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# *Correspondence Memorandum*

**Date:** April 19, 2022

**To:** Group Insurance Board

**From:** Korbey White, Health Program Manager
Office of Strategic Health Policy

**Subject:** 2023 Health Program Agreement Changes

**The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) approve changing the language in the 2023 Health Program Agreement regarding the timeline of Primary Care Physician (PCP) or Primary Care Clinic (PCC) assignment.**

## Background

The Department of Employee Trust Funds (ETF) annually reviews the contractual agreement 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 Board, and its members. ETF presented 2023 proposed Agreement changes at the February 2022 Board meeting (Ref. GIB | 02.16.22 | 7D). Based on feedback by ETF, industry groups, and Segal, the Board's consulting actuary, ETF recommends proceeding with one suggested change to the Agreement.

## Primary Care Provider Assignment

The Agreement requires members to select or be assigned a PCP or PCC while enrolled in the GHIP. The language in the Agreement requires health plans to follow-up with members who do not identify a PCP/PCC assigned at the time of their enrollment, encourages them to find a PCP/PCC, and/or assigns members to providers if they do not choose one. One health plan requested a change in language regarding the timing of PCP/PCC assignment. The current language requires plans to follow up within five business days of receipt of enrollment data. For members who enroll during the annual open enrollment period, this could mean that plans contact a member before their coverage with the plan has started, which can be confusing for members.

ETF recommends changing the language of Section III. G. 2. of the Agreement to allow sufficient time for adding PCPs/PCCs post-open enrollment:

a) If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP that is not IN-NETWORK with the selected CONTRACTOR, the

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 04/27/2022

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> CONTRACTOR shall notify the SUBSCRIBER within five (5) BUSINESS DAYS of either the DEPARTMENT'S transmission of the enrollment data or the beginning of the new program year and aid the person in selecting an IN-NETWORK PCP.

ETF does not recommend other changes brought to the Board at the February 2022 Board meeting. Please see Attachment A for details and analysis.

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

Attachment A: 2023 Agreement Changes

| 2022 Program Agreement Reference | Description of Requested Change | Proposed Language | Review Summary | Recommendation | Requested Input from Segal | Segal Response |
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| 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. | ETF already provides a Key Dates & Deliverables Workbook that outlines all deliverables from both ETF and the Health Plans. ETF also provides substantial flexibility to plans as requested if deliverables cannot be met. The 2022 contract included substantial changes that delayed the delivery of a few of the newly developed components; however, ETF does not expect this to become a trend. | ETF does not recommend this change. | | |
| 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. | This is the current standard of practice for ETF; however, there may be critical changes needed that cannot be provided six months in advance due to when those changes are discovered. This language would create undue burden in responding to needed changes. | ETF recommends against creating a time limit, and will instead continue to work with plans to establish reasonable timelines based upon when format changes are known and needed. | | |
| 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. | This is the current standard of practice for ETF; however, there may be critical changes needed that cannot be provided six months in advance due to when those changes are discovered. This language would create undue burden in responding to needed changes. | ETF recommends against creating a time limit, and will instead continue to work with plans to establish reasonable timelines based upon when format changes are known and needed. | | |
| 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. | This is the current standard of practice for ETF; however, there may be critical changes needed that cannot be provided six months in advance due to when those changes are discovered. This language would create undue burden in responding to needed changes. | ETF recommends against creating a time limit, and will instead continue to work with plans to establish reasonable timelines based upon when format changes are known and needed. | | |

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| 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. | The revised Network Access Tool and Key Dates additions should provide a near-instantaneous evaluation of county qualifications. | ETF does not recommend this change, but defers to the new Network Access Tool instructions (included in the Health Plan Contract) and the Key Dates & Deliverables Workbook. | Can we add a preliminary network review, similar to the final network review, that ETF can distribute to plans? Possibly along with the tiering letters? Could discuss timing, logistics, and concerns at future ETF/Segal call. | |
| 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). | This criteria was added several years ago following medical consultant recommendations. ETF is concerned that simply allowing "chronic diagnoses" to pass without prior authorization would result in a substantial increase in surgeries, as well as costs associated. | ETF does not recommend this change. | Any pricing estimate on removing PA as Network Health Plan has suggested? | |

