Questions Submitted by Northern Chapter of Retired Public Employees of Alaska
for October 18, 2007 meeting with Freda Miller

Question: Under the AlaskaCare Retiree Health Plan, is any consideration given to "continuity of care," especially after a retiree reaches Medicare age? If the retiree's longtime medical provider opts out of Medicare, the retiree must change providers or assume full responsibility for payment of services to keep seeing the original provider. It is a nightmare for the patient to have to start cold with another physician or specialist IF THEY CAN FIND ONE, and also costly to do a new history work-up. Meanwhile there is a break in care or the patient has tremendous out-of-pocket expenses. Does the Plan recognize quality of care issues or only focus on paying the minimum required contractually?
A: Of course the plan would prefer that a member is provided continuity of care. It is counterproductive to the health plan's expense experience, not to mention the retiree's health, if there is no continuity. Assuming that the plan's focus is "paying the minimum required contractually" is incorrect. The issue of providers who opt out of Medicare is a broader issue than can be addressed by the Division. Providers understand the ramifications of opting out. Only the federal delegation for Alaska in DC has authority over Medicare law. Alaska Statute Section 39.35.535 (b) makes the AlaskaCare plan supplemental to Medicare at age 65. Please see handouts provided from:

- Centers for Medicare and Medicaid Services titled "Private Contracting and Medicare";
- New York State's Office for the Aging article titled "Medicare Private Contracting";
- and the Social Security Administration's text "Use of Private Contracts by Medicare Beneficiaries" Sec. 1802. [42 U.S.C. 1395a] (b).

Question: Does the AlaskaCare Retiree Plan provide additional coverage if there is not a medical provider in Fairbanks (limited number of specialists here) that is a network provider or Medicare participating or nonparticipating provider?
A: No. Please read the "Medicare Parts A&B and the AlaskaCare Health Plans" brochure for additional information.

Examples: (1) A retiree's covered dependent needed a tonsillectomy, and there are no ENTs in Fairbanks that are network providers. The provider's charges were well above the "recognized charge" for the covered procedure. In this situation, would the Plan pay 80% of the provider's charges or pay travel costs to go to a network provider in Anchorage?
A: Page 46 describes when a travel benefit would be paid for travel outside your local area.

(2) For another retiree, the only pulmonary and respiratory physician in Fairbanks was not accepting new patients. She explains, "I'm not yet on Medicare, but I got very ill my first summer in Fairbanks because I needed to go to Anchorage with no respiratory physician here [Fbks] taking new patients. The Anchorage physician changed my treatment regiment and I got very sick, ending up costing a lot of money to get me back on track. I could not "run to the doctor" for him to see me during an episode of asthma. 'Begging' the respiratory receptionist locally for an appointment, wheezing on the telephone, I finally got in to see a PA, a very well trained one. (I doubt I will ever see the only respiratory physician in Fairbanks.)"
A: The plan cannot dictate to providers who they will accept and who they will not. The lack of providers in any community is a local issue that can only be addressed locally. The health plan has no authority over providers.

Question: At the September ARM Board meetings in Fairbanks, it was learned that there was a sort of re-organization or re-institution of business procedures at the Division of Retirement and Benefits under the new Director, Pat Shier. Could you give a brief overview of the history of the organization and any changes in the present and future?
A: Any new administration brings different thoughts and ideas to the table on how things are to be done. The intent under the current administration is that the plan and its operations should be transparent. Recent actions in evidence of this are the reconstitution of the ARMB Health Care Cost Containment Committee by Commissioner Kreitzer in July. The Division is currently working with Buck Consultants in rewriting the plan booklets to a more understandable and readable format (no plan changes). We have retirees on hand to review the booklets with us and provide suggestions along with the Division on improvements to the wording, etc. There was discussion at the July ARMB HCCCC meeting of adding an improved retiree health plan of benefits offering that may be more attractive to retirees. The alternate plan would only be available by retiree informed consent and signature on waiver that they understand the implications of the change in plan of benefits. There are no firm details of the alternate plan at this time except that it is expected to be more prevention and disease management oriented. The idea was initiated at the HCCCC meeting after legal review determined that this would be acceptable as long as the retiree understood the differences in the two plans, based on a written waiver that has yet to be developed.

