



Health Benefit Program New Health Plan Application

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

To respond to this New Health Plan Application, please refer to the following documents which can be found on ETF's [New Health Plan Application Information and Resources](#) webpage:

- State of Wisconsin Group Health Insurance Program Agreement for Current Program Year
- Department Terms and Conditions
- Certification to Health Insurance Issuer
- Designation of Confidential and Proprietary Information Form
- Data File Specifications
- 834 File Specifications

Any health insurance carrier wishing to provide benefits for the State of Wisconsin Group Health Insurance Program (Health Benefit Program) must submit a completed application to the Wisconsin Department of Employee Trust Funds (Department). The application must address each requirement listed within this New Health Plan Application (Application).

Applicants should provide responses to all elements requested in this Application in a separate document, referencing the deliverable number, in the order in which the deliverables are listed below.

This Application is not for the use of health plans currently under contract with the Department for participation in the Health Benefit Program.

Deliverables

1. The Group Insurance Board (Board) will only consider applicants that provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The Board reserves the right not to contract with any applicant whose premium is not satisfactory to the Board.

Organization types that will be considered for participation in the Health Benefit Program include any of the following types of organizations defined in Wis. Stat. §§ 609.01 (2) and (4):

- Independent practice association HMO (IPA's)
- Prepaid group practice HMO
- Staff model HMO
- Point of service HMO (POS-HMO)
- Preferred Provider Organization (PPO)

Indicate which of the above organization type(s) apply to your organization.

2. Provide the number of years' experience your organization has operated as a health plan. If applicable, specify the number of years in total, as well as the number of years operating in Wisconsin.
3. Provide information on current enrollments, projected growth, and historical data on enrollment trends.
4. Provide a current list of large employer groups (>100 employees) participating in your organization's program(s) or actively sponsoring participation in your organization's program.
5. Provide an organizational chart that contains just one primary point of contact, along with contact information, to whom the Department can direct questions regarding your Application.
6. Provide an attestation indicating that your organization either already has a current SOC 2 Type II certification or will complete a SOC 2 Type II audit by the beginning of the program year you are applying for. No health plan will be allowed to perform business with or on behalf of the Department without a current SOC 2 Type II.
7. Provide an attestation indicating that your organization has the capacity and intention to abide by all the terms and conditions set forth in the attached Program Agreement, Department Terms and Conditions, and the Certification to Health Insurance Issuer.
8. If applicable, provide a list of services your organization contracts for that would be made available to the Department under the Health Benefit Program. Identify the name of the organization that provides those services, and the names and contact information for the key contacts at those organizations who may be involved with onboarding the services for the Health Benefit Program.
9. Provide a list of the current Wisconsin counties your organization services and the counties in which you anticipate providing services for the Health Benefit Program.
10. Submit documentation of financial stability showing financial soundness of your company, adequate working capital (current and projected), and insolvency protection for subscribers. All three underlined deliverables must be addressed. The Board reserves the right, on a case-by-case basis, to request additional documentation of a kind and in a form as appropriate to evidence financial stability.

11. Submit evidence of current licensure under the State of Wisconsin's Office of the Commissioner of Insurance.
12. Provide a sample copy of the contractual agreement established between your organization and the participating physicians who would be providing professional services under the Health Benefit Program. If more than one type of contract is used, please include a sample of each.
13. Provide a detailed explanation of any relationship between your organization and hospitals that would be in-network for the Health Benefit Program. Specify whether there is a contractual relationship between your organization and the hospital(s) involved, an ownership relationship between your organization and the hospital(s) involved, or if the relationship is limited only to the extent that physicians providing services under your program have staff privileges with the hospital(s).
14. Provide a detailed explanation of how providers and hospitals would be compensated under the Health Benefit Program, including a description of any and all incentives involved. If providers are financially compensated by your organization, you must disclose how compensation is established, reviewed, and changed. The Department's intent is to learn how your organization reimburses its providers; the Board is not interested in specific fees or salary information. For example, does your organization work in a fee for service capacity or capitation model?
15. Provide an attestation indicating that your organization will hold members harmless for expenses beyond the copays, coinsurance, and deductibles specified in the Board's Uniform Benefits for in-network providers, as defined under Wis. Stat. § 655.001 (8).
16. Provide an initial marketing plan which demonstrates how the minimum number of contracts (one hundred (100) subscriber contracts or ten percent (10%) of the eligible employees in the service area who have opted to participate in the program) will be obtained for the year in which your organization intends to participate the Health Benefit Program. If your Application is approved, the Department will work with your organization to finalize a marketing plan prior to the Health Benefit Program open enrollment period.
17. Provide your organization's pre-authorization and referral requirements and a brief description explaining criteria for each and the source of the criteria. Verify that your organization is able to authorize services as required by the Uniform Benefits section of the Program Agreement.

18. Provide a description of case management and disease management activities performed by your organization, statistics on current use and outcomes, as well as contact information for employees at your organization who lead disease management and case management activities.
19. Provide a description of available immediate care services your organization offers such as telemedicine and/or a twenty-four (24) hour nurse line as required under the Uniform Benefits section of the Program Agreement.
20. Provide a list of providers your organization has under contract arranged by Wisconsin county and zip code of practice. A map of major provider listings would be acceptable.
21. Provide detailed information regarding your organization's planned Health Benefit Program dedicated toll-free customer service operations including hours of operation, and evidence that your organization currently meets, or has a plan showing how your organization will meet, customer service standards as identified below. Each of the following metrics are based on quarterly measurement periods.
 - a. Claims Processing
 - i. Processing Accuracy: At least a ninety-seven percent (97%) level of processing accuracy. Processing accuracy means all claims processed correctly in every respect, financial and technical (e.g., coding, procedural, system, payment, etc.), divided by total claims processed.
 - ii. Claims Processing Time: At least ninety-five percent (95%) of all claims received must be processed within thirty (30) calendar days of receipt of all necessary information, except for those claims for which the Health Benefit Program is the secondary payer.
 - iii. 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.
 - b. Customer Service
 - i. Call Answer Timeliness: At least eighty percent (80%) of calls received by your organization's customer service (during operating hours) during the measurement period were answered by a live voice within thirty (30) seconds.

