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Correspondence Memorandum

Date: April 26, 2018

To: Group Insurance Board

From: Renee Walk, Strategic Health Policy Advisor
Jeff Bogardus, Manager of Pharmacy Benefit Programs
Office of Strategic Health Policy

Subject: 2019 Health & Pharmacy Program Changes

The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) approve the following:

- **Changes to the Health Program Agreement (Agreement), Uniform Benefits, and pharmacy benefits described below for benefit year 2019.**
- **Select pilot programs offered by Quartz and WEA Trust for further development and implementation in 2018 and 2019.**
- **Changes to the 2018 health program agreement to remove remaining requirements only necessary for a self-funded program.**

Background

At the February meeting ETF staff presented initial proposed changes for benefit year 2019 (Ref. GIB | 2.21.18 | 4B) to the Board as *concepts* in order to gather preliminary input on possible changes to the health and pharmacy benefit programs. This early initial review follows the timeline for the improved input process, implemented by ETF and the Board, which is designed to provide ample opportunity for multiple stakeholders to provide input on changes.

Following that meeting, staff reviewed potential program changes with employer groups via webinar and individual discussions. Staff also received review of benefit change impacts from the Board's actuary, Segal Consulting (Segal), and the health plans participating in the Board's programs. Per the Board's request, health plans provided cost and member impact estimates where possible for each of the proposed changes. Staff used this information to inform an initial set of recommendations. Segal provided the same information and validated health plan estimates across the population.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 5/7/18

Board	Mtg Date	Item #
GIB	5.16.18	4A

Additional Required Cost Savings
In addition, ETF indicated to the Board at the February meeting that it may be necessary to seek additional cost savings through benefit plan design changes in order to meet requirements set forth by the Legislature. However, upon review and consultation with the Department of Administration (DOA) of those requirements and the savings achieved by plan negotiations and the release of reserves, ETF does not anticipate needing benefit changes in order to reach savings targets, pending review of 2019 health plan bids. ETF has adjusted recommendations accordingly.

Recent State Legislative Changes
Two new state law changes affect the Board's programs for 2019: WI Act 191, regarding the prohibition of the Board contracting for abortion services; and WI Act 305, regarding required refill thresholds for prescription eye drops.

WI Act 191 prohibits the Board from "contracting for or providing abortion services," that are ineligible for funding under Wis. Stats. §20.927. This law limits abortion services to those that are medically necessary to save the life of the woman or those that are the result of sexual assault. The Board's current Uniform Benefits only allow for "therapeutic abortions," and this has been historically interpreted to mean abortions that are medically necessary. ETF recommends updating the language of Uniform Benefits, to incorporate statute requirements. The Board's current health program agreements require that participating vendors adhere to all state and federal laws in the provision of services to the Board.

WI Act 305 requires disability insurance policies to cover prescription eye drop refills when 75% or more of the days have elapsed from when the prescription was most recently filled, as long as the prescription allows for refill. The Board's Pharmacy Benefit Manager (PBM) currently enforces a refill threshold of 70% of days elapsed before a refill may be requested at a retail location; the threshold is lower for mail order, to allow for delivery time. ETF recommends no change to the language of Uniform Benefits, as the current refill threshold already supports the change in statute. The Board's current health program agreements require that participating vendors adhere to all state and federal laws in the provision of services to the Board.

Proposed Agreement Changes
ETF continues to recommend all administrative changes to the Agreement submitted with the initial February memo. In addition, ETF recommends the following additional changes:

- **Password security requirements**: During Medicare Advantage plan negotiations, staff reviewed the password security requirements contained in the Agreement. As a result, ETF recommends modifying the password change requirements to every sixty (60) days from ninety (90), and to limit repeating passwords to every ten (10) from every twenty-four (24). ETF information technology staff indicate that these are in line with current security standards.