Question: Did the Plan ever provide or promise reimbursement for the provider of our choice—including "opt out" providers—when Medicare is primary? A short history lesson would be helpful for several of our members who believe that the Plan used to pay for services by providers that opted out of Medicare. Although no one has provided me with specific documentation, they suggest that there was a change at the beginning of the Murkowski administration.
A: History lesson first. Medicare allowed only 2 types of providers until 1997 changed the law for providers who performed covered medical services for

Medicare beneficiaries. Those two types of providers were contracted and non-contracted with Medicare. The Balanced Budget Act allowed for the first time in Medicare history the opportunity for providers to contractually “Opt Out” of the Medicare program for a two year period. Please see the “Medicare Parts A&B and the AlaskaCare Health Plans” brochure for a complete summary of the now 3 different types of providers available to Medicare beneficiaries. Page 17 of the Retiree Insurance Information Booklet specifies how the plan interacts with a private contract for services.

Question: In January 2006 there was a statewide "audit" to verify dependents for retirees. Although it was met with some protest, it showed quite a bit of error in the system as I understand it. The audit is an example of proper business practice to save losses. We heard that there was a lot of potential loss encountered especially in Fairbanks. Could Ms. Miller spend a brief amount of time explaining the reason for the audit, the findings, and the potential cost/benefit?
A: Reason for the audit was to solidify that the plan was not covering ineligible persons on a tax preferential basis. There have been no single members identified who were claiming benefits for ineligible plan participants. The project was not a date in time project, it is still being used today and there are still members who have not yet submitted their dependent’s documentation and who are just now being denied coverage until that information is received by the Division.

Question: What does the State pay Premera per retiree to administer the health plan and what does this cover?
A: Third party administration services for self-insured health plans industry wide are paid on a Per Retiree Per Month, called PRPM (or Per Employee Per Month, called PEPM) rate. The contract signed by Premera in March 2006 stipulated the three year PRPM rate.
The current PRPM rate for medical is $22. The cost includes customer service, claims processing, care facilitation, pharmacy benefit management, appeals process, network availability and clinical support services, basically all claims administrator functions. DVA PRPM cost is $3.61. LTC PRPM cost is $0.44.

Question: I understand that the ARM Board’s Healthcare Cost Containment Committee is looking at possibilities for creating a “well” focused component to our health plan. How can retirees be involved in this conversation or advocate for coverage of more preventative services?
A: Join the conference call to the HCCCC meetings. All members are invited to dial in. Members of the RPEA will also be requested to assist the Division in this process. It is in the best interests of the retiree and the Division to create a health enhanced plan together.

Question: I have read HB 393 which amends Section 2 of AS 21.42 to add coverage for colorectal cancer screening. This Act went into effect January 1, 2007. What language in this legislation excludes the State of Alaska health plan from providing coverage for all colorectal screenings? Section 21.42.377 (b) describes minimum coverage required and "includes coverage for colorectal cancer examinations and laboratory tests specified in American Cancer Society guidelines for colorectal cancer screening of asymptomatic individuals." Section (e) states, "For individuals considered at average risk for colorectal cancer, coverage or benefits shall be provided for the choice of screening, so long as it is conducted in accordance with the specified frequency." [underlining added]
A: The AlaskaCare health plan is not under the authority of the Division of Insurance, created under Statute Title 21. AlaskaCare is a self-funded, governmental, non-ERISA plan that was created under the sole authority of the Commissioner of the Department of Administration in PERS Chapter 39 and TRS Chapter 14.

Q: In the answers you provided for the Southcentral Chapter of RPEA, one of your answers included the following:
"The Division made several changes to the AlaskaCare retiree health plan in 1998 and 1999 based on the recommendations of the PERS/TRS Boards and retiree groups. PERS/TRS Board meeting minutes of that time period are available on the web to anyone who wishes to review them for the specific provisions adopted, per the group's recommendations." I have not been able to locate the minutes of these meetings on the web. Could you please provide the link to these minutes? The current ARM Board is easy to find, but not the historical material.
A: Requests for copies of the minutes need to be requested in writing to the plan administrator. The minutes prior to 2001 are no longer posted on the web. Sorry I was not aware they were no longer housed there.