| 2022 Certificate of Coverage Reference | Description of Requested Change | Proposed Language | Review Summary | Recommendation |
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| 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. | Moved much of the content to a new section in 4.B.6. | Modify definition to remove policy, move policy to new section of Certificate of Coverage |
| 1. Glossary of Terms | Add definition of Hold Harmless | TBD -- create separate definition based on U&C | Added new definition | |
| 2. H. Qualifying Life Events | Updating life events language to limit opportunity to change to a different health plan | | Not allowable under HIPAA. Not moving forward. | HIPPA provides safeguards for individuals, including the ability to change health plans when certain circumstances change for individuals. A review of other statewide plans found similar life event language as ETF. The recommendation made limits members ability to change to another health provider when necessary. For example, when a member moves out the service area of their current 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.<br>… | Long-standing policy has allowed freedom of choice for members. ETF has concerns about limiting member access. | ETF is unable to quantify the impact of this change on the broader program, and therefore cannot recommend moving forward at this time. |
| 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 ……. | It appears that fewer than 20 members receive a cataract revision surgery annually, based upon the code definitions provided by the requesting plan. The average cost for these lenses is ~$110, ranging from from $30 to $379. The most expensive lens was an outlier, representing a specialized extended wear-type lens. These costs are minimal to the plan, but may be impactful to the members experiencing them. | ETF does not recommend the change based upon the impacts to members needing these services and the lack of a guarantee that they would have access if revision surgery is needed, coupled with the low cost of the current benefit to the program. |
| 4. F. Covered Services | Exclude coverage of bariatric surgery | Place bariatric surgery in excluded services category | ETF provided a review to the Board in February of 2022 and has promised future reviews to examine whether cost savings are realized over time. The Board expressed interest in continuing for the time being. | ETF does not recommend this change. |
| 4. F. Covered Services | Recommend removing the separate DME $500 OOPL in Program Option 4/14 | | Segal has identified a possible, limited savings if the OOPL is removed and member costs are allowed to accrue beyond $500 for DME (less than .1% of premium). This would result in greater member out of pocket costs for DME. | ETF has not had the opportunity to discuss this change with local employers enrolled in PO4/14. ETF recommends waiting on this change for now until further discussion happens and and impact analysis for the GHIP can be completed. |

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| 4. F. Covered Services | Diabetic Education - recommendation to remove member cost-share. | | Segal notes that this change could result in relatively large increases to the costs of the GHIP. | ETF does not recommend this change due to the increase in cost associated with the benefit and relevant statutory limitations. |
| 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 | | ETF recommends this change as it allows flexibility for plans to waive PA if not needed. |
| 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:<br>i. Family Practice<br>ii. General Practice<br>III. Internal Medicine<br>iv. Gynecology/Obstetrics<br>v. Pediatrics<br>vi. Midwives (if HEALTH PLAN offers)<br>vii. Nurse Practitioners<br>viii. Physician Assistants<br>ix. Chiropractors<br>x. Mental Health<br>xi. Physical Therapy<br>xii. Occupational Therapy<br>xiii. Speech Therapy | ETF does not feel that the original list of providers was appropriate in all cases; for example, ETF would not expect that PTs be considered primary care providers. This list was based on providers that should be subject to the PCP *copay* , however that is no longer the function of this section. | ETF does not recommend this change. |
| 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. | ETF agrees that plans should not be required to reach out to members prior to the plan year beginning or to assign them a PCP before they have had opportunity to seek one out. | ETF recommends changing the language in the Program Agreement, III. G. 2. to allow time for adding PCPs post-open enrollment, and to remove the language as suggested in the edit. |
| 4. F. Covered Services | Adding a surcharge or financial penalty for members that are eligible to participate in Disease Management programs, and elect not to | | The Board approved a similar change in 2017; however, ETF's current enrollment and eligibility system is unable to support differential premiums. | ETF does not recommend this change due to systems limitations. |
| 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) | | Segal estimates that if trips were limited to 12 per month and the average cost of the trip was $0, this would result in an additional $45-50,000 in costs. ETF is concerned that at this time, plans may not have the networks or contracts in place to offer this across the Board. | ETF does not recommend this as a change to Uniform Benefits and instead will pursue a pilot program arrangement with the proposer. |
| 4. F. Covered Services | Allow plans to offer a fitness benefit to Health Plan Medicare members | | The change as proposed would add $15M to plan costs per Segal estimates. This also would fall under the category of Wellness, which is excluded under the current certificate and managed by the Wellness program vendor | ETF does not recommend this change. |
| 4. F. Covered Services | Allow plans to offer home-delivered meals to Health Plan Medicare members following an inpatient or SNF stay | | Segal estimates that this would result in an additional $4.5M-$7M in costs to the program based upon the existing benefit structure allowed under the Medicare Advantage plan. ETF is also concerned that, given prior outside counsel advice, this may not be allowable without taxation. | ETF does not recommend this change at this time; ETF will review current legal interpretations and revisit if possible in future years. |

