Proposed Changes to the City of La Crosse
2023 Master Plan Document/Summary Plan Description

1) **Effective date of coverage – New Employees – page 42. The document reads:**

As a new *employee*, *You* shall become eligible for coverage effective on the first day of the calendar month following ~~two~~ one (~~2~~1) full calendar month~~s~~ as an *employee* provided *You* are in *active status* and/or employed on that date. ~~*Note that if this results in a waiting period exceeding 90 days, such effective date shall revert to the 1st*~~

Explanation for proposed change: The current waiting period is longer than most public sector employers. New hires typically have a long gap in coverage. This shortens the gap and is closer in line with standard practice.

2) **Timely Notice of Claim – page 7. The document reads:**

TIMELY NOTICE OF CLAIM

Claims must be submitted as soon as possible after the date of the expense was incurred. In no event will a claim be accepted and paid beyond ~~sixteen~~ twelve (~~16~~12) months from the date of expense. In the event that a provider fails to submit a bill with complete information, *you* must act to provide such information to the *Plan Supervisor* in order to meet the ~~sixteen~~ twelve month deadline

Explanation for proposed change: This standard is twelve months. Having a non-standard filing deadline creates the need for the City to request that the claims administer enter into a special agreement to pay claims beyond the standard 12 months and it's at an extra administrative cost to City.

3) **Coverage for Anthem's LiveHealth Online Video Visit with a license therapist or board-certified psychiatrist – found within Schedules of Benefits pages 105, 111, 117 & 123. Coverage currently applies applicable cost sharing (copay, deductible and co-insurance). Proposal to pay at 100%.**

Explanation for proposed change: This provides an additional resource for mental health services and the cost to the City is currently $80, which is typically much less than other mental health services with other providers. The plan pays LiveHealthOnline medical at 100% (having an approximate cost of $59) so this would allow all LiveHealth Online video services to be at no cost to the member.

4) **Hospital Inpatient Benefits – page 10.** The document reads:

The maximum eligible charge for non-intensive private room will not exceed the daily rate for the greatest number of semiprivate rooms in the hospital where confined. If the Hospital does not provide a semiprivate room for the particular hospital stay, the private room rate will be covered. ~~allowance shall not exceed the lesser of: a. The charge for the particular room occupied; or b. The average daily charge for all two-bed rooms in the area.~~

Explanation for proposed change: This language is outdated. Many hospitals have transitioned to only providing private rooms. For hospitals that still offer semi-private rooms, the maximum allowable charge is the hospital's prevalent room rate

5) **Exclusions – page 37.** The document reads:

~~*No benefits will be paid for charges related to whole organ transplants or artificial hearts, except to the extend the Plan provides coverage for initial human kidney, kidney/pancreas, corneal (keratoplasty), limited bone marrow applications, heart, heart/lung, liver, lung, musculoskeletal, and parathyroid transplants for recipients who are plan participants;*~~
Transplant coverage is limited to those transplants that are medically recognized and are non-experimental/investigational in nature. Examples of covered transplants would be, but not limited to: *human kidney, kidney/pancreas, corneal (keratoplasty), limited bone marrow applications, heart, heart/lung, liver, lung, musculoskeletal, and parathyroid transplants for recipients who are plan participants.*

Explanation for proposed change: PBA suggests & USI agrees to modifying the exclusion to remove the specific list of covered procedures and, instead, match language on page 11 (i.e., only transplants that are determined by the Plan supervisor to be experimental, investigational or for research purposes are excluded). This will ensure there is no conflict in language as medical technology advances.

6) Skilled Nursing Facilities – page 19. The document reads:

Limitations: The participant is entitled to a maximum of 60 days per calendar year. ~~Admission must occur within 24 hours of release from an acute care facility and~~ must be in lieu of continued hospital stay.

Explanation for proposed change: The requirement that an admission occur within 24 hours of release from a qualifying confinement is no longer included in PBA's document since all admissions are subject to a precertification recommendation or requirement.

7) Home Health Care – page 21. The document reads:

~~*The maximum weekly allowance for home care coverage will not exceed the usual and customary weekly cost for care in a skilled nursing facility*~~.

