

The Wisconsin Medical Society's Standard Benefit Plan

Wisconsin Medical Society Standard Benefit Plan Committee

Background

In 1992, the Wisconsin Medical Society (Society) published *Wisconsin Care*, the Society's recommendations for health care reform. Published during a time when both the US Congress and the President were debating major changes in the health care system, *Wisconsin Care* envisioned a market-based system for health care service delivery with a strong government role to set the "rules of competition."

Soon after publishing *Wisconsin Care*, the environment changed. The robust economy of the 1990s, the apparent savings achieved by managed care, and the consolidation of the health care market took away the urgency to reform health care. Since then, however, the tide has again turned. By 2002, health care had become the third largest state budget item after education and prisons. Enrollment in Medicaid and BadgerCare increased rapidly, with the state facing a deficit of more than \$3 billion for the 2003-2005 biennium.

It was against this backdrop that the Wisconsin Medical Society Board of Directors voted to convene a Task Force on Health System Reform. The charge of the task force was to guide the Society's role and positions in the current debate on health care expenditures and system reform. To ensure that the task force and its committees analyzed health care funding, access, and qual-

ity from a broad perspective, the Society invited representatives from the Wisconsin Hospital Association, Wisconsin Manufacturers & Commerce, AARP, AFL-CIO, Wisconsin Nurses Association, Wisconsin Physicians Service, Pharmacy Society of Wisconsin, and Wisconsin Education Association Trust to participate.

The Society published its Health System Reform Plan in the *Wisconsin Medical Journal* in January 2003, endorsing 3 main goals for reforming the health care system:

1. To attain universal health insurance coverage
2. To provide high quality health care
3. To control health care costs

The Health System Reform Task Force committees developed objectives for each of the 3 main goals and a working timeline. Two of the objectives were to

- Create a standard coverage package that insurers can price to allow consumers to compare the cost of insurance coverage among insurers.
- Develop a certified, state-defined standard benefits package that is tax-exempt, and classify as taxable compensation any additional coverage beyond the standard package.

Introduced in the legislature in 2005, The Action Plan for Affordable Health Care (SB416/AB834) required legislators to reform health

care by taking steps to lower health care costs by 15% while covering at least 98% of Wisconsin residents by January 1, 2008.

While SB 416 failed to pass, 3 new state-based health care reform proposals were introduced to the legislature in 2006:

- SB 388/AB 807 – Wisconsin Health Security Act (WHSA)
- AB 1140 – Wisconsin Health Plan (WHP)
- SB 698 – Wisconsin Health Care Plan (WHCP)

These proposals provide limited information about the scope of benefits each cover.

The Wisconsin Health Security Act states that it covers "reasonable medical services necessary to maintain health, enable diagnosis, and provide treatment or rehabilitation for an injury, disability or disease."

The Wisconsin Health Plan states that its benefits include "medical and hospital care coverage and related health care services, prescription drug coverage, and limited dental care. ... However, benefits may be reduced ... if the corporation determines that expenses will exceed revenues for a given year or years."

The Wisconsin Health Care Plan states that it covers "all reasonable medical services and prescription drugs necessary to maintain health, enable diagnosis, or provide treatment or rehabilitation for an injury, condition, disability or disease. Specifically excluded from coverage

unless determined to be medically necessary ... are dental and vision care, long term care and reconstructive or cosmetic surgery. An employer may provide employee health care benefits that are not covered by the WHCP.”

Goals

It is difficult to compare financing and projected cost savings of the 3 health system reform proposals when the covered benefits vary. Therefore, the Wisconsin Medical Society Standard Benefits Committee was formed in 2006. The Committee has defined a standard benefits package so that

1. Insurers can price the same benefits to allow consumers transparency in comparing the cost of standard insurance coverage across insurers.
2. Legislators can make apples to apples comparisons of alternative health system reform plans based on a working definition of a ‘state-defined’ standard benefit.

The Wisconsin Medical Society Standard Benefits Plan represents a consensus-based study of existing employer-sponsored group benefit plans in Wisconsin. The Committee members are people who deal with health insurance issues every day. While they used a common-sense approach to develop a list of standard benefits, the list should not be considered “evidence-based.” The full plan can be found on page 64.

Meetings

Teleconferences were held on February 27, March 20, April 24, May 22, June 26 and September 21, 2006.

