DB Retiree Health Plan Modernization

Presentation

Retiree Health Plan Advisory Board

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Modernization Overview

- The legacy retiree health plan is for defined benefit beneficiaries, and does not include members receiving health benefits under the PERS Tier IV or TRS Tier III Defined Contribution Retirement (DCR) medical plan.

- Because of its age, the plan design lacks some key benefit provisions now common in most health plans. It also lacks common cost control mechanisms.

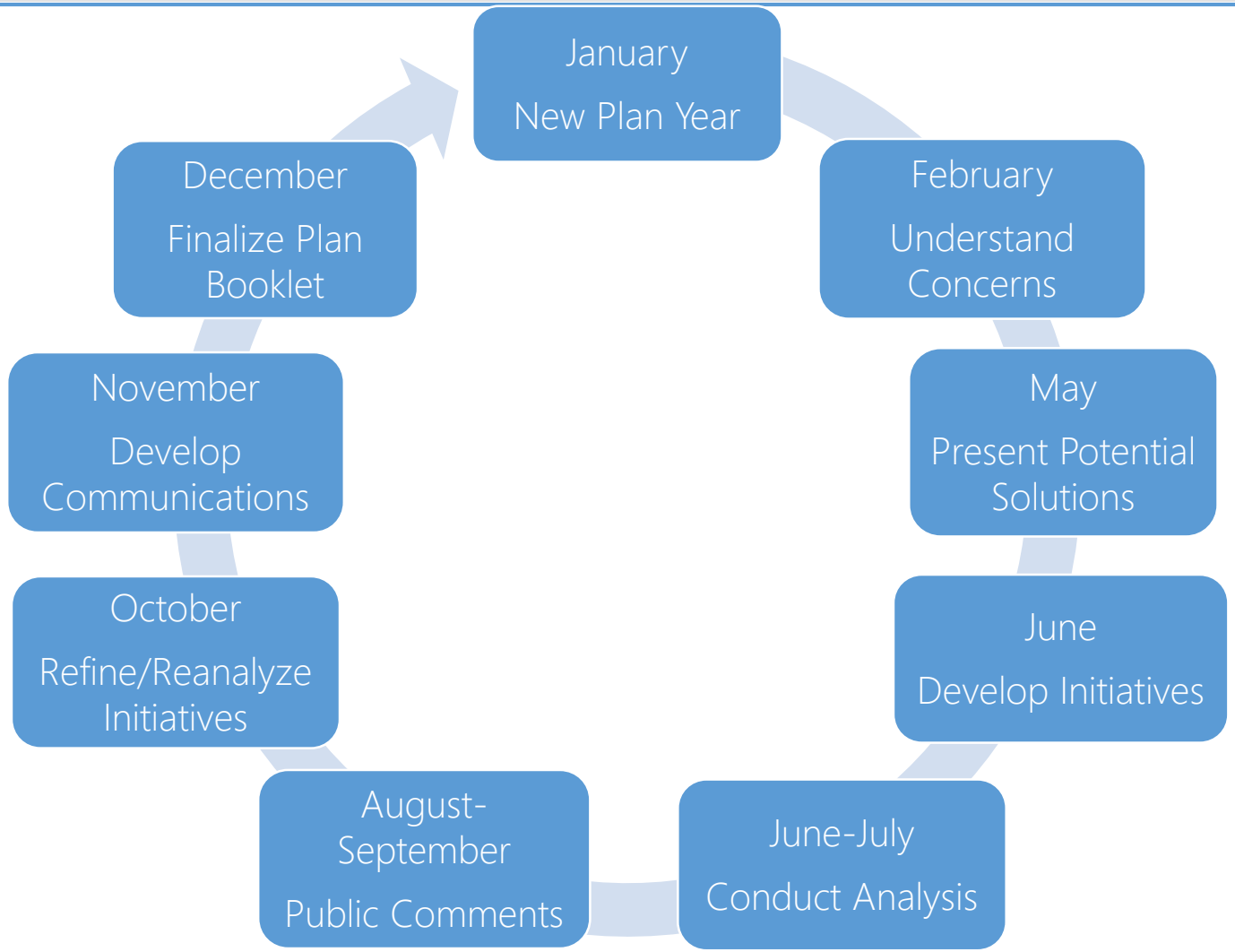
- The goal of the modernization project is to provide value to the member through incorporating common benefits not currently available while preserving the overall benefit of the plan and implementing standard cost saving mechanisms.

