



## The State of New Hampshire Insurance Department

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### HealthFirst Carrier Frequently Asked Questions 11/25/2008

1. Please confirm that the hospital remains in the same tier regardless of the service provided, and that the hospital tier changes no more frequently than 1/year. The hospital will remain in the same tier regardless of service. The Department will not change its default network more than once per year. The Department strongly recommends that carriers do not change the tiers more than annually.
2. Please confirm that the out-of-pocket maximum applies to the core medical services within the plan, but not riders, such as pharmacy. [Total OOP Max applies to everything covered under the plan except for pharmacy. Pharmacy will have a separate OOP Max of \\$5,000 individual/\\$10,000 family.](#)
3. Please confirm that the health plan has met the standard for the pharmacy coverage as long as one hypertensive and diabetic drug are in tier 1. [Yes, as long as at least one brand name antihypertensive and one brand name diabetic drug are in the first tier. Blood Glucose test scripts should also be covered at the first tier.](#)
4. It is very difficult for a health plan to have a provider linked to different benefit designs based on the hospital the patient visited. Currently, the Health First product suggests that the provider bill takes a co-pay if it is done in the office setting, yet the same provider is linked to a deductible if providing the service in the hospital. This would not be difficult if the deductible was not tiered depending on the hospital, but since the provider deductible would change depending on the hospital, we would need to tier the doctor as well. The same doctor may see patients at more than one hospital. We do not believe that health plans can administer a benefit such as this. [Tiering applies to hospital facility costs only. All non-hospital facility charges will be applied to the deductible at the Tier 1 rate.](#)
5. How are out of state hospitals handled? [The carrier will need to file hospitals to be approved for Tier 1. Any hospitals that are not approved will be defaulted to Tier 2 or considered out of the network.](#)
6. It appears that we should file this as an HMO product, yet we recall a discussion at CGI about not filing this as an HMO. Can you please share your thoughts on this? [The carrier will file as a managed care product, but can be marketed according to your license. The carrier may file the product as an HMO.](#)

7. Since BMI testing is usually covered generally within the global office visit reimbursement, we are assuming that we can continue to handle it this way. Please confirm. [Yes.](#)
8. Please elaborate on *coverage* for telemedicine? What coverage is being suggested? [Please see the attached coverage guidance.](#)
9. *Administering "member level" Benefits / Systems* would have significant difficulty tracking deductible disparities, i.e., two member contract where a compliant member is entitled to lower deductible and the other member is not. [We would require participation by both parents in order to achieve the credit. The children's deductible will match that of the parents.](#)
10. *Administering "incentives" /* Because the incentives are "paper-based" and not susceptible to programming, they will likely require manual administration. [This is correct, unless the carriers developed an automated process for addressing submission of incentive requests.](#)
11. *Prenatal Care /* How does application of deductible play out when global billing is used in connection with prenatal care/delivery? [Prenatal care professional services are covered as a preventive benefit. The facility costs are subject to the deductible.](#)
12. *Routine Hearing /* Is it contemplated that coverage will include examination by a hearing specialist for all age groups, or is it permissible to limit the benefit to members 18 and under ? [This is for 18 and under only.](#)
13. *Colonoscopies /* When services are provided outpatient at a particular facility, are those services subject to facility-based tiered cost share and subject to deductible and coinsurance as well? [A \\$250 copay applies regardless of facility.](#)
14. *Tier 1 and Tier 2 /* Should we assume that Tier 1 and Tier 2 deductibles are accumulated separately? If that is not so, we are providing minimal incentive for members to utilize Tier 1 network. [Deductibles are combined. If someone first went to tier 2 hospital and accumulated \\$2500, there would be an incentive to go to a tier 1 hospital. There is still an out of pocket maximum.](#)
15. *"Max out of Pocket" /* Since there is no coinsurance and we assume that Tier 1 and Tier 2 deductibles are accumulated separately, should there be no out-of-pocket max? Again, intent is to encourage members to utilize Tier 1 network. [There is an out of pocket maximum and deductibles are combined. Legislation requires an out of pocket maximum. "The Committee shall recommend an out-of-pocket maximum for the standard wellness plan".](#)
16. *Urgent Care and ER /* Is the intent to have ER facility copay charge cover *all* services rendered at UC or ER? [No, the copay is for the facility. ER physician fee, CT scan , MRI, medical supplies are subject to deductible.](#)
17. *PT/OT/ST services /* Is a limitation on visits and/or yearly max contemplated for this benefit? [Limit is up to 20 visits each for PT, ST and OT per member per calendar or plan year.](#)

18. *Chiropractic* / Can we assume that the chiropractic exclusion covers not only professional services but diagnostic tests (x-rays) provided by chiropractors. **Yes.**
19. *Labs* / Is coverage “in full” confined to routine and diagnostic lab services or is coverage required for *all* lab...if the latter, should it be a site of service based reimbursement? **It would be for all physician or commercial outpatient laboratory. Hospital-based outpatient, emergency room based and inpatient laboratory services would apply to the deductible.**
20. *Mental Health* / Is an annual outpatient visit limit contemplated and/or permissible for small employer groups? **Outpatient Mental Health and Substance Abuse visit limit is maximum 20 visits per calendar year.**
21. *DME* / Is this coverage intended to roll into the plan level deductible or should it accumulate as a separate deductible? And, if member purchases at a DME provider does a deductible apply. **There is not a separate deductible for DME, it is rolled into the plan level deductible. If the hospital is billing it, then the DME would fall under the tier of the hospital. Otherwise, DME will fall to Tier 1.**
22. *Rx* / A clearer understanding of the mail order pharmacy benefit/incentive is needed and a confirmation that diabetic supplies are to be covered at the generic copay level is requested. **Mail order is treated no differently than retail: 1 copay for up to a 30 day supply.**

### **Rating Concerns / Questions**

We will address rating concerns generally, however, it is the responsibility of the carrier to price the product according to its methods and baseline costs.

23. What is the \$3.25 savings estimate based on care coordination? **Members are required to use the Care Navigator for elective tests and procedures. The savings are associated with a reduction in unnecessary duplicate testing.**

The Care Navigator is an informed decision-making model, designed to provide members with information about treatment options and further educate them about unnecessary duplication of tests and the benefit differentials associated with the tiered network design. Training aids for Nurse Care Navigators and patient materials are available through HealthDialog, commercial sources such as the Cochrane Library (<http://www3.interscience.wiley.com/cgi-bin/mrwhome/106568753/HOME>), and public sources such as the U.S. Centers for Disease Control and Prevention and the National Cancer Institute.

Ideally the Care Navigator is an integrated member of the chronic condition management team so they can address the needs of the whole person and better engage them in condition management programs and optimal pharmaceutical use.

Elective Tests and Procedures Should Include:  
Advanced Radiology (MRI, CT, PET)  
Angioplasty  
Breast Cancer Treatment

Gastric Bypass Surgery  
Hysterectomy  
Orthopedic Surgery including Back Surgery  
Prostatectomy

24. High risk pool assessment should be reduced to .02 pm pm. Correct. The high risk pool assessment was reduced from \$1.19pmpm to \$.02 pmpm.