

# The Alliance Employer Administrative Handbook

**THE ALLIANCE** 

Employers moving health care forward

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# ALLIANCE IMPLEMENTATION

This section details the steps involved in preparing to join The Alliance, including:

- Employer Checklist
- Questions- Who to Contact
- Alliance Employer Responsibilities and Commitments
- Other Network Options
- Alliance Identification & Find a Doctor Website
- Notifying Reinsurers & Utilization Review Firms

## Employer Checklist

1. Determine initial date of access and communicate it to The Alliance.
2. Sign and return contracts to The Alliance.
3. Pay initial fees. (You will be invoiced once we receive the first eligibility file).
4. Communicate Alliance membership to your plan administrator.
5. Determine participation in other network options.
6. Instruct the plan administrator and (when applicable) the national PPO to site The Alliance contractual arrangements for reduced pricing on explanation of benefits and provider billings.
7. Provide copy of ID card to The Alliance to be reviewed and approved prior to printing. (For requirements, see "Alliance Identification" on page A-9.)
8. Instruct your plan administrator to send employee/dependent eligibility information to The Alliance. (See "Employee/Dependent Eligibility" on page C-1.)
9. Schedule employee orientations.
10. Communicate and educate employees on The Alliance Find a Doctor website and on their Alliance network access.
11. Provide copy of current employee summary benefit plan documents and a link to your employee benefit website.
12. Distribute Alliance employee identification; inform employees that failure to show Alliance identification may result in paying higher prices.

# Questions—Who to Contact

## **Member Services.....608.276.6620 or 800.223.4139**

- Accessing Alliance services
- Benefits of Alliance affiliation
- Plan administrator coordination
- Health plan reports
- Custom data requests
- Alliance directory or identification card needs
- Employee orientations
- Alliance workers' compensation program

## **Customer Service.....608.276.6630 or 800.223.4139**

Health plan, provider and third-party administrator questions regarding:

- Network eligibility status
- Claim repricing
- Employee questions regarding participating providers

## **Office**

## **Administration.....608.276.6620**

- Monthly invoices

## Alliance Employer Responsibilities and Commitments

Each Alliance employer agrees to abide by the policies, rules and requirements of the cooperative as established by the bylaws and the board of directors and listed in the cooperative bylaws\*, application, stock subscription, enrollment contract, access agreement, and as follows:

- The Alliance employer facilitates and directs cooperative efforts between The Alliance and the employer's third-party plan administrator, and the corresponding claims' departments.
- The Alliance employer or their plan administrator provides appropriate biographical information regarding eligible employees/dependents with updates at least monthly, including new hires, additions and terminations. (See Employee/Dependent Eligibility on page C-1.)
- The Alliance employer distributes one of the following types of Alliance identification to employees accessing The Alliance network:
  - Alliance stickers for current health plan ID cards; or
  - Insurance cards with The Alliance logo, name, mailing address and payer identification numbers prominently displayed.
- The Alliance employer informs employees that they must show Alliance identification at the time of service or risk losing The Alliance discount for those services.
- The Alliance employer provides information on participating providers to each employee accessing The Alliance. Participating providers are accessible through The Alliance website.
- The Alliance employer submits all employee communications regarding The Alliance to Alliance staff for review prior to distribution.
- The Alliance employer is financially responsible for the payment of claims incurred by employees/dependents.

The Alliance employer directs the plan administrator to pay the negotiated fee to participating providers when acting as the primary payer, or the difference between what has been paid by the primary payer and The Alliance fee schedule amount when The Alliance employer is not primary.

\*If you would like a copy of The Alliance Articles of Incorporation & Cooperative Bylaws, please contact The Alliance Member Services at 800.223.4139 or [mms@the-alliance.org](mailto:mms@the-alliance.org)

- The Alliance employer informs the plan administrator that use of The Alliance fee schedule or repriced amounts for any purpose other than administration of The Alliance employer by plan administrator is not permitted. Use of such information by the plan administrator, its subsidiaries, affiliates, entities with an equity interest in the plan administrator, or employer's consultants for the purpose of gaining insight into The Alliance's agreements with participating providers or for negotiating their own agreement with participating providers constitutes a breach of membership.
- The Alliance employer informs the plan administrator to clearly state reduction in price is based on Alliance or when appropriate, National Wrap Network, contracted arrangements on the explanation of benefits and remittance advices.
- The Alliance member employer instructs the plan administrator that The Alliance-negotiated fee for participating providers supersedes any existing or future arrangements negotiated by or applied by other entities. Notwithstanding the foregoing, however, federal and state regulations, such as Medicare eligibility rules, are specifically not superseded by The Alliance-negotiated fees.
- The Alliance employer encourages the plan administrator to pay all claims in a timely manner (within 30 days is considered an industry standard), noting that **some Alliance contracts with participating providers state that claims that remain unresolved for over 30 days may result in the loss of The Alliance negotiated fee to the employer/employee.** If an employer consistently fails to pay in a timely manner, they can be excluded from certain provider contracts at the provider's request.
- The Alliance employer submits payment of the monthly Alliance invoice upon receipt with the understanding that a 1.5 percent finance charge per month will be applied to all accounts over 30 days past due.
- The Alliance employer provides a copy of the complete and current health benefit plan(s) it sponsors, and employee informational materials regarding the plan, and promptly notifies The Alliance of any substantial revisions.
- The Alliance employer informs The Alliance of other contract arrangements which may be in direct conflict with The Alliance.

# Other Network Options

## Ancillary Networks

### Chiropractic, Mental Health/Substance Abuse, Home Health, and Oral Surgery Networks

In addition to a comprehensive medical/surgical network, The Alliance offers chiropractic, mental health/substance abuse, home health and oral surgery networks. The Alliance contracts with chiropractic, mental health, home health providers and oral surgeons as it does with providers in the medical/surgical network to determine fair market value for their services.

Because of the variety of health benefit plans sponsored by Alliance employers, The Alliance board of directors agreed to an optional status for these networks. In doing so, they set the following parameters:

- Employers' health plans may "opt in" to any network at any time; however, once an Alliance employer has chosen to access an ancillary network, the employer must remain in that network for a minimum of one calendar year.

## QualityPath® Network

### QualityPath program overview

- The Alliance approves providers that apply for the designation, meet national quality criteria and agree to the terms of the QualityPath contract.
- Alliance members steer toward QualityPath providers by reducing (often eliminating) enrollee out-of-pocket cost, and benefit from the quality outcomes, the protection of the warranty, and the lower set prices.
- Employees benefit when selecting QualityPath providers by having lower to no out-of-pocket costs, peace of mind of quality care, and the assistance of the Patient Experience Manager for surgeries.

### Designated providers and procedures:

- Current procedures and providers are available at [www.qualitypath.com](http://www.qualitypath.com).

### The Alliance Member requirements:

- To join the QualityPath program, the Alliance member must sign the QualityPath Network Addendum and update the plan language to reflect the addition.
- Alliance members must implement a benefit design that steers enrollees to QualityPath providers.

These plans must meet the following minimum requirements:

- PPO plans - 100 percent coverage, waiving all enrollee cost-share including deductible, coinsurance and copays
- HSA plans - 100 percent coverage after the deductible is met. In addition, there is a minimum incentive requirement. For surgeries, the minimum incentive is \$1,000. For CTs, MRIs, and colonoscopies, the minimum incentive is \$100.
- Notify The Alliance at least 30 days prior to any change to the benefit plan design or additional incentives offered by the Alliance member to enrollees.