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| 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. | | ETF intends for these services to be covered already, and will consider language to clarify. | ETF recommends this change, and will develop language to include coverage by Pulmonary and Cardiac Rehabilitation departments, as provided by Physicians, Therapists, and qualified staff. |
| 4. F. Covered Services | Adding coverage/services for home delivery/childbirth. | TBD | Upon review, ETF has determined that this coverage is not common in the markeplace. Segal estimates that just under 1% of childbirth occurs at home, and costs an average of $13,000 per birth. This is lower than the cost of births in hospital facilities, but Segal was unable to estimate the rate of complications that might push some home birth costs higher. Overall, costs associated with a change were expected to be neutral. According to literature review, birth risks are higher for women who are older and who are giving birth for the first time, and these risks may be exacerbated in a home birth setting if complications occur. | ETF does not recommend this change. ETF would, however, like to explore the possibility of increasing access to and awareness of midwife-led hospital birth or birthing center options. The literature review mentioned earlier notes that outcomes for both mother and baby are generally more positive with midwife-led care teams, though acknowledged that access in the US may be limited. |
| 4. F. Covered Services | Adding coverage for infertility services | TBD | The requests receives for coverage of infertility services are not typically specific in terms of which services are needed, and ETF recognizes that there can be a broad range of treatments included under this umbrella. A bill introduced to the WI state legislature in 2021 would have required that health plans cover medical and hospital costs associated with diagnosis and treatment of infertility, and "standard fertility preservation services." This bill required that coverage include at least four completed egg retrievals with unlimited embryo transfer and single transfer when recommended and medically appropriate. Diagnosis and treatment would include any procedure or medication that is consistent with ACOG or ASPM guidelines. Coverage of medications and any other restrictions on treatments must be at parity with other medical/pharmacy services. Due to the wide range of services included, Segal estimates that costs could range from an additional $5M to $20M. Segal also estimates tha around 5% of women would use these services. 15 states currently have insurance coverage mandates for some infertility services, and two states have a requirement to offer at least one plan covering some infertility services. | ETF does not recommend this change due to the increase in cost associated with the benefit and relevant statutory limitations. |

