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# *Correspondence Memorandum*

**Date:** April 21, 2022

**To:** Group Insurance Board

**From:** Renee Walk, Lead Policy Advisor
Luis Caracas, Health Policy Advisor
Tricia Sieg, Pharmacy Program Manager
Office of Strategic Health Policy

**Subject:** 2023 Health and Pharmacy Benefit Changes

**The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve modifications to the Uniform Benefits (UB) Certificates of Coverage (CoCs) and the Uniform Pharmacy Benefit (UPB) as described in this memo.**

## Background

ETF presented initial change concepts to the Board for program year 2023 at the February 2022 Board meeting (Ref. GIB | 02.16.22 | 7D). This initial review was intended to provide the Board with a summary of the possible changes under consideration for the coming benefit year. Following the February meeting, ETF reviewed annual potential benefit changes with employer groups, health plans, and Segal, the Board's actuary. Through this process, ETF identified a final set of proposed benefit changes. Recommended changes are included in this memo.

## Health Benefit Change Recommendations

ETF recommends the following changes to the medical services coverage described in UB (additional detail is provided in Attachment A of this memo):

- **New and updated definitions**: Following the passage of the No Surprises Act as a part of the Consolidated Appropriations Act, ETF has reviewed the current language in the CoC and identified opportunities to clarify definitions to better align with the intent of the No Surprises Act. ETF recommends limiting the definition of "Usual and Customary Charges" to only that language which describes those charges, and to move the remaining language describing how usual and customary charges are applied to a new section of the CoC on balance billing rights. ETF also recommends adding definitions for "Hold Harmless" and "Post-Stabilization Care" to support this new section.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy Electronically Signed 05/05/2022

Eileen K Mallow

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| GIB | 5.18.22 | 5C |

- **New section on exceptions to In-Network Care Requirement**: The No Surprises Act clarifies and limits patient liability for certain services provided by out-of-network providers. While the Board's certificate has long supported very similar limits on liability, ETF recommends adding a new section that describes instances when members will not be required to pay and when those rights can be waived. See Attachment B for detailed language changes.

- **Adding flexibility to remote patient monitoring prior authorization:** Health plans recommended that ETF modify the requirement that remote patient monitoring devices be prior authorized to allow flexibility in authorization. The recommended language would now say "Devices *may require* Prior Authorization by your Health Plan in order to be covered." This allows plans to waive authorization in appropriate instances.

- **Removing language requiring primary care providers (PCPs) be designated "at all times":** Health plans requested the removal of the phrase "at all times" from this section; on strict reading, the language implied that plans should enforce PCP designations once the plan received the eligibility file from ETF, which in some cases is before the member is even actively covered by the plan. ETF also recommends concurrent language changes that are discussed in the 2023 Program Agreement Changes memo included in this agenda (Ref. GIB | 05.18.22 | 5B).

- **Adding a Pulmonary Rehabilitation Therapy benefit description:** Neither the current nor previous UB documents have included specific coverage criteria for pulmonary rehabilitation therapy even though coverage for these services is medically necessary. One health plan requested that ETF include specific coverage language to assist with benefit adjudication. ETF recommends the Board add language to the CoCs specifically noting that pulmonary rehabilitation coverage is medically necessary when provided by physicians, therapists, and other qualified providers.

- **Clarifying coverage of family behavioral health therapy when recommended as part of an individual treatment plan:** According to ETF's review, it is not unusual for behavioral health providers to request separate sessions with a patient's immediate family as a part of a Mental Health and Substance Use Disorder treatment plan. Both Segal and health plans noted this coverage is likely already happening in practice, even if current coverage language excludes family therapy. ETF recommends modifying the CoC to remove the family therapy exclusion and clarify family therapy is covered when the member is not present as part of developing or supporting a member's treatment plan.

**Health Benefit Changes Not Recommended**
ETF presented several changes to the Board in February that are not recommended at this time. A few such requests are highlighted below:

- **Excluding coverage of bariatric surgery:** As discussed at the February Board meeting (Ref. GIB | 02.16.22 | 7A), data is still forthcoming regarding the return on investment for adding this benefit in 2020. Literature indicates that such returns may take over two years to realize. ETF does not recommend changing this benefit again until more clear outcomes data is available.