Q: Why does the claims administer and DRB incorporate South Central Alaska (Anchorage) claim data with Interior Alaska (Fairbanks) claim data when calculating the "recognized charge"? This is contrary to the procedures specified on page 14 of the 2003 Alaska Care booklet as Anchorage and Fairbanks are located in seperate geographic areas. I have gone through the appeals process (Aetna -> DRB) three times, each appeal included clear evidence that the recognized charge was not calculated pursuant to page 14 of the plan. Each appeal was not favorabily considered and both Aetna and DRB avoided addressing this issue in their denial letters. Ms Miller can research the specifics of this question by pulling my appeals dated March 12, 2007, November 16, 2006, and December 28, 2006. Ms Stella Brown, DRB, handled these appeals at the State level.
A: Please reference pages 12-15 of the Retiree Insurance Information Booklet. First sentence:

"Payment is based on the recognized charge for covered services. Charges or fees in excess of the recognized charge, as detemined by the claims administrator, are your responsibility to pay."
There is no language on page 12 that requires the claim administrator to separate Anchorage and Fairbanks data. However, please see the listing showing that there are 4 regions in Alaska recognized by the current claims administrator in determining UCR. Fairbanks is in Region 2 while Anchorage is in Region 1. The claims administrator (TPA) determines the recognized charge (also called UCR) because they collect the data from claim submissions. That data is considered proprietary by the third party administrator in applying the correct 90th percentile required by the plan. The Division is within its rights to ask for proof that a certain UCR is the verified recognized charge for a specific service, but this information is requested on a case-by-case basis.

Q: If the medical insurance plan has not changed when Premera replaced Aetna as the claims administrator, why did I have an out of pocket liability of about $12,000 to $15,000 for Home Health Care services that exceeded the "recognized charge" under Aetna yet Premera has paid 100% of the same services from the same provider? Researching the above cited files, should also provide Ms. Miller sufficient information to addess this issue.
A: Because this is a member specific question, it will not be responded to in this forum. I am happy to speak with any individual who has a specific claim issue on a case-by-case basis.

Q: I would like to know why it takes up to 3 months for processing pharmaceutical charges submitted by the member. As of today, I have not received payment for any drugs I have filed claims for since August 03, 2007. I now have about $700. outstanding. The last check that I received was dated 08/18/07 for drugs I filed on in June. This seems excessive to me. The claims are mailed to MEDCO. I use a small locally owned pharmacy. I tried Fred Meyer when my pharmacy could not reach agreement with MEDCO and I'd have to cover it until I was reimbursed. I was most unhappy with Fred's, maybe because I'd had personalized service for 20 years, but unhappy none the less. My pharmacy would love to file for me but without an agreement MEDCO will not let them.
A: Individual member issues will not be addressed in this group setting. Premera representatives here with us today can assist you with any specific issues you may be experiencing.

Please see pages 35-37 of the Retiree Insurance Information Booklet for information on reimbursement of prescriptions purchased from either a participating pharmacy or from the mail order program. Please see pages 89-90, under the heading "Prescription Drugs", for information on reimbursement of prescriptions from a non-participating pharmacy. All pharmacies in Alaska were invited to contract with Medco during transition to Premera. A business has the right to chose to participate or not with the claims administrator. A

non-participating pharmacy cannot electronically submit claims directly to the TPA. The process for a non-participating pharmacy is that they request payment from their customer at the time the prescription is dispensed and provide a receipt for members to submit for reimbursement on a claim form, per pages 89-90, to the health plan.

Q: I worked for the Delta-Greely School District for 10 years, so I have the medical benefits, with my retirement, for myself and my husband. If I was to die first, would my husband receive part of my retirement and would his health care still be paid after I'm gone?
A: The benefits available to you upon your spouse's death depend on what benefits your spouse chose at the time of retirement. There are several options that can be chosen that affect spousal benefits. Contact the Division of Retirement and Benefits Retirement Section at 800-821-2251 to check your specific benefit election.

Q: Having read the Q&A from the other meetings, I want to press the following questions for the upcoming meeting. We have heard the explanations about how current State and Federal laws result in the rapid narrowing of medical practitioners willing to serve Medicare covered people and why AlaskaCare will not cover any of the medical expenses that cannot be billed to Medicare because of physician opt-outs, etc. Beyond the explanations, can we expect anyone in the Division of Retirement and Benefits or the Administration to vigorously ADVOCATE with legislators for changes in the laws so that retirees over age 65 have the benefit of USEABLE AlaskaCare insurance?? As it is now, almost no practitioners in Anchorage (and elsewhere in Alaska?) will accept new Medicare patients--whether those physicians are offically "opt-out" or not.
A: The Division's responsibility is as the fiduciary of the Retiree Health Fund in administering the plan of benefits.

