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Correspondence Memorandum

Date: April 14, 2021

To: Group Insurance Board

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Subject: 2022 Health Program Agreement Changes

The Department of Employee Trust Funds (ETF) recommends the Group Insurance Board (Board) approve the following changes to the Health Program Agreement (Agreement) and one change to the Employer Health Insurance Standards, Guidelines and Administration Employer Manual (Guidelines):

- **Clarify and reiterate requirements related to information security protocols.**
- **Clarify language requiring plans to pay for out-of-network care if suitable providers are not available in network.**
- **Add language to support coverage of testing and vaccines during the COVID-19 pandemic.**
- **Permit a subscriber to change health plans upon the establishment of a new legal guardianship or a custody change.**

Background

ETF presented initial change concepts to the Board for benefit year 2022 (Ref. GIB | 02.17.21 | 7D) at the February 2021 Board meeting. This initial review is intended to provide ample opportunity for stakeholder input and Board consideration.

Following the February meeting, ETF reviewed potential program changes with health plans and the Board's actuary, Segal. Through this process, ETF developed a final set of proposed contract language revisions for the Board to review.

ETF is also in the process of restructuring the Agreement in total to improve administration and simplify language.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy
Eileen K Mallow Electronically Signed 5/3/21

Board	Mtg Date	Item #
GIB	5.12.21	8E

Agreement Restructuring
As a part of the request for proposals to self-insure and regionalize the Group Health Insurance Program (GHIP) in 2016, ETF made a substantial revision to the contract document that governed GHIP benefits. That document, referred to as the Guidelines, was broken down into three separate parts — two employer administration manuals (one for state employers and one for local employers) and the Agreement. During this revision, ETF also added new requirements, as well as performance standards and penalties. The original revision was also written to support a self-insured program structure.

Following the Joint Committee on Finance's rejection of self-insured contracts, ETF quickly updated the Agreement to return the program to a fully-insured format. Over the past four years, ETF has worked to fine-tune the Agreement as written and within the structure established in 2016.

The current structure, however, is not necessarily intuitive to the users of the document, and some of the concepts and language in the newer Agreement are unclear. In addition, when the Medicare Advantage vendor joined the GHIP in 2018, language was added throughout the document to integrate that program. While this ensured that the vendor would sign the same agreement as all other plans, it further complicated the language in the Agreement. As a next step in improvement, ETF began to sort through each section of the Agreement to determine what should still be included in the Agreement, what was missing, and what should be removed.

The product for the 2022 program year will be a reorganized document that largely preserves the original intent of the 2016 Agreement but streamlines and better categorizes the information it presents. It creates separate sections for Medicare Advantage, similar to how Medicare Plus and the Access Plan have been created in the past. It also pulls more information that is relevant to member experience into the Uniform Benefits section, creating a more robust Certificate of Coverage document.

An outline of the new Agreement structure is provided in Attachment A of this memo. A final version of the restructured agreement will be provided to the Board in August.

Proposed Agreement Language Changes
In addition to the restructuring activity, ETF also proposes the following changes to administrative services provided for by the Agreement:

- **Add language to support compliance with the Consolidated Appropriations Act of 2021 (CAA).** Provisions in the CAA include the No Surprises Act related to surprise billing, general price transparency requirements, and Mental Health Parity and Addiction Equity Act (MHPAEA) compliance reviews and reports. ETF expects plans to ensure compliance to all of these provisions, including providing the required notices as well as access to price transparency. Further, ETF has discussed methods for demonstrating MHPAEA compliance with plans and will codify this approach in the program agreement.

- **Other clarifying language updates.** Both health plans and ETF identified several opportunities to add or adjust language to clarify the current intent of sections such as the Information Systems and Security Review and clarification of the documentation needed for support and maintenance of disabled adult dependents.

Details of the recommended changes, as well as changes not recommended by ETF, are included in Attachment B of this memo.

Eligibility Changes
The State Employer (or Local Employer) *Health Insurance Standards, Guidelines and Administration Employer Manual* (Guidelines) is both the contract between employers and the Board, and the complete source of information about how an employer must meet its roles and responsibilities in the GHIP.

The Guidelines contain eligibility requirements. Currently employees who add a dependent due to marriage, birth, adoption, paternity declaration, a National Medical Support Notice, a new legal guardianship or a court order changing custody may enroll for coverage or change from single to family coverage. However, employees who are adding a dependent due to a new legal guardianship or a court order placing a child with them under custody do not have the ability to change health plans. This is a longstanding policy. While it is infrequent that employees in these circumstances submit a request to change plans, they are not pleased when ETF explains that this is not permitted. It is difficult to explain why this policy is in place.

ETF recommends changing this policy to permit employees who are adding a dependent due to a new guardianship or court-ordered custody placement to change health plans if they file an application within 30 days of the event. Coverage would be effective the first of the month following receipt of the application. ETF anticipates better customer service and no negative impact with this change. If approved, it will be communicated to members using the Life Event Guide and in applicable areas of the frequently asked questions and answers that appear on ETF's website. These tools are widely used by ETF staff, employers, and members.

Staff will be available at the board meeting to answer any questions.