Exclusions

This plan provides no benefits for the following:

I. General Exclusions

1. Health care services that aren’t

Committee

The Standard Benefit Plan committee consisted of several insurance executives, medical directors, and practicing physicians. Members included:

- Bradley Manning, Jr, MD – Chair, University of Wisconsin Medical Foundation; President, Wisconsin Medical Society
- Mark Belknap, MD – Duluth Clinic
- Lisa Benson, MD – Marshfield Clinic
- Ron Harms, MD – Employee Trust Funds
- Cindy Helstad, PhD – Wisconsin Medical Society
- Lowell Keppel, MD – formerly Blue Cross Blue Shield
- Ellie Rohrdanz, CEBS, RHU – Wisconsin Medical Society Insurance Services
- Marvin Wiener, MD – United Healthcare Medicaid

Medically Necessary for the treatment of an illness or injury as determined by the Medical Director.

2. Health care services that are Experimental or Investigative.
3. That portion of the amount billed for a health care service covered under this policy that exceeds the Plan’s determination of the Usual and Customary charge for such health care service.
4. Health care services provided when the member’s coverage was not effective under this plan. This includes health care services provided either prior to the member’s effective coverage date or after the member’s coverage terminated under this policy.
5. Professional services not provided by a physician or any of the health care providers listed in the definition of Health Care Provider.
6. Health care services provided by members of a member’s immediate family or anyone else living with him/her.
7. Health care services not specifically identified as being covered under this policy.
8. Health care services provided in connection with a health care service not covered under

this policy. An example would be inpatient hospital services in connection with a health care service not covered under this policy.

II. Other Administrative Exclusions

9. Health services used in educational training or vocational training.
10. Health care services covered by Medicare, if a member has or is eligible for Medicare, to the extent benefits are or would be available from Medicare, except for such health care services for which under applicable federal law this policy is the primary payer and Medicare is the secondary payer.
11. Health care services furnished by the US Veterans Administration, except for such health care services for which under applicable federal law this policy is the primary payer and the US Veterans Administration is the secondary payer.
12. Health care services furnished by any federal or state agency or local political subdivision when the member is not liable for the costs in the absence of insurance, unless such coverage under this policy is required by any state or federal law.
13. Health care services for which

Summary of Services

Individual Deductible Options

Coinsurance

Annual Coinsurance Limit (the annual maximum amount of covered charges for which a participant pays coinsurance; then the insurance plan pays 100%)

Each health system reform plan specifies these limits

Participant Lifetime Maximum Benefit

Preventative Services as Medically Necessary or as stated in the US Preventive Services Task Force recommendations

- Immunizations (except for travel or work)
- Well-baby Care to Age 6 (includes routine office visits, check ups, labs, and X-rays)
- Mammograms and Pap Tests
- Blood Lead Tests to Age 5

Hospital Services

- Semi Private Room & Board, Miscellaneous Hospital Expenses, Intensive Care Unit
- Ambulatory Surgery (same day) Fees
- Outpatient Facility Fees
- Outpatient Radiology, Pathology, and Lab Services

Emergency Services

- Emergency Room (facility charge)
- Emergency Room Care (including Physician Charges and Miscellaneous Expenses)
- Ambulance Services (*Prior approval required for non-emergency transport) Ground or air up to \$2000/trip.

Professional Services

- Office Visits (including chiropractors)
- Maternity Services (prenatal, delivery, and postnatal care including complications of pregnancy)
- Medical and Surgical Services
- Corneal Transplants, Bone and Skin Grafts
- Rehabilitative Therapy (Occupational, Physical, Speech, Respiratory) up to 40 visits
- Radiation and Chemotherapy Services
- Cardiac Rehabilitation (up to 48 sessions)
- Infertility (diagnostic procedures only)
- Oral Surgery and Dental Repair (due to an injury)
- X-rays and Lab Services
- Independent Anesthesiologist, Pathologist, and Radiologist Services

Home Health Care

- Home Health Services (up to 40 visits per year)
- Home IV Therapy and Supplies (Prior approval required)

Health Care Services

- Breast Reconstruction (following covered mastectomy)
- Diabetic Equipment, Supplies, and Self-management Educational Programs
- Temporomandibular Joint (TMJ) Disorders (diagnosis and non-surgical treatment up to \$1250 per year)
- Skilled Nursing Care (up to 30 days per confinement; Prior approval required)
- Durable Medical Equipment and supplies (Medically necessary)

Hospice Care Services

Transplants (Determined to be medically necessary)

Heart, Heart/Lung, Lung, Liver, Pancreas, Bone Marrow (as stated in the policy) (up to a separate lifetime maximum benefit of \$500,000; *Prior approval required)

Kidney Transplants and Dialysis Treatments (up to \$30,000 per year; Prior approval required)

Alcoholism, Drug Abuse and Nervous or Mental Disorders Services

Prescription Drugs (including Insulin and Transplant Drugs; Prior approval required for certain drugs)