Second question: Will DRB help draft legislative bills to correct this problem?
A: Legislation that would be applicable to this issue can only be addressed at the federal level.

Third question: Will someone in DRB and the Governor's office lobby the Congress for changes in Medicare statutes and regulations so that Alaska practitioners will be willing to accept Medicare patients?
A: The Division's responsibility is as the fiduciary of the retiree health fund. The Governor's Office has not shared with the Division any potential action on this issue.

Q: I was pre-approved for a surgery just before the change from Aetna to Premera. I was concerned about the timing, so I called the Division of Retirement and Benefits to ask for confirmation that Premera would honor Aetna's approvals. I hoped to get something in writing, since I was sure the state's contract with Premera covered that point, but the woman on the phone

told me that I could not get such confirmation, no matter how long I talked to her. Strangely, a couple of weeks later both the state and Premera did send me such confirmation. In the future what can I do to ensure that the information I get from the state office is correct? If I am given incorrect information directly by the DRB office, and I act on it, who is responsible for any penalties I may incur?
A: The Benefits Section staff was aware during transition that instruction to Premera was to honor Aetna pre-approvals that had already been provided to the member. If you are given incorrect information, the Division has the responsibility to correct the information. Responsibility for penalties would need to be determined on a case-by-case basis, depending on the proven circumstances.

Q: Why do the insurance administrators lose so much of our paperwork, and what can be done about it? While I was trying to be approved for my surgery, Aetna lost all of my information the first time I sent it, and several pages the next two times.
(Some cynical people have told me that they actually throw it away.)
A: I cannot speak for what Aetna did and can assure you that the contractors for the AlaskaCare plan are under incentives to process paperwork as timely and accurately as possible. Again, individual incidents require specific research and cannot be answered in this forum.

Q: Why are the insurance companies allowed to deny a person's surgery or treatment without giving a real reason? When Aetna first denied my surgery, they said only that I did not meet the qualifications, not mentioning which requirements I did not meet. Their letter was cunning and evasive. I had indeed fullfilled every one of the requirements. Getting the information out of them was like pulling teeth. It was humiliating.
A: Please accept my sincere apologies for your unsatisfactory experience. As the Division no longer has a contract with Aetna the Division is unable to correct whatever may have happened prior to the end of their contract. We are working daily with Premera to assure members are receiving satisfactory service. If you are not, please contact Premera first and then the Division if your less than satisfactory service experience is not rectified.

Q: What does a person do when the booklet clearly says something is covered, but the insurance administrator denies you anyway? By the time a person is done being denied for all his appeals, he could be dead.
A: Applicable Statutes, Regulations, and the Retiree Health Insurance Information Booklet comprise the terms of the Health Plan. If there are questions regarding specific coverage, Premera should be contacted to provide that information. The Division's Benefits Section staff is available at 800-821-2251 to answer questions that you think may have been answered incorrectly by the claims administrator. The Benefits Section staff is instructed to

conference you in with a Premera representative for a three-way conversation when there is an issue such as this.

Appeal procedures are defined by regulation (2 AAC 39.510) and require that the claims administrator's appeal process be fully utilized prior to appeal to the plan administrator.

Q: Why do the insurance administrators promise to call you back, then completely forget about you? Why does the state let them get away with not calling us back, over and over and over? Both Aetna and Premera are guilty of this.
A: Premera would need to respond to the affected member directly on this question. The claims administrators are subject to performance guarantees that require a certain level of service or penalties are assessed. The Division does not look favorably on any employee who does not call a member back when promised, whether that employee works for Premera or the Division.

