BACKGROUND

The County's current HR policy provides that eligible County retirees 65 and older must enroll in Medicare Parts A and B to be eligible to participate in the County's Medicare supplemental medical plan. The County's Medicare supplemental medical plan was administered by Cigna until the end of calendar year 2019. Beginning with calendar year 2020, the County's medical plans are administered by Blue Cross Blue Shield of North Carolina (BCBS).

The County's Cigna administered Medicare supplemental medical plan allowed Medicare retirees to "visit any provider" as a main feature of the plan, according to information provided to retirees on My Cigna. The County's BCBS administered Medicare supplemental medical plan requires that providers be part of the BCBS network for Medicare retirees to receive supplemental coverage.

When the County changed plan administrators to BCBS, the County adopted as its Medicare supplemental medical plan an Exclusive Provider Organization (EPO), which is a major change from the County's previous plan.

The federal government, at HealthCare.gov, defines an Exclusive Provider Organization as "A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency)."

In addition to the network requirement, the County's Medicare supplemental medical plan now also requires that various covered services be pre-authorized by BCBS.

The following questions will be posed to the County and to BCBS, after which the County will give a briefing to retirees on upcoming plan changes for calendar year 2022.

QUESTIONS FOR COUNTY

County's Request for Proposals (RFP), Evaluation of Proposals, and Plan

- In 2014 when the County issued an RFP for a new Plan Administrator, it included representative retirees in the evaluation process. Why wasn't the County inclusive this time?
  - For the past 15 years, the County has reviewed and bid the core benefits every 3–5 years to provide the employees and retirees with high quality, cost-effective benefits. The County routinely invites internal stakeholders and business partners to participate in this RFP process. The County can include a representative from the retiree group in future RFP processes.
  - In 2014, the RFP for the Retiree Medical Plan was the first and only time the County submitted an RFP for a "sub-group." The County Manager wanted feedback from retirees since the County considered converting to a fully insured Medicare medical plan.

- Why did the County change its Medicare supplemental medical plan to be an EPO?
  - The County continuously reviews the cost of all medical plans. The vendor that was selected to provide this plan offers services through their provider network (EPO). The County's obligation is to provide retirees with a Medicare medical plan, which it still does.

  - While an indemnity plan allows a member to go to any provider for service, the member may not get the discount of a provider being in network. This makes an indemnity plan by design more expensive.

- While an EPO limits coverage to in-network providers—thereby lowering overall costs—BCBS has a network that extends across the country. This reduces the likelihood that a member's provider is not in BCBS's network. BCBS ran a claims report from Jan. 2020 thru July 2021 (roughly 18 mos. of data), the report showed
  - 98.6% match of providers are in network.
  - 98.% match on ancillary providers is in network (e.g., laboratory, radiology, pharmacy or rehabilitative services, physical therapy, occupational therapy, etc.).

- Is there any benefit of an EPO to retirees?
  - Yes. Because of the negotiated contracts between providers and insurance carriers, deeper discounts are in place that benefits both the retiree and County. In network providers agree not to bill consumers for more than the amount agreed upon between the carrier and provider; protecting consumers from "balance billing" and extra costs that the County cannot control.

    For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

- Did the County request an EPO in the County's Request for Proposals for a new Plan Administrator?
  - Mecklenburg County did not specifically request an EPO but rather indicated a need for a comparable plan that existed at that time.

- Why does our Summary of Benefits and Coverage on Blue Connect state that our Plan Type is a PPO? Why does our BCBS card state PPO in the lower right corner?
  - Per BCBS, PPO is the network and EPO is the plan type. The symbol identifies to providers the network contract status.

- Individual Medicare Supplements that are available for purchase in NC are not EPOs. What group Medicare supplemental medical plan EPOs from other employers did the County study to model and evaluate this plan? Were these plans Medicare Supplements or Medicare Advantage?
  - To our knowledge, there were no specific Medicare Supplemental Plan evaluated in the RFP. The County did not study plan designs of other employers for the Medicare supplemental or any other benefit plan.

- The County plan administered by Cigna did not require pre-authorization for any covered services, except pre-certification for inpatient care. How did the County determine for its current plan administered by BCBS which services should be subject to pre-authorization and what are the County's authorization criteria?
  - In Cigna's 2019 Plan Document for Retiree Plan, it states on page 28 certain medical pharmaceuticals are subject to prior authorization whether inpatient, outpatient, physician's office or in covered person's home. Page 32 states, "prior authorization is required for certain prescription drugs prescribed by a physician. The reason for obtaining a PA is to determine whether the drug is medically necessary according to Cigna's coverage criteria."

