# Notable Changes Under Consideration for the 2010 Guidelines, Addendum, and State and Local Contracts

| Section & Page Number (in Attachment B) | | | Description | Reason for Change |
|---|---|---|---|---|
| **Guidelines / Addendum** | **State Contract** | **Local Contract** | | |
| Guidelines<br>I.<br>Pages 1 – 3 | | | Rearranged language to better explain the local government program and added language to explain the surcharge assessment and underwriting process. | To reflect current processes. |
| Guidelines<br>II., D., 4 .- 6.<br>Page 4 | | | Added language for the Department to request health plans to demonstrate their efforts in encouraging network providers to participate in various quality initiatives. | To replace requirements in Addendum 1C that has been eliminated. |
| Guidelines<br>II., D., 8.<br>Page 5 | | | a) Added language specifying the utilization/disease management submission is in the format as determined by the Department.<br>b) Added language specifying that health plans requiring a primary care provider or clinic selection must have processes to allow members to reasonably change their selection. | a) To provide flexibility to the Department to modify the submission as deemed necessary.<br>b) To replace requirements in Addendum 1C that has been eliminated. |
| Guidelines<br>II., E., 7.<br>Page 6 | | | Added language stating that health plans are expected to incorporate the CMS policy into their provider and hospital contracts to withhold payments for care associated with treating certain infections and medical errors. | Refer to discussion item #1 on page 2 of the memo. |
| Guidelines<br>II., H.<br>Page 7 | | | a) Revised language as to further encourage health plans to separate higher cost providers into separate plans.<br>b) Revised the requirements for the Medicare coordinated family rate categories. | a) To encourage health plans to pursue this, as it has been permissible under the contract.<br>b) Refer to discussion item #3 on page 2 of the memo. |
| Guidelines<br>II., J.<br>Pages 8 - 10 | | | Updated the time table for annual submissions. | • To delete the Addendum 1C submission<br>• To add the health plan features comparison summary,<br>• To clarify the group experience submission,<br>• To require a PDF of the provider directory on health plans' web sites,<br>• To specify contract attachments, and<br>• To change the timing of the utilization/disease management report. |

| Section & Page Number (in Attachment B) | | | Description | Reason for Change |
|---|---|---|---|---|
| **Guidelines / Addendum** | **State Contract** | **Local Contract** | | |
| Addendum 1<br>Pages 11 - 13 | | | a) Added language clarifying Table 8B requirements.<br>b) Deleted Addendums 1B & 1C. | a) To replace requirements in Addendum 1B.<br>b) No longer needed. |
| | Article 1.1<br>Page 14 | Same | Updated the definition to include a person who is receiving a long-term disability. | To clarify current practice. |
| | Article 1.7<br>Pages 14 - 15 | Same | a) Rearranged the language to flow with the Administrative Rule.<br>b) Revised language to require an application to cover eligible dependents. | a) For consistency purposes.<br>b) Refer to discussion item #4 on page 3 of the memo. |
| | Article 2.2 (5)<br>Page 16 | Same | Added language specifying health plans must comply with laws regarding patient privacy. | Recommended by staff to clarify current practice. |
| | Article 2.2 (6)<br>Page 16 | Same | Added language requiring health plans to maintain a written contingency plan and to submit it upon request. | Recommended by staff to ensure health plans can continue operation. |
| | Article 2.3 (4)<br>Page 16 | Same | Added language to limit retrospective premium adjustments to two months. | Refer to discussion item #5 on page 3 of the memo. |
| | Article 2.5 (2)<br>Page 16 | Same | Reduced the per member per month from health plans for the costs of informational materials. | Reviewed annually and updated as appropriate. |
| | Article 2.8 (2)<br>Page 17 | Same | Revised language describing processing of applications. | To update processes due to implementation of electronic enrollment data transmission. |
| | Article 2.10 (7)<br>Page 17 | Same | Added language specifying this provision complies with all laws regarding patient privacy. | Recommended by staff to clarify current practice. |
| | N/A | Article 3.1 (2)<br>Page 18 | Added language specifying that ineligible participants can elect continuation coverage for up to 36 months. | Refer to discussion item #8 on page 3 of the memo. |
| | N/A | Article 3.1 (3)<br>Page 18 | Added language requiring a local employer who is assessed a surcharge to participate in the program a minimum of three years. | To protect the risk pool of the local program. |
| | N/A | Article 3.1 (5)<br>Page 19 | Revised the waiver provision so that only large employers (>50) may retain a second plan for up to four years due to the timing of collective bargaining, provided the employer also meets the 65% participation requirement. | Refer to discussion item #7 on page 3 of the memo. |

| Section & Page Number (in Attachment B) | | | Description | Reason for Change |
|---|---|---|---|---|
| **Guidelines / Addendum** | **State Contract** | **Local Contract** | | |
| | Article 3.3 (7)(a) Page 20 | Same | Added language clarifying an enrollment opportunity exists for the employee who deferred coverage when an eligible dependent loses other coverage. | To articulate an enrollment opportunity that is available under federal law. |
| | Article 3.3 (7)(b) Page 20 | Same | Added language describing the 60-day enrollment opportunity due to loss of eligibility for, or eligibility to participate in a premium assistance program. | To comply with the Children's Health Insurance Program Reauthorization Act of 2009. |
| | Article 3.4 (7) Page 20 | Same | Added language clarifying that the addition of a dependent due to a National Medical Support Notice or establishment of paternity creates an opportunity to switch health plans. | To clarify current practice. |
| | Article 3.9 (2) Page 21 | Same | a) Added language specifying rehired annuitants continue their same coverage by filing an application.<br>b) Added language specifying rehired annuitants are not eligible for the graduate assistant program. (State contract only) | a) To clarify existing practice.<br>b) Refer to discussion item #6 on page 3 of the memo. |
| | Article 3.12 (3) Page 21 | Same | Added language specifying employees on a leave of absence have the same enrollment opportunities as described in section 3.3 (7). | To clarify existing practice. |
| | Article 3.12 (4) (c) Page 21 | N/A | Updated language describing the timeframe for employees to apply for coverage after release from active duty. | Technical change. |
| | Article 3.14 (1) Page 22 | Same | Updated language to explain eligibility for returning students and dependents born to covered spouse following the death of a subscriber. | To clarify coverage following an Administrative Rule change. |
| | Article 3.16 (2) Page 22 | Same | Added language clarifying the Medicare-reduced premium rate applies when coverage is provided under a non-employer group number. | To account for existing practice of employer run out of premium after termination of employment. |
| | Article 3.16 (7) Page 22 | Same | Added language clarifying that Medicare becomes the primary payor after the 30-month coordination period when the member is enrolled in Parts A and B. | To clarify existing practice. |
| | Article 3.18 (1) (d) Page 23 | Same | Added language clarifying the sick leave escrow application can provide notice to cancel coverage. | To clarify existing practice. |