2026 Final Recommendations on Agreement and Benefit Changes

Proposed Changes to the Program Agreement Benefits

Proposed Change	Description	Requested By	Recommendation
III. Program Administration E. Communications 3. Contractor Web Content and Web-Portal (g.)	Remove the Extended Validation (EV) requirement from the provision. Proposed change: Web Content and Web-Portal g. The CONTRACTOR'S web-portal must be SECURED with a minimum of SHA2-256 (or similar system such as SHA-256 as approved by the DEPARTMENT) bit ~~EV~~ certificates to provide the latest in encryption and cryptography.	Network Health	This is recommended. No impact to quality. This change is acceptable to ETF Bureau of Information Security Management and Budget, Contract, Admin., & Procurement.
Exhibit B - Department Terms and Conditions Section 24.0 Confidential Information, Privacy and HIPAA Business Associate Agreement Subsection (e).	Add language regarding confidential information storage outside the United States and Territories. Proposed change: REQUIREMENT TO KEEP CONFIDENTIAL INFORMATION WITHIN THE UNITED STATES: The Contractor's transmission, transportation or storage of Confidential Information outside the contiguous United States, or access of Confidential Information from outside the contiguous United States, is prohibited except (a) on prior written authorization by the Department or (b) when all of the following conditions are satisfied: (i) storage of Confidential Information remains within the United States, (ii) Contractor utilizes a secure virtual desktop for offshore resources access, (iii) Contractor employs industry-standard secure network monitoring, data breach safeguards and reporting, (iv) Contractor utilizes multi-factor authentication systems regarding access to Confidential Information by offshore resources, and (v) Contractor maintains a SOC2 and any applicable bridge letters during the Contract Period.	Dean Health	This is **not** recommended. Budget, Contract, Admin., & Procurement confirmed off-shoring of data is already against ETF policies and Wis. Stat. §19.36 limitations upon access and withholding.
IV. Performance Standards and Penalties I. Quarterly Performance Standards & Penalties 2. Customer Service	Revise penalty structure based on health plan size. The current penalty for the customer service performance standards listed below (2.a – 2.d) is $5,000 for each percentage point for which the standard is not met in each quarter. The revised penalty calculation will be based on the size of the health plan (small, medium, large), relative to the plan's membership size. Plan size, penalties by plan size, and sample penalty calculations are below: • Small Plans (Fewer than 10,000 members) o Penalty: $1,000 per percentage point below 80% o Example: Plan achieves 75% → 5% shortfall × $1,000 = $5,000 penalty • Medium Plans (10,000-50,000 members) o Penalty: $3,000 per percentage point below 80% o Example: Plan achieves 75% → 5% shortfall × $3,000 = $15,000 penalty • Large Plans (More than 50,000 members) o Penalty: $5,000 per percentage point below 80% o Example: Plan achieves 75% → 5% shortfall × $5,000 = $25,000 penalty Performance Standards a. Call Answer Timeliness: At least eighty percent (80%) of calls received by the CONTRACTOR'S customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds. (See Section III.H.3. Customer Service.) b. Call Abandonment Rate: No more than three percent (3%) of calls abandoned, measured by the number of total calls that are not answered by customer service (caller hangs up before answer) divided by the number of total calls received. (See Section III.H.3. Customer Service.) c. Open Call Resolution Turn-Around-Time: At least ninety percent (90%) of customer service calls that require follow-up or research will be resolved within two (2) BUSINESS DAYS of initial call. Measured by the number of issues initiated by a call and resolved (completed without need for referral or follow-up action) within two (2) BUSINESS DAYS, divided by the total number of issues initiated by a call. (See Section III.H.3. Customer Service.) d. Electronic Written Inquiry Response: At least ninety-eight percent (98%) of customer service issues submitted by email and website are responded to within two (2) BUSINESS DAYS. (See Section III.H.3. Customer Service.)	MercyCare	This is recommended. The new penalty calcuation method is more equitable to the smaller plans.