Retiree Modernization

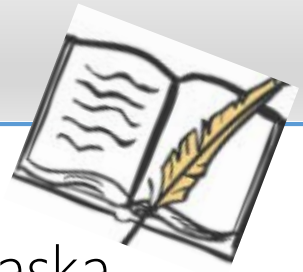
- The Division of Retirement and Benefits (DRB) proposes making several amendments to the legacy retiree medical plan over the next two years as part of a retiree plan modernization project.

- In addition, DRB would like to improve the plan documentation to incorporate prior amendments into the body of the plan. This would make it easier for members to understand and provide more transparent and specific direction as to how AlaskaCare claims should be adjudicated.

Division Health Plan Cycle



History



- Health benefits are offered in accordance with Alaska Statute 39.30.090 and 39.30.091 to eligible retirees.
- The plan was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for the diagnosis and treatment of an injury or disease.
- The plan changed from a fully-insured product to a self-funded benefit in 1997.

Historical Changes

The plan has changed to adopt mainstream health services while maintaining the value of the benefits.

Year	Description of Change
1983	Deductible and coinsurance waived when retiree received $50,000 in benefits. Added second surgical opinions.
1984	Copayment for generic drugs eliminated; implemented Individual Case Management.
1985	Deductible increased from $50 to $100; lifetime limit increased from $250,000 to $1,000,000.
1990	Added maintenance of coordination of benefits (COB).
1991	Added prescription drug mail order benefit; generic copay set at $0, copay for brand name prescriptions set at $5 copay for both retail and mail order; added 100% coverage for skilled nursing care.
1993	Added obesity treatment.

Historical Changes Continued

The plan changed substantially between 1999 and 2000.

Year	Description of Change
1999 - 2000	Increased travel to cover roundtrip costs
1999 - 2000	Increased lifetime limit from $1,000,000 to $2,000,000
1999 - 2000	Annual deductible from $100 to $150
1999 - 2000	Annual out-of-pocket limit from $690 to $800
1999 - 2000	Implemented traditional COB
1999 - 2000	Mail order $0 copay and retail to $4 generic/$8 brand name
1999 - 2000	Added precertification and out-of-network penalties to mental health benefits

Article 12, Section 7 – Alaska Constitution

Membership in employee retirement systems of the State or its political subdivisions shall constitute a contractual relationship. Accrued benefits of these systems shall not be diminished or impaired.

- The constitution does not prohibit the plan administrator from making changes.
  - The disadvantages of changes must be offset by new advantages to the group taken as a whole (rather than an individual member).
  - There is an exception if an individual can show that a change results in serious hardship.

Areas of Focus

#	Concern	Possible Solution
1	Limited preventive care services	Add coverage for full suite of preventive services
2	Lifetime limit of $2M	Remove or increase limit
3	Low cost share reduces sensitivity to price & increases unnecessary services	Increase deductible and out-of-pocket maximum
4	Increasing costs of pharmacy benefits	Implement 3-tier pharmacy benefit, change out-of-network benefits
5	Outdated pharmacy design	Limit to 90 day fill, exclude OTC equivalents
6	Safety and efficacy of drugs	Limit compound coverage for non-FDA approved drugs
7	Limited travel benefits	Enhance travel benefits
8	Confusion over rehabilitative services	Implement clear service limits or hire specialized vendor
9	Confusion over dental implants	Exclude some implants from medical plan and cover under dental plan
10	High use of hi-tech imaging & testing	In-network enhanced clinical review
11	Dependent coverage limits	Statutory change
12	Confusing plan booklet	Update to include regulations, amendments & benefit clarifications

1. Limited Preventive Care Services

Concern: The plan has limited preventive services and currently covers:

- Mammograms, pap smears, & Prostate Specific Antigen test

Possible Solution: Add full preventive services to the plan.*

- Members using a network provider have normal deductible, coinsurance, copays, and annual out-of-pocket limits.
- Members using an out-of-network provider would be paid at a reduced coinsurance (60%) and their portion of the cost would not count towards the annual out-of-pocket limit.
- There would be an exception for areas where no network provider is available.

*Preventive services are defined as those that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.

2. Lifetime Limit of $2 Million

Concern: With medical costs increasing, more retirees are reaching their lifetime maximum.

Possible Solution: Remove or increase the $2,000,000 lifetime limit.

3. Low Cost Share

Concern: Low annual deductible and out-of-pocket limits reduces member sensitivity to price and is associated with increased utilization of unnecessary services.

Possible Solution:

- Increase individual deductible to $300 annually
- Decrease family deductible from a limit of 3, to a limit of 2.
- Increase annual individual out-of-pocket maximum to $1,600 (including $300 deductible).
- Limit family annual out-of-pocket maximum to $3,200 (including deductible).