## Enrollee requirements:

- To be eligible for QualityPath benefits for surgeries, enrollees must call The Alliance Patient Experience Manager. Calls to the employer or to another vendor do not count towards this requirement.
- To be eligible for QualityPath benefits for colonoscopies, enrollees must inform The Alliance through the online Tell Us form or by calling Customer Service. Calls to the employer or to another vendor do not count towards this requirement.
- To be eligible for any warranty, enrollees must follow all requirements as listed at [www.qualitypath.com](http://www.qualitypath.com).
- Detailed benefit information for enrollees is available at [www.qualitypath.com](http://www.qualitypath.com).

## Enrollee eligibility:

- Enrollees who access The Alliance through a secondary insurance are not eligible for the QualityPath benefits and services.
- Enrollees in exclusive provider organization (EPO) plans are not eligible.
- Enrollees in a network offered by the Alliance member outside of The Alliance primary service area are eligible only if the member has implemented this option.

## Program guidelines:

- There is no additional fee to participate in the QualityPath program.
- New QualityPath procedures will automatically be added for all participating Alliance members on the effective date of the new procedure.
- Alliance members participating in QualityPath will offer all QualityPath procedures to their enrollees.
- Alliance members participating in QualityPath will provide equal financial incentives for all QualityPath designated providers for the same procedure.
- Alliance members participating in QualityPath may provide different financial incentives for different QualityPath procedures.
- Alliance members participating in QualityPath will not provide financial incentives to steer to providers who are not QualityPath designated for a QualityPath procedure.
- The Alliance reserves the right to change the program language as noted in the Member Handbook or on [www.qualitypath.com](http://www.qualitypath.com) at any point with a 90-day notice to all participating members. The new language will apply only to episodes that begin on or after the effective date of the new language.
- Alliance members may leave the QualityPath program at any point with a written notice. The member's participation will cease at the end of the month following receipt by The Alliance of the written notification.

## Exclusive Provider Organization (EPO) Network

The Alliance has an agreement with Mercy Health Systems, Janesville, Wis., offering employers an option to limit care to only providers of Mercy Health Systems.

## Alliance Workers' Compensation Program

The objective of The Alliance workers' compensation program is to provide a network of participating providers who deliver workers' compensation medical care for Alliance members enrolled in the program. If an Alliance employer's workers' compensation program is administered by a workers' compensation carrier, The Alliance must establish an agreement with the carrier before the employer can access the network. In a limited number of cases, provider agreements do not allow the application of discounts to workers' compensation claims. Check with Alliance Member Services staff to assess how these limitations might impact your plan.

## Optional Services

Preferred pricing is available to Alliance employers for dental, vision, national provider network, and prescription benefit management services.

## Alliance Identification

**Employees/dependents participating in an Alliance plan must identify themselves as such to all providers when accessing physician or hospital services.**

Employees should be instructed to notify the clinic or hospital billing office of their participation in The Alliance each time they seek care by verbally confirming their Alliance participation and showing proper identification.

If an Alliance eligible employee/dependent does not show proper Alliance identification, claims may not be sent through The Alliance for repricing and data collection and the patient may lose the benefit of Alliance contracted rates. **To guarantee appropriate Alliance savings and accurate data, it is critical that employees have proper Alliance identification and inform their health care providers of their participation.**

Identification cards should indicate that providers should submit all medical claims, except those for prescription drugs, dental and vision (if a carve-out), to The Alliance directly. This provision applies to all health care providers, whether or not they are Alliance providers.

If an Alliance preferred national network is utilized, you will be advised on proper medical ID card needs.

The Alliance will provide art upon request.

## The Alliance Find a Doctor Website

The Alliance Find a Doctor website is a complete listing of Alliance participating providers available via [www.the-alliance.org](http://www.the-alliance.org).

The directory includes medical/surgical, home care, chiropractic, surgery centers, skilled nursing facilities, and mental health/substance abuse providers. Alliance employers which have opted out of the mental health/substance abuse and/or chiropractic networks should let their employees know to use the drop-down menu to select their network or employer name, so that only providers in their network appear.

Provider updates are published once a month in The Alliance weekly e-digest.

Customer Service staff can also provide information about Alliance participating providers. The Customer Service Department can be reached at 608.276.6630 or 800.223.4139.

## Notifying Reinsurers and Utilization Review Firms

It is important that Alliance employers notify their reinsurance and utilization review firms of their Alliance participation. In fact, employers' contracts with these firms may explicitly require such notification.

### Impact of Alliance Participation on Reinsurance

Alliance employers may be able to renegotiate their reinsurance premiums when accessing The Alliance network. The claims savings realized through Alliance participation may slow accumulation of the specific stop-loss deductible, benefiting the reinsurer as well as the employer.

Alliance members may also choose to negotiate with their reinsurance firm about payment of retainage (share of claims savings retained by The Alliance). The reinsurer benefits from the potential delay in reaching the specific deductible and realizes savings from Alliance repricing of claims exceeding the specific stop-loss limit. Some Alliance employers assert that, because the reinsurance company benefits both before and after the specific deductible is met, the reinsurance firm should include retainage as part of the specific deductible accumulation and pay retainage on claims over the specific limit. (See "Calculation of Retainage in Retainage and Invoicing on page E-2.)

The Alliance has worked with reinsurance carriers in evaluating our contracts with health care providers and facilities. Based on their evaluations, carriers have agreed to offer additional discounts on reinsurance rates for employers that access The Alliance.

## Impact of Alliance Participation on Utilization Review

Alliance employers may wish to renegotiate their utilization review fees, as well. Because Alliance negotiated fees with hospitals are based on Diagnostic Related Groups (see definition page F-2), utilization review can be redundant.

### Sample Letter to Reinsurers (for Alliance Members)

<date>  
<reinsurance firm>  
<street address>  
<city/state/ZIP>

Dear <salutation>:

Beginning <date>, <Alliance employer, and its employer-sponsored health plan> will become a member of The Alliance. The Alliance, located in Madison, Wisconsin, has successfully negotiated contracts with hospitals and other health care providers in Wisconsin, Illinois and Iowa.

As part of our agreement with The Alliance, they retain xx (based on years with The Alliance) percent of the gross claims savings they generate for us.

Through our participation in The Alliance, we realize savings on claims below the specific stop-loss deductible. However, <reinsurance firm> also benefits from the potential delay in our reaching the specific stop-loss limit due to the savings we realize. We therefore ask that <reinsurance firm> consider applying the xx (based on years with The Alliance) percent retainage toward the stop-loss deductible, as other reinsurers have agreed to include this as part of the deductible accumulation. Keep in mind that if <Alliance employer> had not joined The Alliance, the specific deductible would be reached sooner.

Because of <Alliance employer>'s Alliance participation, <reinsurance firm> also benefits from considerable savings on claims which would be at or above the specific stop-loss deductible. We therefore also ask that <reinsurance firm> pay The Alliance retainage fees on claims exceeding our specific stop-loss limit.

After discussing this matter with your underwriting and actuarial staff, I anticipate you will provide our stop-loss coverage on this basis.

Please call me with any questions you may have. I look forward to hearing from you.

Sincerely,

<name>, <title>

cc: The Alliance

## Sample Letter to Utilization Review Firms

<date>  
<utilization review firm>  
<street address>  
<city/state/ZIP>

Dear <salutation>:

Beginning <date>, <Alliance employer and its employer-sponsored health plan> will become a participant in The Alliance. The Alliance, located in Madison, Wisconsin, has successfully negotiated contracts with hospitals and other health care providers in Wisconsin, Illinois and Iowa.

The Alliance has negotiated its contracts with hospitals based primarily on DRGs; some items are negotiated based on a specific reduction of billed charges. Participating providers have agreed to accept The Alliance repriced claim amount as full payment for services rendered.

Through our participation in The Alliance, the need for utilization review services is lessened, yet some case management and coordination of care may still be necessary. We therefore ask that <utilization review firm> reduce our utilization review fees.