- **Annual plan onboarding process**: ETF recommends replacing the SOC 1, Type 2 audit requirement with an annual program onboarding process that will include verifying that claims systems have been set up correctly at the beginning of the benefit year. This process will be developed by staff in cooperation with the plans.
- **Fraud and abuse plan monitoring**: The current Agreement requires that plans receive sign-off from staff on fraud, waste, and abuse plans. However, in a fully insured program environment, the health plan carries the risk for completing fraud, waste, and abuse evaluation. Therefore, ETF recommends changing the requirement to ask that plans attest to having a fraud, waste, and abuse plan, and to provide reporting on any material findings to the Department.
- **Reducing paper submissions**: The current contract requires fifteen hard copies to be delivered with any new plan proposal; staff proposes limiting this to only five copies to reduce waste.
- **Monitoring low-value services**: ETF proposes adding a requirement to the Department Initiatives section of the contract that says plans must review a list of services that have been identified through literature review as potentially low value. Additional development of this requirement will be developed in a CHPI meeting this summer. Staff plans to use research by the University of Michigan's Value Based Insurance Design Institute as a starting place and would study the prevalence of these services in the Board's population. Health plans would report on the frequency of these services as well as potential impacts of changing coverage in future years. Any proposed changes to benefits derived from this process would come to the Board through the annual review process.
- **Double coverage limitations**: Under the current agreement members are not allowed to elect coverage under more than one group health insurance program policy. However, the contract does not give ETF any means by which to correct double coverage if the member does not elect a plan within the 30-day correction window given. Additional language will allow ETF to select a plan for the member if he or she does not choose either plan prior to the 30 days having elapsed.

A summary of all proposed agreement language changes by section is provided in Attachment A to this memo.

Proposed Health Uniform Benefit Changes

Following the review of health plans, stakeholders, and Segal, ETF recommends a shorter list of changes for the 2019 plan year than was initially proposed in February. The following list includes Segal's inset estimates of the fiscal and member impact of the changes:

- **Add telehealth benefit category**: ETF recommends covering this benefit at 100% plan cost for non-HDHP members. HDHP members would pay the full cost until the plan deductible was met.
    - *Fiscal Impact:* none
    - *Member Impact:* unavailable, though plans are known to currently cover for the health program members.

- **Move extraction of erupted teeth to dental benefit**: ETF recommends this change to follow industry standard coverage.
    - *Fiscal Impact:* none, will be assumed into Uniform Dental
    - *Member Impact:* unavailable
- **Contact lenses for keratoconus**: This change will allow members with keratoconus to obtain an initial set of hard lenses through the medical plan. The intent is to reduce the number of surgeries that result from not having contact lens correction.
    - *Fiscal Impact:* Additional cost of less than $200,000 (surgery avoidance not included)
    - *Member Impact*: 83 members in available data with diagnosis
- **Exclude removal of skin tags**: The current lack of explicit exclusion means that some skin tags are paid, and others require medical review before denial. Nearly all are cosmetic procedures.
    - *Fiscal Impact:* Savings estimated at $50,000 - $150,000
    - *Member Impact*: 850 claims in plan year
- **Annual limit for foot orthotics**: This change would limit the number of unnecessary prescriptions for custom orthotics received each year.
    - *Fiscal Impact:* Data insufficient to determine, but expected to be minimal
    - *Member Impact:* Unavailable
- **Add coverage of home sleep studies**: Many plans indicated that they cover these, since it is not specifically excluded; however, affirmative coverage may encourage more routing of members to this service as appropriate.
    - *Fiscal Impact:* Savings estimated at $400,000 - $800,000
    - *Member Impact:* Estimated 1,350 members could be diverted to home studies from lab
- **Revision of transplant coverage language**: This change removes clinically-specific language from Uniform Benefits, removes the prior authorization requirement for cochlear implants; and removes the per-member, per-plan, per-lifetime transplant limit. The change is intended to defer to health plan medical staff in determining appropriate coverage and to align more closely with industry standards for prior authorization and exclusions.
    - *Fiscal Impact:* None expected, data is minimal
    - *Member Impact:* Insufficient to project, but not expected to affect utilization
- **Returning local retiree eligibility for program**: Several years ago, the Board disallowed local program retirees from re-entering the program if they left post-retirement. Some local government employers want to provide this coverage to their retirees, and the coverage is paid for either by local accumulated sick leave or by the retirees themselves. Allowing this change would improve the local program experience for some local employers and retirees.
    - *Fiscal Impact:* None (retirees or locals pay cost of program)
    - *Member Impact:* Estimated 254 local retirees over five years

In addition to these changes, ETF recommends several other changes included in Attachment B to this memo that are designed to increase compliance with federal and

state law. These changes are not expected to have a material impact on costs or members, as they affirm the current policy of the Board.

The remaining benefit changes brought to the Board in February are not recommended for the 2019 benefit year. Some would result in an increased cost to the Board's program; others would result in some savings, but also in uncertain member impact. Given the Board does not need to pursue additional program savings in 2019, ETF recommends not pursuing additional changes.