  As for medical services, in Cigna's 2019 Plan Document, page 47, it states "In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on a preservice, concurrent, or post service basis. Certain services require prior authorization to be covered."

Pre-certification and pre-authorization requirements were not specifically outlined in the RFP. Certifications are referenced on page 38 and 39 of the BCBS Benefit Booklet.

County Communications

- Please provide retirees with the name and contact information of a County employee who can assist with questions about the County plan and problems with BCBS.

Wanda Caldwell, HR Manager
Mecklenburg County Government
Human Resources Department
700 East Fourth Street, Suite 220
Charlotte, NC 28202
Office: 980-314-2707
Email: Wanda.Caldwell@Mecklenburgcountync.gov

- Accurate communication, no matter who or the subject, is critical. Retirees feel that communication received from the County regarding our medical benefits is an example of a failure to communicate. Lack of communication of these important issues is causing mistrust on the part of the retirees. It has not helped this situation to get conflicting information from BCBS. This needs to be fixed immediately.
  - Based on feedback from retirees, Mecklenburg County is putting more effort in the Open Enrollment Communication strategy beginning with this year's Open Enrollment.
    - In the annual letter that retirees receive, there will be a link to MeckNC.gov where retirees can get additional plan information.
    - Retirees can attend Open Enrollment Zoom Sessions in the month of October. Sign-up instructions will be posted on Mecknc.gov
    - Retirees will also receive a "reminder" OE Postcards via US Mail.
    - Retirees can contact Mecklenburg County's HR Benefit Manager if they have questions.

- Why has the County repeatedly told Medicare retirees that there were no medical plan changes when an EPO restricts Medicare retirees to only the BCBS network, whereas CIGNA covered all Medicare providers?
  - As you know the County does have the authority to make plan design changes as needed to provide quality healthcare benefits. As we do every year, we consult with reputable professional benefits consultants during the budget season to assist with plan design changes, so I encourage you to review the Summary of Benefit Coverage and Plan document every year. A change in network providers does not constitute a change in medical plan.

- Why did the County allow BCBS to wait until April 2021 to mail information about EPOs to retirees along with revised cards?
  - In March of 2021, a retiree called to inquire about the "EPO" on her card. It was at that time County was aware of the "misprint." Mecklenburg County immediately brought it to BCBS's attention, and it was corrected, and new cards were sent.

- Why didn't the County require BCBS to provide a summary plan description by January 1, 2020 and require that it be mailed to the Medicare retirees? Although for calendar year 2021 BCBS has a link on Blue Connect to the Summary of Benefits and Coverage, the Summary has never been mailed to the Medicare retirees, some of whom do not have internet access.
  - The County has never sent this document to retirees, we will in the future make it available upon a request.

- Please post online for the retirees all relevant information for opting out of the County plan, including the amount of money available to the retiree for reimbursement of premiums, who with the County to contact in order to opt out, the forms that need to be completed, and what is necessary for ongoing reimbursement of the premiums.
  - The County will do this. In the meantime, retirees can contact:

Gregory Payne, HR Consultant - Retirement
Mecklenburg County Government
Human Resources Department
700 East Fourth Street, Suite 220
Charlotte, NC 28202
Office: 980-314-2712
Email: Gregory.Payne@Mecklenburgcountync.gov

QUESTIONS FOR BCBS

Please note that answers to these questions are a provided for your convenience and are not a guarantee of coverage. Please consult with the terms of your plan document for the terms of coverage.

QUESTIONS FOR BCBS

Network Questions

- Does the relevant BCBS network contain only Medicare Participating Providers or are any BCBS network providers Medicare Non-Participating Providers or Opt-Out Providers?
  - The Blue Cross NC network contains providers who have a contract with Blue Cross NC and these providers are reimbursed based on a negotiated contract rate for in-network providers. Contracting status is not dependent on Medicare participation.

- Does the County plan require the use of Medicare Participating Providers in order to receive Medicare supplemental coverage? Did the plan administered by Cigna?
  - The plan with Blue Cross NC is not a Medicare Supplemental plan. Your Blue Cross NC plan provides secondary coverage to your Medicare plan. Any questions related to prior carrier coverage will need to be addressed by Mecklenburg HR.

