RPEA Comparison - Old Booklet to Draft Booklet for AlaskaCare Retiree Health Plan

Added:

- Hospice care
- Transplant language (covered benefit already but was not described in current booklet)
- No home health care daily limit if within 10 days of inpatient discharge to member's home
- Speech therapy for birth defects
- Acupuncturist, ANPs (not NPs), Massage Therapists, Nutritionists to list of recognized providers
- Routine care for newborn
- Off-label Rx use, at claims administrator discretion
- Removes precertification requirements if services are by an in-network provider
- "Common accident deductible" limit of one deductible if two or more family members are involved in one accident
- Increases to 24 months the length of time a member has to get post-injury repair from 12 months
- Reimbursement for taxes paid

Takeaway:

- Non-emergent travel outside US
- Changed definition of dependent
- Reduction in student coverage enrolled for five months and not in member's home ½ year
- Difficult for member to determine which schools may or may not qualify their student for coverage (definition of "school" nebulous)
- Changes incapacitated dependent definition
- Dental/Vision/Audio elections can by changed only after two years of coverage
- "Decreasing Coverage" section added allowing benefit recipient the right to terminate coverage
- Dependents can be dropped without a life event
- Precertification requirements increased substantially (no payment at all if some are not met)
- Changes plan from open choice of providers to PPO plan, payments reduced for choosing out-of-network providers
- Usual, customary and reasonable (UCR) method of calculating payments changed to "Recognized Charge" at discretion of claims administrator
- Change to reimbursement of Rx drugs at 110% AWP or billed charge
- Removes responsibility for appeals process from the Plan Administrator and gives rights fully over to the discretion of the claims administrator
- Dental coverage changed to "Delta Dental" standard coverage (many changes)
- Reduction in teeth cleanings (from up to four down to two per year, unless diabetic, pregnant in 3rd trimester or diagnosis of periodontal disease)

- Reimbursement policies instituted as determined by claims administrator, not "90th percentile" of all claims for like services – out of network providers would be paid at "80th percentile"
- No indication of how claims administrator is to determine "allowed charges" in areas too infrequent to determine amount
- "Recognized charge" can be reduced by Aetna policies
- "Semi-annual" review to update "recognized charge" changed to "periodically" by claims administrator
- Transplants paid at 60% for non-Institute of Excellence facility is used
- Rx does not apply to lifetime maximum
- Travel not paid AT ALL if not preauthorized
- Physical therapy coverage excluded for chronic conditions
- Ground transportation changed to per diem (overnight and non-overnight) amount rather than actual documented costs
- Depo-Provera injections limited to five per year
- $2,000 every two years audio limit reduced to "rolling three-year period"
- Current medical necessity definition replaced by Aetna Clinical Policy Bulletins
- Reduces private room requirement for "medical necessity" as previously defined to "due to contagious illness or immune system" problem
- Limits inpatient coverage to specific list
- Covers ambulance under "hospitalization" coverage rather than medical
- Outpatient Hospital introduced and stipulates room and board charges will be split 40% room/60% "other charges"
- Limits ER visits to "when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician"
- Renames "Outpatient Ambulatory Surgery" section to "Alternatives to Hospital Stays", removing the 100% coverage without deductible assessment incentive for choosing outpatient surgery
- Excludes local anesthesia in Surgery Centers and Birthing Centers
- Removes language specific to how claims are handled if benefits or claims administrator changes while confined in a hospital (may be a reduction if not clear as to coverage)
- Home health services not covered if home health provider is not available
- Excludes home health benefits to a minor or dependent adult if family member or care giver is not present
- Excludes treatment of drug addiction, alcoholism, senility, mental retardation or any other mental illness from skilled nursing facility coverage (may now be covered under Hospice??)
- Removes "Retiree-Elected Second Opinions" benefit
- Excludes coverage for laboratory and radiological studies unless "You have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician"
- Excludes coverage for repeated pre-operative blood tests
- Excludes payment for surgery if test results indicate that surgery should not be performed
- Penalties for non-precertification introduced for MANY procedures

