



Frequently Asked Questions Retiree Health Plan General Questions February 2010

These questions were received from the Retired Public Employees Association and National Educators Association retired members

Looking at the monthly call centers and correspondence statistics, what have been the Top 5 “issues, concerns, complaints” in recent months versus July 2009?

The majority of complaints Wells Fargo Insurance Services (WFIS) fields from members have to do with claims payment. The provider network and UCR are the most prevalent issues discussed.

What are the current “wait times” and volumes at the call centers in recent months versus July 2009? What are response times when WFIS has to “get back” to a retiree on an issue? What are response times to e-mails or letters?

The State’s contract with WFIS requires certain performance standards for answering calls and processing claims and failure to meet those standards will result in penalties to WFIS. They report this information to the DRB each week. The current call wait times are under 60 seconds and the call abandonment rates, people who hang up without talking to a customer service agent, are very low at around 2%. The current turnaround time on all mail is 13 days with new mail processing within 9 to 10 days.

Why is WFIS sometimes basing UCR calculations on Seattle prices, when respected research [Commonwealth North] shows that medical costs in Alaska are 40% higher than Seattle? In one case, a retiree was billed for \$54,000 more using the Seattle UCR. Retirees have told us this was not a problem with Premera.

The recognized charge, frequently referred to as Usual, Customary, and Reasonable (UCR) is calculated as described on pages 13 and 14 of the Retiree booklet using claims paid data for the area where the service was received. Most services are paid using data from their Alaska region; for example, claims for Juneau are paid using Southeast Alaska data. Some services such as surgery are paid using data from the entire State. Where a service is uncommon in the State and insufficient data exists, calculations may be made using national data plus a conversion factor or using a percentage over Medicare.

Regarding coordination of benefits for RX’s when both spouses are covered, can you provide the instructions we can give to local pharmacies so they can do the billing electronically without retirees having to fill out paperwork after the fact?

When both spouses are enrolled in and covered under each other’s plans, the pharmacy may file a claim under both accounts to have the benefits coordinated. The member must provide the

pharmacy with both health ID cards. Any pharmacy having problems with filing for the COB should be referred to the pharmacy help desk at the number is on the ID card – this help desk is available 24 hours per day, 7 days per week.

What percent of claims appeals are resolved in favor of the retiree at each step of the appeals process?

WFIS appeals data is not available as we are only in month six of their contract.

What is the status of the purchase of Beech Street and its parent company? What are the implications for retirees?

This sale is under review and there are no implications expected for AlaskaCare members at this time.

What concessions does WFIS/Beech Street ask of providers to become part of the provider network?

Beech Street asks providers to discount their billed charges and agree not to bill the member for the amount over the contracted rate.

What are the benefits to a provider to become a member of the WFIS/Beech Street network?

Providers benefit from increased member business at their practice. They also receive contractual guarantees with respect to payment amount and speed of payment.

How many providers were in the Premera network in the spring of 2009 versus the number in the Beech Street/Viant network now? How many new providers have been added in the last 3 months? How do you track which providers have rates that are within UCR? Will you make that information available to retirees?

Premera network information is available on their web site. Depending on location, there may be more or less than are in the current AlaskaCare servicing network.

At the end of 2008, Beech Street's Alaska network had 557 providers. During contract negotiations, the State requested and WFIS/Beech agreed to a focused campaign to increase the network size. In 2009, Beech Street's Alaska network added 253 providers – 219 were added after July 2009. Two additional campaigns were launched after July 1 to increase the number of specialists and mental health providers. Currently, the Beech Street Alaska network has 889 providers while their lower 48 network is over 600,000 providers.

All network providers have rates that are within UCR. Most other provider's rates are within UCR as well. In fact, less than 3% of claims have any amount of UCR reductions.

Providers cannot be tracked based on whether or not they are within UCR because provider information is not associated with UCR data. In addition, UCR looks at individual claim codes and a provider might only have one code that exceeds UCR but otherwise is within the limits for all other claims.

Many retirees have complained that the State and WFIS is not doing a good enough job with getting providers in network at least the same level as under the Premera administration. They have provided examples of how they are now paying much more out of pocket than previously. They are saying it is a much bigger concern than what they were led to believe in June and July of this year. How can you fix this?

