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Correspondence Memorandum

Date: April 21, 2023

To: Group Insurance Board

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

Subject: 2024 Program Agreement and Benefit Changes

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve the modifications to the Program Agreement (PA), Uniform Benefits (UB) Certificates of Coverage (CoCs), and the Uniform Pharmacy Benefit (UPB).

Background

ETF presented initial change concepts for program year 2024 to the Board at the February 22, 2023, meeting (Ref. GIB | 02.22.23 | 10C). This initial review was intended to provide the Board with a summary of possible changes under consideration for the coming benefit year. Following the February meeting, ETF reviewed the 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. Changes that are both recommended and unrecommended are highlighted in this memo. (For a complete list of benefit changes, see Attachment A.)

This recommendation does not take into consideration any potential Board action to curtail the Group Health Insurance Program (GHIP) costs and related premiums by adjusting member cost-sharing and/or adjusting benefits described in the "2024 Preliminary Reserve Estimates" memo (Ref. GIB | 05.17.23 | 3B).

PA Changes Recommended

PA changes were presented to health plans at the Council on Health Program Improvement (CHPI) meeting in April. Health plans were informed of the recommended and unrecommended changes that ETF would be requesting the Board to approve.

Department Initiatives

Eileen K Mallow

Reviewed and approved by Eileen Mallow, Director, Office of Strategic Health Policy
Electronically Signed 05/01/2023

Board	Mtg Date	Item #
GIB	05.17.23	3C

The following Department Initiatives are currently included in the PA:

- Care coordination;
- Prior authorization for high-tech radiology;
- Prior authorization for low back surgery;
- Availability of shared decision-making tools;
- Advance care planning/palliative care; and
- Monitoring of potentially low-value services.

Per the Board's health plans, prior authorization for high-tech radiology and low back surgery are already done as a part of standard business practices. Plans also stated that shared decision-making is best administered via providers and not the health plan. Many health plans do not currently monitor potentially low-value services and, if ETF required them to do so, it would result in additional costs, system upgrades, and staff time. Additionally, it is the industry standard to limit potentially low-value services. Advance care planning and palliative care are already noted in the CoC and is further expounded in the 2024 CoC update detailed later in this memo.

ETF recommends removing all the currently listed Department Initiatives, except for care coordination. ETF also recommends adding a sentence to Section G. Care Management (1.a. Department Initiatives) about the ability to request input and collaboration from the GHIP contractors on population health management initiatives.

Data Collection Requirements

ETF will add general language to Section IV. K. of the PA requiring plans to submit data in a format agreed-upon by plans and ETF to align with Federal and State compliance standards. ETF will also include language that any penalties incurred by ETF, which are a direct result of plans not submitting required data, will be passed-through to plans as a penalty. This will be in addition to the per-day-late reporting penalties already in the contract.

Performance Standards and Penalties

In places noted by the health plans, ETF will revise Section IV of the PA regarding performance standards and penalties. This revision will consist of replacing the words "calendar day" with the words "business day" regarding the timeline in which a penalty is incurred for failing to reach a target metric.

PA Changes Not Recommended

ETF does not recommend the following PA changes:

Confidentiality, Privacy, and HIPAA Business Associate Agreement

ETF received a request to incorporate terms that allow health plans to leverage offshore resources for customer service without prior ETF review. This request has been denied. ETF has concerns about removing the requirement for keeping members' confidential information within the United States. Currently, ETF does not allow members' confidential information to be transferred, stored, or transmitted outside of the United

States. ETF is concerned that allowing access to members' confidential information outside of the United States would cause members' personal information to become more vulnerable to cyber-attacks and data breaches with limited legal protections available in certain countries.

Data and Information Security
A request was made by a health plan to only send specific data based on their commercial group of ETF members versus the plan's commercial and Medicare book of business. This request was denied because ETF uses broader market data through the Wisconsin Health Information Organization (WHIO) in analytics and rate setting.

Health Benefit Changes Recommended
ETF recommends administrative updates to the CoC, such as expanding and clarifying definitions, reviewing to simplify language with Coordination of Benefits, and updating Member Rights and Responsibilities sections with resource links. Additional updates to the CoC are detailed below.

