

In October 2007, the following question about Medicare and AlaskaCare was submitted and answered by Benefits Manager Freda Miller.

Q: I understand that Alaska Care is supplemental to Medicare by virtue of Alaska Statute 39.35.535(b).

I understand that the Administration Department's interpretation of the word "supplemental" for Medicare **A** is that when Medicare **A** does not cover the Retiree then Alaska Care will fully cover the Retiree. Alaska Care pays when Medicare won't.

I understand that the Administration Department's interpretation of the word "supplemental" for Medicare **B** is that when Medicare **B** does not cover the Retiree because the Retiree is outside the country then Alaska Care will cover the Retiree. Alaska Care pays when Medicare won't.

I know that the Administration's interpretation of the word "supplemental" for Medicare **B** in 2002 was to fully cover my visits to my doctor of several decades who had opted out of Medicare B (I have receipts). Alaska Care paid when Medicare would not.

Starting in 2003, under the new Murkowski administration, a new interpretation appeared as spelled out on page 17 of our current, May 2003, information booklet. My health care benefits to the doctor who had been treating me for 25 years were cut off like throwing a switch. Alaska Care no longer paid when Medicare would not.

I have what I hope is a simple question: If Governor Murkowski can take away a benefit by clicking the switch off, can Governor Palin restore the benefit by clicking the switch on?"

A: As to the member's question about the Effect of Medicare, statutory reference Sec. 39.35.535(b) states:

- The benefits payable to persons age 65 or older supplement *any* (emphasis added) benefits provided under the federal old age, survivors and disability insurance program.

The State as an employer opted out of Social Security for some retirement system members, so these retirees will never be eligible for Medicare Part A (hospitalization only) coverage. Under the retiree health plan, if a person can prove by submission of their appointment to Social Security letter that they are not eligible for Medicare Part A, the plan considers that they are not entitled to Medicare Part A coverage at all. The plan continues to pay these member's hospitalization (Part A) claims as before.

For Part B coverage, all US citizens, whether they have paid into Social Security enough to be eligible for premium free Part A or not, are required to pay a monthly premium for Medicare Part B. Part B is not provided free upon qualification like the Part A coverage is.

Because all members must pay the premium for Part B, the plan assumes ALL members have purchased and are covered by Medicare Part B. Almost all services provided outside of the US are excluded from Medicare coverage, but if the retiree health plan covers that service it would allow coverage even if Medicare does not. Page 17 of the Retiree Insurance Information Booklet states:

- If you do not enroll in Medicare coverage (the assumption here is Part B since you don't "enroll" in Part A but are provided it premium free if you qualify), the estimated amount Medicare would have paid will be deducted from your claim before processing by this plan.

The plan's inference is to Part B, not Part A. Now to the Opt Out question, a relatively new provision of Medicare.

The Balanced Budget Act of 1997 created a way, for the first time in Medicare's almost 40 year history, for a physician to totally disregard the federal old age program as a payment source, even though a beneficiary may have the coverage and be fully entitled to its benefits. When a member enters into a private contract with a provider the member is voluntarily waiving their right to payment from the federal old age program (Medicare). This action shifts the unfettered cost entirely to the retiree health fund.

"Opt Out" providers are required to sign a contract with Medicare and are under strict laws governing the practice in order to "opt out". As with any new federal law there is always confusion and insecurity regarding the interpretation of the law, and as such, many providers did nothing for a while after 1997 until they were sure what would happen if they did "Opt Out". I don't know when the first physician or group opted out of Medicare in Alaska, but when the Division became aware of the federal law's provision allowing the removal of the Medicare payment, there was a counter-measure placed in the plan to prohibit cost shifting from the federal government onto the retiree health fund. Providers are aware (and must have patients sign a statement that they understand) that most health plans will not pay for services provided to an otherwise entitled Medicare beneficiary when the patient signs a private contract for their services. On page 5 of the Retiree Insurance Information Booklet it states:

- These benefits may change from time to time.

If the plan were unable to meet the challenges arising from new federal laws as well as new technology, it would be difficult to continue offering as rich of a benefit as we are afforded today. The member who asked this question was most likely one of the first in the state to enter into a private contract with a provider to receive "Opt Out" services. In an Opt Out situation, ALL Medicare beneficiaries are required to sign a private contract with the provider that explicitly states (according to Medicare law) that the beneficiary knows that their services will be paid out of the patient's own pocket at whatever cost the provider stipulates. If a member does not sign such contract, the services of the Opt Out provider would be outside the provisions of the law.

The answer to the Alaskan Medicare "Opt Out" dilemma was created at the federal level and can only be solved at the federal level. As more and more providers Opt Out of the Medicare program, all of us are faced with additional challenges, in Alaska and around the country. If you would like additional information, or if you need clarification on anything I've related, please let me know.