Beech Street has contacted by phone and have mailed over 1400 providers in Alaska and as noted above has substantially increased the size of the network. AlaskaCare members nationwide can request Beech to contact their providers regarding participation in the network by completing a nomination form on the AlaskaCare website. Members may also ask their doctors to consider participation.

If a WFIS employee questions the legitimacy of a RX, what is the protocol about who is contacted, the pharmacist, the prescribing physician, the patient, someone else? Or is protocol to deny the claim and let the patient appeal

As has been the case in the past, certain drugs require prior authorization and will be rejected if authorization is not obtained. When this occurs, Envision works directly with the physician to obtain the information required issue the authorization.

We have had a number of complaints from retirees that have had claims sent electronically to WFIS, or faxed to WFIS, or claims mailed to WFIS, that seem to get lost at a high rate. Some retirees report having to send claims in 2-3 times before anyone would acknowledge receiving them. How can we fix this?

The Division would need to know more specifics to get to the root of the problem. Remember that electronic claims from providers are submitted by the provider to a clearinghouse and on to the TPA. If they reject along the way, it is the providers' responsibility to work their error reports. Member submitted claims should be mailed to the Anchorage office address on the claim form for best service – they will be imaged there and electronically transmitted to the claim office for processing.

I was pleased that WFIS has Alaska offices in Anchorage and Juneau to assist members in person and on the toll free number. How do callers get connected to the Anchorage or Juneau office if the call is answered in W. Virginia?

The Anchorage, Juneau and Charleston offices are linked together in a common phone system. The calls are handled by the first Customer Service Representative (CSR) available regardless of office. In order to ensure we meet the requirements regarding hold times and abandonment rate we are unable to route specific calls to Alaska CSRs. Our Charleston CSRs are some of our most qualified people (many have been with us 10 years or more) and they work exclusively on AlaskaCare. While we are still in the beginning stages of evaluating our performance, our call centers have received very high ratings from AlaskaCare members that we've randomly surveyed.

We are still receiving calls from retirees that received written authorization for travel under Premera, and are still having trouble getting bills paid for the expenses that occurred shortly after the beginning of FY-10. What can be done to fix this?

Members should submit their travel claims with their Premera authorization for the most prompt service. If a member has an issue they are not able to resolve, they should contact WFIS and if necessary, the Division.

What requirements does the contract with Premera and with WFIS have about time lines for payment of claims? How frequently has WFIS met those requirements in the last few months? How many claims a month are not meeting the time line requirements?

The contracts indicate a 12-day turnaround to process clean, complete claims. Although there were some initial delays in the first few months following the transition and over the recent holiday, WFIS has been able to process claims in a timelier manner. They are currently averaging a 9 to 10 day turnaround.

If a retiree has a diagnostic code for a procedure, is WFIS able to tell the retiree whether or not this procedure is a covered expense? Will they?

WFIS determines whether or not a claim is covered at the time the claim is adjudicated. There are a number of factors that are considered when doing this which makes a predetermination without all of the information problematic. However, WFIS does their best to answer member questions when they call. They can quote the plan benefits, determine medical necessity, verify provider network status, and research UCR assuming the member has the procedure codes.

Appeal information was not previously on WFIS or R&B web sites. Is it now? If not, will it soon be posted?

The Retiree Health Claim Appeal brochure is, and has been, located on the Division website under Quick Links – Forms/Brochures as well as under the retiree insurance pages. The brochure is being updated to include the current claims administrator appeal address for WFIS. Appeal information is also included on each EOB statement. Health appeal brochures and EOB appeal messaging has also been available in the same manner for the previous claims administrators.

Is there a cutoff date for appealing any Premera determination? We assume any such date would be tied to the date the claim was denied?

As stated in the brochure and on the EOBs, appeals must be received by the claims administrator within 180 days of the date of the EOB or of the date the precertification denial letter was issued.

If a doctor deems sclerotherapy is medically necessary to correct a problem with varicose veins, will retiree insurance cover this procedure?

This is a medical claim review question and specifics should be provided to the claims office for review.

A retiree received medications while hospitalized this summer, and the claim for reimbursement was denied. What basis would WFIS have to deny a claim for a RX that was medically necessary and physician prescribed?