- Please provide a description of our BCBS network including how it works here and in all parts of the state and country, how it is coordinated with Medicare, and how closely our BCBS network is aligned with Medicare.
  - Blue Options is our seamless, nationwide PPO network. It is the broadest network available but still maintains high quality standards through rigorous provider credentialing, claim surveillance, and fraud monitoring.

- If your BCBS network provider uses the services of a non-network provider, such as for pathology or lab work, will the pathology or lab work provider be covered under the County plan?
  - No. The plan does not have out-of-network coverage. You are required to visit an in-network doctor in order to have coverage under the plan. For example, if a non-participating lab is used, the claim would deny as a non-covered service.

Deductible and Coinsurance

- The Medicare Part A inpatient hospital deductible for 2021 is $1,484 for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. Does the County's BCBS administered plan pay any portion of this deductible?
  - The deductible under the Blue Cross NC plan is separate from the Medicare deductible and is not combined when claims are processed. The member will need to meet the Medicare deductible and the Blue Cross NC deductible.

- The Part A daily coinsurance for 2021 for the 61st-90th day is $371 in a benefit period. Does the BCBS administered plan pay any portion of this coinsurance?
  - The coinsurance under the Blue Cross NC plan is separate from the Medicare deductible and is not combined when claims are processed. The member will need to meet the Medicare coinsurance and the Blue Cross NC coinsurance.

- The Part A daily coinsurance for 2021 for lifetime reserve days is $742 in a benefit period. Does the BCBS administered plan pay any portion of this coinsurance?

- The coinsurance under the Blue Cross NC plan is separate from the Medicare deductible and is not combined when claims are processed. The member will need to meet the Medicare coinsurance and the Blue Cross NC coinsurance.

- The Part A Skilled Nursing Facility coinsurance for 2021 for days 21 through 100 of extended care services in a benefit period is $185. Does the BCBS administered plan pay any portion of this coinsurance? For the 101st day and after what does this BCBS administered plan pay?
  - The coinsurance under the Blue Cross NC plan is separate from the Medicare coinsurance and is not combined when claims are processed. The member will have the Medicare coinsurance to meet and will also need to meet the Blue Cross NC coinsurance. Please refer to the member guide for 2021 for additional information.

- Are Medicare deductibles included in the Maximum Out of Pocket total?
  - No, there are separate deductibles and out of pocket for Medicare and the Blue Cross NC plan.

- The Medicare Part B annual deductible for 2021 is $203. Does the BCBS administered plan pay any portion of this deductible?
  - The deductible under the Blue Cross NC plan is separate from the Medicare deductible and is not combined when claims are processed. The member will need to meet the Medicare deductible and the Blue Cross NC deductible.

Administration of Benefits

- Claim adjudication is complex and handled on a case by case basis. Please refer to the member guide for 2021 to answer the following questions that were submitted. You can call Blue Cross NC customer service for additional questions related to your plan.
  - What costs are included in the Maximum Out of Pocket total for Medicare retirees?
  - What does this BCBS administered plan pay for Part A Blood for both hospital confinement and out-patient when furnished by a hospital or skilled nursing facility during a covered stay?
  - What does this BCBS administered plan pay for Hospice Care?
  - What does this BCBS administered plan pay for Part B medical expenses after the Medicare deductible is met?
  - What does this BCBS administered plan pay for Part B medical expenses after the Maximum Out of Pocket is reached?
  - What does this BCBS administered plan pay for Outpatient Mental Illness services?
  - What does this BCBS administered plan pay for Blood under Part B?
  - What does this BCBS administered plan pay for Clinical Laboratory Services under Part B?
  - Under Medicare Parts A & B, what does this BCBS administered plan pay for Medicare -covered Preventative Health Care Periodic Health Screenings?
  - Under Medicare Parts A & B, what does this BCBS administered plan pay for Medicare approved Home Health Care, both services and supplies?
  - Under Medicare Parts A & B, what does this BCBS administered plan pay for Durable Medical Equipment?
  - For persons enrolled in Medicare Parts A & B (Original Medicare) Medicare no longer limits how much it pays for medically necessary outpatient therapy services in one calendar year such as for physical therapy, speech-language therapy, and occupational therapy. Under Part B Medicare pays 80% of the approved amount for these sessions. Does this BCBS administered plan pay the 20% coinsurance

for all Medicare approved sessions (subject to BCBS plan deductible) or does the plan limit the number of sessions for which it will pay during the calendar year?