Adding Clarity to Hospice Care Section and Further Defining Palliative Care
ETF recommends expanding coverage of advance care planning. The current CoC only covers advance care planning once a terminal diagnosis is received. However, advance care planning is appropriate much earlier in life and before terminal decisions are necessary. Palliative care focuses on easing pain and discomfort, reducing stress, and helping people have the highest quality of life possible; while hospice care focuses on quality of life when a cure is no longer possible, or the burdens of treatment outweigh the benefits. Attachment A outlines the proposed language that ETF recommends including within the Covered Services section under Hospice Care, which further separates and defines palliative care and advance care planning.

Removing Infusion Pump Rental Requirement in Durable Diabetic Equipment and Related Supplies
ETF recommends removing the rental of infusion pumps prior to purchase. Infusion pumps are used to deliver nutrients or medications, such as insulin or other hormones, antibiotics, chemotherapy drugs, and pain relievers. While pumps may be rented, patients typically keep the pump long-term, so there is no benefit to renting the pump for 30 days. Segal determined the average price to rent a pump per month is $200. Based on current utilization, the cost impact was deemed immaterial.

Clarifying Hospital Services and Inpatient Confinements
ETF recommends adding clarification to support continuity of care for members who change health plan providers during an inpatient stay. Currently, if a member changes health plans while confined as an inpatient, the prior and new health plan work together to transition the member's care and coverage to the new health plan. Adding clarification would prevent members from possibly being required to move to a new in-

network facility to receive inpatient care services due to a change in health plan provider.

Removing Requirement Language in Physical, Speech, and Occupational Therapy
ETF recommends removing the expectation that therapy will yield significant patient improvement within two months of beginning treatment. Currently, prior authorization is not required for the first 50 visits. According to the Board's health plans, improvements may need more than several months and there is no clear way to determine if guaranteed improvement can be made within the current two-month period expectation. Therefore, it would not be appropriate to limit coverage automatically.

Adding Flexibility Around Prior Authorization
ETF recommends updating all sections of the CoC that require prior authorization and adding the ability to waive the requirement to provide additional flexibility to health plans. ETF also recommends further clarifying language around the difference between a referral and prior authorization within the Glossary of Terms (see Attachment A for details).

Clarifying Exclusion to Vision Correction
ETF reviewed the vision correction coverage language in the Exclusion and Limitations section after a request by a member. The request specifically involved coverage for scleral contact lenses, which are prescribed for keratoconus and other similar conditions. The cost for these scleral contact lenses can be between $2,000–$4,000. Segal analysis on keratoconus and other similar conditions is that they are very rare (54.5 in 100,000 people in the United States), and the expected cost to ETF would be negligible. The recommendation for this change is intended to allow health plan clinical staff to determine appropriate coverage and to align more closely with industry standards (see Attachment A for details).

Health Benefit Changes Not Recommended
The following changes to the CoC are not recommended due to the cost impacts to the plan without commensurate savings.

Full Coverage for Vasectomies in Reproductive Services and Contraceptives
Contraceptive Services are included in current coverage; however, members may be required to pay copays or coinsurance costs. ETF explored covering the full cost of vasectomies. Research and analysis by Segal determined the average cost of a vasectomy is around $1,000. According to online research, 11.4% of men between the ages of 30 and 45 have had a vasectomy in the United States[1]. Assuming a similar

[1] Eisenberg ML, Henderson JT, Amory JK, Smith JF, Walsh TJ. Racial differences in vasectomy utilization in the United States: data from the national survey of family growth. Urology. 2009 Nov;74(5):1020-4. doi: 10.1016/j.urology.2009.06.042. Epub 2009 Sep 20. PMID: 19773036; PMCID: PMC2784091.

utilization rate for men between the ages of 30 and 45, the cost estimate would be around $2.5M–$3M.

Fertility Coverage

ETF, along with Segal, revisited research into fertility coverage at the request of a member. In reviewing multiple fertility services, Segal estimated a wide range of costs that be from $5M–$20M, depending on the type of services each patient would utilize. Two states (California and Texas[2]) have a mandate to offer at least one plan covering some fertility services. Due to the fiscal implications of adding this benefit, it is not feasible to add the benefit at this time.

