

Southcentral RPEA Members,

The following document was part of a presentation by Freda Miller, Benefits Manager for the State of Alaska, at the September 11 Forum on Health Care and Retirement Benefits in Anchorage. It addresses health care questions submitted by the Southcentral RPEA chapter. The questions originated with chapter members.

The page references in her answers are to the *Alaska Care Retiree Insurance Information* booklet. You should have received this resource sometime in the past. It is about 140 pages in length and measures 5.5 inches by 8.5 inches. It has the date May 2003 on the cover.

I found this information useful, and I hope you will too. We greatly appreciate the time and effort Ms. Miller and her associates committed to this project. Their presentation on September 11 was excellent, and these written answers to members' questions will be helpful for many.

Bob Madigan  
Chair, Southcentral Chapter, RPEA

---

### **Questions From RPEA Members**

We have asked our members what kinds of questions they have this year. Below is what they told us.

#### **Coverage**

Q: Are annual eye examinations permitted or covered once every 12 months, or once in each calendar year?

A: **Page 76, 3<sup>rd</sup> bullet.** One eye examination is covered per plan year (Jan-Dec). No requirement of 12 months between services.

Q: If a retiree decides to go to a foreign country for medical care is it covered by AlaskaCare?

A: **Page 5, Introduction paragraph.** "Your health coverage is good worldwide".

Q: Is any part of the Shingles vaccine covered. If so what part is? And if not, are there any plans to cover it?

A: **Page 5, Introduction paragraph, first sentence.** Plan covers services necessary for the diagnosis and treatment of an injury or disease.

Q: How about a quick synopsis of the differences between Tier 1, 2, 3, and 4.

A: For health plan purposes, PERS Tiers I-III and TRS I and II have the same health coverage, same booklet, same provisions. Difference is the requirement to reach retirement eligibility, and whether a retiree is required to pay for health coverage or not based on the retirement requirements. **See the PERS/TRS comparison chart.** PERS Tier IV and TRS Tier III will have a different health plan, still under development. Information is available from the Division's website.

Q: If a husband and wife are double covered under AlaskaCare, does the care provider have to submit a claim against each coverage, or does Premera automatically process it against the secondary coverage also?

A: Premera coordinates benefits internally for dual covered members, the same as before. Members must submit their "Other Health Insurance" questionnaire so Premera knows to connect the two accounts before it will happen automatically.

Q: What is available in home health care coverage?

A: Under the medical plan, **pages 22-24.** Up to 120 home health care visits per benefit year. Under the Bronze LTC plan: **see pages 14-16.** Under the Silver, Gold and Platinum LTC plans: **see pages 17-19.** Confusion in the definition of Home Health Agency, **see top of page 18 in the Silver, Gold and Platinum LTC booklet, and the bottom of page 15 in the Bronze LTC booklet** for the definition of a plan qualified home health care agency.

A: Can you outline the process that would have to be followed to make changes in the coverage? Would the ARM board have a role in this?

Q: The Commissioner of the Department of Administration has sole authority to make changes to the Retiree Health Plan. The Commissioner is a member of the ARM board. Newly reconstituted Health Care Cost Containment Committee has already started exciting work on ways to improve the health of future retirees and to better assist current retirees with chronic disease management. **Read your Board minutes to know what is happening. First ARMB HCCCC held on July 26<sup>th</sup> in Anchorage.**

### **Problems**

Q: Why does Premera reject certain types of claims that Aetna had approved.

A: Would have to know what service is being rejected now that was paid in the past to assess this question. Strictly hypothetical shot in the dark without specific details.

Q: Retirement and Benefits never answer their phone and e-mails are bounced from person to person and sometimes eventually answered. What's with the inefficiencies? We make long distance calls to talk to answering Machines!

A: Apologies. Staff of 8 technicians is serving approximately 70,000 members from 8 am to 5 pm. Queue line rolls to answering machine if no tech is available within a reasonable amount of time. Answering machine messages are returned within 24 hours. Toll free number is available: 800-821-2251. E-mail is also available at: [DOA.DRB.benefits@alaska.gov](mailto:DOA.DRB.benefits@alaska.gov)

Q: Doctors' offices seem to have a very difficult time with bill coding these days. What's the cause of this?

A: Complexity of services provided and inadequate staff education. Coding degrees are available through two year collegiate programs. Used to be the doctor hired staff that were entry level and trained them to their specific needs. CPT, HCPCS and ICD-9 coding are complex methods to report what was done and why during a patient/physician encounter. Doctors rarely are coding experts, and they shouldn't be. Their job is to manage your health. Hiring staff that is trained or provided coding training on an ongoing basis is crucial. Updates to coding manuals are made every year by the American Medical Association and the Centers for Medicare Medicaid Services (formerly known as the Healthcare Financing Administration). Code books were developed initially by the World Health Organization.