Please call me with any questions you may have. I look forward to hearing from you.

Sincerely,

<name>, <title>

cc: The Alliance

# ADMINISTRATIVE POLICIES

Included in this section are The Alliance policies regarding the following:

- Alliance Proprietary Information
- Confidentiality of Employer, Health Plan, and Patient-Specific Information
- Use of Names and Logos
- Termination of Contract
- Procedure for Customer Concerns

## Alliance Proprietary Information

The Alliance fee schedule and provider contracts are the proprietary information of the Employer Health Care Alliance Cooperative (The Alliance) and will not be published, disclosed or disseminated. Alliance employers, employees/ dependents and plan administrators have access to information on the repricing of individual claims and Alliance cost of medical care comparisons by calling the Customer Service Department at 608.276.6630 or 800.223.4139. Use of The Alliance fee schedule or repriced amounts for any other purpose other than administration of The Alliance employer by plan administrator is not permitted. Use of such information by the plan administrator, its subsidiaries, affiliates, entities with an equity interest in the plan administrator, or employer's consultants for the purpose of gaining insight into The Alliance's agreements with participating providers or for negotiating their own agreement with participating providers constitutes a breach of membership.

The Alliance Employer Administrative Handbook is considered proprietary information of The Alliance and is provided as a resource to the employer. The manual at no time should be published, disclosed or disseminated outside The Alliance employers. Failure to abide by this request will result in a board of director's review.

All rights, title and interest in any aggregate de-identified health information produced by The Alliance as part of its de-identification and data aggregation services to its membership shall be the sole and exclusive property of The Alliance. The decision whether to share such information with any third parties, including any issues of format and price, are exclusively within the discretion of The Alliance.

## Confidentiality of Employer, Health Plan, and Patient-Specific Information

In general, The Alliance will maintain the confidentiality of information relating to the employer, including the description of its health plans and all statistical data.

The Alliance activities described in this section of The Alliance Employer Administrative Handbook (the "Handbook") shall be those of a "Business Associate" and shall be performed on behalf of the employer's "Health Plan," in compliance with (1) the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as amended to incorporate Subtitle D of the Health Information Technology for Economic and Clinical Health Act, Title XIII of Public Law 111-005 (42 U.S.C.A. Section 17921 et seq., subchapter III, Privacy) ("HITECH"). Collectively, HIPAA, HITECH and the implementing regulations shall be referred to in the Handbook as the "HIPAA Regulations."

The Alliance activities described in this section of the Handbook that may be performed, from time to time, on behalf of the Health Plan include, but are not limited to, the following activities:

- Processing the Health Plan's claims for payment, including claims repricing activities;
- Performing administrative functions relating to the administration of claims;

- Contracting with providers for discounted reimbursement rates and/or quality medical services;
- Performing data analysis as part of the Health Plan's quality initiatives, utilization review and benefits management;
- Performing administrative services, including creation of de-identified health information and Limited Data Sets, relating to data aggregation;
- Aggregating the data of all of The Alliance members as part of such quality initiatives, utilization review and benefits management;
- Performing administrative services relating to data aggregation;
- Performing research on behalf of the Health Plan;
- Performing research on behalf of The Alliance, itself.

With regard to these activities, The Alliance and the Health Plan shall comply with the HIPAA Regulations, as follows:

## Definitions

Capitalized terms not otherwise defined in this section of the Handbook shall have the meanings given to them in the HIPAA Regulations, which are incorporated herein by reference.

## Use and Disclosure of Protected Health Information

The Alliance shall use and/or disclose the Protected Health Information created for or received from or on behalf of the Health Plan, including electronic Protected Health Information, ("PHI") only to the extent necessary to satisfy The Alliance's obligations as described in this section of the Handbook and as otherwise agreed between The Alliance and the Health Plan. The Health Plan shall not instruct The Alliance to use or disclose PHI in any manner that would otherwise violate the HIPAA Regulations.

## Prohibition on Unauthorized Use or Disclosure of PHI

The Alliance shall not use or disclose any PHI except as permitted or required by this section of the Handbook, the HIPAA Regulations and as required by law or as otherwise authorized in writing by the Health Plan. The Alliance shall comply with the applicable provisions of the HIPAA Regulations and state laws, rules and regulations applicable to individually identifiable health information that are not preempted by federal law. The Alliance may use, maintain and disclose data contained in a Limited Data Set as set forth in this section of the Handbook. The Alliance may maintain, use and disclose identified information as permitted by law.

## The Alliance's Operations

The Alliance may use PHI it creates for or receives from the Health Plan, in its capacity as Business Associate, to the extent necessary for The Alliance's proper management and administration or to carry out its legal responsibilities. The Alliance may also disclose PHI for such reasons, if:

- The disclosure is required by law; or
- The Alliance obtains reasonable assurance, evidenced by written contract, from any person or organization to which The Alliance shall disclose such PHI that such person or organization shall:
  - > Hold such PHI in confidence and use or further disclose it only for the purpose for which The Alliance disclosed it to the person or organization or as required by law; and
  - > Notify The Alliance (who shall promptly notify the Health Plan) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached as soon as possible.

## Creating De-Identified Health Information

The Alliance may de-identify health information as necessary to perform services for member Health Plans, including but not limited to Data Aggregation Services.

## Data Aggregation Services

The Alliance may aggregate PHI of the Health Plan with the Protected Health Information of the health plans of other employers participating in the cooperative to provide Data Aggregation Services related to the Health Plan's Health Care Operations.

## Limited Data Set

The Alliance may create a Limited Data Set from the PHI on behalf of the Health Plan. In doing so, The Alliance shall abide by the following terms, which constitute a Data Use Agreement between Health Plan and The Alliance:

- The Alliance agrees to not use or further disclose the Limited Data Set other than in compliance with its mission statement and organizational purpose, which use and disclosure includes disclosure to The Alliance's tax-exempt research foundation and which mission includes the aggregation and analysis of data for quality initiatives, utilization review and benefits management.
- The Alliance agrees to use appropriate safeguards to prevent use or disclosure of PHI and the Limited Data Set other than in activities in compliance with its mission statement and organizational purpose.

- The Alliance agrees to report to the Health Plan any use or disclosure of the Limited Data Set not provided for by the Handbook.
- The Alliance agrees to ensure that any agent, including a subcontractor to whom it provides the Limited Data Set data, agrees in writing to the same restrictions and conditions that apply through this section of the Handbook to The Alliance with respect to such information.
- The Alliance agrees not to use the Limited Data Set in such a way as to identify any individual and further agrees not to contact any individual whose health information may be included in the Limited Data Set.
- The Alliance may use the Limited Data Set to provide Data Aggregation services to the Health Plan.

## PHI Safeguards

The Alliance shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of any PHI relating to the Health Plan.

## Electronic Health Information Security and Integrity

The Alliance has developed and implemented, and maintains and uses appropriate administrative, technical and physical security measures consistent with and in compliance with applicable portions of the HIPAA Regulations to preserve the confidentiality, integrity and availability of all electronic PHI that it creates, receives, maintains or transmits on behalf of the Health Plan. The Alliance shall document and keep these security measures current in accordance with the HIPAA Regulations (including 42 U.S.C.A. section 17931).

## Protection of Exchanged Information in Electronic Transactions

If The Alliance conducts any Standard Transaction for or on behalf of the Health Plan, The Alliance shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of the HIPAA Regulations. The Alliance shall not, and shall not permit its subcontractors or agents to, enter into any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of the Health Plan that:

- changes the definition, Health Information condition or use of a Health Information element or segment in a Standard Transaction;
- adds any Health Information elements or segments to the maximum defined Health Information set;
- uses any code or Health Information elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standards Implementation Specification(s); or
- changes the meaning or intent of the Standard's Implementation Specification(s).