Specific information would be required in order to check this issue.

A retiree is frustrated with still not having claims paid correctly for services in April 2009. The retiree has dealt with numerous employees of Premera, with staff from R&B. They finally acknowledged the bill should have been paid, but as of November, the retiree still had not received reimbursement. She has spent countless hours for a simple bill. She has been involved with at least one conference call with R&B and Premera. Who should she call that can resolve the problem?

Members can call the Benefits Section at 800-821-2251 or 465-8600 in Juneau for assistance. If at anytime members are not receiving adequate assistance from the Benefits Section customer service representatives they may request a supervisor's assistance.

What provision in the contract allows WFIS [or subcontractors] to deny the payment of RX drugs if the drug prescribed is "atypical" in the eyes of WFIS, if the drug is medically necessary [not Viagra, etc.]? These are drugs that have been paid for by AlaskaCare TPA's for years.

More information is needed to determine what is meant by an atypical drug. A specific example would be of help here.

What enhancements have been made to R&B and WFIS web sites since July 2009?

The DRB has made several updates to its AlaskaCare information page including adding frequently asked questions and copies of member notifications. *AlaskaCare.gov*, which is a State site managed currently by WFIS, has had some visual changes. Both have had many form updates made as forms have become available or been revised. It is anticipated that *AlaskaCare.gov* will be taken in house by the DRB in 2010 to allow a more consolidated website.

What was the basis for increasing retiree insurance premiums in January 2009 for Dental Audio and Visual coverage? Has the DVA fund, paid by retirees, been audited in the last 5 years? If so, by whom?

Insurance premiums are reviewed annually and are impacted by claims experience – the cost of claims being paid by the fund. The actuarial consultant for the DRB annually reviews the retiree premium rates and calculates the need for rate increases based on the claim experience. All of the AlaskaCare funds are audited annually by KPMG.

It should be noted that the January 2009 increase of approximately 5% was the first increase in premium since January 2005.

What is the State doing to help alleviate the problem of retirees' lack of access to medical services because so few providers accept Medicare patients?

While there are a few providers who have opted out of Medicare completely, most providers have not done so. However, many physicians limit the number of Medicare-eligible patients they see because of the substantially lower reimbursement Medicare provides. As the difference between what Medicare will pay and what physicians charge grows, it is possible more physicians will choose to opt-out of the Medicare system. These are serious issues, but at their core, they are Federal issues and require a Federal solution. The Department of Administration and its contractors continually

monitor the medical community in Alaska and elsewhere. Our hope is to learn from other jurisdictions how to keep providers from exiting Medicare, and making sure we do not incentivize “opt-out” decisions in any way.

Members should ask their provider if he/she accepts assignment and will accept them as a Medicare patient – most will be willing to continue to provide service to an existing patient even after they become Medicare eligible. If necessary, to find a provider who does accept assignment, they may go to www.medicare.gov for a directory of participating Medicare providers.

Is it correct that Medicare does not pay for dental, audio or visual [non-surgery] services for those on Medicare, so if a retiree has DVA through the State, claims would be paid according to the current plan book?

Specific Medicare coverage questions should be directed to Medicare but it is our understanding that non-medical dental, vision and audio services are not covered by Medicare. They would be paid according to the current plan book.

Some retirees have had to be hospitalized for surgery. Some do ask about the costs from their surgeon and the hospital when making arrangements. Try as hard as they might, they couldn't find out what other non-hospital staff [such as radiologists, anesthesiologists, etc. might be providing them services and then billing them. Retirees have found after the fact many of these medical practitioners are not taking Medicare, therefore WFIS won't pay, so the retiree is stuck with hundreds to many thousands of dollars in medical expenses. The retiree has no idea in advance of who will be providing these ancillary services. How can the State/WFIS help retirees not get stuck with these huge out of pocket expenses?

The DRB has not received complaints regarding these types of issues in the past and would need to see information on specific claims,

However, members should continue to press for information about their providers as patients have the right to know who their health care providers are to allow them to make informed healthcare decisions.