Q: What recourse is there when the insurance company denies the application and the appeal; so one is forced to hire an attorney? Should they be required to cover the legal fees that one incurs to make them do the legal, ethical and moral thing? In normal court cases, the loser is often required to pay the legal fees. What is going on?
A: The Retiree Health Plan is self-funded so there is no "insurance company". Not sure what application is being referenced. Under appeal, the member has specific rights. Please see the appeal brochure available on the DRB website at http://www.state.ak.us/drb/forms/ben067.pdf

Q: Why do they not pay what the booklet says they will? (Cynical people have told me it is so the CEO can buy a bigger yacht. Or maybe it's so the Governor can buy a bigger jet.) When I finally did have my surgery, Premera paid only 13% of the surgeon's bill, even though the booklet clearly states they will pay 90% (based on some mysterious formula). I had to write a letter listing the charges of every surgeon in the area who does the surgery, and pointing out that the amount they paid was not even enough to have the surgery performed in a third world country.
For some reason, they paid after I wrote the letter. You could have knocked me over with a feather. I was pre-approved and the payment criteria are clear. I should not have had this problem.
A: Premera is required to follow the provisions of the plan. The recognized charge is defined on pages 13-15. Specific claim issues will not be addressed in the group setting. For claim payment questions, please contact Premera at 877-762-9597.

Q: Why does a person have to jump through so many overwhelming hoops to get weight loss surgery, a life-saving proceedure, yet not do so for other surgeries? Recent science has proved that it is the only reliable way for

morbidly obese people to lose weight and improve their health. It is not only good for obese people. It is good for the state as well, because the surgery eliminates the very expensive future charges the state will face or sleep apnea; high cholesterol and high blood pressure, with their resulting heart problems and strokes; diabetes; increased joint problems and arthritis; various cancers, and on and on. This potentially represents a huge savings to the state. Alaska has one of the highest obesity rates in the nation and the world. I am happy the state recognizes this problem and is willing to try to do something about it. It would be good for everyone if the state could take away some of the obstacles to weight-loss surgery. What is the chance of changing this?
A: Bariatric surgery is invasive major surgery that should be approached as a last resort to accomplish weight loss. There are clinical reasons why surgery may not be the best option. The criteria in place assures that the patient is best served by this type of intervention, and can include psychological testing to assure that the patient will be able to maintain the eating habits required post-surgery. For additional information regarding the standard criteria necessary to assess potential for positive outcomes, members are invited to read the National Institutes of Health sponsored publication "The Practical Guide – Identification, Evaluation and Treatment of Overweight and Obesity in Adults", available at http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf
Also available at this meeting is a copy of the Mayo Clinic.com article "Gastric bypass surgery: Who is it for?"

1) Out of Network: What is the basis for using "Out of Network" as deduction in claims on the EOBs? Since Premera started managing the State's health insurance claims, we have had to pay a larger portion of the medical bills. Many of the EOBs reduce the allowable amounts that are paid by Premera because the medical professionals in Fairbanks are "Out of Network". We reviewed Premera's "preferred providers" list on their website, and there are no "preferred providers" listed in our area for ENT, Orthopedic Surgeons, etc. Why do Fairbanks retirees have to pay more now? Does the State expect Fairbanks retirees to travel to Anchorage or the Lower 48 to see doctors and have surgery in order to get 100% of their medical claims accepted? Has this practice been sanctioned by the State? If so, how does the State justify reducing the health care benefits for retirees living outside of Anchorage?
A: See answer to previous question on the subject of the recognized charge and regions used. The Division has no authority over provider's fees and they may set their charges as they so determine. The health plan's allowance is based on the "recognized charge" criteria listed on pages 13-15 based on actual claims submitted for identical services.

Preventive Screening Services: The Premera website provides a list of "Preventive Screening Services" that became effective on 3/1/07. The "cancer screening" list includes "Occult Blood", "PAP Smear" and PSA tests. According to the latest medical research Colorectal Cancer (CRC) is a common and lethal disease. In 2006, more than 55,000 Americans died of CRC, which was 10% of

all cancer related deaths. CRC now ranks second to lung cancer as a cause of cancer death with 90% of all CRC cases occurring after age 50. Survival rates have improved with early detection. Are sigmoidoscopies and colonoscopies covered under the retiree's health coverage?
A: The Retiree Health Plan (see page 5 of the booklet) provides extensive and valuable benefits for you and your family including hospitalization, medical, surgical, maternity care, and other services *necessary for the diagnosis and treatment of an injury or disease.* (Emphasis added.) Covered preventive services are listed on page 37 and 38 of the plan booklet. Colonoscopies and sigmoidoscopies are a covered benefit if they are performed to diagnose an illness, injury or disease. Any service performed as a screen, without symptoms present, are not covered by the plan. The Division produced a cost analysis for the plan to provide colorectal screening mandated by HB393 that was presented to the legislature. The Commissioner determined at that time that the screening would not be added to the plan of coverage.