## Subcontractors and Agents

The Alliance shall require each subcontractor or agent to whom The Alliance may provide PHI that is received from, or created or received by, The Alliance on behalf of the Health Plan to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on The Alliance in this section of the Handbook and the HIPAA regulations.

## Access to and Amending PHI

If The Alliance maintains a Designated Record Set on behalf of the Health Plan, The Alliance shall, at the written request and direction of the Health Plan, (1) provide access to such PHI in order to assist the Health Plan in meeting its obligations under the HIPAA Regulations and (2) make any amendment(s) to such PHI as the Health Plan directs or agree to pursuant to the HIPAA Regulations.

## Accounting of Disclosures of PHI

So that the Health Plan may meet its disclosure accounting obligations under the HIPAA Regulations, The Alliance shall document disclosures of PHI made by The Alliance which are not excepted from disclosure accounting requirements under the HIPAA Regulations. The Health Plan shall be solely responsible for tracking and providing Individuals an accounting of any disclosures made by Health Plan to The Alliance.

## Access to Books and Records

The Alliance shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of the Health Plan available to the Health Plan and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") for the purpose of determining the Health Plan's compliance with the HIPAA Regulations. The Health Plan's access shall be upon reasonable notice to The Alliance, at its place of business and during business hours.

## Reporting

The Alliance shall report to the Health Plan any Event (defined as a Successful Security Incident, or any use, access, modification, disclosure or destruction of PHI not authorized by this section of the Handbook, by law or in writing by the Health Plan, including Breaches of Unsecured PHI as required by 45 CFR §164.510). This shall include Events discovered by The Alliance or by any subcontractor of The Alliance. The Alliance recognizes and agrees that any acquisition, access, use or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule (Subpart E of 45 C.F.R. Part 164) is presumed to be a Breach. The Alliance shall meet its reporting obligations as follows:

- The Alliance shall provide preliminary notice of the discovery of the Event to the Health Plan's Privacy Official without unreasonable delay and in no event later than fifteen (15) calendar days after discovery of the Event. This notice shall identify a contact person at the alliance with whom the Health Plan Privacy Official may correspond regarding the Event.

- The Alliance shall, without unreasonable delay and in no event later than thirty (30) calendar days after discovery of the Event, provide the Health Plan Privacy Official a written report that will:
  - > Identify (if known) each individual whose Unsecured Protected Health Information has been, or is reasonably believed by The Alliance to have been accessed, acquired, or disclosed;
  - > Identify the nature of the non-permitted access, use, or disclosure including the date of the incident and the date of discovery;
  - > Identify the PHI accessed, used, or disclosed (e.g., name; social security number; date of birth);
  - > Identify what corrective action The Alliance (or The Alliance's subcontractor) took or will take to prevent further non-permitted accesses, uses, or disclosures;
  - > Identify what The Alliance (or the Alliance's subcontractor) did or will do to mitigate any deleterious effect of the non-permitted access, use, or disclosure; and
  - > Provide such other information as the Health Plan Privacy Official may reasonably request.
- The Alliance shall assist the Health Plan in performing (or at Health Plan's direction, perform) a risk assessment to determine if there is a low probability that the PHI has been compromised, with the understanding that the Health Plan shall make the final determination of whether a Breach has occurred.
- The Alliance shall cooperate with Health Plan in meeting the Health Plan's obligations under the HIPAA Regulations with respect to Breach notification.
- Unsuccessful Security Incidents shall include, but not be limited to, pings and other broadcast attacks on the firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as such incidents do not result in unauthorized access, use or disclosure of Health Plan's electronic PHI. Unsuccessful Security Incidents are not "Events" subject to the reporting procedures outlined above. The Alliance and Health Plan acknowledge the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents. Upon written request by the Health Plan, the Alliance shall provide a report that:
  - > identifies the types of Unsuccessful Security Incidents experienced by The Alliance during a specified period, and
  - > indicates whether The Alliance believes its current defensive security measures are adequate to address all Unsuccessful Security Incidents, given the scope and nature of such attempts; and

- > identifies the measures The Alliance will implement to address any security inadequacies it identifies in this process.

## Sale of PHI

The Alliance shall not receive direct or indirect payment in exchange for any PHI relating to the Health Plan or its Individuals, including Electronic Health Records, unless The Alliance receives authorization by all affected Individuals, except as permitted under the HIPAA Regulations.

## Marketing

The Alliance shall not receive direct or indirect payment for marketing communications which include PHI relating to the Health Plan or its Individuals without authorization from the affected Individuals unless such communication is permitted under the HIPAA Regulations.

## Restrictions on Uses, Disclosures and Requests

The Alliance will limit all uses, disclosures and requests of PHI, including electronic PHI, to the Limited Data Set to the extent possible or, if that is not sufficient, then to the minimum necessary to accomplish the intended purpose of such use, disclosure or request to the extent required by the HIPAA Regulations. The Health Plan shall maintain a written policy delineating the standards it will use in determining the minimum necessary information for its uses and disclosures of PHI in accordance with the HIPAA Regulations. In creating Limited Data Sets, The Alliance will follow the provisions set forth in this section of the Handbook. Upon the request of an Individual, The Alliance will not disclose such Individual's PHI for purposes of Payment or Health Care Operations if the Individual paid in full out of pocket for the health care item or service to which the PHI relates, in accordance with 45 C.F.R. section 164.522.

## Mitigation

The Alliance shall mitigate, to the extent practicable, any harmful effect known to The Alliance of a use or disclosure of PHI by The Alliance in violation of the requirements of this section of the Handbook.

## Termination for Cause

In addition to any other termination provisions set forth in this section of the Handbook, and as required by the HIPAA Regulations, if the Health Plan or The Alliance ("Non-Breaching Party") becomes aware that the other party has engaged in a material breach ("Breaching Party"), then the Non-Breaching Party shall:

- Provide an opportunity for the Breaching Party to cure the breach or end the violation and terminate employer's participation in the Cooperative if the Breaching Party does not cure the breach or end the violation within the time specified by the Non-Breaching Party.
- Immediately terminate employer's participation in the Cooperative if cure is not possible.

## Return or Destruction of Health Information

Upon termination, cancellation, expiration or other conclusion of the employer's participation in the Cooperative, The Alliance, if feasible, shall return to the Health Plan or destroy all PHI held in any form or media, including PHI that is in the possession of subcontractors or agents of The Alliance. In the event that returning or destroying the PHI is infeasible, The Alliance shall retain the PHI, extend the confidentiality protections of this section of the Handbook to all such retained PHI and maintain the confidentiality of all such PHI for so long as The Alliance maintains such PHI.

## Independent Contractor

The Alliance and the Health Plan are and shall remain independent contractors throughout the course of their relationship. Nothing in this Handbook or otherwise shall be construed to constitute The Alliance and the Health Plan as partners, joint ventures, agents or anything other than independent contractors.

## Automatic Amendment

Upon the effective date of any amendment to the HIPAA Regulations, this section of the Handbook shall automatically be deemed to be amended to incorporate such amendment so that The Alliance and the Health Plan remain in compliance with the HIPAA Regulations.