4. Increasing Cost of Pharmacy Benefits

Concern: Members use higher percentage of brand medication when cheaper alternatives are available.

Possible Solution: Implement a 3-tier pharmacy benefit.

- Member copay is associated with type of drug
- Generic drugs have lowest copayments
- Higher cost drugs available in lower cost equivalent forms have higher copays

Tier	Type of Drug	Copay Retail	Copay Mail Order
Tier 1	Generic	$4	$0
Tier 2	Preferred Brand	$8	$0
Tier 3	Non-Preferred Brand	$25	$10

4. Increasing Cost of Pharmacy Benefits cont'd

Concern: Pharmacy costs are increasing and using out-of-network providers is more expensive.

Possible Solution: Change coverage for prescriptions filled at an out-of-network pharmacy.

- Prescriptions filled at an out-of-network pharmacy:
  - Plan pays 60% coinsurance,
  - Member pays 40% until annual $1,000 out-of-pocket maximum is reached.
- No change to prescriptions filled at network pharmacies.
- The plan will continue to offer a broad pharmacy network.

5. Outdated Pharmacy Design

Concern: Outdated plan design allows for 100 unit supply

Possible Solution: Limit the maximum fill to 90-day supply

Concern: Plan covers medications that have an over the counter (OTC) equivalent.

Possible Solution: Exclude coverage of prescriptions with an OTC equivalent.

- Members can purchase OTC alternatives that may be less expensive.

6. Safety and Efficacy of Drugs

Concern: Increasing cost, safety and efficacy concerns over compounded medications.

Possible Solution: Limit coverage of compound medications to compounds that utilize at least one non-bulk, FDA-approved legend drug.

- Medical exceptions will be allowed to avoid allergies or provide dosages or mixtures that are not available commercially.

7. Limited Travel Benefits

Concern: Limited coverage for travel making members responsible for most costs.

Possible Solutions:

- Provide travel concierge to purchase airline tickets for member.
- Add companion airline ticket coverage.
- Add travel benefit for diagnostic testing less expensive elsewhere.
- Add additional travel benefits to centers of excellence for certain non-emergency procedures (knee replacement, hip replacement, etc.)

8. Confusion Over Rehabilitative Services

Concern: Coverage of short-term rehabilitative care coverage for chiropractic, physical therapy (PT), occupational therapy (OT), and speech therapy (SPT) is confusing for members and providers and creates large administrative burden for division.

Possible Solutions:

- 20 visit limit per benefit year
  - Provides clear benefit limits for members and providers
  - Added benefit for those with chronic conditions
- 45 visit limit for all chiropractic, PT/OT/SPT services
  - Provides clear benefit limits for members and providers
  - Removes requirement for continued significant improvement
- Contract with vendor specializing in medical management

9. Confusion Over Dental Implants

Concern: Confusion about coverage for implants under the medical or dental plan.

Possible Solution:

Clarify that dental implants due to periodontal disease are covered under the dental plan. The medical plan will cover implants required because of accident or non-dental disease. Implants required because of a dental condition are covered under the dental plan.

10. High Use of Hi-Tech Imaging & Testing

Concern: Significantly higher use of diagnostic and testing services across all AlaskaCare plans poses risk to members and increases plan costs.

Possible Solution: Adopt enhanced imaging review program.

- Additional level of scrutiny around high cost testing and diagnostics including:
  - High tech radiology
  - Diagnostic cardiology
  - Sleep management studies
  - Cardiac rhythm implant devices
- Program applies to network providers only.
- Does not apply when retiree plan is secondary payer.

11. Dependent Coverage Limits

Concern: The plan administrator cannot extend dependent coverage to age 26 as part of the modernization project.

- State retirement statutes define "dependent child" up to age 19, or until age 23 if a full time student. In addition, the child must be unmarried, and dependent on the retiree for support.*
- The plan is exempt from many provisions of the Patient Protection and Affordable Care Act (PPACA) including those that extended coverage to dependent children to age 26.

Possible Solution: Change to statutory definition.

* There are exceptions if the child is totally and permanently disabled.

12. Confusing Plan Booklet

Concern: Confusing for member as they have to look in multiple places for amendments, clarifications, and regulations because they are not included in booklet.

Possible Solution:

- Insert amendments into body of the plan document
- Insert eligibility regulation information into the body of the plan document
- Add benefit clarification information to plan document
- Number sections for ease of reference

Group Discussion