Q: How can retirees move medical caregivers, insurers and legislators to do something about the serious lack of MD's willing to accept Medicare patients? It benefits insurers and medical professionals to not lobby for Medicare acceptance, and it seriously prevents good health care for those 65 and older.

A: It's a matter of economics and community action. Medical consumers (all of us) have a responsibility to voice our opinion on this subject with the provider community. Medical providers understand what the decision to opt out means to the Medicare covered individuals in their communities. The amount of money a provider can accept from a Medicare beneficiary is limited by Medicare, which is the economic driver. The economic situation that Medicare places a provider in can only be addressed at the federal level.

Q: Is there a reason some people are experiencing a substantial increase in the expense of mammograms, e.g. a radiologist listed 2 different charges:

1. Charge for digital mammogram,
2. Charge for digitalization of mammogram, and there was a balance of \$100 due after the insurance paid. Aren't mammograms supposed to be fully covered?

A: Benefits under this plan only pay 100% under specific circumstances. Double retiree, out of pocket maximum met for the year, etc. There are always two charges for a mammogram. One is to pay for the x-ray or digital film produced. The other is for the radiologist to medically interpret the film for an individual and report those results to the referring provider. In a specific claim situation where \$100 is not covered, call Premera to ask questions about the claim. It could be that the provider charged more than the allowable, the \$100 may be a negotiated discount to the provider or there may have been a processing error.

Q: It has been reported that the State is afraid to change any coverage in the retirees benefit plan because RPEA sued them when they tried to change it previously. If this is true, does the State realize that the problem was caused by the State's unilateral action in not listening to the concerns of the affected groups?

A: 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. The Division believes that the retiree health fund is better spent on healthcare services for retirees, rather than legal defense of changes made to the coverage, considering the changes were mutually determined with the covered member groups.

### **Future Developments**

Q: What is being done to change the system to allow for preventive health care (vaccinations, etc).

A: An encouraging legal opinion recently indicated that the Division could create an optional "well" focused retiree health plan. This study is in its infancy, the concept was initially discussed at the July 26<sup>th</sup> ARMB HCCC meeting. Look for more to be discussed in the future meeting minutes of the ARM Board's Healthcare Cost Containment Committee, or plan to participate.

Q: Does the state plan to cover physicals?

A: See response above. The current AlaskaCare plan most likely will not cover physicals. Any alternate retiree plan could and probably would cover physicals at a certain dollar limit.

A: Are there any plans to cover acupuncture? Massage?

Q: See page 57, first bullet at the top of the page for acupuncture coverage. Acupuncture is covered, but most people don't use it in this way. Massage: see page 38, under the heading Rehabilitative Care. Massage therapy is covered if performed in a recognized provider's office and is billed (claimed) using the recognized provider's Tax ID number. Massage therapists individually are not recognized providers by the plan, see pages 19 and 20, under the heading Provider Services, so they are individually not covered. The claim for massage must be filed by a recognized provider using their Tax ID number.

Q: Is there, or will there be coverage for therapeutic massage for patients with cancer or other major illnesses?

A: Coverage for massage therapy is available. See answer above.

### **Provider Networks**

Q: What is a network provider?

A: A provider or facility who has voluntarily entered into a written and negotiated contract with the claims administrator to provide services at a specific amount of reimbursement. The contract requires that the provider agrees not to bill the patient any more than their contract specifies as the negotiated rate, even when that amount is less than they normally collect.

Q: Is a network provider the same as a preferred provider?

A: Yes. Just different terms. Also known as participating providers.

Q: What is the advantage of using a network provider?

A: These types of providers are prohibited from balance billing the patient. What does THAT mean? When you see a non-network provider, they can collect from you, the patient, the difference between what they charge and what the plan allows. A network provider has agreed not to charge the patient the difference and adjusts the bill at their office when they receive the explanation of provider payment. Provider contracts are negotiable and voluntary. (Providers are required to have one fee schedule regardless of a patient's plan of coverage.)

## Medicare

Q: Why is Medicare the primary insurer? Is it required by federal law, or does the state have an option to be the primary insurer?

A: [Alaska statute 39.35.535\(b\)](#) is the law that makes the AlaskaCare plan supplemental to Medicare at age 65. Medicare law (federal) determines the order of benefit determination under Medicare's coordination of benefits rules, which make Medicare primary except in specific circumstances at age 65.

