

FY 2009-2010 Open Enrollment Frequently Asked Questions

I have not received my Open Enrollment material at home. What should I do?

The only Open Enrollment material that was mailed to your home address was a Worksheet that will assist you in entering your benefit elections in the new Benefits Enrollment System. Worksheets were mailed on Friday, May 1, 2009 and should be received soon, as long as your home address was correct in the PeopleSoft system. A copy of the Worksheet is also available on the EHI home page, under the Open Enrollment tab, in the left column.

Open Enrollment materials, including the *What's New* Open Enrollment booklet, are only available online at the Employee Health Initiative Department's Web sites. The internal site is located on the Electronic Business Center (EBC) Intranet at ebc.maricopa.gov/ehi. The external site is located on the Internet at www.maricopa.gov/benefits.

Durable Medical Equipment will have a \$75 per item copayment for all of the CIGNA medical plans (except for the Choice Fund Health Savings Account). Does this copay apply to new masks, tubes and filters that are periodically required for a CPAP (Continuous Positive Airway Pressure) machine? Will ostomy supplies be charged a \$75 Durable Medical Equipment copay?

While the CPAP machine is considered durable medical equipment, the items listed above are considered consumable medical supplies and do not have a copay.

Ostomy supplies are also considered consumable medical supplies and do not have a copay.

In reference to the new in-network facility-based deductible, are there any free-standing out-patient surgical centers that are not affiliated with a hospital, and if so would the deductible apply?

There are free-standing outpatient surgical centers, however services received will be subject to the deductible because the facilities bill using a facility revenue code. This code is the trigger that determine a deductible should be charged.

For the Choice Fund Health Savings Account, how much and when does the County fund the Health Savings Account?

The County funds the Choice Fund Health Savings Account in the amount of \$500 for individual coverage (employee only) or \$1,000 for family coverage

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(employee + dependent(s)) if you are enrolled for full year coverage. If you are enrolling in the Choice Fund Health Savings Account plan during Open Enrollment, you are enrolling for the full plan year. If you enrolled for a partial year when you first became benefit-eligible, the County contribution to your Health Savings Account would be pro-rated by the number of months you were enrolled in this plan during the benefit plan year.

The County contribution occurs as soon as administratively possible following the beginning of the plan year. A number of events must occur before funding can be completed, especially if you are enrolling in this plan for the first time.

- An HS.A Enrollment Package must be completed first. The EHI Department sends enrollees the Enrollment Package after Open Enrollment closes after May 29, 2009.
- The employee completes the forms contained in the Enrollment Package and sends them either to EHI or directly to JPMorgan Chase. (The preferred method is to send to EHI for imaging and delivery via secure email.)
- Then the Health Savings Account has to be opened at JPMorgan Chase. The employee is notified by letter sent via U.S. Postal Service mail when the account is opened.
- Once the account has been opened EHI also receives notification and then the funding process begins with an employer deduction amount being sent to payroll.
- When the funding has been collected through payroll, EHI then sends the funds to your Health Savings Account.

In regards to the Case Management Incentive, can you tell me what constitutes a "specific complex" medical condition?

Certain diagnoses trigger review for potential referrals to case management, as nationally recognized literature indicates that case management may make a positive difference in the outcome. Those diagnoses include:

- Prematurity;
- High-risk maternity/NICU admissions;
- Oncology;
- Traumatic brain injury;
- Multiple trauma injury;
- Respiratory failure;
- End-stage renal disease

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- Transplants and organ failure;
- Multiple sclerosis and progressive neurological disorders;
- Rheumatoid arthritis;
- Hemophilia;
- HIV;
- Spinal cord trauma; and
- Burns.

A diagnosis does not automatically result in a referral to case management, since a diagnosis alone does not necessarily indicate that case management can add value for the individual. CIGNA uses multiple sources of information, such as claims data, lab data, prescription drug data, and CIGNA nurses' notes, to gain a more thorough understanding of the individual's particular situation.

In addition to specific diagnoses CIGNA reviews:

- Utilization patterns, including emergency room visits, visits to multiple doctors, inpatient admissions and/or risk for readmission and out-of-network utilization;
- High dollar claims;
- Potential gaps in care, including treatment that does not appear to meet nationally accepted standards of care for the illness or lack of compliance with the treatment plan;
- Behavior patterns, such as not filling prescriptions according to the prescribed schedule;
- Participation in and/or referrals from other CIGNA programs, such as enrollment in a CIGNA Well Aware for Better Health[®] disease management program;
- Recorded notes from CIGNA professionals;
- Information about the individual's particular situation, including length of the disease, intensity of the disease, and a support system of family, friends or community services; and
- Potential need for case management assistance with skilled nursing facility or hospice placement.