- Excludes therapy coverage for persons with Down's Syndrome, Cerebral Palsy and other developmental delays
- Excludes "cost" of anesthetic and limits coverage to "administration" of anesthetic
- Removes high-risk pregnancy screening benefit
- Changes coverage requirements for durable medical equipment
- Excludes trusses and braces from medical plan (covered per page 41 of current Retiree Booklet)
- Rx can be denied at pharmacist discretion
- FDA approved drugs "but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee" charged at out of network amount
- Aetna has the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to section 7.15
- Excludes Rx coverage for compound medications if one of the drugs in that therapeutic drug class is not a prescription drug
- Excludes replacement of lost or stolen prescriptions
- Prescription drug that is in a similar or identical class, or has a similar or identical mode of action or exhibits similar or identical outcomes (over the counter) can be substituted for an Rx
- Reduces benefit for Rx purchased "out of network", even in an emergency
- Limits reimbursement for out of network pharmacy to "recognized charge" tied to contracted rates
- Generic substitution of Rx at pharmacy allowed without notice
- Excludes self-injectable drugs
- Excludes injectable drugs if an oral form is available
- Excludes food items, even if it is the only form of nutrition
- Excludes specific spinal treatments (but allows it in other areas???)
- Excludes treatment for obesity (but allows it in other areas???)
- Excludes massage therapy (but allows it in other areas???)
- Mental health inpatient treatment allowed only if your condition requires services only available as an inpatient
- Removes "two consecutive years" requirement from substance abuse limit so that lifetime limit is reduced to two years of total annual benefit (limits benefit if relapsed after the first year benefit is paid)
- Reduces inpatient coverage for member by paying Medicare Part A premiums beginning Jan 1, 2015 (non-optional cost shift to Medicare)
- Allows choice to terminate AlaskaCare coverage and opt for Medicare coverage only
- Excludes COB from audio and vision plan benefits
- Excludes prescription vitamins in Rx benefit
- Excludes charges for midwife at home birth
- Specifically excludes ambulance charges for routine transportation to receive inpatient or outpatient services
- Removes appeal process and inserts a complex chart of timelines that a member has to appeal

- Introduces separate rules/time limits for Urgent Care Claims/Pre-service Claims/Post-service Claims
- Recognized Charge can no longer be appealed
- Reduces coverage for air, ground or water ambulance if "not required"
- Protective Clause absolves the State and TPA for failure to make payments under the terms of the contract
- Receipt and Release states that any payment satisfies claim
- Misrepresentation introduces fraud resulting in retroactive termination of AlaskaCare benefits
- Dental plan entirely replaced by Delta Dental "standard plan"
- Full mouth x-rays paid once every five years rather than annually
- Dental services may be reduced to lowest benefit to treat condition, not what dentist did
- Restricts lens coverage to only "new" or "changed" prescription
- Excludes lens benefit if not changed or new, even if benefit is available
- Excludes frame coverage unless lens prescription is changed
- Removes lens options (scratch resistant coating, antireflective coating, polycarbonate lenses) from coverage
- Seems to indicate that if a non-participating provider is seen the member must pay and then self-submit a claim (does the plan not accept claims, electronically or otherwise, directly from out of network providers?)
- Removes 90th percentile as recognized charge for audio benefit (claims administrator determines recognized charge but doesn't say how)
- Changes hearing aid benefit to a "rolling three year period"
- Parts C and D were included in Medicare coverage limitation
- Allows financial pursuit of members for overpayments made in error by claims administrator
- Documents sent to Division or claims administrator may be disavowed unless member has proof they were sent (certified mail receipt or receipt stamp)

Other Considerations:

- Eligibility language (changed from specific details to "Automatic" and "Voluntary", requiring member to interpret statutes and regulations to determine whether they pay premiums for the health coverage or not)
- Readability level too high (6th to 8th grade level recommended for SPD's)
- Amendment dated December 31, 2013 waived member's protected rights without recourse
- Timeframe of comment period too short for adequate response
- Definition of Plan Administrator/Fiduciary of Plan is needed
- Excludes payment for "Never Events" but doesn't say what these are or what criteria is used to determine them
- Draft plan appears to be a PPO plan requiring steerage to network providers or benefits are reduced – although visible lack of network providers in Alaska with claims administrator