## Release of Health Plan Data to Employer

Under the HIPAA Regulations, an employer must implement adequate separation between it and the Health Plan it sponsors, including restricting access to PHI to those of its employees performing administrative functions on behalf of the Health Plan. The Alliance shall disclose, therefore, PHI to the employer only at the direction of the Health Plan, and the Health Plan shall ensure that any such disclosure meets one or more of the following conditions:

- the Health Plan receives written authorization from an Individual to disclose that Individual's PHI to the employer;
- the Health Plan discloses information to the employer on whether an individual is participating in the Health Plan;
- the Health Plan provides the employer with PHI in the form of Summary Health Information for the purpose of obtaining premium bids from health insurance issuers;
- the Health Plan provides the employer with PHI in the form of Summary Health Information for the purpose of assessing, modifying, amending or terminating the Health Plan;
- the Health Plan receives certification from the employer that the plan documents have been modified as required by the HIPAA Regulations, and the uses and disclosures of PHI by the employer will be restricted to plan administration functions performed by the employer on behalf of the Health Plan in accordance with the plan document;

- the Health Plan receives certification from the employer that the employer will not use the PHI for any employment-related decisions and that plan documents have been amended as required before disclosing PHI to the employer;
  - > the Health Plan includes a separate statement in its Notice of Privacy Practices informing participants that PHI may be disclosed to the employer; or
  - > the Health Plan only discloses the minimum necessary amount and type of PHI to the employer.

## Complaints

If Health Plan has concerns or complaints about The Alliance's use and disclosure of PHI, Health Plan is encouraged to contact The Alliance's Privacy Officer at 608.276.6620.

## Use of Names and Logos

The content and design of all materials containing The Alliance name and/or logo which will be distributed by The Alliance Employer or their plan administrators must be reviewed and approved by The Alliance prior to distribution.

The Alliance will not use an employer's name or logo in any marketing materials without prior approval.

## Termination of Contract

As stated in the cooperative membership agreement:

"The term of this Agreement and the first month of The Alliance's services as described in the Handbook shall commence on the Effective Date and shall continue for an initial term of 12 months, renewing thereafter for consecutive annual terms unless written notice of termination is received by the Cooperative not less than 30 days nor more than 60 days prior to the anniversary of the Effective Date or earlier terminated pursuant to the Handbook or applicable law."

The Alliance reserves the right to charge retainage if not notified of termination within these time limits. The Alliance reserves the right to charge access fees based on a six-month moving average for the remainder of the specified contract arrangement if an employer fails to provide appropriate termination notification.

Unless The Alliance employer specifies otherwise, claims with dates of service prior to the employer's termination date will continue to be repriced for 12 months after termination. Because retainage is due on these run-out claims, invoices may continue to be generated after the employer's termination date. After this 12-month period, all eligibility information will be removed from The Alliance database and no claims will be repriced.

Invoices for access and retainage are issued monthly. Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due. Monthly access will continue to be assessed for all accounts 60 days past due; however, claims repricing will be discontinued.

The Alliance also reserves the right to terminate an employer's access to the network or membership in the cooperative upon failure to meet the financial terms outlined in the access and retainage invoicing process. (See Retainage and Invoicing on page E-1.)

## **Retirement of Equity upon Termination of Contract**

Upon joining The Alliance, each member purchases one share of capital stock per Alliance enrolled employee at a one-time fee of \$10 per share, which becomes the member's capital equity stock in The Alliance cooperative. Throughout membership, each group benefits from the cooperative's success through allocated equity, which is part of the patronage distribution The Alliance makes at the end of a fiscal year when an operating surplus remains after expenses and other obligations are met.

Retirement of equity is considered by Alliance management and acted on by the Board of Directors annually. The cooperative typically retires (i.e., pays back) the equity that has been on the books the longest; in other words, by the oldest year first. Former members' equity is retired on an accelerated basis relative to current members. Please note that the cooperative's bylaws do not set a timeframe for equity payouts. There are no requirements to redeem equity and there are no time periods established for its payout. All payout decisions are made by The Alliance Board of Directors based on the cooperative's financial well-being. Issues that are weighed typically include operating reserves, operational plans and long-term financial needs.

Employers are welcome to check annually to learn the board's current position on equity payouts.

## **Procedure for Customer Concerns**

The Alliance has established a procedure for addressing customer concerns related to any aspect of services provided by The Alliance. Employees / Employers are encouraged to bring their concern to Alliance staff.

### **Informal Procedure**

Alliance representatives will assist the employee/employer on an informal basis. If satisfactory resolution cannot be reached, The Alliance representative will advance the concern to the formal procedure. The employee / employer is encouraged to bring their concern to the Alliance CEO if not reaching satisfactory resolution.

### **Formal Procedure**

Depending on the nature and extent of the concern, it will be reviewed by appropriate Alliance management and/or The Alliance board of directors. A formal written response will be provided to the initiating party within 30 days of resolution. The employee / employer is encouraged to advance their concern to the Alliance Board of Directors if not reaching satisfactory resolution.

CEO and board of director contact information as of June 2017 is listed on the following page:

**CEO Contact Information**

- Cheryl DeMars- The Alliance President & CEO: 608.210.6621, [cdemars@the-alliance.org](mailto:cdemars@the-alliance.org)

**Board Member Contact Information**

- Wendy Collins (Board Secretary)- The Alliance Executive Assistant/Office Manager: 608.210.6632, [wcollins@the-alliance.org](mailto:wcollins@the-alliance.org)
- Wendy Culver, SPHR (Board Chair)- Mead & Hunt Human Resources Director: 608.273.6380, [wendy.culver@meadhunt.com](mailto:wendy.culver@meadhunt.com)
- Paul Meyer- The Alliance COO & Board Treasurer: 608.210.66654, [pmeyer@the-alliance.org](mailto:pmeyer@the-alliance.org)
- Larry Pribyl (Vice Chair)- Trachte Building Systems CFO: 608.327.3185, [lpribyl@trachte.com](mailto:lpribyl@trachte.com)

# EMPLOYEE/DEPENDENT ELIGIBILITY

Alliance employers and/or their plan administrators must supply The Alliance with accurate and current employee/dependent biographical information on an ongoing basis. Claims for individuals not in The Alliance database will be repriced according to The Alliance backdating policy detailed in this section.

Included in this section are:

- Eligibility Information–Procedure and Enrollment Form
- Backdating
- Out-of-Area Employees/Dependents
- ZIP Codes

# Eligibility Information–Procedure and Enrollment Form

## Eligibility Information–Who’s Responsible

For Alliance employers to take full advantage of useful and necessary claims information and benefit from Alliance savings negotiated on their behalf, The Alliance must have accurate and current eligible employee/dependent biographical information. This information may be provided to The Alliance by the third-party administrator or the employer’s human resources department, but **the ultimate responsibility for keeping The Alliance informed of additions, deletions and changes in eligibility rests with the employer.**

## Initial Eligibility

The “first eligible” date for all employees/dependents is The Alliance employer’s effective date listed on the cooperative membership agreement.

## Providing Updates

Updates should be provided to The Alliance on an ongoing basis (monthly at a minimum). Information about:

- new hires (with effective date);
- terminations (with termination date); and
- changes in status (name, address, family status, etc.)

should be provided in a timely manner so employees/dependents can benefit from Alliance repricing.

All additions and/or changes in employee/dependent status must be accompanied by an effective date determined by the employer. The effective date is the date the employee/dependent is eligible for Alliance services, which may or may not be the date of hire. The Alliance claims department will contact the employer’s designated representative in human resources or the health plan to obtain an effective date for additions or changes not dated.

Employee/dependent terminations should be accompanied by a termination date. When submitting eligibility information electronically, it is important that “termed” employees and dependents appear in the electronic file with their termination date so The Alliance can update its biographical database.

Electronic submission of eligibility information is preferable but it may be submitted on paper–by providing a copy of the insurance application or a completed Alliance Employee Enrollment Form (sample included in this section).

## Requesting Rosters for Review

Alliance employers may request a hard copy or an electronic copy roster of employees/dependents in The Alliance database at any time for verification. Contact Member Services at 608.276.6620 or 800.223.4139 for details.

