

RPEA Northern Chapter Benefit Questions
February 2009

Responses in Blue are from the Division of Retirement and Benefits.

1. Medicare is always a hot topic and generates lots of questions, concerns, and anxiety (especially among pre-Medicare retirees). Here are a few questions submitted by members:
 - a. The Division's brochure, "Medicare Parts A & B and the AlaskaCare Retiree Health Plan," states that "Any service AlaskaCare covers that Medicare does not cover will be paid at the normal 80% rate, just as it was before you were enrolled in Medicare." A couple members have asked for clarification and a specific example of such a service.
 - i. Naturopaths are recognized providers under AlaskaCare, but not under the Medicare program. If a member sees a Naturopathic Doctor (ND), Medicare cannot be billed for their services. A claim can be filed with AlaskaCare first and if the service of the Naturopath is covered under the terms of the plan, the claim would be paid at the normal rate of 80% of the allowed amount for that service, after your deductible is satisfied. This is standard protocol for any service or provider type that Medicare doesn't cover that is covered under AlaskaCare. See also the answer to question "d" below.
 - b. One of our members retired early with a disability and has 100% benefit coverage pre-Medicare. Is this level of reimbursement continued now that he is Medicare eligible? Will a service AlaskaCare covers that Medicare does not cover be paid at 100% (rather than the 80% stated in the brochure)?

The benefit percentage (80% or 100%) under AlaskaCare does not change with Medicare eligibility. Please note, however, that when Medicare is primary and AlaskaCare secondary, AlaskaCare pays the amount that Medicare lists on your Explanation of Medicare Benefits as the amount you are responsible to pay, as determined by Medicare law.
 - c. Does AlaskaCare become primary when a Medicare-eligible retiree receives medical care outside of the United States?
 - i. Medicare covers care provided outside the U.S. in very limited situations. See the Medicare & You 2009 brochure available at <http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf> for Medicare coverage guidelines. AlaskaCare covers you worldwide, so if the service is covered under the plan it is covered regardless of whether Medicare covers it or not. The only difference is who would pay first and how much would be paid by Medicare. Remember, AlaskaCare pays the amount listed on your Explanation of Medicare Benefits as your responsibility.
 - d. Why doesn't the Division of Retirement and Benefits send the Medicare & AlaskaCare brochure to retirees prior to their 65th birthday?
 - i. The Division has been sending letters to members three months before they turn 65 as a courtesy. The letter includes a "Medicare and the AlaskaCare Health Plans" brochure. This letter is sent as a courtesy only, please remember, and is not a requirement by either Medicare or

AlaskaCare. The Division has recognized that there may have been times in the past where the courtesy letters were not created nor mailed as scheduled.

- e. I heard that since Medicare does not pay for visits to a naturopath, AlaskaCare pays as primary. Is this correct?
 - i. Be careful about using the term “Primary” and “Secondary”. This designation relates only to the coordination of benefits order of benefit determination and is specific to an individual’s current situation and cannot be used “broad brush”.
 - ii. AlaskaCare will allow services provided by a Naturopath that are not covered by Medicare ONLY if the service is listed as a covered service under the provisions of the AlaskaCare plan. Example: vitamin supplements are not covered by the plan, but an office visit to treat a disease, illness or injury is covered under AlaskaCare. If you see a Naturopath and have a covered office visit but receive non-covered vitamin supplements, only the office visit would be reimbursed by AlaskaCare, the supplements would be denied as not covered under AlaskaCare.
- f. After Medicare has received and processed a claim for service, are all claims automatically forwarded to our Plan Administrator for processing? If Medicare does not cover a service, is the claim forwarded to AlaskaCare? Does the retiree have any responsibility for being sure claims are filed with both Medicare and AlaskaCare?
 - i. Premera enrolls each AlaskaCare member at age 65 in electronic crossover of claims processed by Medicare. A member may opt-out of this service by contacting Premera customer service at 877-762-9597. Please note that not all third party administrators do it this way, some have an opt-in design where you must authorize them to enroll you in Medicare crossover before the process occurs, rather than an opt-out enrollment design like Premera’s. It is always the retiree’s responsibility to follow-up on any claim that has not been filed with any payer that covers them. Services are purchased by the retiree, not the Plan.
- g. There may be questions and concerns about finding providers that accept Medicare patients, although I understand this challenge cannot be addressed at the state level (other than increased state funding support of community health centers).
 - i. Governor Sarah Palin announced January 27, 2009 her appointments to the Alaska Health Care Commission, charged with making recommendations for a statewide plan to address the quality, accessibility, and availability of health care for all Alaskans. As the state health planning and coordinating body, the commission is charged with developing and recommending to the governor and Legislature by January 15, 2010 a health care policy. That policy should include personal responsibility, cost-cutting, safe water and sewer systems, a sustainable health care workforce, increasing insurance coverage, and universal health care access.