Proposed Pharmacy Benefit Changes

In addition to the above changes to health Uniform Benefits, ETF identified several potential changes to the pharmacy benefit. ETF recommends proceeding with the following changes:

- **Carve-out Uniform Pharmacy Benefit (UPB) language**: The intent of this change is to align the pharmacy contract more closely with the Board's other carved-out benefits, such as dental, and to better reflect how the program has been administered. The change will also make it easier for staff to update contracts with vendors, and to draw distinctions between which vendor should cover a particular benefit in cases where there could be perceived overlap. There will be no change to member benefits as a result of this modification.
    - o *Estimated fiscal impact:* none
    - o *Estimated member impact*: none
- **Increase cost-sharing for Level 3 "DAW-1" drugs**: When a physician prescribes a "DAW-1" or "dispense-as-written-code-1" drug, the physician is indicating to the pharmacy and the pharmacy benefit plan that the drug may not be substituted for anything else on the formulary. In many cases, these prescriptions are for non-preferred, brand-name drugs that are currently covered at Level 3 on the Board's drug formulary. These drugs have no generic equivalent but may still have alternatives that are preferred on the formulary.

  A member whose physician writes a prescription to be dispensed as written for one of these drugs currently can get the drug at a 40% coinsurance, up to $150. Under the proposed change, this would increase to the current coinsurance plus the difference between the cost of the alternative drug available at a lower coverage level. This results in the member paying nearly full price for the medication.

  ETF recommends this change to further encourage members who can take a lower-cost, preferred alternative medication to do so. However, if a member cannot take an alternative medication for medical reasons, their provider may submit a Food & Drug Administration (FDA) MedWatch form to the Board's pharmacy benefit manager (PBM), detailing why the member cannot take an alternative medication. Once this form is submitted to the PBM, the member will again be able to fill the prescription at the 40% coinsurance rate without the additional cost differential.

  - *Estimated fiscal impact:* savings of $1.6M for the period June 1, 2017 through November 30, 2017
  - *Estimated member impact:* 803 members for the period June 1, 2017 through November 30, 2017
- **Value-based plan design for chronic conditions:** ETF recommends proceeding with the value-based plan design for chronic conditions that are managed by StayWell, the Board's wellness vendor. StayWell and the Board's PBM, Navitus Health Solutions (Navitus), have prior experience in designing and implementing cost sharing reduction programs for members who adhere to a disease management protocol. ETF proposes implementing such a program for members with diabetes who participate in a StayWell diabetes program. The program would be designed similarly to one implemented in the State of Minnesota in 2015; staff are working to establish a partnership with Minnesota's employee health program to evaluate the implementation and impact of such a program. Staff are also investigating whether additional disease states or medications should be included in a value-based plan design program, and will return any additional recommendations to the Board in August.
  - *Estimated fiscal impact:* undetermined
  - *Estimated member impact:* 4.2% of population reported having diabetes in Q1 2018, per StayWell disease management report

ETF also proposed these changes to the pharmacy benefit program at the February meeting: increasing the out of pocket limit (OOPL) for prescription drugs and modifying the benefit for Medicare-eligible members to increase the amount of federal subsidy available to the program. We have since determined that the impact to members in both out-of-pocket costs and communications challenges made these changes not feasible for 2019.

Proposed Health Plan Pilot Programs

As part of the annual process for gathering plans' requests for program changes, ETF gave plans the opportunity to propose disease and case management programming pilots that may benefit participants. Pilots were required to be prior implemented in some way in the health plan's commercial population, to focus on an area where health program membership shows particular need for support, and to offer the potential for future cost savings. Two plans – Quartz and WEA Trust -- proposed pilots by the due date.

Both Quartz and WEA Trust proposed offering access to Kiio (branded MobileBack through Quartz) to group health insurance program participants. Kiio offers members with low back pain a mobile application that guides the member through exercises that reduce pain and build strength. The exercises contained in the Kiio program are evidence-based; initial reports from both plans show high member satisfaction with outcomes. ETF recommends implementing this program in 2018. If approved, we will return an implementation timeline with the technical updates memo provided to the Board in August.

In addition to Kiio, WEA Trust also proposed offering the Livongo diabetes program. The Livongo program provides cellular-connected diabetes meters and test strips by home delivery to members with diabetes who opt into the program. The meter itself provides feedback to the participant on when to take glucose readings and what to do if a reading is out of range. Members who are severely out of range receive contact from a Livongo certified diabetes educator by phone. Participants can also opt to schedule coaching time with a diabetes educator to learn more about managing their condition. ETF recommends implementing this pilot program in January 2019. If approved, we will return an implementation timeline with the technical updates memo provided to the Board in August.

