GSRA Members' Questions for Department of Community Health (DCH)

Annual Meeting – October 21, 2009

GSRA submitted, on behalf of its members, questions to the Department of Community Health's Nancy Goldstein, Division Director of the State Health Benefit Plan, regarding some of the provisions of the SHBP. Director Goldstein and other SHBP staff verbally responded to many of the questions at the GSRA Annual Meeting on October 21, 2009, and submitted written responses to the following GSRA questions. Director Goldstein's submission included the following caution:

> "The Department of Community Health has prepared the following brief responses to your questions. These responses are general in nature and should not be considered a confirmation of benefits in any specific situation. More information is available in the Active and Retiree Decision Guides and the Summary Plan Descriptions."

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1. **Effective January 1, 2010, retirees age 65+ will no longer receive any State subsidy in their premiums for options other than the MAP. Why did DCH change the policy to force SHBP retirees age 65 and older to go into the Medicare Advantage Plan?**
   A: In 2008, the State of Georgia Other Post Employment Benefits (OPEB) valuation was $16.4 billion in unfunded liability for retiree health care. The DCH was instructed to reduce this liability in order to maintain a fiscally sound status and avoid adverse impact to the State bond ratings. On October 30, 2008, the DCH presented two major policy changes designed to impact the liability 1. New hires would only be allowed to enroll in one of the CDHP options their first year starting January 1, 2009. 2. State subsidies for Medicare eligible retiree coverage would be limited to the Medicare Advantage options starting January 1, 2010.

2. **Given the reason for eliminating any employer subsidy of premiums for retirees age 65+ and, therefore, forcing retirees to move to the MAP, what is the anticipated 2010 State savings per retiree age 65+?**
   A: The projected 2010 savings for reduced expenses per retired member 65+ = $770/year.

3. **We heard that the reason for dropping Kaiser Permanente was a result of DCH's desire to reduce overall cost. How does dropping the Kaiser option help to reduce cost? Since DCH has reported that the benefit payments of the SHBP were about $100 million greater than anticipated in FY 2009, how did the Kaiser per-member cost compare with the HMO, PPO, and HRA per-member costs?**
   A: *Kaiser is being dropped because they participated in the 2008 procurement to consolidate carriers to two, each offering five options. Kaiser did not win the bid. Blue Cross Blue Shield was also dropped due to the procurement results. During CY 2009 to date, Kaiser is costing the state more on a per member per month (pmpm) basis than any other SHBP option, including even the PPO. Kaiser costs are running at $357 pmpm, while the next highest cost HMO is at $308 pmpm.*

4. **In the retiree meeting that I attended, a SHBP representative was not present to answer questions. The UHC and CIGNA representatives could not answer my questions. Who at DCH will answer our questions and what is the phone number to call? Will all retirees' questions and answers from DCH be posted on the DCH website?**
   A: *SHBP held 183 retiree meetings across the state. Due to budget constraints and limited resources, SHBP staff was not able to attend the meetings. The vendors had Medicare Advantage plan experts available to answer questions at the meetings. Retirees with additional questions may call the SHBP Call Center at (404) 656-6322 or (800) 810-1863 or may call the vendors directly. There are Q&As*

listed on the Web site. We do not plan to add all of the questions we receive from retirees.

5. **We understand from the benefit material that you are changing the name of the PPO option to the OAP, "Open Access Plan." What is the reason for this change and what does it mean to us?**
   A: *CIGNA already used their OAP network for 2009 – we are just changing the name to correctly reflect the network. UHC is switching to their OAP network on 1/1/2010. With the OAP networks the carriers are able to achieve larger discounts from providers which results in lower cost for the state and for members. There is no impact at all for CIGNA members. There are a small amount of providers in Georgia (less than 200) who do not participate in the OAP network.*

6. **We understand that DCH is changing the Coordination of Benefits policy to a "maintenance of benefits" provision.**
   - **What does this mean to retirees under age 65 who also have coverage under their spouses' plans?**
   - **What does this mean to retirees (65+) who choose to pay the higher premium for the OAP or HRA and retain original Medicare A, B, and D?**

   A: *The HMO and High Deductible Health Plan options already use the "maintenance of benefits" provision. Therefore, SHBP members enrolled in these options will not experience a change. SHBP members with dual coverage who are enrolled in the OAP option (formerly PPO) or the HRA option often paid nothing out of pocket for treatment under the old Coordination of Benefits policy. Under the new Coordination of Benefits Policy, the SHBP member with dual coverage will always have to pay co-pays and/or co-insurance. SHBP members with dual coverage should review the Coordination of Benefits rule and examples in the Decision Guide when determining whether dual coverage is still cost-effective.*