Explanation for proposed change: Language of this nature is no longer included in PBA documents. The maximum allowable charge is generally determined by Network contracts and negotiated discounts.

8) Hospice Care – page 22. The document reads:

~~Hospice Care Benefits are limited to 180 daily visits per lifetime~~.

Explanation for proposed change: Visit limitations are generally not applicable to hospice care given the nature of the service.

9) Durable Medical Equipment includes the following– page 26. The document reads:

J. CPAP/BIPAP ~~is eligible when one of the following~~ criteria applies:

~~i. *Participant* has a diagnosis of obstructive sleep apnea syndrome (as defined as apneahypopnea index (AHI) or respiratory disturbance index (RDI) greater than 20 or an apnea-hypopnea index (AHI) or respiratory index (RDI) greater than 10 and daytime hypersomnolance objectivity documented by:~~

~~1) A multiple Sleep Latency Test (MSLT) showing a mean sleep latency of less than 10 minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day; or~~

~~2) An Epworth score of 10 or greater minutes and a sleep diary indicating an average of 7 hours or greater of sleep a day.~~

~~ii. *Prescription* CPAP/BIPAP is written by a pulmonologist or a sleep disorder *specialist*.~~

~~iii. Initial prior authorization approval will be for one month. Follow up with the pulmonologist will be required for additional rental or for the rent-to-purchase option.~~

Explanation for proposed change: PBA & USI recommend taking off criteria as it can become outdated and allow the medical review organization to use their criteria to determine medical necessity.

10) Experimental Exclusion – item 17, b. – page 34. The document excludes:

b. drugs, tests, and technology which:
i. the FDA has not approved for general use;
ii. are considered Experimental;
iii. are for investigational use~~; or~~
iv. ~~are approved for a specific medical condition but are applied to another condition~~.

Explanation for proposed change: PBA considers off-label drug use to be non-experimental when specific conditions are met and the drug is otherwise medically necessary to treat the specific condition.

11) Nutritional Counseling Exclusion/Limitation 58 Page 37, The document reads:

No benefits will be paid for nutritional counseling unless medically necessary and under the supervision of or provided by a registered dietician. ~~except to the extent the Plan provides coverage for morbid obesity, cancer, diabetes, heart disease, high blood pressure, anorexia nervosa or bulimia or as required under law~~

Explanation for proposed change: Nutritional counseling is generally covered when medically necessary, rather than listing specific conditions. For example, nutritional counseling may be necessary to treat severe kidney disease.

12) Exclusion #60 - Page 37. The document reads:

~~No benefits will be paid for services and supplies associated with the following conditions, including for low or declining physical or mental functioning compared to the normal range that may be due to conditions such as aging, gender, personal choices of lifestyle (such as poor exercise, poor diet, obesity other than morbid obesity), emotional or interpersonal conditions (other than defined as mental illness).~~

Explanation for proposed change: PBA and USI do not believe that this is common language found within a MPD/SPD and recommends taking it out.

13) **Prescription Drug Benefits covered benefits – page 39.** The document reads

For diabetic management: Insulin; disposable insulin needles, lancets, syringes; and disposable blood, urine, pump supplies, swabs, glucose and acetone testing agents/test strips and sensors. Continuous glucose monitor and disposable insulin delivery device can be obtained under pharmacy benefit and are limited to one per calendar year ~~for diabetic management~~.

Explanation for proposed change: Offering continuous glucose monitors and disposable insulin delivery systems are currently obtained through a durable medical equipment provider through the medical plan. USI recommends also offering these through the pharmacy benefit as the cost is comparable and members can obtain supplies quicker.

14) Coordination of Benefits – page 58. The document reads:

~~When the City Plan is the Secondary Plan, it shall credit back to a plan participant any copay and/or co-insurance amounts applied per service encounter and annual deductible amounts it would have applied and charged during a year against the amount due for such plan participant during such year in the absence of another coordinating plan. Any amount initially saved by the City Plan for a plan participant (other than plan savings related to drug benefits) is accumulated in a COB credit account for such plan participant. When such credit amounts exist and a claim service line is processed where the allowable expense is not met by the combined benefits of other coordinating plans, the unpaid amount is taken from such credit savings of the plan participant and is used to pay up to the allowable expense not otherwise payable – common copay amounts applied per service encounter, co-insurance, annual deductible amount, and copay percentage amounts.~~

Explanation for proposed change: PBA and USI do not believe that this is common language found within a MPD/SPD and recommends taking it out.