Per the terms of the contract, both programs must be offered at no additional charge to the Board.

2018 Agreement Changes

ETF requests the Board approve changes to the 2018 contract to remove the remaining requirements that are only applicable in a self-insured program. These reports include:

- Non-discrimination testing
- Quarterly out-of-network claims report
- Hospital bill audit
- SOC I, Type 2 reporting

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

Attachment A. 2019 Health Program Agreement Proposed Changes

Description of Change Requested	ETF 2018 Contract Reference	Original Language	Proposed Change / Language
Rate-setting process	130B	The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any rate or take other action up to and including limiting new enrollment with the CONTRACTOR when the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.	The CONTRACTOR must submit rate bid(s) for the following benefit year as directed by the DEPARTMENT. The CONTRACTOR's sealed bids are submitted in the format as specified by the DEPARTMENT. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserved the right to reject any rate, limit new enrollment with the CONTRACTOR, or take other action as appropriate if the BOARD'S consulting actuary determines the CONTRACTOR has failed to include adequate documentation on the development of rates.
TTY Line	140A c)	TTY note in non-discrimination statement	CLARIFICATION: TTY is one example of an acceptable approach to providing accessible phone service. If plans offer another service please notify the Health Program Manager, and ensure that your notice either clearly denotes the separate accessible phone number or instructs members how to access using the main phone line

Information Systems; password security requirements	145 4) c) and d)	c) Requires users to change passwords at least every ninety (90) days, d) Does not repeat any of the last twenty-four (24) passwords used,	c) Requires users to change passwords at least every sixty (60) DAYS, d) Does not repeat any of the last~~twenty four (24)~~ ten (10) passwords used,
Clarify enrollment discrepancy modifications	150A 4) a)	a) The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt. The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.	The CONTRACTOR must resolve all enrollment discrepancies (any difference of values between the DEPARTMENT'S database and the CONTRACTOR'S database) outside of the exception report described in item b) below as identified within one (1) BUSINESS DAY of notification by the DEPARTMENT or identification by the CONTRACTOR.
Remove nondiscrimination testing requirement	155C	155C Nondiscrimination Testing The CONTRACTOR shall work in conjunction with the DEPARTMENT or its designee to complete Internal Revenue Code (IRC) Sec. 105 (h) compliant nondiscrimination testing for the DEPARTMENT at least annually. The DEPARTMENT or its designee will provide a schedule, process for testing, and data requirements. The CONTRACTOR shall complete any necessary requirements by the due date(s) specified by the DEPARTMENT or its designee.	(Remove text)

Contract Termination	155I 1)a)	a) The CONTRACT maximum is reached.	The BENEFIT maximum is reached
Contract Termination	155I 2)	1) If the BOARD terminates this CONTRACT, then all rights to BENEFITS shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include,but are not limited to: transferring the patient to another facility; billing the BOARD a fee for service rendered; or permitting out-of-network providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.	1) If the BOARD terminates this CONTRACT, then all rights to BENEFITS provided by the CONTRACTOR shall cease as of the date of termination. The CONTRACTOR will cooperate with the BOARD in attempting to make equitable arrangements for continuing care of PARTICIPANTS who are INPATIENTS on the termination date. Such arrangements may include,but are not limited to: transferring the patient to another facility; ~~billing the BOARD a fee for service rendered;~~ or permitting out-of-network providers to assume responsibility for rendering care. The overall intent is to be in the best interest of the PARTICIPANT.
Allow primary care clinic (PCC) and primary care physician (PCP) to meet designation criteria	210	Primary Care Provider [entire section]	Subscribers and Dependents shall be required to select a primary care provider (PCP) or a primary care clinic (PCC).

Updates to PCP language	210		The CONTRACTOR must monitor all PARTICIPANT records to ensure there is an assigned, INNETWORK PCP at all times. If a PARTICIPANT does not choose a PCP, or the PCP is no longer available, the CONTRACTOR will assign a PCP, notify the PARTICIPANT in writing, and provide instructions for changing the assigned PCP. The CONTRACTOR can assign a temporary PCP when deemed necessary.
ID Card turnaround time	205B	1) The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, except as noted in item 2) below. 2) For elections made during the IT'S YOUR CHOICE OPEN ENROLLMENT period, the CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 10. The CONTACTOR must notify the DEPARTMENT Program Manager of any delays with issuing the ID cards. The CONTRACTOR shall send a written confirmation to the DEPARTMENT Program Manager in January indicating the date(s) the ID cards were issued.	The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, or at least 10 days prior to the effective date of coverage. The CONTRACTOR must notify the DEPARTMENT Program Manager of any delays with issuing ID cards. The CONTRACTOR shall send a written notice to the DEPARTMENT Program Manager following the IT'S YOUR CHOICE OPEN ENROLLMENT period regarding the expected mailing date of ID cards for the following enrollment year, as well as a confirmation email indicating the dates that the ID cards were actually sent.