- **Adding home childbirth/delivery coverage:** Literature review for this benefit indicated some potential for savings, but a potential increase in risk associated with home childbirth if a delivery becomes complicated. Health plans were not in favor of this change, and Segal indicated that it is not a common benefit in the marketplace. Segal estimated that the savings associated with childbirth at home would likely be neutralized by the costs associated with complications that require transportation to a hospital and admission. Due to these considerations, ETF does not recommend this change.

- **Adding coverage for infertility services:** Infertility services include a wide range of treatments, from hormone therapies to in-vitro fertilization. Recent proposed legislation in Wisconsin includes a specific set of services[1], which are not currently covered by the Board's certificate. ETF has also received member and employer requests in the past for services that are outside the proposed set of services. Segal estimated that costs could range from an additional $5M to $20M each year, depending upon coverage and based on 5% of women in the Board's programs using the benefit. Segal noted that, if added, coverage of treatments, procedures, and medication must be at parity with other covered services. Due to the estimated increase in costs without concurrent opportunity for savings and the limiting language of Wis. Stats. §40.03(6)(c), ETF cannot recommend adding this benefit.

- **Adding coverage for peer support specialists:** While growing evidence supports the effectiveness of peer support specialist in behavioral health care teams, these providers are not currently covered in most commercial health insurance plans. Networks or employers of these care providers are still limited, and so ETF cannot recommend adding the benefit now since it would almost certainly not be uniformly available across the Board's membership. However, ETF has begun conversations with health plans who are interested in including these providers in their benefit offerings and hopes to find opportunities to pilot these services soon.

[1] Wisconsin State Legislature, 2021 Senate Bill 693. https://docs.legis.wisconsin.gov/2021/related/proposals/sb693. Accessed April 12, 2022.

- **Adding coverage for marriage counseling:** Marriage or couples counseling is intended to specifically focus on the relationship between two people. This is different than the family counseling coverage recommended above, where the primary objective is to address the diagnosis of an individual through therapy that includes other members of that person's family. Most commercial health plans do not include coverage for couples counseling. It is challenging to provide a cost estimate for coverage. Sessions typically cost between $100 to $200 per hour. There also remains the possibility that covering such services could technically provide benefits to ineligible individuals if the member's spouse is not enrolled in the Board's programs. ETF does not recommend coverage for couples counseling at this time.

Additional services that were included in the Board's February 2022 memo that are not recommended for coverage are detailed in Attachment A of this memo.

**Pharmacy Benefit Changes Recommended**
At the February 2022 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:

- **Implementing a clear bagging program through University of Wisconsin (UW) Specialty Pharmacy for members receiving care within the UW Hospital System:** At the November 2021 Board meeting, ETF presented a specialty drugs and site of care report (Ref. GIB I 11.17.21 I 5A) outlining options. One option was a clear bagging program through the UW Hospital system as a future consideration. UW Specialty Pharmacy is already one of the two specialty pharmacies that non-Medicare members must use to get their level 4 drugs through the Board's pharmacy benefit. Starting a clear bagging program with UW Specialty Pharmacy allows for the potential start of a cost savings program with a partner who knows the Board's pharmacy benefit, has worked with the Board's pharmacy benefit manager (PBM), and already serves the Board's members. Staff is committed to providing updates to the Board on clear bagging program's progress, cost savings, and member experience.

    - *Health Impact*: Minimal; There is no change to coverage under the benefit.

    - *Quality Impact*: Moderate; Members will still get their Level 4 specialty drugs from the same provider in the same location they currently are. The only differences are that members who see a provider in the UW Hospital System will have their drugs provided by UW Specialty Pharmacy. Members may receive multiple explanation of benefits (EOBs) statements since the administration of the drug will be paid by their medical benefit, while the drug itself will be covered by the pharmacy benefit. Education about the clear bagging program for members, ETF staff, and employers will help alleviate any confusion.

- *Cost Impact*: Minimal; Members will have to pay $50 for their Level 4 specialty drugs every time they are administered the drug until they reach their out-of-pocket limit (OOPL). The GHIP will benefit from receiving rebates and additional discounts through the pharmacy benefit that are not directly available through the medical benefit. These savings, like all pharmacy rebates and discounts in the GHIP, are used to reduce premium costs for members.

**Updating the Uniform Pharmacy Benefits Certificate of Coverage**
ETF will be updating the Uniform Pharmacy Benefits Certificate of Coverage (UPBCC) for 2023. The current UPBCC is written in a way that makes it hard for members, employers, and ETF staff to find and understand the information in the document. The 2023 UPBCC will be user friendly, easier to read and understand, and use less technical language. This change will be similar to changes made to the 2022 Uniform Benefits Certificate of Coverage for benefits offered under the GHIP. The change to the Uniform Pharmacy Benefits Certificate of Coverage will not change coverage and therefore no Board action is required.