III. Program Administration D. Data and Information Security 4. Data Integration and Use (e.)(ii.)	Adjusting and simplifying language so that data sharing is occurring between WebMD and only health plans who use the data. Proposed change: ii. Wellness and Chronic Condition Management Data – ~~The~~ CONTRACTORS who can ~~must be able to~~ accept and accommodate a monthly file from the DEPARTMENT'S wellness and chronic condition management vendor that includes data for the CONTRACTOR'S PARTICIPANTS will work with DEPARTMENT'S wellness and chronic condition management vendor to identify the most recent Wellness Data Specifications for biometrics, health assessments, and health coaching and chronic condition management, and integrate that data into the CONTRACTOR'S medical management program. ~~This data may include results from biometric screenings, health assessments, and unique PARTICIPANT information regarding enrollment in health coachign and/or chronic condition management programs. The file format must comply with the most recent Wellness Data Specificiations as provided by the DEPARTMENT.~~	ETF	This is recommended. Limiting sending data to only those vendors who use the data to ensure member data is protected and directing health plans to work directly with the wellness and condition management vendor to get file specifications.
III. Program Administration D. Data and Information Security 4. Data Integration and Use (e.)(i.)	Update language so the health plans get latest file specs directly from PBM. Proposed change: 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 must be in a file format compliant with the most recent Pharmacy Data Specifications provided by the ~~DEPARTMENT in consultation with the~~ PBM.	ETF	This is recommended. Directing health plans to work directly with the pharmacy benefit manager to get the file specifications.
III. Program Administration E. Communications 3. Contractor Web Content and Web-Portal (b.)	Add requirement to refer to wellness and chronic condition management program and pharmacy benefit. Proposed change: b. The CONTRACTOR must include, within its customized website and/or web-portal dedicated to PARTICIPANTS, links to the DEPARTMENT'S wellness and chronic condition management program, and the DEPARTMENT'S PBM vendor's pharmacy benefit web portal and/or public facing website.	ETF	This is recommended. Updating language to assist members with finding wellness and chronic condition management and pharmacy benefits included in their GHIP coverage.
III. Program Administration G. Care Management 1. Department Initiatives (a.) (i.) adding (ii.)	Adding diabetes management and prevention initiative (new section ii). Proposed change: i. ~~The current DEPARTMENT Initiative is limited to~~ Care Coordination. The CONTRACTOR must ensure care coordination is offered for PARTICIPANTS with high-risk health condition(s) by conducting outreach within three (3) to five (5) BUSINESS DAYS of a PARTICIPANT'S initial discharge from an INPATIENT HOSPITAL stay of more than twenty-four (24) hours. ii. Diabetes Management and Prevention. The CONTRACTOR must provide PARTICIPANTS with diabetes management and prevention programming and/or refer PARTICIPANTS to the DEPARTMENT'S wellness and chronic condition management program vendor's diabetes management and prevention services.	ETF	This is recommended. This change will add guidance for health plans to follow regarding disease management.
III. Program Administration G. Care Management 3. Population Health Management (a.) (iii.)	Align language to other data sharing edits (see lines 8-11 above) and refer to wellness and chronic condition management vendor benefits. Proposed change: iii. As applicable, coordinating programming with the DEPARTMENT'S wellness and chronic condition management vendor(s) by:... •Referring PARTICIPANTS to the appropriate resources provided by the DEPARTMENT'S wellness and chronic condition management vendor(s). The CONTRACTOR must provide the DEPARTMENT documentation annually via the Population Health Management Report, that demonstrates their efforts in actively promoting the services available to PARTICIPANTS through the DEPARTMENT'S wellness and chronic condition management program. This includes but is not limited to general and targeted communications and referrals.	ETF	This is recommended. This change will provide expectations on documenting efforts to actively promote services available through the wellness and condition management program.