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When all of these factors are taken into consideration, CIGNA identifies that in some instances a diagnosis that would suggest appropriateness for case management is not referred. As an example, CIGNA may find that an individual with an HIV diagnosis is compliant with prescribed medications and is not using emergency room or inpatient services, and does not need case management services. On the other hand, someone with a less severe diagnosis may demonstrate a number of behaviors that case management can address. For example, at the time of inpatient authorization, or through review of CIGNA predictive model reports, a member may be referred into case management who has a complicated migraine/pain management situation, or other individuals who appear at high risk despite a seemingly routine diagnosis. All individuals needing a transplant are referred to case management regardless of the diagnosis prompting the transplant.

It is the combination of in-context diagnosis review and the review of multiple other factors that help CIGNA to quickly and efficiently identify individuals for whom case management services are likely to provide value.

Am I correct CIGNA will be determining the medical necessity for the employee and therefore making the determination for follow-up with a Case Manager?

A Senior Medical Executive/Medical Director will be reviewing these cases on a case-by-case basis.

Is the need for a Case Manager being determined through participation in the Biometric Screening and Health Assessment?

No.

Is the employee's own health care provider involved in the decision making process and treatment plan after CIGNA makes their initial assessment?

Yes they are engaged in the process

Are there certain health risks that have been already pre-determined to require a Case Manager?

Complex/Catastrophic conditions are managed by case management, i.e. High Risk Maternity, NICU (Neonatal Intensive Care Unit) Infants with health concerns, Cancer, Head/Spinal cord injuries.

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If Cigna is managing the employee/patient's treatment plan and the employee receives a second opinion from his/her physician which is not in agreement with the Case Manager, what course of action would be followed?

There is an appeal process and a peer review can be done between the attending physician and CIGNA.

How does an employee who is currently waiving benefits because they are covered under their spouse's insurance renew waiving benefits in order to continue to receive the waiver payment?

If the employee is currently "waiving" County medical insurance because he/she has coverage under their spouse's insurance, to renew the waiver payment, the employee must provide verification of current coverage to the EHI Department. Below are the instructions provided in the Benefits Enrollment system:

"You are required to provide annual documentation of your other group medical insurance coverage to the EHI department to qualify for the medical waiver payment. (Arizona Health Care Cost Containment System (AHCCCS) coverage does not qualify as group medical insurance coverage for this purpose and therefore does not qualify you to receive the medical waiver payment.) The documentation must identify you as a covered member and include the name of the primary insured, the insurance company's name, address and phone number, group name and number, member identification number and coverage effective date. Please fax to EHI at 602-506-2354 or call 602-506-1010 if you have questions."

It is suggested that the employee read the section "What Happens if I Don't Complete Open Enrollment?" on page 7 in the *What's New Open Enrollment* booklet regarding their other benefit options.

If the employee is currently enrolled in a County-sponsored medical plan and wants to change his/her enrollment status to "waived", he/she must change their election in the Benefit Enrollment system and provide verification of coverage under other group medical insurance in order to receive the waiver payment.

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If you enroll in a Flexible Spending Account and choose to have a certain amount set aside every pay period, can you change that designated amount after open enrollment has closed (sometime during the benefit year)?

Annual enrollment Flexible Spending Account (FSA) elections and contribution amounts cannot be changed after the close of open enrollment unless the employee has a qualifying event (such as birth or marriage) during the plan year and that event is consistent with changing the amount of their FSA election. For example, if the qualified event is a birth, then that event would be consistent with needing to increase (but not to decrease) the FSA amount.

Is the full amount of your contributions to the Flexible Spending Account available immediately, or can you only submit claims for the amounts that have currently accrued in your account?

For the health care Flexible Spending Account (FSA), generally your annual contribution amount is available immediately at the beginning of the plan year. However, there are some specific rules regarding payment for orthodontia expenses.

For the dependent care FSA, your annual contribution amount is only available as you make your contributions to the account.

If I'm enrolled in the Consumer Choice Pharmacy plan and if I don't use the amount allotted to me in Level 1 and it rolls over to the next plan year, is there a way I can find out what has been rolled over from last year and the current balance?

Advise the employee to contact the EHI Department at 602-506-1010 or to email BenefitsService and a Benefit Specialist will research this for the employee.

If I'm enrolled in the Consumer Choice Pharmacy plan and if I'm in Level 2 and paying 100%, how is the amount calculated? I see it says "average wholesale price minus discount for maximum allowable cost plus dispensing fee" but how do I find these components?

This information is not available to EHI until after a claim has been processed. EHI can review the pharmacy claim with the employee and advise of the amounts of each component.

The employee can also log on to www.mywhi.com and find the total cost for a drug that they are interested in purchasing if they are already enrolled in the

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Consumer Choice plan, but he/she will not be able to see each pricing component.

Does the new in-network deductible apply to every time an employee has an applicable procedure at one of the designated facilities? Or do they only meet that deductible once the entire year, no matter how many applicable scans/tests they may have that year?

The new annual in-network deductible only applies once per year. Once the deductible is met, it will not be applied again during that plan year.

Is the deductible in addition to the out-of-pocket maximum, or included in that total amount?

Yes, the deductible is in addition to the out-of-pocket maximum for all plans except the Choice Fund HSA plan.