit coverage of cranial helmets and/or remodeling bands for infants	Cranial remodeling bands and/or helmets will only be covered with Prior Authorization from the Health Plan. Before coverage is allowed, there must be a two-month trial of conservative therapy (e.g., repositioning child opposite preferred position, "tummy time") that fails to improve the shape of the child's head, and the degree of deformity must be determined moderate to severe.
4. F. Covered Services	Remove language limiting orthoptics treatment	**Vision Services** ~~Two visits for orthoptic eye training are covered per lifetime per Participant; the first session for training, the second for follow-up. Additional visits are excluded.~~
4. F. Covered Services	Add coverage of spinal decompression therapy therapy.	**Physical Therapy** **…** Spinal decompression therapy is covered.
4. F. Covered Services	Add coverage of Iontophoresis for drug delivery	**Physical Therapy** **…** Iontophoresis for drug delivery to manage pain is covered.

4. F. Covered Services	Cover hospital-provided DME at hospital coinsurance rate	**Durable Medical Equipment and Medical Supplies** When prescribed by an In-Network Provider for treatment of a diagnosed Illness or Injury and purchased from an In-Network Provider outside of a Hospital setting, Medical Supplies and Durable Medical Equipment will be covered subject to cost sharing as outlined in the Schedule of Benefits. Durable Medical Equipment supplied in a Hospital setting will be covered subject to the cost sharing assigned to Inpatient Hospital services.
4. F. Covered Services	Adding coverage for peer support specialists	TBD -- new coverage of a particular provider type for counseling/support services
5. A. Excluded Services	Add clarifying language to indicate lens coverage only after initial cataract surgery, differentiating initial surgery versus revision surgery.	Fitting of contact lenses, exception for the initial lens per surgical eye directly related to initial cataract surgery or keratoconus. Cataract revision surgery excluded.
5. A. Excluded Services	Adding specific language about enteral feedings.	Food or food supplements except when provided during a covered outpatient or inpatient Confinement. This exclusion includes enteral feeding bolus.
5. A. Excluded Services	Removing exclusion for marriage and family therapy	(removing exclusion)
Schedules of Benefits	Remove 50 visit limit from Schedules of Benefits	
Schedules of Benefits	Change Phase I and Phase II to Outpatient Cardiac Rehabilitation	
Schedules of Benefits	Update Remote Patient Monitoring copay on PO2/12	
Schedules of Benefits	Correct Adult Cochlear Implant language in PO2/12	
Schedules of Benefits	All SoBs--update "hospital" language for consistency	
Schedules of Benefits	Update language in PO7/17 across services to make clear that deductible applies first	
Schedules of Benefits	All SoBs--add back similar language about all deductibles, copays, and coinsurance applying toward OOPLs	
Schedules of Benefits	All SoBs--add clarifying language about separate DME coinsurance	
Schedules of Benefits	Add "copayment" following the dollar amount in "you pay".	
Uniform Pharmacy Benefit	Continuous Glucose Monitors - recommend this be moved 100% to pharmacy.	
Uniform Pharmacy Benefit	Add Wegovy and other weight loss drugs to the pharmacy drug formulary	Drugs would be added to the non-EGWP Formulary
Uniform Pharmacy Benefit	Allow a drug a member receives a lifetime exception for coverage through the grievance and appeals process to be exempt from any future formualry changes such as when a drug changes tiers	Allow a drug a member receives a lifetime exception for coverage for through the grievance and appeals process to be exempt from any future formulary changes including when the drug changes formulary tiers