III. Program Administration, E. Communications, 3. CONTRACTOR Web Content and Web-Portal (a.) (j.) (k.) (l.) and (p.)	Adding "microsite" after any reference to "website" in these subsections a. The CONTRACTOR must host and maintain a customized website providing dedicated HEALTH BENEFIT PROGRAM web content (that may be provided via a microsite that meets all criteria below), and a web-portal dedicated to PARTICIPANTS. Web content on the microsite will provide basic HEALTH BENEFIT PROGRAM information... j. After CONTRACTOR'S initial website and web-portal implementation, the CONTRACTOR must grant the DEPARTMENT access to the website or microsite and web-portal test environment for the DEPARTMENT'S review and approval no less than four (4) weeks prior to the subsequent annual launch dates for each, and for each new major iteration of the website or microsite and web-portal. k. The CONTRACTOR must submit to the DEPARTMENT for review and approval the updated website or microsite content for the upcoming OPEN ENROLLMENT period... l. The CONTRACTOR must obtain prior approval from the DEPARTMENT Program Manager for the inclusion of any links on the CONTRACTOR'S website or microsite pages that include HEALTH BENEFIT PROGRAM information or on the web-portal to external (governmental and non-governmental) websites/portals or website or microsite pages. p. The CONTRACTOR'S website or microsite must be hosted in a SECURE data center with system monitoring, managed firewall services and managed backup services within the United States and be available twenty-four (24) hours a DAY, seven (7) DAYS a week, except for regularly scheduled maintenance.	ETF	This is recommended. A microsite can be used to create specialized marketing materials that focuses on a specific topic.
Section I. Definitions IN-NETWORK	Update the definition of IN-NETWORK to adjust how contrators/vendors provide provider directories to members. Proposed Language: IN-NETWORK refers to a PROVIDER who has agreed in writing to provide, prescribe, or direct healthcare services, supplies, or other items covered under UNIFORM BENEFITS to PARTICIPANTS. The PROVIDER'S written participation agreement with a CONTRACTOR must be in force at the time such services, supplies, or other items covered under UNIFORM BENEFITS are provided to a PARTICIPANT. The CONTRACTOR agrees to ~~give PARTICIPANTS lists of affiliated PROVIDERS~~ make available to PARTICIPANTS an online affiliated PROVIDER directory and, provide a written listing of affiliated PROVIDERS upon request. Some PROVIDERS require prior authorization by the CONTRACTOR in advance of the services being provided.	ETF	This is recommended. Modifying how health plans provide the network to members.
III. Program Administration A. Enrollment and Eligibility Maintenance 4. Identification (ID) Cards (b.)	Updating the frequency that Identification (ID) Cards are issued. Proposed change: b. The CONTRATOR must issue new ID cards upon enrollment and following BENEFITS changes that impact the information printed on the ID cards. The CONTRACTOR is not required to send new ID cards to existing members if no information on the card has changed.	ETF	This is recommended. We have plans that send out ID cards every year regardless if there is a change or not. This recommendation is clarifying that plans "must" send out new ID cards only if there is a change in the information printed on the ID card or coverage changes.
III. Program Administration D. Data and Information Security 5. Data Warehouse File Requirements (b.)(v.)	Clarifying language to add Wisconsin and surrounding states to data for In-Network providers. Proposed change: v. Data for all IN-NETWORK PROVIDERS in Wisconsin and the surrounding states (Minnesota, Iowa, Illinois, and Upper Michigan), including subcontracted PROVIDERS, as specified by the DEPARTMENT. For neighboring states, health plans are expected, at a minimum, to include the IN-NETWORK PROVIDERS for whom they have processed claims.	ETF	This is recommended. This is intended to specify that health plans need to include Wisconsin and surrounding states in data for all In-Network Providers.
III. Program Administration F. Provider Access 1. Provider Access Standards (a.) (b.)	Clarifying language to sort provider network lists for Wisconsin zip codes only. a. The CONTRACTOR must submit an annual Wisconsin PROVIDER network list for the upcoming benefit period to the DEPARTMENT and the BOARD'S consulting actuary. This is in addition to the monthly PROVIDER data submission detailed in Section III.D. Data and Information Security. b. The CONTRACTOR must sort Wisconsin PROVIDERS by zip code based on where they are physically located within each county and major city in the region. Major cities are those that have over thirtythree percent (33%) of the county population. These providers must agree to accept new patients.	ETF	This is recommended. This is intended to specify that health plans need to submit a provider network list and sort those providers by zip code for Wisconsin providers only.
III. Program Administration F. Provider Access 3. Continuity of Care (b. iii.)	Adding an additional subsection (iii) to align with Wis. Admin. Code INS § 9.35 (1) (b) to inform the Department of any provider who moves from In-Network to Out-of-Network. **Wis. Admin. Code INS § 9.35 (1) (b) 1.:** "Upon termination of a provider from a defined network plan, the insurer offering a defined network plan shall notify all affected enrollees of the termination and each enrollee's options for receiving continued care from the terminated provider not later than 30 days prior to the termination, or upon notice by the provider if the insurer receives less than 30 days notice. The insurer offering a defined network plan shall provide information on substitute providers to all affected enrollees." Proposed addition: iii. If an IN-NETWORK PROVIDER fails to notify CONTRACTOR that they are no longer an IN-NETWORK provider (e.g., PROVIDER leaves an IN-NETWORK practice group and goes to work for an OUT-OF-NETWORK practice group), CONTRACTOR will send the notification described above upon CONTRACTOR'S receipt of notice of termination by the PROVIDER. (See Wis. Admin. Code INS § 9.35 (1) (b) 1.)	ETF	This is recommended. To ensure all GHIP health plans comply with Wis. Admin. Code INS. Chapter 9, Defined Network Plans.
IV. Performance Standards and Penalties J. Data Warehouse Deliverable Requirements 2. Provider Data Transfer to Data Warehouse	Clarifying language to add Wisconsin and surrounding states to data for In-Network providers. Proposed change: Monthly, the CONTRACTOR must submit to the DEPARTMENT'S data warehouse, in the most recent file format specified by the DEPARTMENT, the specified data for all IN-NETWORK PROVIDERS including subcontracted PROVIDERS in Wisconsin and the surrounding states (Minnesota, Iowa, Illinois, and Upper Michigan), as specified by the DEPARTMENT. (See Section III.D.4. Data Integration and Use.)	ETF	This is recommended. This is intended to specify that health plans need to include Wisconsin and surrounding states in data for all In-Network Providers.

