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Correspondence Memorandum

Date: October 23, 2017

To: Group Insurance Board

From: Arlene Larson, Federal Health Programs & Policy Manager
Shayna Schomber, Optional Plans & Uniform Dental Benefits Manager
Office of Strategic Health Policy

Subject: 2018 Program and Operational Clarifications for the Group Health Insurance Program

This memo is informational purposes only. No Board action is required.

Background

This memo presents a few items of clarification for the Group Health Insurance Program administration and benefits. Staff identified these issues during preparations for the It's Your Choice (IYC) open enrollment period.

Data Warehouse Fee Adjustment

While 2018 premium rates were being established, an analysis of fees for the data warehouse was performed. In 2017, a fee of $1.83 per contract per month had been applied to prepare for estimated implementation costs under the Truven Health Analytics (Truven) contract. Realized costs were lower than expected, and it was determined that the fee could be waived in 2018. A fee is anticipated for 2019.

IYC Medicare Plus

During the creation of the certificate of coverage (certificate) for members, a review was performed to update the benefits and exclusions for the pharmacy benefits. It was found that:

- There was a misstatement of Medicare benefits in the outline of coverage regarding psychiatric treatment. The language was corrected to say that Medicare will pay 80% and IYC Medicare Plus will pay 20%.
- Following the addition of pharmacy benefits and exclusions into the certificate, a number of definitions were also updated. For example, references to the definition of In-Network providers was not applicable and was changed to Participating Providers. IYC Medicare Plus defines Participating Providers as those who accept Medicare assignment.

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Lisa Ellinger Electronically Signed 11/3/17

Board	Mtg Date	Item #
GIB	11.15.17	3B

IYC Access Plan and State Maintenance Plan (SMP)

WEA Trust (WEA) requested a clarification of the out-of-network benefit for hearing aids for children. The benefit for adults includes a $1,000 plan maximum payment after deductible and coinsurance. This plan maximum payment is not permitted under state mandates for children for in-network care. The statutes do not set benefit requirements for out-of-network care. The establishment of Uniform Benefits out-of-network benefits is by plan discretion and subject to ETF approval.

WEA stated that it is administratively burdensome to apply a benefit cap to out-of-network hearing aids for children. They informed staff that within their other PPO plans, no child had ever received an out-of-network hearing aid. Staff agreed that a clarification to remove any reference to the out-of-network benefit maximum payment was reasonable.

Service Area Correction

At the August meeting, it was reported that Portage County had three Tier 1 plans available for State members and two available for Local members. Network Health had been omitted from the list and is another qualified Tier 1 plan available to State and Local members in Portage County.

Staff will be at the Board meeting to answer any questions.