Is it correct that retirees that haven't worked the minimum number of quarters under Social Security to be eligible for Medicare Part A, will have their hospitalization claims after age 65 paid at the regular 80% rate under the State retiree plan?

This information is located in the Medicare brochure available on DRB's website. Members who are not eligible for Part A may obtain a letter from Medicare stating that and provide it to WFIS. At that time, AlaskaCare will continue to pay for Part A (facility) expenses as primary. It should be noted that these members will not benefit from having two health plans to coordinate and pay up to 100% of items which both plans cover. In addition, lowering the cost to the AlaskaCare plan helps stretch the retiree's lifetime maximum.

What is the status of plans to possibly change names/member ID numbers of AlaskaCare cards?

Upon review, it was found that the current ID cards are in the same format used and preferred by health plans nationwide as they disclose only a minimum amount of personal information about the member. Based on this, there are no plans to change the ID card at this time.

Please tell us how UCR rates are determined and what they are based upon.

Please see the UCR question above.

Are customer satisfaction forms sent out every time a customer service representative interacts with a retiree? If not, what % gets them? How does WFIS use this information? What is WFIS practice about providing personal information on the retiree to the customer service representative?

The State's contract with WFIS includes performance guarantees based on customer satisfaction and the survey is used to measure that. One survey per customer service agent is sent out daily to a member that they have spoken to. WFIS averages approximately 50 calls per day per customer service representative (CSR) and there are usually at least 20 CSR's on the phone each day. Survey information is compiled and provided to the State quarterly to report on the performance guarantee.

If there are negative comments on the survey, a Team Leader will research the issue and respond to the member by phone or in writing and address any service issue with the CSR.

CSRs have access to member's personal information that has been provided by the State, a provider or the member as required to perform their job. All CSR's have been trained regarding HIPAA privacy and have signed confidentiality agreements.

Retirees were told years ago the 2003 Medical Benefits Booklet was being revised and would be out NLT 2007. What is the completion date? How much consultant time and money has been spent on the effort so far?

The State plans to revise all booklets to update their format and incorporate changes in addresses, etc. A firm deadline for completion has not been set. At this time, no consultant time or money has been spent on the retiree booklet as the employee booklet, which they assisted with, will be used as a model.

Does R&B/WFIS track the number of claims in which the provider is NOT in network, and what % of those claims are costing retirees more money than if the provider was in network?

WFIS tracks the number of network claims vs. non network claims and reports this information to the State quarterly. There is no way to quantify the value of what more network providers would mean in terms of dollars. Provider contracts are done on an individual basis and vary by provider type and geographic region.

We understand many insurance companies/TPA's have begun posting provider prices on the web sites so patients can access cost information. This allows patients to compare prices among network and non-network providers, check on the price of diagnostic tests and other treatments. Would WFIS be willing to provide this type of information on their websites.

AlaskaCare and WFIS are supportive of any initiative to put more information in the hands of members so that they may make better informed healthcare decisions. This will be a major focus in 2010. There are certain federal laws that prevent hospitals from comparing their charges to other hospitals within a geographic area. These laws are intended as a consumer protection to prevent hospital collusion on price within a certain geographic region, however they do create unintended

challenges in the area of provider cost transparency. We are working on ways to share as much information as possible within the confines of the law.

At what point should a plan member contact DRB with their problem or questions if they have not received an appropriate explanation or response from Wells Fargo Insurance Services?

Members who are not able to resolve issues with any DRB contractor are welcome to contact the Benefits Section at 800-821-2251 or 465-8600 in Juneau.

Is there an ongoing effort to increase the number of network providers? After being contacted by an out-of-state RPEA member, I searched online for dentists in the Las Vegas area and found only one listed as a member of the network.

Please see the network information provided in the questions above. In addition, there is not currently a dental network.

How are Usual and Customary Rates determined and how does a Plan member access information about UCRs? For example, if a member is going to have an expensive medical procedure and cannot find a network provider, the member would like to know what to expect in insurance plan reimbursement.

Please see the UCR information provided in the questions above.

Is DRB considering opening enrollment to the Long Term Care Plans for older retirees who have not elected this coverage?

The last open enrollment was provided to all retirees in 2000 due to the creation of new Long Term Care options. The DRB has no plans to provide another open enrollment at this time.