- Tiered program (4 tiers)
- Birth control

- the member has no obligation to pay.
14. Health care services for any injury or illness caused by: (1) atomic or thermonuclear explosion or resulting radiation; or (2) any type of military action, friendly or hostile.
 15. Health care services provided while held, detained, or imprisoned in a local, state, or federal penal or correctional institution or while in the custody of law-enforcement officials, except as specifically stated in s. 609.65, Wisconsin Statutes. Persons on work release are not considered to be held, detained, or imprisoned if they are otherwise eligible members.
 16. Third party ordered treatment or testing.
 17. Health care services received outside the United States, Canada, Puerto Rico, or the US Virgin Islands except in emergency.
 18. Custodial care or rest care.
 19. Health care services not supported by information contained in the member's medical records or from other relevant sources.
 20. Telephone, computer, or internet consultations between a member and any health care provider.
 21. Completion of claim forms or forms necessary for a member's return to work or school.
 22. Charges for an appointment a member did not attend.
 23. Health care services for which proof of claim isn't provided to the Plan within 120 days or 1 year if a person is incapacitated.
 24. Sales tax or any other tax, levy, or assessment by any federal or state agency or local political subdivision.
 25. Maintenance care/supportive care.
 26. Health care services not for or related to an illness or injury, other than as specifically stated in this policy.
- III. Specific Procedure Exclusions*
27. Health care services for, or used in connection with, transplants of human and non-human parts, tissues or substances, implants of artificial or natural organs or any complications of such transplants or implants, unless otherwise indicated under summary of services.
 28. Cosmetic treatment or surgery.
 29. Reconstructive surgery, except for such surgery required: (1) to repair a significant defect caused by an injury occurring while the member is covered under this policy; or (2) to repair a defect caused by a congenital anomaly causing a functional impairment of a dependent child who has been covered continuously from birth under this policy or any of the Plan's other health insurance policies and such treatment was covered under such prior policy; or (3) as a result of a covered mastectomy; or (4) due to a physical illness.
 30. Health care services for obesity, weight reduction, dietetic control, or morbid obesity, except when Medically Necessary.
 31. Reversal of sterilization procedures.
 32. Abortion procedures for the termination of pregnancy except for risks to a mother's health.
 33. Artificial insemination or fertilization methods including, but not limited to, in vivo and in vitro fertilization, embryo transfer, gamete intra fallopian transfer (GIFT) and similar procedures and related hospital, professional and diagnostic services and medications that are incidental to such insemination or fertilization methods.
 34. Treatment, services and supplies, including, but not limited to, surgical services, devices and drugs for, or used in connection with, sexual dysfunction, including but not limited to impotence, or for the purpose of enhancing or affecting sexual performance, regardless of whether the origin of the sexual dysfunction is organic or psychological in nature, including, but not limited to, Viagra, Caverject, MUSE, Yohimbine, Femprox or their generic equivalent, penile implants, and sex therapy.
 35. Health care services for, or leading to, sex transformation surgery, the sex transformation surgery, and sex hormones related to such surgery.
 36. Health care services provided: (1) in the examination, treatment or removal of all or part of corns, callosities, hypertrophy or hyperplasia of the skin or subcutaneous tissues of the feet; (2) in the cutting, trimming or other non-operative partial removal of toenails; (3) in connection with any of those specified in (1) and (2); except in patients with diabetes, peripheral vascular disease or neuropathy when Medically Necessary.
 37. Health care services provided in connection with the temporomandibular joint or TMJ syndrome, except for diagnosis and non-surgical treatment up to \$1250 per year.
 38. All oral surgeries are excluded except for the following covered services: (1) Surgical removal of bony impacted teeth; (2) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, or surgical procedures to correct injuries to these structures; (3) Excision of exostoses of the jaws and hard palate; (4) Frenotomy; (5) Incision and drainage of

cellulitis of the mouth; and (6) Incision of accessory sinuses, salivary glands or ducts.

IV. Specific Diagnostic and Treatment Exclusions

39. Indirect services provided by health care providers for services such as, but not limited to: creating of a laboratory's standards, procedures, and protocols; calibrating equipment; supervising the testing; setting up parameters for test results; and reviewing the quality assurance data.
40. Therapy and testing for treatment of allergies, including, but not limited to services related to clinical ecology, environmental allergy, allergic immune system dysregulation, sublingual antigen(s), RAST test, extracts, neutralization tests and/or treatment unless such therapy or testing is approved by the American Academy of Allergy and Immunology.
41. Genetic testing, including, but not limited to using DNA to determine the presence of a genetic disease or disorder except where determined to be Medically Necessary.

V. Specific Ancillary Services Exclusions

42. Dental treatment, services, procedures, drugs, medicines, devices, and supplies.
43. Preparation, fitting, or purchase of eyeglasses or contact lenses; or vision therapy.
44. Outpatient physical, speech, occupational, and respiratory therapy, when performed in the home is not covered unless given by a Medicare-certified provider and the attending physician certifies that: a) hospitalization or confinement in a licensed skilled nursing facility would be needed if the member didn't have home care; and b)

members of the member's immediate family, or others living with the member, couldn't give him/her needed care and treatment without undue hardship.

45. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs and all related material and products for these programs.
46. Therapy services such as recreational therapy, educational therapy, and physical fitness or exercise programs unless otherwise indicated under summary of services.
47. Health education, marriage counseling, holistic medicine, or other programs with an objective to provide complete personal fulfillment.
48. Sleep therapy, massage therapy, acupuncture, or alternative services.
49. Housekeeping, shopping, or meal preparation services.

VI. Specific Medication or Durable Medical Equipment Exclusions

50. Over the counter medications except at the discretion of the plan.
51. Retin-A, Minoxidil, Rogaine, or their medical equivalent in the topical application form, unless Medically Necessary.
52. Medications, drugs, or hormones to stimulate human biological growth, unless there is a laboratory-confirmed physician's diagnosis of the member's growth hormone deficiency.
53. Immunizations primarily provided due to a member's work or travel.
54. Food received on an outpatient basis, food supplements, or vitamins.
55. Medical supplies and durable medical equipment for the member's comfort, personal hygiene or convenience, includ-

ing, but not limited to: air conditioners; air cleaners; humidifiers; physical fitness equipment; physician's equipment; disposable supplies, other than colostomy supplies; self-help devices not medical in nature.

56. Durable medical equipment or prosthetics that have special features.
57. Motor vehicles except when medically necessary.
58. Treatment of weak, strained, flat, unstable, or unbalanced feet; arch supports; heel wedges; lifts; orthopedic shoes; or the fitting of orthotics to aid walking or running.
59. Wigs, prosthetic hairpieces, hair transplants, or hair implants.

Definitions

1. Medically Necessary Health Care Services

Health care that is "medically necessary" refers to a service that is

- a) Required to prevent, identify, or treat a recipient's illness, injury, or disability, and
- b) Meets the following standards:
 - i. Is consistent with the recipient's symptoms or with prevention, diagnosis, or treatment of the recipient's illness, injury, or disability.
 - ii. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided.
 - iii. Is appropriate with regard to generally accepted standards of medical practice.
 - iv. Is not medically contraindicated with regard to the recipient's symptoms or other medically necessary services being provided to the recipient.
 - v. Is of proven medical value or usefulness and is not experimental in nature.

- vi. Is not duplicative with respect to other services being provided to the recipient.
- vii. Is not solely for the convenience of the recipient, the recipient's family, or a provider.
- viii. With respect to prior authorization of a service and to other prospective coverage determinations made by the Medical Director, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient.
- ix. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

2. Experimental or Investigative Health Care Services

Any procedures, treatment, supply, device, equipment, facility, or drug determined by the Medical Director, or his or her designee, NOT to

- a) Be a proven and effective treatment for the condition for which it is intended or used; or
- b) Have final approval from the appropriate government regulatory body; or
- c) Have the scientific evidence published in peer-reviewed literature that permits conclusions concerning the effect of the technology on health outcomes; or
- d) Improve the net health outcome; or
- e) Be as beneficial as any established alternative; or
- f) Show improvement outside the investigational settings.

3. Usual and Customary Charge

"Usual and customary charge" means the 70th percentile of the St. Anthony's Press fee schedule.

4. Health Care Provider

"Health care provider" is a health care professional, a health care facil-

ity, or a health care service or organization.

5. Prior Authorization Procedure

"Prior authorization" means the written authorization issued by the payor to a provider prior to the provision of a service.

6. Cosmetic Treatment

"Cosmetic treatment" means a treatment performed solely for the sake of appearance where no functional impairment exists.

7. Maintenance Care and Supportive Care

"Maintenance care and supportive care" means a treatment performed either in the absence of any symptoms in order to prevent the occurrence of symptoms, or a treatment administered to maintain baseline symptoms where the treatment will not result in the elimination of the symptoms.

Wisconsin Medical Journal

The mission of the *Wisconsin Medical Journal* is to provide a vehicle for professional communication and continuing education of Wisconsin physicians.

The *Wisconsin Medical Journal* (ISSN 1098-1861) is the official publication of the Wisconsin Medical Society and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor is responsible for overseeing the production, business operation and contents of the *Wisconsin Medical Journal*. The editorial board, chaired by the medical editor, solicits and peer reviews all scientific articles; it does not screen public health, socioeconomic or organizational articles. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *Wisconsin Medical Journal* nor the Society take responsibility. The *Wisconsin Medical Journal* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

For reprints of this article, contact the *Wisconsin Medical Journal* at 866.442.3800 or e-mail wmj@wismed.org.

© 2007 Wisconsin Medical Society