Q: What can retirees expect in charges when they turn 65 and have to enroll in Medicare?

A: Recognize the difference between Part A and Part B of Medicare. [See the Medicare Parts A & B and the AlaskaCare Health Plan brochure](#), available on the Division's website, or in printed versions that can be mailed to you, for the specifics on how these 2 benefit plans interact with each other.

Q: Do retirees who are not yet eligible for Medicare have to use a Premera PPO (preferred?) provider? If so, this seems to be a change in our benefits...please explain.

A: No, this is not a provision of the plan. However, cost to the plan and the patient may be less if a preferred provider is used. The retiree plan has what is called a "passive PPO". Retirees aren't required to see a participating provider, but if you do, the chances are very good that you will pay less for the same services you purchase from a non-preferred provider. In an "active PPO" there are monetary reductions if a provider outside the network is used.

Q: Why are benefits reduced when we become eligible for Medicare?

A: Benefits are not reduced, although dollars paid by the plan are usually lower due to the requirement for the AlaskaCare retiree health plan to become supplemental to Medicare at age 65 (see Alaska Statute referenced above). Medicare law governing providers is the largest consideration. Services covered by the AlaskaCare plan that are not covered by the Medicare plan are still covered at 80%.

Q: What are the different types of providers with respect to Medicare, and how are each paid by Medicare and AlaskaCare?

Is there a list of providers who will take new Medicare patients?

A: There are 3 Medicare provider types. Participating, Non-participating and Opt Out providers. [See the Medicare Parts A & B and the AlaskaCare Health Plan brochure](#) for details, available on the Division's website, or in printed versions that can be mailed to you. Medicare's website contains a list but it was recently reported that the list there was overstated. Remember, the Medicare program and its operation is federally determined.

Q: What are the consequences of signing a private contract with a provider who has opted out of Medicare?

A: See page 17 of the AlaskaCare plan booklet, under the heading “Effect of Medicare”, the bold paragraph. The AlaskaCare plan will not pay for services of a Medicare Opt Out provider. The retiree is responsible for whatever amount the provider determines are the charges for the service(s) purchased. These providers have a contract with Medicare to NOT bill the Medicare program for a period of two years. There are federal requirements that opt out providers MUST follow when providing services to a Medicare beneficiary. Call Medicare at 1-800-MEDICARE (633-4227) with questions regarding providers who have “Opted Out” of Medicare, or see their website at [www.medicare.gov](http://www.medicare.gov).

### **E-mail Questions**

Q: We were told there would be no changes in our coverage when Premera took over. But there is now an additional cost for chiropractic services -- EOBs say "Charge exceeds allowable rate". It started out at \$5.00 and is now \$3.00. This is in effect a change (reduction) in coverage. Please explain.

A: Coverage has not changed. Chiropractic services continue to be covered as stipulated in the plan booklet. If the EOB says “Charge exceeds allowable rate” the member needs to call Premera customer service at 877-762-9597 and ask questions. Is this provider a participating provider for my plan? (If so, then you don’t owe the difference between the amount billed and the amount allowed.) Is the difference my responsibility to pay? Also see page 13 of the AlaskaCare plan booklet under the heading “Recognized Charge”, for an explanation of how the allowed amounts for services are determined by the plan. “Recognized charge” is also called “UCR” (usual, customary, and reasonable) and “allowed amount”. The recognized charge is re-evaluated bi-annually.

Q: Is there an annual cap on the dollar amount that Premera will pay per year for physical therapy? If so, what is the maximum amount?

A: No, there is no physical therapy annual limit under the retiree plan. See page 38 for coverage provisions of physical therapy. These services include massage therapy, as we discussed in a question above. Physical therapy is only considered medically necessary if significant improvement in body function is occurring and is expected to continue. At a point in the coverage for physical therapy, medical records are requested to determine the medical necessity of continued coverage. Coverage may be denied for additional services that are deemed not medically necessary, as determined by the claims administrator, after review of the medical record, or they may be covered if the medical record

supports medical necessity for the services. The trigger of coverage is whether the services are medically necessary or not. Also see page 5, first sentence, and page 53, bullet 11.

Q: Under what conditions does Premera pay for lipid panel, CBC, and TSH lab tests - for a non-Medicare patient?