## Identifying Alliance Network Accessed

Provide detailed information to The Alliance on which networks are accessed by employees/dependents. Options include: Alliance Standard Network, QualityPath Network, Exclusive Provider Organization Network, and Workers' Compensation Network.

## Backdating

"Backdating" refers to the act of adding eligibility information to The Alliance database for employees/dependents accessing The Alliance after care has been rendered. The following policy applies in cases in which an employee/dependent is not in The Alliance database due to an oversight or error on the part of The Alliance employer or third-party administrator:

"Upon Alliance notification, backdating of all eligibility shall not exceed 90 days. The courtesy of backdating within 90 days will be extended to employees who were Alliance eligible at the time services were rendered but were not in The Alliance database due to the employer's or third-party administrator's failure to notify The Alliance. A copy of the original application/enrollment form must be submitted to The Alliance."

The enrollment form included in this section may be copied by the employer or third-party administrator to update The Alliance database.

## Out-of-Area Employees/Dependents

Employees/dependents who are not enrolled in The Alliance due to their geographic location may choose to receive medical services in The Alliance service area.

Eligibility information about these employees/dependents should be received by The Alliance before medical services are rendered in order for the employee and employer to benefit from The Alliance negotiated fee. Claims will be repriced until the employer or third-party administrator notifies The Alliance that the individual is no longer accessing an Alliance participating provider. The Alliance employer will be billed monthly access fees for these employees/dependents during this time. Alliance members will also be billed retainage on the employee's/dependent's claims for that period.

Employers should remind out-of-area employees/dependents to identify themselves as Alliance participants at the time they receive services in The Alliance service area.

## ZIP Codes

A list of Alliance service area ZIP codes resides on The Alliance website at [www.the-alliance.org](http://www.the-alliance.org) and is provided upon request to assist employers when determining Alliance eligibility by residence.

# CLAIMS PROCESSING

This section provides basic information about The Alliance claim repricing system. Detailed information for third-party administrators may be found in The Alliance Third- Party Administrator Kit, distributed to administrators working with The Alliance or via The Alliance website.

This section includes:

- Provider Contractual Arrangements
- Electronic Claim Transmission
- Incoming Claims
- The Alliance Claim Cover Sheet
- Coordination of Benefits
- Non-Covered Services

# Provider Contractual Arrangements

## The Alliance Provider Fees

The Alliance has negotiated a reimbursement schedule which represents a local “fair market value” fee for the services of hospitals, physicians, and other health care providers in The Alliance service area.

The Alliance negotiated fee represents the maximum allowable payment for physician services. Payment is made based on the original billed charge or The Alliance negotiated fee, whichever is less.

## Making Payment Based on The Alliance Negotiated Fee

On behalf of Alliance employers third-party administrators must pay Alliance eligible employee/dependent claims according to The Alliance repricing system. Alliance participating providers will accept only The Alliance negotiated fee for Alliance eligible employees and dependents, regardless of other contractual arrangements that may be in place. To reinforce accurate and appropriate payment, claims payers must refer to the payment directive on The Alliance cover sheet attached to paper claims (see “The Alliance Claim Cover Sheet” later in this section on page D-4) or for electronic claims, in the appropriate claim status field.

## Claim Submission to The Alliance

Hospital and physician claims incurred by Alliance eligible employees and dependents are submitted to The Alliance by participating providers within 45 days of the date of service. Hospital claims are submitted on a UB04 format and physician claims are submitted on a HCFA-1500 format. Claims may be submitted electronically or on paper.

## UW Timeliness Provision

Per The Alliance’s contract with the University of Wisconsin Hospitals and Clinics, there is a 40-day timeliness provision in place. If payment is not received by UW Hospitals and Clinics from the member’s Third Party Administrator within 40 days of receipt of the claim at The Alliance, half of the discount is lost.

# Electronic Claim Transmission

The Alliance works with several clearinghouses allowing transmission of repriced claims to plan administrators. More than 70% of the claims received and repriced by The Alliance are submitted electronically to The Alliance by the provider of service.

Alliance employers whose third-party administrators are not currently capable of or willing to receive repriced claims electronically are urged to encourage them to explore the opportunity for electronic claim transmission from The Alliance. For more information about electronic claim transmission, contact The Alliance at 608.276.6630 or 800.223.4139.

## Incoming Claims

All incoming paper claims are date stamped as they are received (claims received after noon are date stamped for the following day). Claims are then distributed among Alliance claim processors. Each processor verifies that the patient is an Alliance eligible employee/dependent before processing the claim.

### Non-Alliance Employee/Dependent

Claims received for individuals not in The Alliance biographical database are stamped "Non-Alliance Member" and forwarded to the third-party administrator for:

- verification of Alliance eligibility; and
- processing of the claim as usual if the patient is not Alliance eligible; or
- re-submission of the original claim with a completed Alliance or plan administrator eligibility form to The Alliance for repricing and data collection if the patient is Alliance eligible as of the date of service (see "Backdating" in Employee/Dependent Eligibility on page C-1.)

### The Alliance Claim Cover Sheet

An Alliance cover sheet is printed and attached to each paper claim before it is mailed to the appropriate payer. The status message of the cover sheet contains instructions which are essential in determining payment of claims. The payment directive is relayed in the appropriate claim status field of an electronically transferred claim. (A separate cover sheet is not generated for electronic claims.) A sample cover sheet is included in this section.

### Three-Day Turnaround Required by Contractual Obligation

The Alliance maintains a claims data entry and repricing system with a turnaround time of no more than three working days per contractual obligation with providers.

# The Alliance Claim Cover Sheet

Below is a reduced sample of a claim cover sheet that may be provided to an employer's health plan. Also included is a key to reading Alliance cover sheets. **Please note that the status message of the cover sheet contain instructions, which are essential in determining payment of claims.**

**HCFA REPRICING SHEET**

<p><b>(A)</b> Payer: <b>UMR - Midwest Security/Onalask</b></p> <p><b>(B)</b> Employer: <b>Alliance, The</b></p> <p>Insured: <b>PERSON, TEST</b></p> <p><b>(E)</b> Patient: <b>PERSON, TEST</b></p> <p>Covers period: <b>10/29/2008</b> thru <b>10/29/2008</b></p> <p><b>(C)</b> 100 PROVIDER: <b>421017512 Upland Hills Health, Inc.</b></p>	<p>Name: <b>UMR - Midwest Security/Onalask</b></p> <p>Group / ID#: <b>(C) 00113-01</b></p> <p><b>(D)</b> 98765432101</p> <p><b>(F)</b> 98765432101</p>	<p><b>THE ALLIANCE</b>  The Alliance Employers providing health care forever</p> <p>The Alliance PO Box 44365 Madison, WI 53744 Ph (608) 276-6620 Fax (608) 210-6677</p> <p>DOB: <b>01/01/1950</b></p> <p><b>(I)</b> 01/01/1950</p> <p><b>CLAIM HAS ATTACHMENTS OR IS NON-STANDARD</b></p>
--	--	--

PHYSICIAN	RENDERING LOCATION	BILLING ADDRESS
<b>Hostetler, Barbara</b> MD level degree NPI: 1649248022	800 Compassion Way Dodgeville, WI 53533 NPI:	PO Box 800 Dodgeville, WI 53533 NPI: 1487745501

Condition related to: Employment? **N**    Auto accident? **N**    Other **Y**

Ill/Inj date: **10/29/2008**    Unable to work: to

Local use:    Hospitalization: to

Diagnosis codes: **8483**    3.    **(H)** Pat acct#: **0213612-02**    Prior pymt: **0.00**

2. **E8120**    4.