Proposed Changes to Certificate of Coverage Benefits

Proposed Change	Description	Requested By	Recommendation
2. Eligibility, Enrollment, and Termination I. Qualifying Life Event 10. Retirement	Add language due to implementation of the Insurance Administration System (IAS), if a member wants to change plans due to adding Medicare, they need to file an application before their Medicare effective date to have the change occur at the same time as Medicare begins. If late, the plan will change the first of the month after receipt of the application. Proposed Language: If you are already retired and you become Medicare eligible, you must enroll in Part A and Part B (See Section 2. F. Medicare Enrollment). When you first enroll in Medicare, you could also choose to move to a different Benefit Plan, such as IYC Medicare Advantage or IYC Medicare Plus, or you may choose to cancel your GHIP coverage. ~~You must file an application within 30 calendar days of enrolling in Medicare, or you may submit an application up to three months before your Medicare coverage takes effect.~~ You must submit your application prior to your Medicare effective date. This can be sent up to three months in advance. Coverage with your new plan will be effective on the same date as Medicare. You may also submit the application up to 30 days after your Medicare effective date, but then coverage will be effective the first of the month after ETF receives your application.	ETF	This is recommended. To provide clarification with implementation of Insurance Administration System (IAS).
2. Eligibility, Enrollment, and Termination K. COBRA/Continuation	Add language due to implementation of the Insurance Administration System (IAS), Employer will no longer provide COBRA paperwork. That will come from Voya Financial (COBRA and HRA offering comprehensive package of workplace benefits). Proposed change: If you leave employment, you may be eligible for COBRA Continuation of your GHIP coverage. ~~Your Employer~~ The COBRA contractor will provide you with the paperwork you need to file. You must submit a completed application to ETF that is postmarked within 60 calendar days of the date you were notified of the right to continue, or 60 calendar days from the date your coverage would otherwise end, whichever is later.	ETF	This is recommended. To provide clarification with implementation of Insurance Administration System (IAS).
2. Eligibility, Enrollment, and Termination I. Qualifying Life Event 11. Death of a Spouse	Request to permit members to change health plans following a death of a subscriber or dependent. Proposed change: 11. Death of a Spouse or Dependent If your spouse or Dependent dies while they are enrolled in the GHIP, you may change from family coverage to individual if no one else is on your policy, and/or change to another HEALTH PLAN. If you have other Dependents, you must keep your family coverage. If you were enrolled in your spouse's non-GHIP insurance and lost eligibility or all the Employer contribution due to the death, you may enroll in the GHIP. You should submit your application within 30 calendar days of losing your other coverage.	Member	This is recommended. Per Segal cost would be negligible.
2. Eligibility, Enrollment, and Termination L. Layoffs and Leaves of Absence	Request for policy change to allow employees on layoff or Leave of Absence (LOA) to reenroll upon return to work regardless of if their coverage is lapsed due to non payment or they canceled their coverage.	State Employer	Currently being reviewed. Concern about changing a policy with the implementation of IAS imminent. COC 2.K. Liz B/Carley OK to do with IAS with go-live. This affects Health, Supps, Life, ICI. Securian doesn't like this change. UW says change for all benefits or not at all. Asking for data from UW and STAR to help Securian price and determine scope.
4. Benefits and Coverages B. Exceptions to In-Network Care Requirement 4. Out-of-Network Coverage for Full-Time Students	Add clarifying language to align with Wis. Stat. § 609.655. Wis. Stat. § 609.655 states "(a) "Dependent student" means an individual who satisfies all of the following: 1. Is covered as a dependent child under the terms of a policy or certificate issued by a defined network plan insurer. **2. Is enrolled in a school located in this state but outside the geographical service area of the defined network plan.**" Proposed change: If your Dependent is a full-time student attending school within the State of Wisconsin but outside of your Health Plan's Service Area, certain outpatient mental health services and treatment of alcohol or drug abuse will be covered Out-of-Network, as required by Wis. Stat. § 609.655. See Mental Health and Substance Use Disorder Services below for more information.	Network Health and Quartz	This is recommended. This change aligns with Wis. Stat. § 609.655.
5.Exclusions and Limitations A. Excluded Services 4. Durable Medical Equipment, Durable Diabetic Equipment and Medical Supplies (b.) (xiv.)	Remove Continuous Passive Motion (CPM) devices from the Durable Medical Equipment and Medical Supplies exclusion example. CPM are mechanical devices that use continuous motion to help straighten and bend limbs. Proposed change: Durable Medical Equipment and Medical Supplies that are provided solely for comfort, personal hygiene and convenience items. Examples of these items include, but are not limited to: xiv.Cold therapy ~~and continuous passive motion devices~~	Quartz	This is **not** recommended. Many studies have shown inconsistent results regarding the effectiveness of CPM, with some finding no significant benefit compared to standard physical therapy. Per Segal: These machines can range in pricing from $700 to $8,000 depending on the device (some are multi-purpose). These machines are not alternatives to physical therapy. We couldn't find much information on the utilization.
5.Exclusion and Limitations A. Excluded Services 22. Travel and Transportation	Add medical evacuation to the exclusions under Travel and Transportation. Proposed change: a. Charges for, or in connection with, travel, except for ambulance transportation as outlined in Section 4.F. Covered Services. This includes but is not limited to meals, lodging and transportation(e.g. medical evacuation).	Quartz	This is **not** recommended. Per Segal feels that the current language would already exclude medical evacuations; therefore, adding this new language would have no impact.
4. Benefits and Coverages F. Covered Services 17. Durable Diabetic Equipment and Related Supplies	Move coverage of Continuous Glucose Monitoring Devices solely under the pharmacy benefit. Proposed change: Durable diabetic equipment includes automated injection devices, ~~continuous glucose monitoring devices,~~ and insulin infusion pumps.	Quartz, Group Health Cooperative-Eau Claire, and HealthPartners	This is recommended. Currently CGMs are covered under both medical and pharmacy benefits. Under the medical benefit CGMs are durable medical equipment with a 20% coinsurance after deductible and under pharmacy they are covered on tier 2 with a 20% copay ($50 max). It is an industry standard that CGMs be covered under pharmacy benefits. We are one of our health plans only clients that still cover CGMs under health plan. Per DAISI analysis, most of the cost to CGMs already allocated under pharmacy. Segal's prior analysis of moving CGMs from the medical benefit to the pharmacy benefit estimated that cost of each CGM was about $1,000 and there could be a shift of about $0.5 million from the medical to pharamcy benefit. There are limited rebates available under the pharmacy beneft that the Board could realize. We will work with our health plans to inform members and prescribers of this change shortly after the Board votes and again during/close to open enrollment.
5. Exclusions and Limitations A. Exlcuded Services 13. Other Non-Covered Services	Add penile implants for treatment of erectile dysfunction to the exclusions under Other Non-Covered Services. Proposed Language: g. Penile implants for treatment of erectile dysfunction.	Quartz	This is **not** recommended. Utilization is low and the Certificate of Coverage is silent to allow health plans to determine if medically necessary