A: The coverage is the same for Medicare covered and non-Medicare covered individuals, as we saw in statute 39.35.535(b). If the provider has indicated that the tests were performed to diagnose illness, injury or disease, (as indicated on the claim form by numeric code) the lab tests would be covered per the provisions of the plan. If the provider has indicated that the tests were performed in the absence of symptoms, or on a routine or screening basis (as indicated on the claim form by numeric code) the lab tests would not be covered. It depends on why the tests were performed, as reported on the claim form by the provider. See page 53, bullets 3, 4, 10 and 11.

Q: Every time a provider submits a claim to Premera under my primary policy, even before I get an EOB I receive a "Request for Additional Information" saying "In order to process this claim we need the EOB from the secondary insurance company." This request is copied to the provider. It is a source of confusion and irritation to me and to the provider, since they are NOT submitting a claim under my tertiary insurance, only my primary. At that point Premera should issue an EOB under my primary, so that my provider can submit a claim to my secondary insurer along with the Premera EOB. If the provider then needs to submit a tertiary claim, they will do so. Why does Premera send out these confusing and unnecessary letters?

A: Have you completed an "Other Health Insurance" coverage questionnaire and sent it to Premera? These are available on-line or in the AlaskaCare Welcome Kit. The questionnaire notifies Premera of all the coverages you have under AlaskaCare and other plans and assists them in processing your claim using the correct order of benefits determination. It may be, since you have three different coverages, that your provider's billing office is filing your claims using an identification number to a coverage that is not your primary plan. I recommend copying all 3 of your health plan identification cards on one piece of paper in the correct processing order and making several copies for your providers. Indicate on the copy which coverage is primary, secondary, etc. That makes it easier for your provider to file your claims, and may alleviate this from happening. Remember, your spouse's providers need to know this as well, but the chances of the order of coverage being the same for you and for your spouse when you have 3 plans is slim. Copy the ID cards in the correct order for them to give their providers, too. Important item to remember: Premera is required to process the claim AS IT IS PRESENTED. If the ID # on the claim is not the correct one,

Premera cannot simply send it to process under a different account. That would be outside their authority because it is assumed upon receipt the claim has been submitted correctly by the provider.

Q: The lack of physicians who accept Medicare patients in Anchorage is appalling. What is the state doing to make medical care more accessible to those retirees on Medicare?

A: The Division has no authority over providers of service who do or do not accept Medicare. See the questions above related to this subject for ways to affect changes in your community.

Q: Has the state done anything to assist plan participants who after receiving inpatient hospital care are notified that some independently practicing providers within the hospital (whose bills are separate from the hospital bill, for various services the patients were not even aware of) do not accept Medicare? Especially in emergency room care, patients are often not in possession of their full faculties to be able to investigate and determine whether each of these providers accepts Medicare, or whether there are other providers who will.

A: A preferred provider directory is available on Premera's website. Visit the site and look at the providers who are preferred in your area. You have the right and responsibility to ask questions of the providers and facilities where you purchase care, including asking about the status of the provider with Medicare. If you are unable to vocalize this yourself, talk with the facility before an emergency arises, so they know your wishes. If you require care in an emergency, you may not care whether the charges are made by a participating Medicare provider or not, as long as you receive good quality care.

Even if you are seen by a provider who doesn't "accept" Medicare, these providers are still limited in the amount they can collect from you. They are legally prohibited from collecting more than 115% of Medicare's allowed amount for those services. The AlaskaCare plan typically pays the amount listed on the Medicare EOB as "Your Responsibility to Pay". See Medicare Parts A&B and the AlaskaCare Health Plan brochure for additional information.

Q: What is the status of the Medicare patient's AlaskaCare coverage in this situation? If he's brought into the ER unconscious and later receives a bill from a consulting radiologist he never heard of, who read the X-rays and who does not accept Medicare, is the patient on the hook for the full charges?

A: The answer is no. Not accepting Medicare isn't the same thing as opting-out of Medicare. Even opt-out providers have certain rules to follow when the services they provide to a Medicare beneficiary are in an emergency. Contact Medicare for the specific rules. The AlaskaCare

plan usually pays the amount listed on the Medicare EOB as “Your Responsibility to Pay”, on the back of your Medicare EOB, less any AlaskaCare deductible amount as yet unpaid. If you have a question about the payment of a specific claim, call Premera customer service at 877-762-9597.

Suggestions for all AlaskaCare covered members:

- Keep a copy of your AlaskaCare Retiree Health Plan booklet handy;
- Read it before you need it, and;
- Reference it before you purchase specific, non-emergent health services.

Remember, YOU are the healthcare consumer. You have the right to ask questions and to receive accurate and responsible answers.