Nurseline / Telehealth Requirement	220B	220B Telehealth / Nurse Line 1) The CONTRACTOR must provide telehealth services as directed by the DEPARTMENT. 2) The CONTRACTOR must provide a twenty-four (24)-hour nurse line available at no cost to all PARTICIPANTS.	220B Telehealth / Nurse Line The CONTRACTOR must provide access to immediate care services such as telehealth and/or a twenty-four (24)-hour nurse line to PARTICIPANTS. Such services must provide at minimum consultation services that assist PARTICIPANTS in determining whether additional treatment for a condition should be sought. Such consultation services that result in referral to physical site care instead of definitive treatment should be provided at no cost to all PARTICIPANTS.
Remove quarterly requirement to supply out-of-network claims report to department	220C & 305, item 7	The CONTRACTOR must submit to the DEPARTMENT a QUARTERLY report of all claims (including non-urgent and non-emergent) paid to OUT-OF-NETWORK providers that includes the billed amount and amount paid to the provider in the format specified by the DEPARTMENT.	Remove language.

Update emergent care language	220C Emergency / Urgent / Catastrophic Care	The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK or OUT-OF-NETWORK providers at the IN-NETWORK level of benefits. This OUT-OF-NETWORK care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in UNIFORM BENEFITS unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. The CONTRACTOR affiliated with larger nationwide networks may offer coverage through affiliated networks as long as there is no additional cost to the HEALTH BENEFIT PROGRAM or PARTICIPANT for doing so. The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, and/or a transfer to a more suitable facility when appropriate.	The CONTRACTOR must cover emergency and urgent care and related catastrophic medical care received from IN-NETWORK or OUT-OF-NETWORK providers at the IN-NETWORK level of benefits. This OUT-OF-NETWORK care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in UNIFORM BENEFITS unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. The CONTRACTOR must make every effort to settle claim disputes in a reasonable time frame. ~~The CONTRACTOR affiliated with larger nationwide networks may offer coverage through affiliated networks as long as there is no additional cost to the HEALTH BENEFIT PROGRAM or PARTICIPANT for doing so.~~ The CONTRACTOR will work with OUT-OF-NETWORK providers to manage and reduce medical claim costs incurred in emergency and urgent situations. The CONTRACTOR must coordinate care in these situations, including directing care IN-NETWORK, authorizing follow up care on a case-by-case basis, and/or a transfer to a more suitable facility when appropriate. The CONTRACTOR will provide coverage certain mental health services OUT-OF-NETWORK as required by law for college students who are PARTICIPANTS in the HEALTH PLAN.

Clarify carryover of benefit accumulators when changing plans	220J 1)	1) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will continue to accumulate for the benefit period in the following situations: a) If a PARTICIPANT changes the level of coverage (e.g., single to family, but does not change benefit plans, b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change benefit plans. Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will start over at zero ($0) dollars as of the EFFECTIVE DATE of the change in the following situations: a) If a PARTICIPANT changes benefit plans, b) If a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.	1) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will continue to accumulate for the benefit period in the following situations: a) If a PARTICIPANT changes the level of coverage (e.g., single to family) or changes benefit plans, but does not change CONTRACTORS. b) If a PARTICIPANT has a spouse-to-spouse transfer resulting in a change of SUBSCRIBER, but does not change CONTRACTORS. 2) Accumulations to annual medical BENEFIT maximums, medical deductibles, and medical OOPLs under UNIFORM BENEFITS will start over at zero ($0) dollars as of the EFFECTIVE DATE of the change if a PARTICIPANT changes from being a PARTICIPANT of the state program to the LOCAL program, or vice versa.