4. Benefits and Coverages F. Covered Services 32. Physical, Speech and Occupational Therapy	Add a limit of a maximum benefit of 50 visits for all therapies combined under Physical, Speech, and Occupational Therapy. This would remove the language that up to 50 additional visits may be available with Prior Authorization. Proposed change: Up to 50 visits per Participant for all therapies combined are covered per calendar year. Your Health Plan may review utilization and clinical information during the initial 50 visits to verify medical necessity (See Section 4. E. Disease Management, Prior Authorizations, and Utilization Review for additional information). ~~Additional visits may be available with Prior Authorization from your Health Plan, up to a maximum of 50 additional visits per therapy, per Participant, per calendar year.~~	Quartz	This is **not** recommended. Currently, prior authorization is not required for the first 50 visits. After 50 visits prior authorization is required and health plans can determine if additional visits are medically necessary.
4. Benefits and Coverages F. Covered Services 8. Biofeedback	Expand specific conditions (fecal incontinence, chronic constipation, and refractory severe tinnitus related to mental health parity) under Biofeedback to align with evolving evidence and member need. Proposed change: Biofeedback is covered when provided to treat the following conditions: a. Headaches b. Spastic torticollis c. Urinary incontinence d. Fecal incontinence e. Chronic constipation f. Refractory severe tinnitus related to mental health parity Biofeedback is not covered for treatment of any other conditions; see Section 5. Exclusions, for additional information.	Quartz	This is recommended. National health plans, as well as current GHIP health plans within their commerical plans, already cover these conditions. These conditions are considered medically necessary.
4. Benefits and Coverages F. Covered Services 28. Mental Health and Substance Use Disorder Services	Specifically naming Pathological Gambling under Covered Services. Quartz would like clarification if Pathological Gambling is covered under routine Behavioral Health benefits. Quartz covers behavioral health care for this diagnosis within all other Commercial products.	Quartz	This is **not** recommended. Pathological gambling is considered a behavioral addiction and mental health condition. Following the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, services to diagnose and treat mental health and substance use disorder are covered by the GHIP.
4. Benefits and Coverages F. Covered Services 23. Home Care Benefits	Add clarification regarding coverage of International Normalized Ratio (INR) Anti-Coagulation Home Monitoring. Quartz requests clarification on as to whether INR Anti-Coagulation Home Monitoring is a covered benefit. Currently, home INR monitoring is not covered by Quartz Commercial products.	Quartz	This is **not** recommended. No change needed at this time. Certificate of Coverage is silent to allow health plans to determine if medically necessary.
4. Benefits and Coverages F. Covered Services 46. Transplants	Add uterus and hair to the exclusions under Transplants. Quartz requests clarification on what is not covered for transplanation, including uterus and hair as not covered benefits.	Quartz	This is **not** recommended. No change needed at this time. Certificate of Coverage is silent to allow health plans to determine if medically necessary.
4. Benefits and Coverages F. Covered Services Adding new benefit to cover Acupuncture	Add acupuncture as a covered benefit for the following eligible diagnoses: treatment of nausea/vomiting when associated with pregnancy, chemotherapy, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Proposed Language: Acupuncture services are covered only when: • Provided for the treatment of nausea/vomiting when associated with pregnancy, chemotherapy, or for the treatment of chronic pain, including migraine or tension headaches, fibromyalgia, chronic neck and back pain, knee pain due to arthritis, or myofascial pain. Acupuncture is not covered for the treatment of any other conditions; and, • Obtained from licensed acupuncture providers or licensed physicians. Coverage is limited to 12 visits per benefit period.	Quartz	This is **not** recommended. Exclusion was previously removed to allow plans the ability to consider covering acupuncture under the Alternate Care Provision in appropriate cases. There are also concerns regarding network availability of licensed providers.
5. Exclusions and Limitations A. Excluded Services 4. Durable Medical Equipment, Durable Diabetic Equipment and Medical Supplies	Add speech generation devices for persons with a permanent severe expressive speech disability to Covered Services with prior authorization.	Quartz	This is **not** recommended. Speech Generating Devices are hand-held electronic devices that play words or phrases that help people with speech/ communication issues, and they are mainly used by children. Coverage for Speech Generating Devices already exists when determined medically necessary. Currently, under exlusion and limitions "alternative communication devices (for example, electronic keyborad for hearing impairment) is not covered. Per Segal: Speech Generating Devices can be very pricey costing hundreds or thousands of dollars. A child should see a pathologist to determine the most suitable device. There are cheaper options available such as text-to-speech apps on a tablet. The utilization rate is very low with an estimation that .12% of the population may need an SGD, with only 11,000-12,000 being sold annually. Assuming a cost of around $1000 per machine and this very low utilization rate, we expect a small cost ranging up to $350K.
4. Benefits and Coverages F. Covered Services 38. Reproductive Services and Contraceptives (a.)	Add language to specifically name prenatal and postnatal care to Reproductive Services and Contraceptives. Proposed Language: Routine prenatal care and exams, and routine postnatal care are covered. This includes health exams, assessments, education and counseling relating to the period immediately after childbirth. Maternity services for prenatal and postnatal care are covered, including services such as normal deliveries, ectopic pregnancies, cesarean sections, abortions allowable under Wis. Stat. §40.03 (6) (m), and miscarriages.	HealthPartners	This is not recommended. Current language states maternity services for prenatal and postnatal care are covered.
4. Benefits and Coverages F. Covered Services 18. Durable Medical Equipment and Medical Supplies	Adjust language in Durable Medical Equipment and Medical Supplies to remove Prior Authorization requirement. Proposed change: All **Durable Medical Equipment** purchases, or monthly rentals ~~must~~ may have **Prior Authorization** as determined by your **Health Plan**.	HealthPartners	This is recommended. Will update language to allow flexibility in authorization.
4. Benefits and Coverages F. Covered Services 48. Vision Services	Remove benefit differential for what are considered preventive eye exams based on age. Current Language: Vision screenings for Participants aged 5 and younger are considered preventive and are not subject to Deductible or office visit Copayments when provided by an In-Network Provider. Vision screenings for Participants aged 6 and older are not considered preventive and are subject to Deductible and specialty Provider office visit Copayment as applicable.	HealthPartners	This is **not** recommended. Current language follows ACA and USPSTF. Would be a cost to change benefit.
7. Member Rights and Responsibilities F. Proof of Claim	Adding clarity by removing "as soon as reasonably possible" and giving discretion to the Department/ETF. Proposed change: Claims for services must be submitted to the Health Plan/and or PBM within 12 months, or later, as determined by the Department. If the Health Plan/and or PBM does not receive the claims within 12 months, the Health Plan/and or PBM may deny coverage of the claims.	Ombudsman Services	This is recommended. Will update clarifying language.