**Pharmacy Changes Not Recommended**
At the November 2021 and February 2022 Board meetings, there were other administrative service changes/additions that were discussed as options for 2023. After working with Navitus, frontline ETF staff members, health plan vendors, and examining data from our data warehouse, ETF is not recommending moving forward in 2023 with these proposals.

- **Limiting coverage of Continuous Glucose Monitoring (CGM) devices to the pharmacy benefit:** At the May 2021 Board meeting, the Board approved allowing CGM coverage under both the medical and pharmacy benefit starting on January 1, 2022 (Ref. GIB I 5.12.21 I 8F). Health plan coverage of CGMs varies, while the pharmacy benefit covers three CGMs (FreeStyle Libre, Dexcom, and Omnipod Dash). Health plans currently do not include National Drug Codes (NDCs) in the data sent to the Board's data warehouse, and so specific utilization data is limited. Health plans are working to include that data by July 2022. Given the limited available data and the recent nature of the change to CGM coverage, ETF does not recommend moving coverage completely to the pharmacy benefit at this time.

- **Adding weight loss drugs, such as Wegovy, to the Commercial pharmacy formulary:** In late 2021, Navitus's Pharmacy and Therapeutics (P&T) Committee voted to allow Navitus clients the option to add weight loss drugs to formularies. According to Navitus, a small number of their clients have added weight loss drugs to their formulary. The majority of their clients/plans still exclude them. ETF has heard from groups such as the Wisconsin State Chapter of the American Society for Metabolic and Bariatric Surgery, the Wisconsin Academy of Nutrition

and Dietetics, and the Obesity Action Coalition requesting weight loss drugs. Segal provided an analysis of adding one drug (Wegovy) to the pharmacy formulary. Segal assumed that 20% of the Board's membership would be interested in weight loss and 3% of those members would be prescribed the drug and found that this would lead to a cost increase of $20 to $30 million a year. As discussed earlier in this memo, the Board is limited under Wis. Stats. §40.03(6)(c) from entering into contracts that would increase the cost of the program without concurrent savings elsewhere, and neither Segal nor ETF was able to determine any projected savings from these drugs at this time. ETF will continue to review literature and cost-benefit analyses on weight-loss drugs as they become available to determine whether these drugs should be added in the future.

- **Allowing a drug that is granted a lifetime exception through the grievance and appeals process to be exempt from any future formulary changes:** Currently, a member can appeal a denial of drug coverage through the grievance and appeals process. If a member wins their appeal, the member can be granted a lifetime exception for coverage as long as they are prescribed the drug. However, the drug can change formulary tiers, meaning the coinsurance or copay can change. ETF's Ombudsperson Services suggested that members who gain this lifetime exception be exempt from any future formulary changes. According to Navitus, this could lead to confusion at the pharmacy when the member fills a prescription. This could lead to the pharmacy having to contact Navitus and a long wait time for the member to obtain their drug because of the conflict between the current formulary and what the member is being charged. An exemption from any future formulary changes could also mean that, should the drug move to a lower coverage tier, the member would still pay a higher cost sharing amount.

- **Implementing a brown bagging program:** Brown bagging was an option presented to the Board in November 2021. In brown bagging, a patient picks up a prescription at a pharmacy or has it delivered to their home, and then the patient takes the drug to a provider for administration. This means an increased number of people handle a drug before it is administered, which increases risks that the drug will not be handled according to protocols, including temperature control. Responsibility for these protocols would fall to members who may not be able to follow these requirements and may lead to increased drug waste.

- **Implementing a white bagging program:** White bagging was another option for delivery of specialty drugs presented to the Board in November 2021. In white bagging, a specialty pharmacy ships a patient's prescription directly to the provider, and the drug is held until the patient arrives for the drug to be administered. Through discussions with the Wisconsin Hospital Association and Wisconsin Association of Health Plans, ETF learned that some hospital systems in Wisconsin have policies that ban administering drugs that come from outside

pharmacies, which would limit white bagging availability for GHIP members. ETF will continue to monitor any legislative changes and/or hospital policy changes that may allow for the white bagging to be offered as a UB in the future and keep the Board apprised of any changes.