Dietitian and Nutritional Counseling Coverage for Weight Loss

ETF explored expanding dietitian services for weight loss purposes. Medical Nutrition Therapy (MNT) is typically provided by a registered dietician. Using DAISI data, Segal estimated that the cost per visit would range from $135–$200 per visit and that members would receive between one and three sessions per year. Based on a potential utilization of 5% to 15% of eligible members, Segal estimated that adding coverage for all three obesity classifications (Class I BMI 30–35, Class II BMI 35–40, Class III BMI 40 or higher) would cost between $656,470–$3,976,063 per year.

Segal found little available literature with evidence of return on investment (ROI) for MNT that was provided specifically for weight loss. Extrapolating instead from the ROI reported in studies where MNT was used to address other chronic conditions, which is already covered by the GHIP, Segal estimated savings between $0–$477,582. This resulted in a net estimated cost to the GHIP of approximately $178,888 to $3,976,063. If the coverage categories were narrowed to only cover Classes II and III BMI, Segal projected a small possible savings of $5,214 per year in the best-case scenario; or, if savings were not realized, up to a cost of $1,804,603.

As currently paid for by Well Wisconsin, lifestyle management coaching (where weight loss coaching is categorized) costs $46 per visit. In 2022, the Board spent approximately $900,000 for lifestyle management coaching; and approximately 75% of calls pertained to weight, diet, or exercise. Coaching provides similar support related to diet that MNT does. Coaches available through the Well Wisconsin Program are registered nurses, dieticians, exercise physiologists, health educators, and psychologists. Furthermore, coaching is available to members regardless of BMI. If the Board opted to move funding from Well Wisconsin to the medical benefit in order to reimburse for MNT, the amount required would likely be more than the $675,000 currently spent through Well Wisconsin for weight, diet, and exercise coaching. This would require reductions to other benefits provided by the Well Wisconsin Program. Because of the lower per-person costs and the ability to offer uniform access to members across health plans and geographic areas, ETF continues to recommend that

[2] Weigel G, Ranji U, Long M, Salganicoff A. Coverage and Use of Fertility Services in the U.S. 2020 Sept.

the Board focus coverage of weight management with coaching through the Well Wisconsin Program.

Over-the-Counter Hearing Aid Coverage

ETF's current coverage for hearing aids is $1,000 max per hearing aid per ear every three years. The Federal Drug Administration (FDA) allow some hearing aids to be sold over the counter with the aim to widen their availability for purchase at stores and online without a medical exam, prescription, or fitting by an audiologist. The average cost of over-the-counter hearing aids is $1,600, compared to $4,600 for prescription hearing[3]. Over-the-counter hearing aids are specifically designed for adults with mild to moderate hearing loss. Individuals that struggle to hear conversations in quiet settings or have hearing loss in only one ear are considered to have more significant hearing loss than over-the-counter aids are intended to address. ETF will not recommend adding this benefit due to cost but will continue to monitor the impact of adding this benefit for a future plan year.

Coverage for Sports Physical Examinations

Routine physical examinations are currently covered once every calendar year. A request was made for ETF to cover additional exams when required for sports participation, due to costs for additional exams. This request would be excluded by the Medical Necessity section in the current Plan Year 2023 CoC, which states "all services must be medically necessary, as determined by your Health Plan." Additionally, Segal estimated ETF has about 32,000 children between the ages of 7 and 17. Around 50%–55% of kids under the age of 18 participate in sports. Assuming that 80% of those children that play sports get a sports physical at a price of $50, the cost would be between $400K–$500K. Due to the cost, ETF does not recommend adding this benefit.

Expanding Telehealth Coverage

The provision extending telehealth relief as part of the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act ends at the end of the 2024 plan year. The CARES Act currently provides pre-deductible coverage of telehealth services for members enrolled in high-deductible health plans (HDHPs). Adding pre-deductible telehealth coverage could jeopardize the HDHP's qualified status in the 2025 year. There are approximately 57,000 members in the HDHP. The projected cost of adding pre-deductible coverage of telehealth services as a permanent benefit is between $200K–$450K. Due to the fiscal implications, ETF does not recommend adding this benefit.