4. Benefits and Coverages F. Covered Services Adding new benefit to cover Couples and Marriage Counseling.	Adding Couples/Marriage Counseling to Covered Services. Coverage for our spouses and ourselves is though. I humbly ask that staff looks into adding this since divorce rates are high with our jobs. I am a peer supporter and a large number of the discussions I have involve trouble at homes with significant others. I believe the state has a golden opportunity to help retain staff and help reduce mental anguish.	Member	This is **not** recommended. Family Counseling is covered when part of developing or supporting a treatment plan under Mental Health and Substance Use Disorder Services. Per Segal: 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 $250 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.
4. Benefits and Coverages F. Covered Services 7. Bariatric Surgery	Adding coverage for tummy tuck after Bariactric Surgery.	Member	This is **not** recommended. Per Segal: According to data from Merative, about 240 members annually are tagged with the CPT Code "43775", which is the code for Bariatric Surgery. According to studies, about 6% of people who had Bariatric Surgery choose to have an abdominoplasty (tummy tuck). The average cost of a tummy tuck in Wisconsin is about $8632. If the plan covers this benefit, we could see higher utilization. Segal estimates this cost to be $125K-$250K depending on the utilization of members getting a tummy tuck after bariatric surgery.
4. Benefits and Coverages F. Covered Services 32. Physical, Speech, and Occupational Therapy	Limit 25 visits per discipline (Physical, Speech, and Occupational Therapy). Currently the Certificate of Coverage has up to 50 visits per Participants for all therapies combined.	Network Health	This is **not** recommended. Improvements may need more than several months and there is no clear way to determine if guaranteed improvement can be made within 25 visits. Therefore, it would not be appropriate to limit coverage automatically.
5. Exclusions and Limitations A. Excluded Services 14. Reproductive Services	Add or exclude services related to the diagnosis of sexual dysfunction. Currently the Certificate of Coverage is silent.	Dean Health	This is **not** recommended. Segal cost analysis: According to Merative Data, there were around 550 office visits dealing with Sexual Dysfunction totaling about $95K in 2022. Each visit was on average about $170. Since sexual dysfunction claims are already in the data, it seems that at least some of the plans are covering this benefit. National statistics show that around 30% of adults suffer from sexual dysfunction, with only about 25% of those adults seeking treatment. The cost would be no more than $3M if ETF's utilization followed the national statistics. However, it's unclear what proportion of these would be treated through emerging online companies (HIMS, Roman, etc.) instead of a doctor.
5. Exclusions and Limitations A. Excluded Services 23. Weight Loss, Diet Programs, and Food or Supplements	Add coverage for medical food (enteral feeding). This is intended for specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.	Member	This is **not** recommended. Typically food products are not covered as a part of the GHIP, outside of those provided in a hospital setting. ETF recognizes that there may be instances where bolus feeding may be the most cost-effective treatment option for a condition and would be covered when medically necessary. Food or food supplements are not covered except when provided during a covered outpatient or impatient confinement.

Proposed Changes to Employer Manuals

Proposed Change	Description	Requested By	Recommendation
State Agency Health Insurance Standards, Guidelines and Administration Employer Manuals	Clarify PCP requirement language. Question: how to handle requests from members to change health plans when they learn they've selected a PCP in a plan that doesn't include them. An example is someone who selected Quartz UW but wants to see doctors at Quartz-Central or Quartz-West. Proposed Language: If a SUBSCRIBER files an application during a prescribed enrollment period listing a PCP/PCC that is not in-network with the selected HEALTH PLAN, the HEALTH PLAN must notify the SUBSCRIBER within five business days and aid the PARTICIPANT in selecting an in-network PCP/PCC. If the SUBSCRIBER is not responsive to the HEALTH PLAN'S efforts, the HEALTH PLAN will assign a PCP/PCC, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP/PCC. In the event a SUBSCRIBER chose the wrong HEALTH PLAN, they ~~files an application during a prescribed enrollment period listing a plan and a primary physician, clinic or care system that is not available in the plan selected, the HEALTH PLAN shall immediately notify the EMPLOYER. The SUBSCRIBER shall~~ may be allowed to correct their ~~plan~~ selection to one which has that physician or clinic available or to change physician or clinic selected, upon notice to the EMPLOYER that the error occurredand as approved by ETF. The HEALTH PLAN change ~~application~~ shall be effective the later of first of the month following receipt of the application or the EFFECTIVE DATE of the original application.~~The HEALTH PLAN may not simply reassign a primary physician or clinic.~~	Employer	This is recommended. Manual updated to align with Certificate of Coverage 4.F.35. Health Plans are bound by the Certificate of Coverage. This Employer Manual change is for the information of employers.

