Notable Changes Under Consideration for the 2007 Guidelines, Addendum, and State and Local Contracts

Section & Page # (when applicable)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
Guidelines I. Page 1-3			a) Added language allowing the Board the right to designate the SMP as the low-cost, qualified plan for local employers for purposes of determining employer contribution limits when the SMP meets the minimum provider requirements used for qualifying the alternate health plans and there are no qualified alternate health plans available in the county. b) Added language allowing the Board the flexibility to split the SMP in plans in different tiers based on the efficiencies of provider groups.	a) Refer to discussion item #1 on page 3 of the memo. b) Refer to discussion item #3 on page 3 of the memo.
Guidelines II., D., 10. Page 1-9			Added language explaining Uniform Benefits is a “carve-out” plan for participants on Medicare.	To ensure plans are administering the benefits consistently and recognize it is not a “supplemental” plan.
Guidelines II., D., 14. Page 1-10			Added language reinforcing the requirement for plans to notify the Department of the termination and/or reinstatement of coverage for those subscribers who pay the premium directly to the plan.	To make plans more aware of this contractual requirement, which is currently listed in the Time Table in Section II., J. of the Guidelines.
Guidelines II., F. Page 1-12			Clarified language on the information pertaining to capital equipment and expenditures that plans are to submit on proposals to participate in the health insurance program.	To remove outdated language.
Guidelines II., H., 2. Page 1-16			Added language clarifying that rates for Medicare coordinated coverage must be justified by experience and may not exceed 50% of rates for active employees.	To clarify existing practice as some plans misunderstand the 50% cap and submit the bid for Medicare coverage at 50% of the rate for active employees.
Guidelines II., J. Page 1-19			a) Revised language to require plans to submit an estimated premium bid every year. b) Added language describing new quality improvement –related submission requirements.	a) Refer to discussion item #2 on page 2 of the memo. b) Per the changes to pages 2-36 and 2-37 of the Addendum, which are described below.

Section & Page # (when applicable)			Description	Reason for Change
Guidelines / Addendum	**State Contract**	**Local Contract**		
Addendum 1C Pages 2-36 & 2-37			Revised to separate utilization review from quality improvement activities and to require documentation of specified activities related to quality improvement.	Refer to discussion item #4 on page 3 of the memo.
Addendum 2 Page 2-38			Added language to clarify the provider guarantee provision applies to subcontracted providers.	Requested by an employer to clarify existing practice in response to subcontracted chiropractors that left the network mid-year.
Addendum 2 Page 2-39			Deleted language requiring health plans to submit the Drug Enforcement Administration (DEA) number for their providers.	It was determined it is no longer necessary to collect that information, which some plans indicated their contract with providers did not allow them to disclose.
	Signature Page Page 3-2	N/A	Added identifiable information to be completed by the plan, consistent with information required on requests for bids and proposals.	Requested by Department staff to more easily identify the entity to whom premium payment is being made.
	Article 1.6 (1) & (3)	Same	Clarified the termination date for dependents age 19 or over and for dependents that plans determine are no longer disabled.	To clarify existing practice.
	Article 2.3 (4)	Same	Added language to permit retrospective adjustments to premium prior to January 1 of the previous year in situations when it is determined to be an appropriate resolution to an appeal to the Board.	Recommended by Department staff in response to a recent appeal to the Board.
	Article 2.4 (3)	Same	Added language requiring plans to follow the Department's protocols for the transfer of data.	To clarify existing practice to ensure protected health information is handled appropriately.
	N/A	Article 3.1 (6)	Revised language referencing the payment of deductibles under a Section 125 plan.	Correction.
	Article 3.15 (2) (a)	Same	Revised language on time requirement to submit an application for health insurance after applying for an immediate annuity or LTDI benefit.	To clarify existing practice.