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| 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. | Segal estimates the use of these helmets to be anywhere from 1-10% of babies, at a cost of about $3,000 each. Coverage does not appear to be consistent amongst plans. ETF prefers to limit the amount of clinically-specific criteria in its certificate due to inherent challenges in maintaining such criteria without clinical staff expertise. | ETF does not recommend changing language in the Certificate; instead, ETF will work with plans over the coming year to review criteria, identify where coverage requirements diverge, and try to reduce the amount of variation in coverage. |
| 4. F. Covered Services | Remove language limiting orthoptics treatment | **Vision Services**<br>~~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.~~ | Per Segal, a typical program of orthoptic training includes six one-hour sessions, at a total cost of about $1,000. However, both Segal and ETF have found that the available literature around these treatments is mixed in terms of efficacy. | ETF does not recommend this change, due to the lack of clinical consensus on effectiveness versus other, more cost-effective therapy. |
| 4. F. Covered Services | Add coverage of spinal decompression therapy therapy. | **Physical Therapy**<br>**...**<br>Spinal decompression therapy is covered. | ETF and Segal both completed literature reviews on this therapy. The available evidence is limited, as this appears to not be common. ETF found that, of the available evidence, spinal decompression therapy was not shown to be more effective than PT exercise series. Spinal decompression therapy appeared to show short-term relief, but not long-term healing, and review indicates that it is still considered experimental. More evidence is needed before determining efficacy. Segal estimates that currently sessions cost around $5,000 per year for 35 sessions, and anticipated that a small proportion of people would use the service. | ETF does not recommend this change, due to limited evidence of effectiveness in current literature and the availability of other evidence-based treatments. |
| 4. F. Covered Services | Add coverage of Iontophoresis for drug delivery | **Physical Therapy**<br>**...**<br>Iontophoresis for drug delivery to manage pain is covered. | Both ETF and Segal found limited information on this treatment. The original request was for the use of this treatment for drug delivery, but the available literature only described the treatment in the context of therapy for excessive sweating. Segal was not able to provide a cost estimate for the use case requested. | ETF does not recommend this change due to limited evidence of effectiveness. |
| 4. F. Covered Services | Cover hospital-provided DME at hospital coinsurance rate | **Durable Medical Equipment and Medical Supplies**<br>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. | Clarified plan's interpretation of policy, no further changes required. | ETF does not recommend any changes; original issue identified has been clarified and language changes were not necessary. |
| 4. F. Covered Services | Adding coverage for peer support specialists | TBD -- new coverage of a particular provider type for counseling/support services | While there is some evidence that peer support specialists can positively contribute to recovery, the current network of available professionals is still limited. ETF and Segal both found that the average salary for a peer support worker is $30,000/year, and the actual costs to the plan and to the Board's programs would depend on how such professionals are employed (e.g., direct employment, contract with employing organization, etc.). One of the Board's health plans has expressed interest in adding this service to their overall offerings and ETF has asked that plan to provide a pilot proposal in the future if those plans pan out. | ETF does not recommend any benefit changes at this time, but will support any pilot program opportunities proposed for these services while the provider base establishes itself. |
| 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. | See line 7 above. | See line 7 above. |

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| 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. | ETF typically expects that food products are not covered as a part of the GHIP, outside of those provided in a hospital setting. However, adding an explicit exclusion typically limits the flexibility of plans to cover services under the Alternate Care Provision of the Program Agreement. ETF recognizes that there may be instances where bolus feeding may be the most cost-effective treatment option for a condition. | ETF does not recommend this change. Current language would support excluding coverage, but the lack of an explicit exclusion allows flexibility for coverage in limited circumstances. |
| 5. A. Excluded Services | Removing exclusion for marriage and family therapy | (removing exclusion) | ETF has reviewed available literature on both marriage counseling and family therapy. While neither are regularly covered, there was more available evidence supporting the benefits of family therapy to the recovery of individuals who are seeking help for a substance use disorder or mental health condition. ETF and Segal both suspect that, due to provider mis-coding, some coverage is already happening in the program. Regarding marriage counseling, coverage is typically more challenging if the benefit is solely to address relationship dysfunction, as this is not a codable diagnosis. Currently, however, indivudals may be allowed to bring a spouse into a therapy session if this would benefit the treatment of the condition that the individual is seeking care for. | ETF recommends clarifying language in the certificate to allow coverage of family therapy if part of the recommended treatment plan for an individual who is covered and undergoing care for MH/SUD (e.g., counseling session with parents of a child in treatment to discuss support). Similarly, ETF recommends clarifying that others may join an individual's therapy session if recommended by a therapist to address an individual's diagnosis. ETF does not recommend covering marriage or couples counseling solely to address challenges in a relationship. |