Proposed Changes to Schedule of Benefits

Proposed Change	Description	Requested By	Recommendation
All Schedule of Benefits (SoBs) Emergency and Urgent Care	Clarify member cost share for Emergency Care	HealthPartners	This is not recommended. The requested proposed is a non-issue and has been resolved.
All Schedule of Benefits (SoBs) All Health Benefits Decision Guides Emergency Care	Remove the language stating the ER copay is waived if admitted for observation for 24 hours or more. Proposed change: The copayment is waived if you are admitted as an inpatient ~~or for observation for 24 hours or more~~.	Quartz	This is not recommended. Observation status refers to a condition that healthcare providers want to monitor to see if the individual requires inpatient admission. Removing this benefit would move the cost ($60-$75 depending on plan design) onto the members.
ALL Schedule of Benefits (SoBs)	Increase cost shares to address medical and Rx inflationary pressures.	Dean Health	Line 59-76 are outlined in the Cost Sharing and Benefit Reduction Considerations section of the 2026 Final Benefit Changes memo.
Deductible/Coinsurance (All Plans)			
IYC Health Plan Deductible $250/$500	Increase deductible by a minimum of $250 Proposed change: $500/$1000	Dean Health	Per Segal: Segal estimates that a deductible increase of $250 would decrease the Actuarial Value of the plan by 1.2%, which is equivalent to estimated annual savings of $12.7M. Segal estimates that a deductible increase of $500 would decrease the Actuarial Value of the plan by 1.9%, which is equivalent to estimated annual savings of $20.6M. Segal estimates that a deductible increase of $750 would decrease the Actuarial Value of the plan by 2.5%, which is equivalent to estimated annual savings of $27.0M.
IYC OOPL $1,250/$2,500	Increase OOPL a minimum of $500/$1,000 Proposed change: $1,750/$3,500	Dean Health	Per Segal: Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.8%, which is equivalent to estimated annual savings of $8.1M.
IYC 10% Coinsurance	Increase to 20% coinsurance Proposed change: Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible ~~except for Durable Medical Equipment and Medical Supplies~~. You pay: ~~10~~ 20% after deductible is met Plan pays: ~~90~~ 80% after deductible is met	Dean Health	Per Segal: Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.7%, which is equivalent to estimated annual savings of $7.9M.
HDHP 10% Coinsurance	Increase to 20% coinsurance Proposed change: Medical Coinsurance The percentage of costs for a covered service you pay after meeting your deductible except for Durable Medical Equipment and Medical Supplies. You pay: ~~10~~ 20% after deductible is met Plan pays: ~~90~~ 80% after deductible is met	Dean Health	Per Segal: Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.4%, which is equivalent to estimated annual savings of $917K.
HDHP OOPL/MOOP $2,500/$5,000	Increase a minimum of $500 Proposed change: $3,000/$6,000	Dean Health	Per Segal: Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.8%, which is equivalent to estimated annual savings of $1.6M.
Access Plan OON OOPLs (non-HDHP State and PO6.16)	Current OOPL is $500/$1,000 deductible, 70%/30% coinsurance to $2,000/$4,000 maximum OOPL.	Dean Health	Per Segal: Typically, plans keep the same relationship between in-network benefits and out-of-network benefits when they make plan design changes. Since the current ratio for OOPL's between in-network and out-of-network is 1.6X, Segal recommends increasing the out-of-network OOPL by $800 if the in-network OOPL is increased by $500.
Access Plan OON OOPLs (HDHP State and PO7.17)	Current OOPL is $2,000/$4,000 deductible, 70%/30% coinsurance to $3,800/$7,600 maximum OOPL.	Dean Health	Per Segal: Typically, plans keep the same relationship between in-network benefits and out-of-network benefits when they make plan design changes. Since the current ratio of OOPL between in-network and out-of-network is 1.52X, Segal recommends increasing the out-of-network OOPL by $750 if the in-network OOPL is increased by $500.
For Local Employer Groups:			
HDHP	Offer a higher deductible HDHP with a higher OOPL/MOOP	Dean Health	Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.8%, which is equivalent to estimated annual savings of $1.6M.
PO2/PO12 (Traditional Full Pay)	Request to mirror State offering eligibility - Medicare Prime only; eliminate ability to offer as primary plan election for all active employees	Dean Health	This is not recommended. This program option is very popular with local employers and their employees. Dean is asking that it no longer be offered to non-Medicare members. Local employers will likely not approve of this change. Some may leave the GHIP.
PO4/PO14 ($500 Deductible)	Add 20% coinsurance after deductible; increase deductible to $750	Dean Health	Per Segal: Segal estimates that this plan change would decrease the Actuarial Value of the plan by 10%, which is equivalent to estimated annual savings of $13.0M. Currently, this plan does not have an OOP Max. Because of coinsurance after the deductible, there would be a need for an OOP Max. Thus, we assumed the federal OOP Max ($9450/$18900) as the OOP Max for this plan.

Access Plan OON OOPLs (Traditional PO2.12)	Current OOPL is $500/$1,000 deductible, 80%/20% coinsurance to $2,000/$4,000 maximum OOPL.	Dean Health	Per Segal: The recommended out of network OOP increase would be based on the in-network OOP increase. Typically, plans keep the same relationship between in-network benefits and out-of-network benefits when they make plan design changes. Since the current ratio for OOPL's between in-network and out-of-network is 1.6X, Segal recommends increasing the out-of-network OOPL by $800 if the in-network OOPL is increased by $500.
Access Plan OON OOPLs (Deductible PO4.14)	Current OOPL is $1,000/$2,000 deductible, 70%/30% coinsurance to $4,000/$8,000 maximum OOPL.	Dean Health	Per Segal: The recommended out of network OOP increase would be based on the in-network OOP increase. Typically, plans keep the same relationship between in-network benefits and out-of-network benefits when they make plan design changes. Since the current ratio of OOPL between in-network and out-of-network is 1.52X, Segal recommends increasing the out-of-network OOPL by $750 if the in-network OOPL is increased by $500.
Copay Increases (all plans)			
$15 PCP/$25 Specialist	Increase to $25 copay/Increase to $40 copay	Dean Health	Segal estimates that this plan change would decrease the Actuarial Value of the plan by 0.4%-0.5% depending on the plan, which is equivalent to estimated annual savings of $6.3M.
Request to increase Emergency Room copays to $150, $200.	Current Emergency Room copay is $75 across all plans (except for $60 for P02/P12 and P04/P14).	What would be the impact to claims/premiums and utilization?	Segal estimates that increasing the emergency room copay to $150 would decrease the Actuarial Value of the plan by 0.1%-0.2% depending on the plan, which is equivalent to estimated annual savings of $1.4M. Segal estimates that increasing the emergency room copay to $200 would decrease the Actuarial Value of the plan by 0.1%-0.3% depending on the plan, which is equivalent to estimated annual savings of $2.2M.

Proposed Changes to Well Wisconsin Benefits

Proposed Change	Description	Requested By	Recommendation
Well Wisconsin Changes for Medicare Advantage members	Extend Well Wisconsin Program incentive to Medicare Advantage members	ETF	This is recommended. Members on the Medicare Advantage plan will be able to participate in the incentive program the same as other plan options, which will make this benefit uniform. UnitedHealthcare is in agreement with this addition.
Transition *It's Your Health: Diabetes* to uniform benefit	The recommendation is to remove the "pilot program" status and shift *It's Your Health: Diabetes* into a uniform/standard benefit offering, as administered by the wellness and condition management vendor and pharmacy benefit manager.	ETF	This is recommended. Merative's data analysis has shown positive health, quality, and cost results for this program. Significant costs are not expected to occur with this change.