Provider Access standards, clarifying that Chiros are considered under GeoAccess	230A	In addition to the access standards set forth in Wis. Stat. § 609.22, the CONTRACTOR must meet at least 90% geoaccess in the county for INPATIENT HOSPITALS and PCPs (includes Internal Medicine, Family Medicine and General Medicine) or the following minimum requirements for all counties and major cities in the county to be qualified:	In addition to the access standards set forth in Wis. Stat. §609.22, the CONTRACTOR must meet at least 90% geoaccess in the county for INPATIENT HOSPITALS, chiropractors and PCPs or the following minimum requirements for all countie and major cities in the county to be qualified:
Direct pay premium process	255 / 305 1) / 315E 5)	The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.	The CONTRACTOR must support an Automated Clearinghouse (ACH) mechanism that allows for direct pay PREMIUM to be submitted via electronic funds transfer (EFT). Direct pay PREMIUMS may also be submitted to the CONTRACTOR via mail. If the SUBSCRIBER fails to make required PREMIUM payments by the due dates established by the CONTRACTOR, and approved by the DEPARTMENT, the health care coverage shall be canceled by the CONTRACTOR. The CONTRACTOR must provide written notification to the DEPARTMENT within five (5) BUSINESS DAYS of receiving written notice of cancellation from the SUBSCRIBER or within one (1) month of the effective date of termination due to non-payment of PREMIUM, whichever occurs first. LOCAL ANNUITANTS are irrevocably cancelled, see Section 125E.
Conversion / Marketplace Notification	260C	The CONTRACTOR must provide the SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. § 632.897, and/or a Marketplace plan, in the event of termination of employment.	The CONTRACTOR must provide the SUBSCRIBER, upon request, written notification of how to enroll in a conversion policy set forth in Wis. Stat. 632.897, and/or a Marketplace plan, in the event of termination of employment

Hospital Bill Audit	255D	The CONTRACTOR shall perform a HOSPITAL bill audit program process using guidelines approved by the DEPARTMENT for all HOSPITAL and specialty HOSPITAL claims with charges in excess of two hundred thousand dollars ($200,000) per CONFINEMENT and QUARTERLY provide results of material findings to the DEPARTMENT. The CONTRACTOR will work with the DEPARTMENT to understand and meet their requirements for HOSPITAL bill audits.	Remove text
Audit and Other Services; annual plan onboarding process	155C	At its discretion, the BOARD may require independent third-party audit or review of any function relating to the HEALTH BENEFIT PROGRAM, including a pre-implementation configuration audit. The BOARD may also designate a common vendor which shall provide the annual description of BENEFITS and such other information or services it deems appropriate.	In addition to third-party audits, the CONTRACTOR shall make available prior to the beginning of any benefit year a full description of the configuration of the CONTRACTOR'S claims processing system at the request of the DEPARTMENT. The CONTRACTOR will also certify to the DEPARTMENT that the claims processing system will properly process claims according to the CONTRACT prior to the start of the benefit year.
Audit and Other Services; removing SOC1, Type 2 Audit	155C	The CONTRACTOR shall agree to a Service Organization Control SOC) 1, Type 2 audit of internal controls conducted by an independent CPA firm at the CONTRACTOR'S expense that is in accordance with the Statement of Standard Attestation Engagements (SSAE) 18 and provide a copy of the CPA's report to the DEPARTMENT. The DEPARTMENT will allow time on a case by case basis to provide this information if the CONTRACTOR doesn't currently have a completed SSAE 18 audit. The audit report must be submitted annually	Remove text

Fraud and Abuse; attestation of fraud monitoring plan	155D	The CONTRACTOR, within thirty (30) DAYS of the execution of this CONTRACT, must submit a fraud and abuse review plan to the DEPARTMENT. Upon the DEPARTMENT'S approval of the plan, the CONTRACTOR must perform QUARTERLY (unless another timeframe is agreed upon by the DEPARTMENT) fraud and abuse reviews and provide results of material findings to the DEPARTMENT.	The CONTRACTOR must regularly complete fraud, waste, and abuse review according to a stated plan. Upon execution of this CONTRACT, the CONTRACTOR will attest that such a plan exists, and will provide a written copy of the plan to the DEPARTMENT upon request. The CONTRACTOR must provide results of any material findings to the DEPARTMENT.
Privacy Breach notification	155G		Section removed; covered extensively in Department Terms and Conditions that are signed with all ETF contracts
Department May Designate Vendor	155E	At its discretion, the DEPARTMENT may designate a common vendor who shall provide the annual description of BENEFITS and such other information or services it deems appropriate, including audit services.	At its discretion, the DEPARTMENT may designate a common vendor who shall provide services related to the program as the DEPARTMENT deems appropriate.
Reducing paper in Submission of Proposals	160H 1)	1) Fifteen (15) copies.	1) An electronic copy of all proposal elements. 2) Five (5) paper copies.
Enrollment Files	205A		Combined with Section 150