American Academy of Pediatrics (AAP) Guidance Children and Adolescent Obesity

The AAP completed a study on childhood obesity and recently released specific health behavior recommendations and strategies for pediatricians. Effective programs

[3] Everett C, MS, RDN. Over-the-Counter (OTC) Hearing Aids – What to Know. 2023 Mar.

described in the technical report incorporated nutrition, physical activity, and behavior change strategies simultaneously. The recommended strategies focus on educating the whole family on healthy cooking, incorporating some forms of daily physical activities, developing community support outside of the family to reduce stigma, and eliminating sugary drinks. Pediatrician appointments are currently covered under the CoC, thus ETF recommends no change in benefits.

Pharmacy Benefit Change Recommended
At the February 2023 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: Copay Assistance Accumulator Program.

Copay Assistance Accumulator Program
Many drug manufacturers offer copay assistance programs that help reduce copays for prescription drugs. These include discount cards, coupons, or enrollment into a program. Participants must read the terms and conditions for each program, be aware of when the program ends, and know when the maximum allowed dollar limit will be met. It is not uncommon for a program to last up to a year, while others can be renewed for longer.

Members who currently participate in copay assistance programs have their copays reduced or eliminated. The Board, as the payer for the remaining cost of the prescription drugs, sees no benefit when a member participates in a manufacturer copay assistance program.

Navitus can create a benefit that will allow non-Medicare members to enroll in drug manufacturer coupons and copay assistance programs for over 350 specialty and HIV medications. Members will still be able to fill specialty drugs at either the Lumicera Health Services Specialty Pharmacy or the University of Wisconsin (UW) Specialty Pharmacy. These are the two in-network specialty pharmacies covered under the pharmacy benefit for non-Medicare members. Most drugs under the benefit will have no copay. If a member is required to pay a copay on a drug in the program, the copay will count towards the member's out-of-pocket limit (OOPL).

Currently, a non-Medicare member on a Level 4 specialty drug pays a $50 copay each time they fill their prescription until they hit the Level 3 and Level 4 OOPL of $9,100 for an individual plan and $18,200 for a family plan. In 2022, no members hit their OOPL for prescription drugs. While the member pays the $50 copay, the Board pays the remainder of the price of a specialty drug. Level 4 drugs offer very little in rebates as compared to drugs on the other levels of the formulary. They are also typically the most expensive drugs.

In 2022, 4,238 non-Medicare members had specialty pharmacy prescriptions filled through the pharmacy benefit. The total cost of these specialty prescriptions was

$163,799,127. This means that 1% of utilizing members accounted for 41.9% of the total prescription drug non-Medicare member spending in 2022.

Under current coverage, a member would pay $600 yearly ($50 per fill), which accumulates to the Level 4 OOPL. If the member uses a coupon card, the member does not have out-of-pocket costs. Coupon cards process similarly to secondary insurance after the Board's pharmacy benefit pays, so any additional available discount beyond the copay from the coupon card would not be used.

Enrollment in the coupon card reduces the member's copays below the $50 standard copay for the entire year. The Board can reduce its costs by implementing this proposed benefit design change without impacting the member's final out-of-pocket costs for traditional plans.

If non-Medicare members had been enrolled in a copay assistance accumulator program such as this one in 2022, they would have saved $1.79 million in out-of-pocket costs. The Board would have saved a little more than $26 million.

The new benefit does not affect which drugs are covered by the pharmacy formulary. If a specialty drug is not in the program, the member will continue to receive the drug for the $50 Level 4 copay.

Navitus can also create a benefit design with an option for HDHP members to have a reduced risk of losing tax exemption for their Health Savings Account (HSA). The benefit applies the remaining deductible (which helps HDHP members remain in accordance with federal tax law) still realize savings from the program, and counts any money the member pays towards a specialty drug towards their deductible. Any copay assistance dollars received would not apply to their deductible and maximum out-of-pocket limit (MOOP). Other pharmacy and healthcare costs that members are currently responsible for will continue to accrue towards their deductible and MOOP.

If the Board chooses to implement this benefit design, ETF will communicate information about the program to all members during the 2024 open enrollment period using decision guides and the ETF's website. Navitus will work with members on specific medications to get enrolled in manufacturer copay programs. Navitus' customer service team will be able to answer all questions from members about the benefit.

Pharmacy Changes Not Recommended

At both the November 2022 and February 2023 Board meetings, other administrative services changes and additions were discussed. After working with Navitus and Segal, as well as examining data from ETF's data warehouse, ETF is not recommending moving forward in 2024 with the proposals described below.

