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CORRESPONDENCE MEMORANDUM

DATE: January 20, 2006

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 2007

In the past, 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 2007, we are providing the following information on the expected issues and timelines for the GUIDELINES development.

The anticipated timeline for the 2007 contract is as follows:

- With the input of the Board's actuary, staff establishes preliminary recommendations for changes/clarifications for the 2007 contract year. The health plans have been asked to identify any issues that warrant clarification in the GUIDELINES or Uniform Benefits.
- On or about February 28th, an ETF staff discussion group will meet and identify those issues to be included in the first draft of GUIDELINES.
- On or about March 3rd, we will send health plans the draft of the 2007 GUIDELINES/ Administrative Provisions and Uniform Benefits. The health plans' comments on the draft changes will be due on or about March 10th.
- On or about March 14th, the discussion group will meet to finalize recommendations to the Board. The discussion group's written recommendations are due by March 28th.
- The recommendations will be presented for approval at the April 18th meeting of the Board.

The following briefly summarizes several issues that may be reviewed during this process, but is not exhaustive. Participants, health 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 2007 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 considered 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 updating and/or deleting the "Capital Equipment and Expenditures" section under the general requirements for health plans to participate in the group health insurance program.
- Require health plans to submit an estimated premium bid every year. Currently, estimated premium bids are required on the odd-numbered years only.
- Require health plans to submit documentation of their educational efforts to providers about quality initiatives, e.g., Checkpoint, Leapfrog, etc.
- Clarify process for determining eligibility for disabled dependents, e.g., dependents taking COBRA when health plan is reviewing initial disabled status for dependent, etc.
- Require additional identifying information on the contract signature page, such as the Federal Employer Identification Number.
- Consider a modification to health plans' optional offering of dental benefits.

Changes to the Local Contract:

- Apply the same provider qualification criteria for the State Maintenance Plan (SMP) and where it is determined to be the only qualified health plan, use SMP as the low-cost, qualified plan for purposes of determining employer contribution limits under the 105% formula. Currently, the Standard Plan is used as the low-cost qualified plan in counties where SMP is placed. Also introduce language for those employers located in counties with SMP to address the use of tiering when used in determining employer contribution.

Uniform Benefits:

- Consider adding coverage for osteotomies. Currently, osteotomies may be covered under the TMJ benefit.
- Consider deleting the exclusion for dental implants under the accidental loss of teeth provision.
- Clarify the exclusion for services due to complications from non-covered services to specify it does not include complications for services not medical in nature (e.g., ear piercing, tattoos, etc.). Also consider adding a time limit for complications to arise, e.g., complications arising within 18 months of non-covered medical services.
- Review of coverage for gambling addiction and diagnostic procedures under the mental health/alcohol/drug abuse benefit.
- Clarify that pharmacy benefits apply towards the lifetime maximum benefit.
- Review pharmacy out-of-pocket maximum limits.
- Continued review of Medicare Part D impact.