Remove shared-decisionmaking survey from Department Initiatives	215B	4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.	4) Shared Decision Making (SDM) – The CONTRACTOR must provide a credible SDM program, at a minimum, to PARTICIPANTS who are eighteen (18) years of age and older as part of the prior authorization process for consultation with an orthopedist or neurosurgeon for low back surgery. The SDM program must provide Patient Decision Aids (PDA) that meet the International Patient Decision Aids Standards (IPDAS). The SDM process must include an opportunity for PARTICIPANTS, prior to the procedure date but after receiving the PDA, to discuss a particular intervention with their PCP, care manager or health educator who is trained to have a discussion. ~~and must include a PARTICIPANT satisfaction survey that will be provided to all PARTICIPANTS who receive a PDA.~~
Monitoring Low-Value Services	215B		6) Monitoring of Potentially Low-Value Services – The CONTRACTOR must provide reporting on select services identified by the DEPARTMENT as potentially low value to PARTICIPANTS. The DEPARTMENT will develop the list of services to be studied on an annual basis. The CONTRACTOR will provide analysis of the utilization of services and potential impact of alternate care pathways.
PPOs offering out-of-network benefits	220F	The BOARD may offer different copayment and deductible schedules for OUT OF NETWORK providers	The BOARD may permit CONTRACTORS to offer different copayment and deductible schedules for OUT OF NETWORK providers

Double Coverage	125D	A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the HEALTH BENEFIT PROGRAM (including state and LOCAL). In the event it is determined that a DEPENDENT is covered by two (2) separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have thirty (30) DAYS to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The EFFECTIVE DATE will be the first of the month following receipt of the application.	A DEPENDENT or SUBSCRIBER cannot be covered at the same time by two separate SUBSCRIBERS of the HEALTH BENEFIT PROGRAM (including state and LOCAL). In the event it is determined that a DEPENDENT is covered by two (2) separate SUBSCRIBERS, the SUBSCRIBERS will be notified and will have thirty (30) DAYS to determine which SUBSCRIBER will remove coverage of the DEPENDENT and submit an application to remove the DEPENDENT. The EFFECTIVE DATE will be the first of the month following receipt of the application. If no application is submitted within the thirty (30) DAY period, the DEPARTMENT will designate one PARTICIPANT as the SUBSCRIBER and re-enroll all other PARTICIPANTS as DEPENDENTS.

Attachment B. Uniform Benefit Proposed Changes

Description of Change Requested	ETF 2018 Contract Reference	Change Proposed	Impact Estimate	2019 Recommendation
Add new benefit category for online care at 100% coverage, not subject to deductible	400 - Uniform Benefits I. Schedule of Benefits	Telehealth visits with definitive treatment are generally lower cost than services received at physical sites of care.	Fiscal Impact: none Member Impact: Unavailable	Include
Consider moving the coverage of extraction of infected teeth to the Dental benefit.	400 - Uniform Benefits I. Schedule of Benefits 16) Oral Surgery	Industry standard is to cover extraction of non-erupted teeth in medical plan and erupted teeth in dental plan.	Fiscal Impact: none, moving to UDB Member Impact: Unavailable	Include
Add coverage for contact lenses for the treatment of keratoconus	400 Uniform Benefits, IV. Exclusions & Limitations (11) General (p)	Contact lenses for the treatment of keratoconus is the standard of care; the alternative treatment is corneal transplant.	Fiscal Impact: minimal cost, <$200k, could avoid some surgeries Member Impact: 83 unique cases	Include
Add "removal of skin tags" to Exclusions	400 Uniform Benefits, IV. Exclusions & Limitations, 11) General ad)	This is largely considered cosmetic in nature, but failure to note means that claims must be reviewed for medical necessity.	Fiscal Impact: minimal savings, $50k - $150k Member Impact: 850 claims paid in 2017	Include
Consider limits for custom molded foot orthotics	400 Uniform Benefits, III. Benefits and Services, C (3)(b)	Prefabricated orthotics are often sufficient according to plans; many plans have limitations per year.	Fiscal Impact: None Member Impact: Unavailable	Include