    - For persons enrolled in Medicare Parts A & B (Original Medicare) Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain with an additional 8 sessions if you show improvement, with an annual cap of 20 acupuncture treatments. Does this BCBS administered plan pay the 20% coinsurance for all of these Medicare approved sessions?
    - What does this BCBS administered plan pay for medically necessary medical care during Foreign Travel? Domestic travel? What network restrictions apply? If a retiree is traveling domestically and needs medical intervention, but not an emergency, will BCBS cover this if a BCBS provider is not readily available?
    - Does this BCBS administered plan cover anything not covered by Medicare? If so, what?
    - Identify and describe everything that is subject to prior authorization and review by BCBS under this BCBS administered plan and the criteria used for authorization.
    - Under what circumstances will coverage be denied or reduced by the County under this BCBS administered plan?
    - Please describe how our claims are processed by BCBS including before the deductible is met, after the deductible is met, before the maximum out of pocket is reached, and after the maximum out of pocket is reached.
    - What percentages of costs of service are paid by BCBS once the Maximum Out of Pocket total is reached?
    - What relevance does the BCBS allowed amount have in determining payments under Part A and of the Part B 20% coinsurance by BCBS and the Medicare retiree? Does this affect the amount paid by the retiree?
    - Please explain how the coinsurance works for Medicare retirees once their deductible has been met.
    - Under what conditions does BCBS cover emergency care? What is the definition of emergency care?

- At the lower right corner of our BCBS cards, there is written Blue e with PPO in a suitcase. What do these symbols mean to the retirees and to in state and out of state providers?
    - These symbols identify to providers the network contract status.

- Situation – Medicare's 80% + BCBSNC Blue Option does not always pay 100% like a true Medicare Supplement, leaving the retiree to pay some balance. This did not happen with the Cigna administered County plan. It appears this is because Blue Options is not a Medicare Supplement but an entirely different free-standing policy. What is it?
    - Any questions related to prior carrier coverage will need to be addressed by Mecklenburg HR.

- Retirees have been told that prescription drug charges count toward the Maximum Out of Pocket total, yet the Summary of Benefits and Coverage seems to state otherwise. Which is correct?
    - Prescription drug coverage is offered through another vendor; however, pharmacy out-of-pocket costs are tracked towards the medical out-of-pocket maximum through integration with the pharmacy vendor.

- Why is the BCBS allowed amount different than the Medicare approved amount?
    - Blue Cross NC contracts individually with providers in our network.

- What happens if a Medicare retiree is discharged from the hospital to short term rehabilitation and there is no BCBS network short term rehabilitation bed available? Is there

County coverage under that circumstance? Would the retiree be sent to an available BCBS network facility in another town?
  - This would be handled on a case by case basis.

- Is there coverage, and if so, what is the coinsurance, under this BCBS administered plan if a County Medicare retiree receives services covered by this plan from a BCBS network provider who has opted out of Medicare?
  - Benefits will be covered based on language in member booklet for 2021. Medicare participation is not required for the Blue Cross Blue Options PPO network.

General

- What percentage of NC medical providers and physicians are not in the County's BCBS Medicare retirees plan? Note: there are 15,727 physicians in NC per one source.

Provider Type	Count	% in Market
PCP	10,933	95.3%
Specialist	9,157	95.2%
Acute Care Facility	104	99.1%

- Why does our Summary of Benefits and Coverage on Blue Connect state that our plan is a PPO?
  - PPO is the network and EPO is the plan type

Blue Cross NC declines to answer at this time

- Does BCBS NC sell individual EPO Medicare Supplement plans? Does BCBS NC sell or administer other group EPO Medicare Supplement Plans, and if so, how many?
- What are the network restrictions if the Medicare retiree relocates outside of NC? If a retiree relocates outside of NC does the benefit remain an EPO or does the benefit become a PPO with reduced coverage instead of no coverage? Under what rate plan are providers paid? What if there are no BCBS network providers nearby?
- Once the Lifetime Reserve days are used, does this plan administered by BCBS provide for an additional 365 days? Does this plan provide for any coverage beyond the 365 days?
- Does this BCBS administered plan pay for Part B Excess Charges above the Medicare Approved Amounts?
- How many Medicare retirees have been denied County coverage or have had their coverage reduced by BCBS as a result of using out of network services in 2020 and 2021, and what has been the cost for these retirees?
- If you reside in a long-term care facility and the facility uses services of an out of network provider whose selection over which you have no control, would that provider be covered under the County plan?