DOS	POS	TOS	CPT/HCPCS	Diag	Charges	Units	Repriced
<b>(I)</b> 10/29/2008	<b>23</b>		<b>99282</b>	<b>1</b>	<b>200.00</b>	<b>1</b>	<b>79.40</b>

**CLAIM SUMMARY    >> MEDICARE CLAIM <<**

Signed: **11/07/2008**    Charges: **(J) 200.00**    Status: **PARTICIPATING PROVIDER**

Received: **11/07/2008**    Repriced: **(K) 79.40**    Pay "Repriced" amount

Entered: **11/07/2008** CVOIGT    Savings: **120.60**    **(L)**

This attachment does not replace the designation of eligibility and benefits provided by the paying agent 6885003410  
CVOIGT 1-1

**Alliance cover sheet key:**

- |  |   |
|--|---|
| <p><b>(A)</b> Benefit Plan Admin (BPA) name</p> <p><b>(B)</b> Employer name</p> <p><b>(C)</b> BPA number if available</p> <p><b>(D)</b> Alliance employer number</p> <p><b>(E)</b> Patient name</p> <p><b>(F)</b> Social Security number</p> | <p><b>(G)</b> Provider tax ID, name &amp; location</p> <p><b>(H)</b> Provider account number</p> <p><b>(I)</b> Date of service</p> <p><b>(J)</b> Total charges billed by provider</p> <p><b>(K)</b> Total Alliance reprice amount</p> <p><b>(L)</b> Status message/payment instructions</p> |
|--|---|

**Sample payment instructions which may appear under “L” on Alliance Claim Cover Sheet (previous page). This list is not all inclusive\*:**

- “National Network Provider, Pay repriced amount”
- “Non-participating provider, Repricing Not applicable”
- “Employer has not elected coverage in this network”

## Coordination of Benefits

The Alliance does not coordinate benefits. However, Alliance provider contracts contain the following, or similar, language regarding secondary claims:

“Provider agrees to accept The Alliance repriced amount as full reimbursement regardless of whether employer is the primary or secondary payer. Medicare claims are excluded from Alliance repricing.”

All secondary claims are repriced as though they are primary to determine the “total” reimbursement amount. The Alliance fee reflects The Alliance contracted fee based on total billed charges. Payers should use this information when determining the balance due to the provider after the primary payer has made payment.

### Examples

	Example A	Example B
Billed charge	\$2,000	\$2,000
Alliance fee (“total” payment)	1,600	1,600
Primary payment	- 1,300	- 1,700
Secondary payment	\$300	none

Note that in Example B the primary payment exceeded The Alliance repriced fee, so no payment is due from the employee’s secondary carrier.

\*to receive a complete list contact Customer Service at 800.223.4139 or [csr@the-alliance.org](mailto:csr@the-alliance.org).

# Non-Covered Services

## Medical/Surgical Network

Virtually all Alliance participating providers have agreed to accept Alliance negotiated fees for non-covered services. These agreements may benefit employees of Alliance employers with benefit plans which exclude routine office visits and other non-elective services.

Participating providers will not, however, accept Alliance negotiated fees for some elective services which are not medically necessary, such as cosmetic surgery (breast augmentation, rhinoplasty, face lifts), infertility treatment (tubal reanastomosis and HIPA tests), vasectomy reversal, smoking cessation programs, and special programs such as mammogram screenings offered through the American Cancer Society. The services excluded are contract-specific.

## Optional Alliance Ancillary Networks

Employees/dependents of Alliance employers participating in The Alliance mental health/substance abuse, chiropractic, home health, and oral surgery networks may benefit from Alliance repricing once limited benefits for covered services have been exhausted.

## Administration

Third-party administrators continue to be responsible for determining the medical necessity of services provided. Employees/dependents receiving medically necessary services not covered under the employer's benefit plan should be advised of The Alliance negotiated fee (repriced amount) in the explanation of benefits so they may submit payment to the provider based on this amount.

**Alliance employers should verify with their third-party administrator that explanation of benefits forms and remittance advices referencing The Alliance repriced amount will be sent out for non-covered charges.**

Virtually all providers will accept The Alliance negotiated fee as full payment regardless of whether the service is a covered benefit under the plan or whether The Alliance employer, third-party administrator or employee is the responsible party. Alliance employers should encourage employees to request that The Alliance negotiated fees be considered full payment for non-covered services.

# RETAINAGE AND INVOICING

- Calculation of Retainage
- Invoicing Process and Sample Monthly Invoice
- The Monthly Summary of Utilization & Savings Report

# Calculation of Retainage

## Retainage

“Retainage” refers to the share of Alliance members’ claims savings retained by The Alliance for operating expenses. A retainage invoice is issued monthly, reflecting savings generated from claims repriced during the previous month. **Retainage is owed on all claims, even those exceeding the member company’s specific stop-loss limit.** (For information about negotiating with reinsurers, see “Notifying Reinsurers and Utilization Review Firms” in Alliance Implementation on page A-10.)

Retainage is calculated as a percent of gross claims savings.

A retainage cap was implemented June 1, 2000. The cap is designed to limit liability and assist in budgeting for health plan expenses. Check with The Alliance for the current cap rate, which is annualized per employee per month, usually running based on The Alliance fiscal year with some exceptions. The retainage cap will be prorated for new members. Retainage payments are credited each month toward the cap, which is also adjusted monthly to reflect the total number of enrolled employees. The cap represents the total amount paid in retainage during The Alliance fiscal year, unless new employees are added after the cap has been met. When the cap is reached, employers are notified in the monthly Alliance invoice.

Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due.

### Administration Fee- NOVO Health’s Bundled Procedures

Member companies may see a \$750 administration fee per bundled procedure, on the employer bill. This fee applies to most bundled procedures accessed through NOVO Health. This fee is not part of the retainage fee as a member of The Alliance.

The administration fee for NOVO Health’s bundled procedures will be split as \$550 to NOVO Health and \$200 to The Alliance. This fee helps to cover the administrative costs associated with accessing these bundled procedures.

# Invoicing Process and Sample Monthly Invoice

## Monthly Invoice and Reports

An invoice for access fees and retainage is issued monthly to each Alliance employer. Access fees billed are determined by the number of employees included in the file regularly submitted to The Alliance by The Alliance employer. The invoice is accompanied by reports illustrating the previous month's claims savings as a result of Alliance repricing. (See "The Monthly Summary of Utilization and Savings Report" on page E-5.)

## Payment Due Upon Receipt

Payment is due upon receipt of the invoice. A 1.5 percent finance charge per month will be applied to all accounts over 30 days past due. Monthly access will continue to be assessed for all accounts over 60 days past due; however, claims repricing will be discontinued. Providers and the employer will be sent a notice that claims repricing has been discontinued. When payment of the entire past due amount has been received, claims repricing will resume and the appropriate parties will be notified.

## Right of Termination for Nonpayment

The Alliance board of directors reserves the right to terminate any Alliance employer from the cooperative for failure to pay fees according to the terms indicated. (See "Termination of Contract" in Administrative Policies on page B-11.)

**THE ALLIANCE**  
Employers moving health care forward

*Employer Health Care Alliance Cooperative, Inc.*  
*PO Box 44365, Madison, WI 53744*  
*Phone 608-276-6620 Fax 608-276-6626*

## ***INVOICE***

*Invoice Date:* 11/3/2011

*Company Number:*

*Invoice Number:*

*Period Covered:* October 2011

### ***Transaction Description***

### ***Amount Due***

October Access 76 Employees @ \$1 (Minimum \$50 per month)	\$76.00
October Retainage	\$590.45
October NPPN Retainage	\$83.83

---

***GRAND TOTAL DUE:*** **\$750.28**

**TERMS: NET DUE UPON RECEIPT**  
**A 1.5% finance charge will be assessed on balances over 30 days old**

P. O. Box 44365, Madison, WI 53744 \* Phone 608 276 6620 \* Fax 608 276 6626

DATE PREPARED: 11/3/2011

PERIOD COVERED: October 2011

# The Monthly Summary of Utilization and Savings Report

A sample report is included in this section for reference.