Proposed Changes Deferred to 2027 Plan Year

Proposed Change	Description	Requested By	Recommendation
III. Program Administration I. Grievances and Appeals 2. Claim Review (b.)	Incorporate language that vendor "pay and educate" members regarding their claim(s) or prior authorization denial. Member is educated on the one-time exception and notified that there will not be any further exceptions made on the same claim for services, regardless of which GHIP Vendor the member is enrolled in the future. Cost Benefit Analysis on cases with low dollar amounts-less than $500.00 and $200.00.	Ombudsman Services	More claims/utilization data needed on claims lower than $500 and $200.
Office of Internal Audit (OIA) performance standards review and suggestions.	Proposed additions to the Program Agreement: Office of Internal Audit (OIA) suggests additions to the Program Agreement that ETF will conduct a periodic review of the performance standards submitted by health plans. ETF will conduct a secondary review of the performance standards submitted by health plans. Add a penalty for late reported performance standards submissions by health plans. Add CAHPS/HEDIS to performance standards report. GHIP health plans report "Claims Processing Accuracy - Procedure" and "Claims Processing Accuracy - Financial" separately rather than in a combined "Claims Processing Accuracy" measure.	ETF Office of Internal Audit	Changes related to a penalty assesment for late reported/submitted performance standards reports, adding CAHPS and HEDIS to the performance standards or changes to the calculation method regarding claims processing will be considered for 2027.
4. Benefits and Coverages F. Covered Services 18. Durable Medical Equipment and Medical Supplies	Adding new benefit coverage for elastic support hose/garments (JOBST). Currently we cover these items under Durable Medical Equipment and Medical Supplies with this caveat: "Elastic support hose, for example, JOBST, when prescribed by an in-network provider (for Access Plan or other PPO Plan Participants, an Out-of-Network Provider may prescribe and provide covered services). Limited to two pairs per calendar year." Starting 1/1/24 CMS has pulled the compression garments to treat Lymphedema out of their general coverage and given them it's own coverage because the garments comes in pieces so I person could wear more than one piece and some pieces are worn during the day and others can be worn at night. Whereas ETF pays for 2 pairs a year. CMS now for Medicare pays for: - Daytime: 3 garments per affected body part every 6 months - Nighttime: 2 garments per affected body part every 2 years. Maybe for 2027 we should pull this coverage and give it its own designation using terminology like "affected body parts" and "garments	Dean Health	Current coverage for elastic support hose (JOBST) included two pairs per calendar year. Utilization data and cost analysis is needed for adding elastic support hose as a separate benefit or increasing the per year limit. Currently over-the-counter JOBST have a cost range of $30-$130 depending on the affected body part. https://www.jobst-usa.com/products/lymphedema/nighttime-compression-products/jobst-jovipak-arm
4. Benefits and Coverages F. Covered Services 18. Durable Medical Equipment and Medical Supplies	Adding coverage specialized contact lenses to Durable Medical Equipment and Medical Supplies. Proposed Benefit Addition: Specialized Contact Lenses for the treatment of degenerative eye diseases in patients 18 years and younger. Benefit: 20% Coinsurance with Benefit Maximum of $500 per eye every two years or as medically necessary.	Ombudsman Services and Member	Current Vision Services cover yearly eye exams. Supplemental vision coverage provides $150 allowance allotted for one transaction per benefit period. Utilization data and cost analysis is needed for specialized contact lenses and adding 20% coinsurance with beneift maximum of $500 per eye every two years or as medically necessary.
4. Benefits and Coverages F. Covered Services 18. Durable Medical Equipment and Medical Supplies	Align Schedule of Benefits (SoBs) and Certificate of Coverage cost sharing to follow Durable Medical Equipment benefit for hearing aids (limit of 1 per ear every 3 years). Health plans would like to **avoid** the unique cost share set-up on hearing aids, as each claim is a manual process. - Member is responsible for deductible, - Then member pays 20% coinsurance, plan pays 80% up to $1,000 - Then the member is responsible for 100% of the remaining total	Network Health	With overhaul of plan designs and the pharmacy benefit RFP, this change to Durable Medical Equipment will be reviewed for 2027.
4. Benefits and Coverages F. Covered Services 23. Home Care Benefits	Update language related to home care benefits. Current language indicates 50 visits with possible 50 more. Security's Health benefit through Contessa is for a 30 day or 60 day episode, which may include multiple visits per day. Current Language: You are eligible for a maximum of 50 visits per calendar year. Fifty additional visits per calendar year may be available when Prior Authorization is received from the Health Plan.	ETF	Security's benefit is within scope of the current benefit at 15 visits on average. ETF can seek additional feedback from health plans on whether their benefit is driven by visits or days for 2027.
4. Benefits and Coverages F. Covered Services 30. Oral Surgery and Other Dental Services	Add sleep apnea as an eligible diagnosis to Orthognathic Surgery under Oral Surgery and Other Dental Services. Proposed Language: I. Orthognathic surgery for the correction of a severe and handicapping malocclusion determined by a minimum Salzmann Index of 30 or sleep apnea.	Quartz	More claims/utilization data needed to further assess cost implication. Per Segal: According to studies, sleep apnea is prevelent in about 13%-25% of men and 6%-10% of women. Studies also show that pharyngeal procedures are performed more commonly than jaw procedures (95% vs 5% jaw surgeries in the study). Thus, the prevelence for this surgery is rare and the cost is also very expensive. According to Merative data, there has been a total of $1M in incurred claims and around 100 visits the last 2 years in the ETF population dealing with Orthognathic surgery. The average cost of this surgery the last 2 years in ETF's population has been close to $10K. Segal estimates that the annual cost impact will be around $300K-$1M depending on how many members elect for the surgery. Most insurances cover it when medically necessary. This procedure should be a last resort after other treatment options have been explored.