<u>Adding Home Infusion Under the Pharmacy Benefit</u>

This proposed benefit would have allowed members to receive specialty drug infusions in their own homes from trained medical professionals who were paid for through the member's pharmacy benefit. Home infusion of prescription drugs may improve access for members with transportation challenges and cut down on the number of people a member must interact with if they are immunocompromised or vulnerable to disease. Offering this benefit through the pharmacy benefit would have allowed for a more uniform benefit rather than the current state of home infusion paid for through the medical benefit and varies by health insurer.

ETF cannot recommend adding this benefit for 2024 due to continued labor shortages. Navitus's vendor cannot guarantee coverage for home infusions in areas where ETF members reside. Navitus continues to try to find home infusion vendors that can form a home infusion provider network to serve ETF members. ETF hopes to propose this benefit change in the future when greater access can be provided.

Adding Weight-Loss Drugs to the Commercial Pharmacy Formulary

Adding coverage of weight-loss drugs is an item that the Board discussed at the meetings on May 18, 2022 (Ref. GIB | 05.18.22 | 5C), June 30, 2022 (Ref. GIB | 06.30.22 | 4), and the November 16, 2022 (Ref. GIB | 11.16.22 | 13). Unfortunately, the same issues still exist in 2023 that existed in 2022, including a lack of studies about the effects of long-term weight loss drug usage and the high price of the drugs.

Since the November 2022 Board meeting, no new studies have been issued on the subject. However, media coverage has increased regarding the uptick in the use of weight-loss drugs, the off-label use of type 2 diabetes drugs with similar chemical makeups, and how the unknown long-term effects of using these drugs.

Earlier this year, Segal, looking at the cost of weight-loss drugs through Navitus and assuming a utilization rate of 0.6% of members expects a cost increase of between $9M–$14M annually if weight-loss drug coverage was added to the commercial pharmacy formulary.

Both the economic value and impact of weight-loss drugs on obese adults were researched in a 2021 study sponsored by Novo Nordisk[4], the maker of multiple weight-loss drugs. The study showed the maximum savings for those who reduced weight from obese to an overweight BMI was $1,200 per year and those who moved from obese to a healthy BMI was $2,400 per year with a midpoint overall estimate of $135 per month or $1,600 per year.

In 2022, Segal used the information found in this study to estimate that the Board could potentially save up to $2 million annually if members maintained a lower weight. This

[4] Ding, Y., Fan, Z., Blanchette, C. M., Smolarz, B., Weng, W., & Ramasamy, A. (2021). Economic value of nonsurgical weight loss in adults with obesity. Journal of Managed Care + Specialty Pharmacy, 37-50.

means that Segal's 2023 cost analysis shows that the Board would spend between $9M–$14M to save $2 million per year. Due to the estimated increase in costs without concurrent opportunity for savings and the limiting language of Wis. Stat. §40.03(6)(c), ETF does not recommend adding this benefit.

ETF is very aware of the continued interest of members in adding weight-loss drug coverage to the pharmacy benefit, as demonstrated in the "Board Correspondence" memo (Ref. GIB | 05.17.23 | 8F). ETF will continue to update the Board with any information that becomes available about weight-loss drugs and the possibility of coverage.

Changing Coverage of Continuous Glucose Monitoring Devices (CGMs)
At the May 2021 Board meeting (Ref. GIB | 05.12.21 | 8F), the Board approved allowing CGM coverage under both medical and pharmacy benefits starting January 1, 2022. Each health plan covers different subsets of CGM brands, while the pharmacy benefit covers three CGMs: FreeStyle Libre, Dexcom, and Omnipod Dash.

Beginning in July 2022, health plans were asked to start submitting CGM National Drug Codes (NDCs) to the Board's data warehouse to assist in tracking coverage for each brand of CGM. Health plans rely on their medical providers to provide information like NDCs. Medical providers are slowly starting to include this information provided to health plans, but the information received so far is incomplete. 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.

ETF will continue to monitor the coverage of CGMs under both the medical and pharmacy benefit for narrowing of coverage under the medical benefit and/or expansion of coverage under the pharmacy benefit that may lead to limited member disruption if a change in coverage is made.

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

Attachment A: Proposed Benefit Change Language for PA and CoC