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CORRESPONDENCE MEMORANDUM

DATE: January 15, 2004

TO: Group Insurance Board

FROM: Bill Kox, Director, Health Benefits & Insurance Plans
Joan Steele, Manager, Alternate Health Plans

SUBJECT: GUIDELINES/Uniform Benefits – Timeline and Discussion Regarding Contract Changes and Clarifications for Year 2005

For the past five years, a staff discussion group has developed recommendations for changes to the GUIDELINES and Uniform Benefits for the next contract year and Board members or their designated staff have participated. Should the Board wish to continue this process for contract year 2005, we are providing the following information on the expected issues and timelines for the GUIDELINES development.

The anticipated timeline for the 2005 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2005 contract year. The Plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits.
- On or about February 25th, an ETF staff discussion group will meet and identify those issues to be included in the first draft of GUIDELINES.
- On or about March 1st, we will send plans the draft of the 2005 GUIDELINES/ Administrative Provisions and Uniform Benefits. Plans' comments on the draft changes will be due on or about March 12th.
- On or about March 19th, the discussion group will meet to finalize recommendations to the GIB. The discussion group's written recommendations are due by March 24th.
- The recommendations will be presented for GIB approval at its April 20th meeting.

<u>The following briefly summarizes several issues that may be reviewed during this process, but is not exhaustive.</u> Participants, plans or staff have raised these issues over the course of the past year. We also welcome any comments or suggestions from the Board about issues to be reviewed for the 2005 contract.

Some items may have a cost impact while others are clarifications of existing practice with no expected cost. Such costs, if any, will be discussed by the discussion group and presented to the Board in the final recommendation.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

_____ _____
Signature Date

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GUIDELINES/Administrative Provisions:

- Consider having the SMP available to participants who do not reside in an SMP county and/or reside out-of-state. Since SMP is currently a designated Tier 1 plan that does not meet Tier 1 placement requirements, consideration may be given to SMP being placed in its actual tier level in these circumstances.
- Consider whether qualification criteria be modified to allow qualification in a county in which no hospital exists.
- Review the language allowing the Department to impose a financial penalty on plans that are non-compliant with submitting needed information required by the Department.
- Clarify process of retroactively handling situations when a participant fails to notify the Department of Medicare eligibility and is not receiving the Medicare reduced premium.
- Review calendar of submissions to determine if bid submittals should be moved up to allow more time for analysis of tier placements and negotiations.

Changes to the Local Contract:

- Offering another benefit plan option for local employers that would include more participant liability, such as a deductible and coinsurance. This issue was previously discussed with the Board in conjunction with the McCormick Task Force.
- Adding ability to underwrite local employers who wish to join the program. This may include an option of being able to charge an additional plan stabilization fee if it is determined the employer experience would be detrimental to the program.
- For local employers joining the program, consider removing the deferred coverage provisions for their employees who had previously waived coverage through the previous carrier because of comparable coverage through a spouse.
- Consider adding language to allow local employers to escrow for those with sick leave pay.

Uniform Benefits:

- Adjust the pharmacy out-of-pocket maximum consistent with past Board practice or, as an alternative, consider a nominal copayment amount (e.g. $2-Level 1; $5-Level 2) after the out-of-pocket maximum is met, which is similar to what Medicare has proposed.
- Clarify that pharmacy out-of-pocket maximum does not reset if there is a change in plans.
- Determine whether or not specific reference or exclusion should be made for lifestyle drugs, such as Viagra.
- Consider adding coverage for gastric bypass.
- Consider increasing the lifetime maximum for transplant benefits.
- Consider requiring Plans to cover two (2) follow-up visits with a non-network provider following emergency care outside the plan's service area.
- Consider adding coverage under accidental injuries for root canals in conjunction with caps or crowns and dental implants, as these are becoming more standard treatment options.
- Consider whether supportive therapy should be covered under which such therapy might be necessary to prevent a condition from worsening, although no improvement is expected.
- Consider clarifying exclusions for genetic testing/counseling, and durable medical equipment exclusion for home improvements, such as a wheelchair ramp.

- Clarify coverage for congenital conditions in cases where OCI mandated coverage is not clear and determine whether a definition for birth abnormalities should be provided.
- Clarify coverage for surgical treatment of malocclusion when not coverable under the TMJ mandate.
- Discussion of mental health parity costs if the Federal law is extended through 2005.

Please note also that in recent past we have been receiving more comments from retirees covered under the Medicare Plus $100,000 that the maximum lifetime benefit has not been increased in many years and may no longer be adequate. As a result, the guidelines discussion group may wish to address this issue even though it does not directly relate to Uniform Benefits. Any action to change the maximum lifetime benefit would likely be taken by the Board at the August 24, 2004 meeting.