7. **We know that different companies have different processes for approvals and paying claims. Is the SHBP amount paid to CIGNA and UHC the same? If not, what is the difference?**
   A: *The DCH has separate contracts with CIGNA and UHC. The amounts paid to CIGNA and UHC vary based on whether they meet certain goals set forth in the contracts, claims experience, enrollment and other variables.*

8. **Do you think it would be a good idea for a retiree to cancel their SHBP coverage, keep Medicare Part A, Part B, and Part D and buy a Medigap policy?**
   A: *Retirees must evaluate the benefits provided by SHBP versus the premiums to decide if they feel it is in their best interest to keep the SHBP coverage or to drop it and purchase a Medigap policy. Retirees should think this through very carefully because if they drop their SHBP coverage, they will NOT be able to get it back.*

9. **If I select one of the MAP options and I don't like it, can I change back to one of the SHBP options, original Medicare and Medicare Part D before 2011? I understand that I will have to pay the higher premium, but will there be any penalties, such as the Medicare Part D "late" fees? What if I elect to remain in my current option and later decide that I cannot afford the higher premiums and costs, can I change into one of the MAP options before 2011?**
   A: *A retiree could not opt out of the MAP option until the Retiree Option Change Period (ROCP) for 2011. Regarding whether or not a retiree would have to pay late penalties should they elect to go back to original Medicare during the ROCP , if a retiree changes from a MAP option to another SHBP, upon submission of the cancellation of the MAP option to CMS, original Medicare automatically resumes. The retiree will have 60 days to enroll in a Part D plan without any penalties. Retirees who elect*

to remain in their current option and later decide they cannot afford the higher premium will be able to change to one of the MAP options before 2011, upon approval by CMS.

10. **And what about <u>after</u> 2011? When future Retiree Option Change Periods come around, will we be able to change back and forth between the MAPs and other SHBP options the same as we've always been able to? Can we choose an unsubsidized option (PPO, HRA, etc.) one year and a MAP the next, for example?**
A: *Yes, each year retirees may switch options during the ROCP.*

11. **Discuss any differences between medical services covered and costs under the CIGNA MAP plan versus the UHC MAP plan. Include any differences in types of costs that are included in the out-of-pocket maximum under the CIGNA MAP plan vs. those included in the OOP maximum under the UHC MAP plan.**
A: *The United Healthcare and CIGNA plan designs are the same except for the following: CIGNA: Part B Drugs and DME purchased at a pharmacy **do not** apply toward the OOP maximum; United Healthcare: Part B Drugs and DME purchased at a pharmacy **will** apply to the OOP maximum.*

12. **Is the inpatient hospital copay (for 3 or 4 days based on the option) per year or per admission until you reach the OOP maximum?**
A: *The inpatient hospital copay is per admission. Once the annual out-of-pocket maximum has been met, the inpatient hospital copay would not apply for future inpatient hospital admissions.*

13. **Original Medicare approves a set number of days for a given diagnosis, etc. How does UHC/CIGNA handle this limitation? Do UHC & CIGNA use the Medicare guidelines or other medical guidelines?**
A: *Please note that Medicare (CMS) does not approve a set number of days for a hospital admission for a given diagnosis. CMS pays a set amount for a diagnostic grouping (DRG – Diagnostic Related Group) based on the average number of inpatient hospital days treatment of a diagnosis would require. For PFFS plans, United Healthcare and CIGNA would reimburse providers consistent with Medicare reimbursement rules.*

14. **The copay for admission with a diagnosis of mental health is the same as the copay for a physical condition. However, there is a lifetime limitation of 190 days for mental conditions. Please comment on whether the SHBP will implement parity for physical and mental conditions.**
A: *The Medicare Advantage Plans for the SHBP are fully-insured products. These plans have a 190 day limit for benefits when admitted to a psychiatric hospital. There is no limit however, if an individual is admitted to a regular hospital that has a psychiatric unit.*

15. **Explain how the MAP network or "deemed" provider will work.**
A: Unlike a traditional provider network, a retiree can see any Medicare participating provider anywhere in the United States who is willing to accept the terms, conditions and payment rates for the plan. To help ensure the provider understands the retiree is participating in a PFFS plan, it is important for the retiree to show their membership identification card each time they seek medical services.