- ii. 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.
 - iii. 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.
22. Provide an attestation indicating that your organization has the capacity and intention to submit the results of its annual commercial CAHPS survey and HEDIS data results.
23. Provide an attestation indicating your organization's system(s) are able to accept and accommodate a HIPAA 834 file transfer from the Department daily and full file compare, per the most recent 834 Overview and Companion Guide issued by the Department. Or, submit a plan showing that your organization will have this ability.
24. Provide an attestation that your organization has the capacity and intention to provide all data and other information as needed in a file format as identified by the Department. Your organization shall place no restraints on the use of the data; provided that the Department shall not disclose to third parties any data received from organization that constitutes a trade secret as defined under Wisconsin law unless otherwise specified in a Data Sharing Agreement signed by your organization and the Department.
25. Provide an attestation indicating your organization will be able to store the Department-issued Group Health Identification (GHID) number(s) and be able to utilize the GHID number in reporting as specified by the Department. This ID number allows the Department to track all member records across all Department member-related databases.
26. Provide an attestation indicating your organization has the capacity and intention to participate in the data transfers described below, has the ability to absorb any direct or indirect initial and ongoing costs to your organization for these data transfers, and has the ability to make these data transfers.

- Claims Data – Your organization must transmit claim-level data monthly to the Department's data warehouse.
- Pharmacy Claims Data – Your organization must be able to accept and accommodate a daily file from the Department's Pharmacy Benefit Manager (PBM) for your organization's participants and integrate the data as required. If directed by the Department, your organization shall establish a data transfer process to retrieve pharmacy claims data from the Department's data warehouse for your organization's participants and integrate the data as required.
- Wellness Program Data – Your organization must be able to accept and accommodate a weekly file from the Department's Wellness Program vendor that includes data for your organization's participants and integrate that data into your organization's medical management program. This data may include results from biometric screenings, health risk assessments, and unique participant information regarding enrollment in wellness health coaching and/or disease management programs. The file format must comply with the most recent Wellness Data Specifications as provided by the Department.
- Dental Claims Data – If directed by the Department, your organization shall establish a data transfer process to retrieve dental claims data from the Department's data warehouse for your organization's participants and integrate the data into your organization's medical management program.
- WHIO Data – Your organization must submit all claims data (except Medicaid) to WHIO for your organization's commercial and Medicare covered lives residing in Wisconsin at a minimum. Your organization must submit claims to WHIO in a manner compliant with WHIO requirements.

27. Information Risk Review

- a. Provide an overview of your organization's business continuity/disaster recovery plan (BC/DRP). Provide evidence your organization tests and updates its business continuity plans regularly to ensure that they are up to date and effective.
- b. Provide an overview of your organization's Incident Response Plan (IRP).
- c. Provide a copy of your organization's most recent SOC 2 report along with a Letter of Attestation indicating organization's receipt of management's assertion of control compliance from organization's subcontractors.
- d. Provide a summary of the results of your organization's most recent vulnerability test.

- e. Provide a summary of the results of your organization's most recent penetration test.
 - f. Provide confirmation that your organization conducts an annual security risk assessment in accordance with generally accepted principles.
 - g. Describe what software applications and supporting platform your organization will use to secure the Department and member-related records and data. Provide information on how information is secured in transit and at rest.
 - h. Provide a summary of the policies or guidelines your organization has in place related to security/privacy (e.g., annual training, confidentiality agreement).
28. Provide an attestation, signed by an officer of the company who has the authority to legally bind your organization, indicating that all information submitted in and with your Application is truthful and accurate.
29. The Department has contracted with BenefitFocus for an eligibility and enrollment system. Indicate if your organization is part of the BenefitFocus Benefit Catalog Vendor program. If so, please provide your vendor or partner identification number. In addition, provide an attestation indicating that your organization has the capacity and intention to accept enrollments through the BenefitFocus system when it is implemented as requested by the Department and you have the ability to absorb any direct or indirect initial and ongoing costs to your health plan associated with this participation.
30. Complete and submit the Designation of Confidential and Proprietary Information Form.
31. Submit a detailed Health Benefit Program implementation plan for your program, identifying milestones and deliverables listed below. The time span of the plan should begin when your organization is informed of acceptance into the Health Benefit Program through the effective date of coverage for members. The implementation plan should include all aspects of implementation, including programming changes, communication to prospective members, etc. Your implementation plan must at minimum include the following:
- a. Informational mailings to be sent to households one (1) week prior to the start of the annual open enrollment period.

- b. Web content that consists of customized webpages dedicated to the program and specific to the upcoming open enrollment period.
- c. Attendance at the annual health benefits employer kick-off meeting and participation in open enrollment health fairs and/or virtual forum offerings.
- d. Testing and full implementation of the HIPAA 834 enrollment file prior to open enrollment.
- e. Submission of a detailed grievance procedure, including the Department administrative and external review rights and sample grievance decision letters, for the Department's review prior to the beginning of the program year.
- f. Implementation of medical claims administrative services, with systems being fully operational by the beginning of the program year.
- g. Implementation of data transfer processes with the Department's data warehouse and other partner vendors, including full testing, with all files working correctly by the beginning of the program year.
- h. Go live of the dedicated, toll-free customer service telephone line prior to the start of the open enrollment period for the program year.