Attachment A: 2022 Draft Program Agreement Outline
Attachment B: 2022 Program Agreement Changes

Attachment A: 2022 Draft Program Agreement Outline

8. Performance Standards

H. Provider Access
   1. Provider Access Standards

I. Administrative Services & Supports
   1. Claims
   2. Account Management and Staffing

J. Audits
   1. Record Retention

K. Grievances & Appeals
   1. Grievance Process Overview

L. Other
   1. Out-of-Network

V. Access Plan, SMP and Medicare Plus

Certificate(s) of Coverage

Attachment B

ETF 2020 Contract Reference	Proposed Language	Triple Aim Analysis: How will this change impact cost, quality/experience, and health?	ETF Comments/Recommendation
All	*ETF is undertaking a full review of the existing contract document to streamline the content, remove unnecessary requirements, and clarify language. A full version of the program agreement will be available shortly following the May Group Insurance Board meeting.*	The goal of this exercise is to clarify ETF's expectations and to simplify administration for both plans and ETF	ETF has provided a draft outline in Attachment A of the Board memo. ETF continues to work on finalizing the restructured agreement, with a goal to deliver to health plans during the month of May.
New section	Following the issuance of 26 CFR Part 54 and the passage of the Consolidated Appropriations Act of 2021, health plans will provide the necessary resources to meet the transparency requirements described by legislation. Further, health plans will attest annually to their compliance with the transparency requirements related to the Mental Health Parity and Addiction Equity Act (MHPAEA) to ETF in writing. Plans will provide copies of their parity analyses to ETF upon request.	n/a--federal requirement	ETF will require plans to adhere to both the referenced transparency rule and the transparency provisions of the Consolidated Appropriations Act of 2021 as a part of the Program Agreement, including provisions specific to enhancing Mental Health Parity. Specific activities will be discussed with plans as federal guidance is provided.
150D	Reiterating and clarifying requirements around information security protocols.	Improving the safety of member data, lending toward a higher-quality program	ETF's intent is to continue to require adherence to SOC2 or equivalent security standards, and is pleased with the progress made in 2020. Plans should expect this to be an important feature of future contracts. Change title to "Information Security Review"
Clarify proceeding/succeeding contractor	The proceeding CONTRACTOR will administer claims and medical management services for any PARTICIPANT who is CONFINED as INPATIENT at the time of a transfer of coverage to another CONTRACTOR, when the facility in which the PARTICIPANT is CONFINED is not part of the succeeding CONTRACTOR'S network. In this instance, the CONTRACTORS will work together to facilitate a seamless transition in claims administration, medical management services, if applicable, and transferring the PARTICIPANT to an IN-NETWORK facility, if appropriate. Except when a PARTICIPANT'S coverage terminates because of voluntary cancellation or nonpayment of PREMIUM, BENEFITS shall continue to the PARTICIPANT if CONFINED as an INPATIENT, but only until the attending physician determines that CONFINEMENT is no longer medically necessary, the maximum BENEFIT is reached, the end of twelve (12) months after the date of termination, or the CONFINEMENT ceases, whichever occurs first.	Cost: no cost impact expected Quality: no quality impact expected Health: no health impact expected	Change is clerical in nature
Clarification for support and maintenance requirement	The CONTRACTOR shall notify the DEPARTMENT of individual over-age disabled child reviews per DEPARTMENT submission instructions. CONTRACTORS may perform individual reviews at any time of the year. If it is found that the child no longer meets the criteria, termination of the child's coverage must be prospective. The DEPARTMENT must be copied on the notification of the CONTRACTOR'S review as described in the submission instructions. In addition, HEALTH PLANS must report and certify to the DEPARTMENT at least annually the total results from its process to verify the eligibility of over-age disabled children age twenty–six (26) or older, which includes checking that the: 1) Child is incapable of self-support because of a disability that can be expected to be of longcontinued or indefinite duration of at least one year, and 2) Support and maintenance requirement is met (per IRS 501 worksheet b), and 3) Child is not married.	Cost: no impact expected Quality: Consistent experience between health plans Health: no impact expected	Change clarifies requirement under IRS rules
End Stage Renal Disease - Medicare Participants coverage	Add a paragraph to 220H to inform participants that starting the fourth month of dialysis for an ESRD diagnosis participant can voluntarily transition to Medicare Advantage.	Cost: Overall program could see significant cost reduction. Medicare reimbursement should be significantly less and thus provide the best value to the state. The Medicare Advantage plan would generate revenue commenserate with the members medical risk. Additionally, moving drug costs to Medicare could be a significant cost savings to ETF. Quality: Utilization potentially would shift from health plans to Medicare Advantage, however members would still be utilizing these services. Health: No impact to member health anticipated because services will still be sought and provided through Medicare Advantage plan.	ETF proposes adding this to new certificate of coverage in order to ensure members are aware of this ability, since they are not typically users of the Program Agreement
230	Changing language to require plans to pay for out of network care at in network rates if suitable providers can't be found in network	May improve patient access to needed care	This change request was added at the request of a member who has had trouble finding in-network care for a rare condition. It is currently ETF's expectation that plans facilitate this in rare instances, through authorization processes. No change to Program Agreement language is necessary. ETF will ensure this requirement is clarified in the new Certificates of Coverage.
Changing the PCP selection process	No language proposed.	Submitting plan questions the value of selecting/assigning PCP	ETF does not recommend changing this requirement at this time. It is still a priority to ensure PCP/PCC is assigned to new members.
834 processing during Open Enrollment	a) The CONTRACTOR must accept an enrollment file update on a daily basis and accurately process the enrollment file additions, changes, and deletions within two (2) BUSINESS DAYS of the file receipt, except during Open Enrollment when additions, changes and deletions are to be processed within five (5) BUSINESS DAYS.	Cost: no impact expected Quality: plan asserts this will provide consistent experience between health plans Health: no impact expected	ETF does not recommend the change; enrollment files must be processed per the established timeline in order for all parties (employers, ETF, and plans) to meet tight timelines during open enrollment.