16. **What if I show my MAP ID card to my provider who stated that he/she would accept MAP, but the provider files the claim with Medicare anyway. What will Medicare do? What will the MAP vendor do?**

A: *A provider guide explains the terms and conditions of the program and the administrative processes- including the address to file claims. In the event that a claim is sent directly to Medicare, Medicare will see in their processing system that this retiree is enrolled in a Medicare Advantage plan. This will key them to return the claim to the provider and the provider can then submit the claim to United Healthcare or CIGNA for processing.*

17. **Are there areas of the State where you anticipate that retirees may have more trouble getting the providers to become "deemed providers" for the MAP enrolled retiree?**
A: *Based on the information provided by our vendors we have not seen an area of the state with any disproportionate percentage of providers who are not accepting the MA plans. Retirees are encouraged to contact their providers directly to check their MA status.*

18. **Explain what we must do if our providers will not accept the MAP PFFS. Explain how the MAP PFFS option works for out-of-state members.**
A: *If a retiree seeks services from a provider that will not accept the plan, they are encouraged to call United Healthcare or CIGNA. The vendor's customer service teams have access to "deemed" provider data and can help the retiree find a provider who is deemed in their area or anywhere in the United States. The CIGNA and United Healthcare plans provide national coverage and would work the same for out-of-state retirees.*

19. **There is much talk about Congress and the President cutting funding --- up to $500 billion—from Medicare and the Medicare Advantage plans or eliminating the MAP plans. Explain what the State will do if money is substantially cut from the MAP plans.**
A: *If the rumored MA cuts get to the point where it is more expensive to the state to offer MA, then SHBP will consider alternatives. These may include keeping MA as an option, or eliminating MA altogether. In any event retirees would be transitioned to another health plan, likely one of the existing SHBP options that coordinates with Medicare, similar to what they have today.*

20. **Why should retirees be forced into Medicare Advantage knowing that Congress and the President are trying to eliminate it? Are you setting the retirees up to eliminate our health insurance coverage entirely? If not, then what type of coverage should we anticipate under either of these two scenarios?**
A: *The decision to move to MA was made prior to current presidential administration being elected. It would be irresponsible for SHBP to put any major strategic initiatives on hold pending unknown legislation that may take years to pass and/or implement. The state has no intention of eliminating retiree health care coverage and we can assure that we will work with retirees to ease any transition that the passage of any health care reform bill may result in.*

21. **If I am 65+ and don't want to transfer to the MAP, will I stay in my current option if I do nothing during this Retiree Option Change period?**
A: *No. Retirees eligible for the MAP will be automatically enrolled in the MAP if they do nothing (subject to CMS approval). If a retiree wants to keep their current option, the retiree should call SHBP advising that he/she wishes to keep their current option without the state contribution. SHBP will provide the cost and proceed to enroll the retiree in their current option. Or, the retiree may write on their PCF that they wish to remain in their current option and that he/she understands that he/she will pay the full cost of their health coverage.*

22. If I want to enroll for the Premium MAP, do I have to complete the "Change" form or enter my selection into the computer during the Retiree Option Change Period?
A: *Retirees who want to enroll in the Premium MAP must complete the personalized change form or may make their election on the Web site at www.oe2010.ga.gov.*

23. If my spouse continues to work and I am covered under his/her plan—either the SHBP or other employer's health plan—and I am over age 65, will I have to enroll in one of the MAP options?
A: *Retirees who are covered under another group plan because their spouse is actively working whether through the state or another employer and are over 65 will have to enroll in one of the SHBP MAP options.*

24. We understand that our current Part D plan will automatically be cancelled by Medicare when the SHBP notifies Medicare of our enrollment in MAP. Will this be done in time to stop my deduction from my social security check? If not, will it cause problems with Medicare if I cancel my Part D coverage?
A: *SHBP will send the file of elections made during the Retiree Option Change Period to the vendors in late November to submit to CMS. SHBP cannot guarantee that the deductions will be stopped from their social security immediately as we do not know what their cutoff dates are. However, to assure no deduction is taken, the retiree can contact the Part D Plan directly to cancel the coverage.*

25. Are <u>all</u> age 65+ retirees—state, teachers, legislators, judges, school service employees—required to enroll in a MAP option?
A: *No one is required to enroll in a MAP option. In general, all retiree and active employee options are the same for teachers, school service employees, state employees, judges, legislators and even the Governor.*

26. **Explain how to enroll (the option) for coverage when the spouse is under age 65, the retiree is age 65+, and there is a child under age 18 or a student under age 26 under the coverage.**
A: *Retiree age 65 and spouse and child under age 26 – The retiree will either complete the personalized change form or go online at www.oe2010.ga.gov and make an election for one of the MAP options and select the HRA, OAP, HMO or HDHP for the spouse and child. All three individuals must be covered by the same vendor.*

27. **Explain how to enroll if both parents are age 65+ and there is a child under age 18 or a student under age 26 in the current coverage.**
A: *If both the retiree and spouse are 65 or older and have a child without Medicare covered under the plan, the retiree would follow the same steps as outlined in Answer 26 above – elect an MA plan for retiree/spouse and one of the other plans for the child.*

28. Explain how to enroll when both parents are age 65+ and there is a handicapped child (with original Medicare) covered under the retiree's contract.
A: *When both the retiree and spouse are 65 or older and a handicapped child with Medicare coverage is covered under the contract, the retiree would will either complete the personalized change form or go online at www.oe2010.ga.gov and make an election for one of the MAP options. All three individuals will be covered by the MAP option the retiree selects.*