15) Appeals – pages 68-74 . Add a second level appeal on page 72 using the language below.

Explanation for proposed change: It is standard practice to offer a second level appeal prior to a claimant utilizing an external independent review organization.

Second Level Appeal

Request for Review

Upon completion of the first level of appeal, any claimant who has been affected by a decision to deny a claim for benefits, a utilization review decision, or a rescission of coverage determination, or who believes the action determining the amount of benefits to be paid is improper, may submit a written request to the Plan Supervisor to review the claim.

The written request must be submitted to the Plan Supervisor within ninety (90) days after receipt of the Plan's decision on the first level of appeal. The request shall be accompanied by any evidence and argument the claimant wishes to present.

When requesting a review, the claimant should state the reasons the claimant believes the denial was improper and submit any additional information, material, or comments which the claimant considers appropriate.

Review

Upon timely receipt of a request for review, the Plan Supervisor will schedule a review of the claimant's appeal. If any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan Supervisor will provide that information to the claimant free of charge and sufficiently in advance of the due date of the response to the claimant's appeal. If such evidence is received at a point in the process where the Claims Review Committee is unable to provide the claimant with a reasonable opportunity to respond prior to the end of the time period stated below, the time period will be extended
to allow the claimant a reasonable opportunity to respond to the new or additional evidence.

Timing of Notification of Benefit Determination on Second Appeal

The Plan Supervisor will notify the claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims. As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
2. Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
3. Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.
4. Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
5. Calculating Time Periods. The period of time within which the Plan's determination is required to be made will begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

The written decision of the Plan Supervisor shall be based on the record at the review and shall be final, except as otherwise required by law.

16) Schedule of Prescription Drug Benefits – pages 113, 119, 125 and 131. Add the following language:

Specialty Drugs – (CAAP Rx Program)

Specialty medications obtained through the Serve-You CAAP Rx Program, a significant portion (or possibly all) of your copayment will be paid by the manufacturer program.

Any manufacturer funded copayment assistance received under the CAAP Rx program does not apply toward the member's annual out-of-pocket maximum. Copayment assistance programs offered by drug manufacturers may be changed at any time by the drug manufacturer and the benefit provided by CAAP Rx will adjust accordingly

Explanation for proposed change: This voluntary program could create a significant cost savings to the plan and could reduce the member's copayment as well.

17) Recitals – page 1. Update as follows:

RECITALS

City of La Crosse (City), a Wisconsin municipality, hereby establishes its self-funded Medical Benefit Plan (Plan) for the benefit of eligible Employees, Retirees, and their eligible Dependents. The benefits described in this document are ***not*** conditions of employment, nor are they meant to establish a contract between City and its Employees. Neither enrollment nor anything contained in this Plan shall give any Employee the right to be retained in the employ of City nor shall it interfere with the right of City to discharge any Employee at any time.

This document constitutes the entire Plan and supersedes all the prior Plan documents. ~~To the extent the Plan document has been changed, the intent of the change is to incorporate required new Federal Legislative changes such as those due to the Patient Protection and Affordable Care Act, HIPAA, etc. Additionally, any new Wisconsin State Statutory requirements have been incorporated. However, in the event the Federal or State of Wisconsin law requiring any plan provision shown is repealed or amended at any time, the City has the right to revert to any previous provision that is allowed by law.~~

The City has caused this instrument to be executed by its duly authorized officer(s) this _~~1st~~__ day of ~~November~~ _____, 202~~1~~2 effective for healthcare services incurred on or after January 1, 202~~2~~3

City of La Crosse

Attest: _____ _~~Deputy~~ Director of Human Resources
Signature Title

~~*Document amended to reflect new 2022 claims administrator & to update the Maximum out of pocket limits under the ACA to 2022 limits..~~

Explanation for proposed change: USI recommends removing language about reverting to pre-2012 language and language abut following federal and state laws is elsewhere in the document.