Member pays 20% of \$80 plus the **\$20 over UCR**, or \$36
Provider may **balance bill** the member up to the full amount of their charges (\$100).

- b. In many plans, members are required to use the services of a network provider or the co-insurance they pay is higher. This is called a Preferred Provider Organization arrangement and is NOT in place under AlaskaCare. Members have 80% coverage for covered services regardless of whether they use the services of a network or non-network provider. Example above shows the financial impact to the member for choosing in or out of network providers.
3. How does the Plan Administrator establish Usual and Customary rates? Does Premera use the database owned by Ingenix? If so, will AlaskaCare or Premera be involved with or affected by a recent lawsuit against Ingenix regarding use of a database to calculate out-of-network payments?
 - a. UCR is established by Premera using Alaska and Washington claims data.
 - b. Premera does not use the database owned by Ingenix, with the exception of pricing out-of-network charges outside of Washington and Alaska.
 - c. Not to my knowledge.
4. Is the Division studying the possibility of adding additional preventive health care features, especially colorectal exams and a wellness physical? We have heard that the Division has requested a cost analysis from their consultant (Buck?) to assess the cost effectiveness of providing these features. Any results?
 - a. Not at this time.
 - b. Results of Buck's analysis were provided to the ARMB's Health Care Cost Containment Committee.
5. In the Q&A's from October 2007, you mentioned the following:

“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.”

Is the Division still looking at developing an alternative insurance plan?
 - a. The Defined Contribution health plan is being developed to incorporate preventive services and other design features that may be attractive to current retirees to waive into. Once the new plan provisions – including the methods of cost-effective administration – are final, the plan may be offered to existing retirees as an option.
6. One of our members has been treated for more than 30 years for a chronic condition that requires preventive treatment with an expensive medication. It is completely successful in dealing with the medical deterioration unlike all prior treatments. According to medical literature there is no dissimilar or less expensive alternative. After more than 30 years of

proof of the illness, Premera is suddenly questioning the “medical necessity” of taking the drug. What is the purpose of this query?

- a. Sorry, this forum is not the appropriate place to discuss so specific an issue. If this member would like to contact me, I’m happy to research for them to find out what may have occurred.
 - i. Generally: Medical necessity is required by the plan and is determined by the Claims Administrator (Premera currently) according to their clinical coverage guidelines. There is an appeal process in place if a member disagrees with a medical necessity determination, beginning with an appeal to Premera. Time limits apply, so don’t wait if you think their determination is incorrect and a phone call doesn’t clear it up first.
7. RPEA and its members are very interested in working with the Division to seek ways to contain health care costs, improve health outcomes for retirees, and share information. In a written response to RPEA, Commissioner Kreitzer did not seem interested in such a forum, suggesting that the ARM Board’s Health Care Cost Containment Committee (HCCCC) would be an appropriate place for such dialogue. There are several reasons why the HCCCC does not work well for such dialogue. RPEA is especially interested in the following:
- a. The Proposal Evaluation Committee that is reviewing and choosing the next Plan Administrator. We have been told that there is a retiree serving on this committee, although we do not know who. Is it possible to have more open representation of retiree interests? Also, what is the timeline for awarding the new contract?
 - i. Dennis Geary is serving on the PEC. He is experienced in health plan administration and is a valuable resource in this capacity. New contract will be awarded when the successful bidder is selected. I cannot tell you exactly when the contract will be awarded but it will be as soon as the PEC has completed their deliberations. The Division has added Sam Trivette as an invited guest to attend future Health Benefits Evaluation Committee (HBEC) meetings.
 - b. Please update us on the status of the revision of the Retiree Insurance Information Booklet. Will this revision process start any time soon? Will RPEA be involved in reviewing the revised booklet?
 - i. Select Benefits active employee booklet is being completed first. Then the Retiree booklet will follow. The Select Benefits booklet is expected to be ready to go to print in April 2009. The Select Benefits booklet will be used as a template so the turn around time for the Retiree booklet is expected to be much shorter than the time it has taken to create the first booklet. Retirees (some are RPEA members) have volunteered to review the booklets prior to them going to print.
 - c. Could significant savings be achieved by increased use of generic or mail order drugs? RPEA would work to further educate our members about prescription costs and options if appropriate. This is an example of how information sharing and dialogue would help RPEA partner with the Division in efforts to contain health care costs.

- i. Yes. However, there will always be the person who cannot take a generic form of a drug, so there is a saturation point at which the generic fill rate has been maximized. For example – the current retiree generic fill rate is over 90%. RPEA is welcome to further educate members about prescription costs. The Division is willing to provide data assistance.