- **Higher coinsurance rate for infusions received in an outpatient hospital setting:** Another cost-saving option presented at the November 2021 meeting was charging a higher coinsurance rate for drugs administered in an outpatient hospital setting. This would encourage patients to have their infusions performed in a provider's office, where the same drug is often less expensive and hospital facility charges would not apply. This change would lead to member confusion on at least two different fronts. A member would have to be aware that a different coinsurance rate would be charged at an in-network facility for an in-network procedure based on where they are receiving their infusions. As cited in the November 2021 Board Specialty Pharmacy Update, reports consistently find members believe they are going to a provider clinic for their treatment, when in fact they are getting infusions at a hospital outpatient clinic. There could be instances where a drug can't be administered in a provider's office and a member must, through no choice of their own, receive the drug in an outpatient hospital setting. This could be more prevalent in some hospital systems than others and may be a bigger issue for providers in rural areas. This could lead to disproportionate cost sharing increases for people in different hospital settings and parts of Wisconsin and challenge the uniformity of the Board's health insurance benefits.

- **Home infusions paid for through the pharmacy benefit:** This would allow members to receive specialty drug infusions in their own homes from a trained medical professional. Home infusion of specialty drugs could help improve access for members with transportation challenges and cut down on the number of people a member must interact with when they are vulnerable to disease. However, ETF cannot recommend this in 2023 due to the current limited-service area of Navitus's home infusion vendor. Due to labor shortages, the vendor cannot guarantee coverage for home infusions outside of select urban areas, which would create disparities in access. Navitus's vendor is committed to growing its home infusion provider network in Wisconsin. ETF will continue to monitor this growth and may propose the benefit change in the future when access can be provided more equitably.

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

Attachment A: 2023 Certificate of Coverage Requested Changes

Attachment B: Language Changes

## Attachment A: 2023 Certificate of Coverage Requested Changes

| 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. See Attachment B for specific language. |
| 1. Glossary of Terms | Add definition of Hold Harmless | TBD -- create separate definition based on U&C | Added new definition | See Attachment B for specific language. |
| 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. | HIPAA 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 of 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. … | 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. |

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| 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. |
| 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 reocmmends 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. Plans have inquired about this benefit in the past and was told ETF's intention is that we cover it. Plans recommend an additional section for Pulmonary Rehabilitation Therapy be added. | | 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 providers. |
| 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 | ETF does not recommend this change due to the increase in cost associated with the benefit and relevant statutory limitations. |
| 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. |

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| 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. Currently, however, individuals 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. |

## 1. Glossary of Terms

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(new)

**Hold/Held Harmless:** means the **Participant** is not responsible for any additional **Charges** out of pocket beyond the **Copayment, Coinsurance,** or **Deductible** that is required per the **Participant's Schedule of Benefits.**

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(new)

**Post-Stabilization Care:** means care that is related to an **Emergency** service, provided after a **Participant** has been stabilized, and is provided to maintain the stabilized condition or, in some cases, to improve or resolve the **Participant's** condition.

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**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 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 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.~~

## 4. Benefits & Coverages

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### B. Exceptions to In-Network Care Requirement

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### (new) 6. Balance Billing When Out-of-Network

In cases where you are eligible for **Out-of-Network** coverage, the amount the **Health Plan** determines is reasonable to pay for your services may be less than the amount your **Provider** billed. In these cases, you are **Held Harmless** for the difference between the billed and paid **Charge(s)**, other than the **Copayments**, **Coinsurance,** or **Deductibles** specified on your **Schedule of Benefits**.

The only exception to this is if you accepted financial responsibility in writing for specific treatment or services (that is, diagnosis and/or procedure code(s) and related **Charges**) before receiving services.

**Health Plan** approved **Referrals** or **Prior Authorizations** to **Out-of-Network Providers** are not subject to **Usual and Customary Charges**. You 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 were not previously approved for **In-Network** reimbursement by your **Health Plan**.

If you receive **Emergency** or **Urgent Care,** or if you receive ancillary services from an **Out-of-Network Provider** as part of an **In-Network** service (for example, an **Out-of-Network** anesthesiologist for a surgery by an **In-Network** surgeon), you cannot be charged any more than your **In-Network Copayments, Coinsurance,** or **Deductible**. In the case of **Emergency** care, this includes **Post-Stabilization Care**. For more information about ancillary service coverage, see 4.F. Covered Services.