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| 2022 Program Agreement Reference | Description of Requested Change | Proposed Language | Review Summary | Recommendation | Requested Input from Segal | Segal Response |
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| 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. | The revised Network Access Tool and Key Dates additions should provide a near-instantaneous evaluation of county qualifications. | ETF does not recommend this change, but defers to the new Network Access Tool instructions (included in the Health Plan Contract) and the Key Dates & Deliverables Workbook. | Can we add a preliminary network review, similar to the final network review, that ETF can distribute to plans? Possibly along with the tiering letters? Could discuss timing, logistics, and concerns at future ETF/Segal call. | |
| 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). | This criteria was added several years ago following medical consultant recommendations. ETF is concerned that simply allowing "chronic diagnoses" to pass without prior authorization would result in a substantial increase in surgeries, as well as costs associated. | ETF does not recommend this change. | Any pricing estimate on removing PA as Network Health Plan has suggested? | |

| 2022 Certificate of Coverage Reference | Description of Requested Change | Proposed Language | Review Summary | Recommendation |
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| 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. | Moved much of the content to a new section in 4.B.6. | Modify definition to remove policy, move policy to new section of Certificate of Coverage |
| 1. Glossary of Terms | Add definition of Hold Harmless | TBD -- create separate definition based on U&C | Added new definition | |
| 2. H. Qualifying Life Events | Updating life events language to limit opportunity to change to a different health plan | | Not allowable under HIPAA. Not moving forward. | HIPPA provides safeguards for individuals, including the ability to change health plans when certain circumstances change for individuals. A review of other statewide plans found similar life event language as ETF. The recommendation made limits members ability to change to another health provider when necessary. For example, when a member moves out the service area of their current 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.<br>… | Long-standing policy has allowed freedom of choice for members. ETF has concerns about limiting member access. | ETF is unable to quantify the impact of this change on the broader program, and therefore cannot recommend moving forward at this time. |
| 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 ……. | It appears that fewer than 20 members receive a cataract revision surgery annually, based upon the code definitions provided by the requesting plan. The average cost for these lenses is ~$110, ranging from from $30 to $379. The most expensive lens was an outlier, representing a specialized extended wear-type lens. These costs are minimal to the plan, but may be impactful to the members experiencing them. | ETF does not recommend the change based upon the impacts to members needing these services and the lack of a guarantee that they would have access if revision surgery is needed, coupled with the low cost of the current benefit to the program. |
| 4. F. Covered Services | Exclude coverage of bariatric surgery | Place bariatric surgery in excluded services category | ETF provided a review to the Board in February of 2022 and has promised future reviews to examine whether cost savings are realized over time. The Board expressed interest in continuing for the time being. | ETF does not recommend this change. |
| 4. F. Covered Services | Recommend removing the separate DME $500 OOPL in Program Option 4/14 | | Segal has identified a possible, limited savings if the OOPL is removed and member costs are allowed to accrue beyond $500 for DME (less than .1% of premium). This would result in greater member out of pocket costs for DME. | ETF has not had the opportunity to discuss this change with local employers enrolled in PO4/14. ETF recommends waiting on this change for now until further discussion happens and and impact analysis for the GHIP can be completed. |

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| 4. F. Covered Services | Diabetic Education - recommendation to remove member cost-share. | | Segal notes that this change could result in relatively large increases to the costs of the GHIP. | ETF does not recommend this change due to the increase in cost associated with the benefit and relevant statutory limitations. |
| 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 | | ETF recommends this change as it allows flexibility for plans to waive PA if not needed. |
| 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:<br>i. Family Practice<br>ii. General Practice<br>III. Internal Medicine<br>iv. Gynecology/Obstetrics<br>v. Pediatrics<br>vi. Midwives (if HEALTH PLAN offers)<br>vii. Nurse Practitioners<br>viii. Physician Assistants<br>ix. Chiropractors<br>x. Mental Health<br>xi. Physical Therapy<br>xii. Occupational Therapy<br>xiii. Speech Therapy | ETF does not feel that the original list of providers was appropriate in all cases; for example, ETF would not expect that PTs be considered primary care providers. This list was based on providers that should be subject to the PCP *copay* , however that is no longer the function of this section. | ETF does not recommend this change. |
| 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. | ETF agrees that plans should not be required to reach out to members prior to the plan year beginning or to assign them a PCP before they have had opportunity to seek one out. | ETF recommends changing the language in the Program Agreement, III. G. 2. to allow time for adding PCPs post-open enrollment, and to remove the language as suggested in the edit. |
| 4. F. Covered Services | Adding a surcharge or financial penalty for members that are eligible to participate in Disease Management programs, and elect not to | | The Board approved a similar change in 2017; however, ETF's current enrollment and eligibility system is unable to support differential premiums. | ETF does not recommend this change due to systems limitations. |
| 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) | | Segal estimates that if trips were limited to 12 per month and the average cost of the trip was $0, this would result in an additional $45-50,000 in costs. ETF is concerned that at this time, plans may not have the networks or contracts in place to offer this across the Board. | ETF does not recommend this as a change to Uniform Benefits and instead will pursue a pilot program arrangement with the proposer. |
| 4. F. Covered Services | Allow plans to offer a fitness benefit to Health Plan Medicare members | | The change as proposed would add $15M to plan costs per Segal estimates. This also would fall under the category of Wellness, which is excluded under the current certificate and managed by the Wellness program vendor | ETF does not recommend this change. |
| 4. F. Covered Services | Allow plans to offer home-delivered meals to Health Plan Medicare members following an inpatient or SNF stay | | Segal estimates that this would result in an additional $4.5M-$7M in costs to the program based upon the existing benefit structure allowed under the Medicare Advantage plan. ETF is also concerned that, given prior outside counsel advice, this may not be allowable without taxation. | ETF does not recommend this change at this time; ETF will review current legal interpretations and revisit if possible in future years. |