## Summary of Savings and Utilization

This report summarizes the month's claim activity based on claims entered during the previous month.

### **"Alliance In-Network Claims"**

This section of the report summarizes all claims by department. For each department the report tells:

- Department number
- Department name
- Total charges;
- Total repriced amount;
- Total savings both in dollars & %
- Retainage rate; and
- Total Retainage charged

A grand total for all departments is listed at the bottom of the section.

### **"Secondary Claims"**

Secondary claims are In-Network claims that are submitted to The Alliance that indicate a previous payment by another group health insurance plan. Secondary claims are repriced but The Alliance does not charge fees to the employer for this service. This section lists Total Claim Charges only.

### **"Out-of-Network Claims"**

This section lists the number of claims for the month and the total charged.

**“Alliance National Network Partner”**

If an employer contracts with a national network partner of The Alliance, there is an additional section on the monthly report. This section of the report summarizes all claims by department under [Name of National Network] Claims”. For each claim the report tells:

- Department number
- Department name
- Total charges;
- Total repriced amount;
- Total Savings both in dollars & %;
- Retainage rate; and
- Total Retainage charged.

A grand total for all departments is listed at the bottom of the section.

**“Employer-Owned Clinics”**

This section lists the number of claims for the month and the total charged.

**THE ALLIANCE**

Employers moving health care forward

*Employer Health Care Alliance Cooperative, Inc.  
PO Box 44365, Madison, WI 53744  
Phone 608-276-6620 Fax 608-276-6626*

*SUMMARY OF UTILIZATION AND SAVINGS*

<u>ALLIANCE IN-NETWORK CLAIMS</u>	<i>CHARGES</i>	<i>REPRICED</i>	<i>NETWORK SAVINGS</i>	<i>RETAINAGE</i>		
	\$16,068.55	\$11,568.78	\$4,499.77	28.0%	3.3%	\$148.49
	\$34,827.31	\$21,434.51	\$13,392.80	38.5%	3.3%	\$441.96
GRAND TOTAL	\$50,895.86	\$33,003.29	\$17,892.57	35.2%	3.3%	\$590.45
 <u>WRAP CLAIMS</u>						
	<i>CHARGES</i>	<i>REPRICED</i>	<i>NETWORK SAVINGS</i>	<i>RETAINAGE</i>		
	\$386.00	\$221.26	\$164.74	42.7%	25%	\$41.18
	\$2,009.70	\$1,839.10	\$170.60	8.5%	25%	\$42.65
GRAND TOTAL	\$2,395.70	\$2,060.36	\$335.34	14.0%	25%	\$83.83
 <u>OUT OF NETWORK CLAIMS</u>						
		<i>#OFCLAIMS</i>			<i>CHARGES</i>	
					\$1,517.00	
GRAND TOTAL					\$1,517.00	

# DEFINITIONS

Many of the terms used in this handbook are defined in this section. For more information, see related sections (referenced in parentheses).

## Alliance Eligible Employee/Dependent

An Alliance eligible employee/dependent is an employee/dependent of an Alliance employer residing, employed or accessing health care in The Alliance service area. Each Alliance employer determines which employees are eligible for Alliance services. Each employee/dependent becomes eligible for Alliance repricing services only when the following biographical information is in The Alliance database: name, insured's social security number, birth date, gender, and date of Alliance eligibility. (See Employee/Dependent Eligibility on page C-1.)

**The Alliance does not determine benefit eligibility.**

## Alliance Fee Schedule

The Alliance fee schedule represents a local, negotiated "fair market value" for hospital, physician and other network options (ancillary networks: chiropractic, mental health/substance abuse, home health, oral surgery; QualityPath; Exclusive Provider Organization; and workers' compensation) services in The Alliance service area. Alliance participating providers have agreed that The Alliance fee schedule represents total compensation for covered services. The Alliance negotiated fee for participating providers supersedes any existing or future arrangements negotiated by other entities.

## Alliance Fee Schedule for Non-Covered Services

Virtually all Alliance participating providers have agreed to accept Alliance negotiated fees for non-covered services. (See "Non-Covered Services" in Claims Processing on page D-6.)

## Alliance Participating Provider

Alliance participating providers have entered into a contractual agreement with The Alliance to provide health care services to Alliance eligible employees/dependents on a non-exclusive basis. Alliance participating providers have agreed that The Alliance fee schedule represents total compensation for covered services; they will accept only The Alliance negotiated fee for services rendered to Alliance eligible employees/dependents, regardless of other contractual arrangements which may be in place.

## Alliance Find a Doctor Website

To obtain the most current listing of Alliance participating providers, The Alliance Find a Doctor website can be accessed through [www.the-alliance.org](http://www.the-alliance.org). Monthly participating provider updates are published in The Alliance's weekly e-digest for employers.

## Alliance Service Area

The Alliance Service Area currently includes southern Wisconsin, northern Illinois and northeast Iowa and is updated periodically.

## Anniversary Date

Each Alliance employer's anniversary date is the annual anniversary of the effective date of that Alliance employer's contract.

## Backdating

Backdating refers to the act of adding eligibility information to The Alliance database for employees/dependents accessing The Alliance after care has been rendered. (See "Backdating" in Employee/Dependent Eligibility on page C-3.)

## Biographical Data

Biographical data about Alliance eligible employees/dependents must be maintained by each Alliance employer, employer-sponsored group health plan or third-party administrator and communicated to The Alliance. This information must include the employee's name, address, birth date, social security number, gender and eligible dependent information. (See Employee/Dependent Eligibility on page C-1.)

## Coordination of Benefits

The Alliance does not coordinate benefits. (See "Coordination of Benefits" in Claims Processing on page D-5.)

## Diagnostic Related Group (DRG)

DRGs are an inpatient hospital patient classification scheme factoring in case mix, severity of illness, prognosis and treatment difficulty for purposes of standardizing reimbursement mechanisms.

## Effective Date

An Alliance employer's effective date is the date the employer initiates access to Alliance services.

## **Non-Alliance Employee/Dependent**

Non-Alliance employee/dependent includes any person for whom The Alliance has received a claim whose biographical information is not in The Alliance database. (See "Incoming Claims" in Claims Processing on page D-3.)

## **Non-Covered Services**

Virtually all Alliance participating providers have agreed to accept Alliance negotiated fees for non-covered services. (See "Non-Covered Services" in Claims Processing on page D-6.)

## **Out-of-Area Claims**

Claims for services rendered outside The Alliance service area are entered and repriced for data collection and cost comparison only. The plan administrator should apply its "usual and customary" fee unless instructed otherwise by the employer. The Alliance claim cover sheet indicates repricing is not applicable. Plan administrators should be aware of this process for out-of-area claims to avoid incorrect payment. (See "The Alliance Claim Cover Sheet" in Claims Processing on page D-4.)

## **Out-of-Area Employee/Dependent**

Employees/dependents that are not enrolled in The Alliance due to their geographic location may choose to receive medical services in The Alliance service area. (See "Out-of-Area Employees/Dependents" in Employee/Dependent Eligibility on page C-3.)

## **Retainage**

Retainage refers to the share of Alliance members' claims savings retained by The Alliance for operating expenses. (See "Calculation of Retainage" in Retainage and Invoicing on page E-2.)

## **Termination-Patient**

The Alliance will reprice claims for dates of service prior to the patient's termination date (the date the employee/dependent is no longer Alliance eligible). Claims for dates of service up to 90 days after the termination date will be forwarded to the plan administrator without repricing.