Add coverage of home sleep studies prior to approval of inpatient sleep studies when clinically appropriate	400 Uniform Benefits, III. Benefits and Services	Home sleep studies are less costly and can be appropriate in some circumstances.	Fiscal Impact: minimal savings, $400k - $800k Member Impact: Estimated 1,350 members who would divert to lower-cost home study	Include
Revision of transplant coverage language	400 Uniform Benefits, III. Benefits and Services, A.	Remove clinically-specific language. Remove prior-authorization requirements for cochlear implants. Remove per member per plan per lifetime limits.	Fiscal Impact: None expected, data is minimal Member Impact: Insufficient to project, but not expected to impact utilization	Include
Returning Local Retiree Eligibility	400 Uniform Benefits, I. Definitions	Allow local retirees to return under the Wisconsin Public Employers program.	Fiscal Impact: None Member Impact: Unavailable	Include
Modify residential treatment exclusion to comply with federal mental health parity law.	400 Uniform Benefits, IV Exclusions, 4 (ak)	Clarification that plan complies with the Mental Health Parity and Addiction Equity Act.	No fiscal estimate; reinforcement of current policy	Include
Clarify Medicare Part B coverage requirement when Medicare is primary per federal Medicare Secondary Payer rules.	400 Uniform Benefits, IV Exclusions A (11) (b)	Requesting follow up from plans on how best to coordinate care with members.	No fiscal estimate; reinforcement of current policy	Include

Clarify surrogacy coverage exclusion.	400 Uniform Benefits, IV Exclusions and Limitations	Clarifying to comply with Wisconsin Supreme Court ruling that as long as surrogate is a plan member, coverage cannot be revoked. No follow up requested.	No fiscal estimate; reinforcement of current policy	Include
Remove reference to state's mandatory minimum coverage requirements related to autism spectrum services	400 Uniform Benefits, III. Benefits and Services, C (6)	Clarifying language to remove limit reference; plans indicated this limit is no longer needed.	No fiscal estimate; reinforcement of current policy	Include
Drugs Administered in OP Setting should be paid by health plan	400 Uniform Benefits, III. Benefits and Services, D.	Clarification to appropriate setting.	No fiscal estimate; reinforcement of current policy	Include
Add exclusion for equipment required for telehealth visits	400 Uniform Benefits, IV. Exclusions and Limitations	Adding in coordination with coverage change	No fiscal estimate; reinforcement of current policy	Include
Remove exclusion for maternity services received out of plan area	400 Uniform Benefits, IV. Exclusions and Limitations, A (7)	Adding to comply with federal law	No fiscal estimate; reinforcement of current policy	Include
Coinsurance - have all medical services that apply to coinsurance have the same level of coinsurance	400 - Uniform Benefits I. Schedule of Benefits	Change to 90%/10% for all coinsurance benefits	Fiscal Impact: minimal cost, $300k - $900k Member Impact: Unavailable	Exclude

Coinsurance - have all medical services that apply to coinsurance have the same level of coinsurance	400 - Uniform Benefits I. Schedule of Benefits	Change to 80%/20% for all coinsurance benefits	Fiscal Impact: moderate savings, $8M to $12M Member Impact: Unavailable	Exclude
HDHP Plan Only - Remove the copays and structure with a straight deductible/coinsurance plan design.	400 - Uniform Benefits I. Schedule of Benefits	Blended copay/coinsurance in HDHPs is not industry standard and may be confusing to members.	Fiscal Impact: minimal cost, $350k - $650k Member Impact: Unavailable	Exclude
Therapies (Physical, Speech and Occupational) - Change the 50 additional visits from per therapy to a combined benefit.	400 - Uniform Benefits, I. Schedule of Benefits	Management of individual additional visits after aggregate initial visits is a manual process for some plans, and few members exceed 50 total additional visits.	Fiscal Impact: minimal savings, $100k - $300k Member Impact: Unavailable; change could potentially reduce utilization for high utilizers	Exclude
Bariatric Surgery Coverage	400 Uniform Benefits, III. Benefits and Services, A.	Consideration of coverage requested.	Fiscal Impact: Moderate cost, $800k - $2.6M Member Impact: 26 in 2016, last year ETF covered under the Access Plan	Exclude

Attachment C. Clerical Changes to Health Program Agreement & Uniform Benefits

Section	Description of Change
400. Uniform Benefits	Moved Definitions to Section I from Section II.
400. Uniform Benefits	Added definitions to Section I to align with Medicare Advantage contract
400. Uniform Benefits	Separated Schedules of Benefits by Program Option and clarified language.
All	Renumbering after section removal/addition
000. Definitions	Added definitions to 000 to align with Medicare Advantage contract
150 Data Requirements / 240 Data	Combined sections to coordinate all references to data requirements
400. Uniform Benefits	Unified tense, using "PARTICIPANT" in place of "YOU" and "YOUR"
400. Uniform Benefits	Replaced plain-text footnotes with Microsoft Word-Generated footnotes