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| 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. | | ETF intends for these services to be covered already, and will consider language to clarify. | ETF recommends this change, and will develop language to include coverage by Pulmonary and Cardiac Rehabilitation departments, as provided by Physicians, Therapists, and qualified staff. |
| 4. F. Covered Services | Adding coverage/services for home delivery/childbirth. | TBD | Upon review, ETF has determined that this coverage is not common in the markeplace. Segal estimates that just under 1% of childbirth occurs at home, and costs an average of $13,000 per birth. This is lower than the cost of births in hospital facilities, but Segal was unable to estimate the rate of complications that might push some home birth costs higher. Overall, costs associated with a change were expected to be neutral. According to literature review, birth risks are higher for women who are older and who are giving birth for the first time, and these risks may be exacerbated in a home birth setting if complications occur. | ETF does not recommend this change. ETF would, however, like to explore the possibility of increasing access to and awareness of midwife-led hospital birth or birthing center options. The literature review mentioned earlier notes that outcomes for both mother and baby are generally more positive with midwife-led care teams, though acknowledged that access in the US may be limited. |
| 4. F. Covered Services | Adding coverage for infertility services | TBD | The requests receives for coverage of infertility services are not typically specific in terms of which services are needed, and ETF recognizes that there can be a broad range of treatments included under this umbrella. A bill introduced to the WI state legislature in 2021 would have required that health plans cover medical and hospital costs associated with diagnosis and treatment of infertility, and "standard fertility preservation services." This bill required that coverage include at least four completed egg retrievals with unlimited embryo transfer and single transfer when recommended and medically appropriate. Diagnosis and treatment would include any procedure or medication that is consistent with ACOG or ASPM guidelines. Coverage of medications and any other restrictions on treatments must be at parity with other medical/pharmacy services. Due to the wide range of services included, Segal estimates that costs could range from an additional $5M to $20M. Segal also estimates tha around 5% of women would use these services. 15 states currently have insurance coverage mandates for some infertility services, and two states have a requirement to offer at least one plan covering some infertility services. | ETF does not recommend this change due to the increase in cost associated with the benefit and relevant statutory limitations. |