29. I am currently enrolled in the HRA option and I have not used all of my HRA credit. Will I be able to use these amounts? If so, how will I access these unused credits in 2011?
A: *If you as a single enrollee or if everyone in your family moves to one of the MA plans,*

then yes, you will be able to access those unused funds if you have a balance of greater than $10 after a six (6) month claim run out period. These unused funds will go into a stand alone account. These funds will be used to reimburse you for any copayments or coinsurance you pay to physicians and hospitals. United Healthcare will use an automated process to issue you reimbursement checks; there will be no need to submit documentation or proof of payment and CIGNA will require submission of a claim form for reimbursement. Reimbursements to you will continue until all funds are depleted. If one person in your family moves to the MA plan but other family members remain in the HRA option, then all funds will remain in the HRA account. If your family members move to another plan type, the HRA funds will be forfeited.

30. We understand that if a SHBP member discontinues his/her coverage that the member cannot re-enroll in any option with the SHBP. Explain other situations under which a MAP member can lose SHBP coverage.

A: *If a retiree discontinues his/her SHBP coverage, he/she cannot re-enroll at a future date. A SHBP retiree enrolled in a SHBP MAP option can lose his/her SHBP coverage, if he/she decides to drop the MAP coverage by contacting CMS or enrolls in a supplemental Medicare policy or a Part D plan.*

31. It is our understanding that DCH staff no longer submits to the Board of Community Health for approval benefit changes or even the major policy changes, i.e. to eliminate state subsidy to the premiums except to the Medicare Advantage Plan for retirees over age 65. How can members have more input into the benefits and policies of the health plan?

A: At the *request of the Board of Community Health and the Governor, the DCH works with industry experts to develop long term strategies for the SHBP. These strategies are designed to offer industry standard medical benefits while making sure the SHBP has enough money for the long run. These strategies are presented to the Board in open meetings, and they comply with federal and state law. Long term strategies include the adoption of benefit designs, network arrangements, and policies that encourage members to use other insurance they have. Changes in benefit design and policy are always considered during the budget process and the calculation of contribution rates. These budgets and rates are approved by the Board. For example, the long term strategy that included the policy change related to Medicare Advantage was presented to the Board on October 30, 2008, and was used in the calculation of rates approved on May 14, 2009. Here are some ways that SHBP members can have more input into the benefits and policies of the SHBP: 1) Attend Board meetings and get on the email distribution list that announces the tentative agendas for the meetings; 2) Review Board meeting minutes and resolutions, which are posted on the DCH Web site; and 3) Correspond to the Board and the Department of Community Health to provide feedback and ideas. There is also a formal public comment period of 30 days associated with changes to the SHBP rules*

32. Most of the SHBP options are funded on a self-insured basis with an insurance company managing the payment of claims for a fee; therefore, the insurance company is not at risk for adverse fluctuation in benefit cost. Is the Medicare Advantage Plan self-insured or a fully insured product; thereby, transferring the financial claim risk to the vendor? How does this affect the OPEB liability?

A: *The Medicare Advantage plans are fully-insured, however the funding mechanism (self-insured versus fully insured) does not impact the OPEB liability.*

33. Given that DCH reports that the SHBP Fund remains in a negative position for 2010 after all of the changes, what is the DCH proposal to keep the plan solvent during FY 2010 and FY 2011?

A: *While we have reported a projected negative fund during FY 2010 and FY 2011, at this time, we believe there is enough cash available from all revenue sources to ensure that all providers are paid in a timely manner through June 30, 2011. The negative fund balance deficit has been communicated to the Governor's Office of Planning and Budget and it is our expectation that their Amended FY 2010 and/or FY 2011 budget recommendations will address the deficit in some manner.*

34. We have read that the Medicare Advantage PFFS plans must develop a provider network by 2011. Is that a requirement of Medicare? What do you envision will be the result of this requirement—more or less acceptance by providers?

A: *Medicare regulations spelled out in MIPAA (Medicare Improvement for Patients and Providers Act) regarding Group Retiree Medicare Advantage PFFS plans require contracted provider networks starting January 1, 2011. We anticipate there may be some resistance but because providers are accustomed to contractual arrangements in a network situation this should not be a problem. We anticipate that this would be a PPO type network with some of the same features and benefits as a PFFS product and have the added security of pairing a broad contracted provider network with access to non-contracted Medicare accepting providers.*

35. Does DCH have staff or consultants observing the actions being taken by Congress on Health Care Reform? Do you anticipate any of the State's options to be taxed because the total cost exceeds some dollar amount?

A: *DCH's Division of Legislative Affairs is monitoring the actions being taken by Congress. DCH is not able to predict at this time whether any of the options would be taxed.*