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| 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. | Segal estimates the use of these helmets to be anywhere from 1-10% of babies, at a cost of about $3,000 each. Coverage does not appear to be consistent amongst plans. ETF prefers to limit the amount of clinically-specific criteria in its certificate due to inherent challenges in maintaining such criteria without clinical staff expertise. | ETF does not recommend changing language in the Certificate; instead, ETF will work with plans over the coming year to review criteria, identify where coverage requirements diverge, and try to reduce the amount of variation in coverage. |
| 4. F. Covered Services | Remove language limiting orthoptics treatment | **Vision Services**<br>~~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.~~ | Per Segal, a typical program of orthoptic training includes six one-hour sessions, at a total cost of about $1,000. However, both Segal and ETF have found that the available literature around these treatments is mixed in terms of efficacy. | ETF does not recommend this change, due to the lack of clinical consensus on effectiveness versus other, more cost-effective therapy. |
| 4. F. Covered Services | Add coverage of spinal decompression therapy therapy. | **Physical Therapy**<br>**...**<br>Spinal decompression therapy is covered. | ETF and Segal both completed literature reviews on this therapy. The available evidence is limited, as this appears to not be common. ETF found that, of the available evidence, spinal decompression therapy was not shown to be more effective than PT exercise series. Spinal decompression therapy appeared to show short-term relief, but not long-term healing, and review indicates that it is still considered experimental. More evidence is needed before determining efficacy. Segal estimates that currently sessions cost around $5,000 per year for 35 sessions, and anticipated that a small proportion of people would use the service. | ETF does not recommend this change, due to limited evidence of effectiveness in current literature and the availability of other evidence-based treatments. |
| 4. F. Covered Services | Add coverage of Iontophoresis for drug delivery | **Physical Therapy**<br>**...**<br>Iontophoresis for drug delivery to manage pain is covered. | Both ETF and Segal found limited information on this treatment. The original request was for the use of this treatment for drug delivery, but the available literature only described the treatment in the context of therapy for excessive sweating. Segal was not able to provide a cost estimate for the use case requested. | ETF does not recommend this change due to limited evidence of effectiveness. |
| 4. F. Covered Services | Cover hospital-provided DME at hospital coinsurance rate | **Durable Medical Equipment and Medical Supplies**<br>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. | Clarified plan's interpretation of policy, no further changes required. | ETF does not recommend any changes; original issue identified has been clarified and language changes were not necessary. |
| 4. F. Covered Services | Adding coverage for peer support specialists | TBD -- new coverage of a particular provider type for counseling/support services | While there is some evidence that peer support specialists can positively contribute to recovery, the current network of available professionals is still limited. ETF and Segal both found that the average salary for a peer support worker is $30,000/year, and the actual costs to the plan and to the Board's programs would depend on how such professionals are employed (e.g., direct employment, contract with employing organization, etc.). One of the Board's health plans has expressed interest in adding this service to their overall offerings and ETF has asked that plan to provide a pilot proposal in the future if those plans pan out. | ETF does not recommend any benefit changes at this time, but will support any pilot program opportunities proposed for these services while the provider base establishes itself. |
| 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. | See line 7 above. | See line 7 above. |

| 2022 Certificate of Coverage Reference | Description of Requested Change | Proposed Language | Review Summary | Recommendation |
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| 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. | ETF typically expects that food products are not covered as a part of the GHIP, outside of those provided in a hospital setting. However, adding an explicit exclusion typically limits the flexibility of plans to cover services under the Alternate Care Provision of the Program Agreement. ETF recognizes that there may be instances where bolus feeding may be the most cost-effective treatment option for a condition. | ETF does not recommend this change. Current language would support excluding coverage, but the lack of an explicit exclusion allows flexibility for coverage in limited circumstances. |
| 5. A. Excluded Services | Removing exclusion for marriage and family therapy | (removing exclusion) | ETF has reviewed available literature on both marriage counseling and family therapy. While neither are regularly covered, there was more available evidence supporting the benefits of family therapy to the recovery of individuals who are seeking help for a substance use disorder or mental health condition. ETF and Segal both suspect that, due to provider mis-coding, some coverage is already happening in the program. Regarding marriage counseling, coverage is typically more challenging if the benefit is solely to address relationship dysfunction, as this is not a codable diagnosis. Currently, however, indivudals may be allowed to bring a spouse into a therapy session if this would benefit the treatment of the condition that the individual is seeking care for. | ETF recommends clarifying language in the certificate to allow coverage of family therapy if part of the recommended treatment plan for an individual who is covered and undergoing care for MH/SUD (e.g., counseling session with parents of a child in treatment to discuss support). Similarly, ETF recommends clarifying that others may join an individual's therapy session if recommended by a therapist to address an individual's diagnosis. ETF does not recommend covering marriage or couples counseling solely to address challenges in a relationship. |