Health Care Q&A

	Question	Answer
1	Will the State Employee Health Care Plan Change for Actives and Future Non-Medicare Retirees	There will be some changes designed to save money and improve health. But the basic plan choices between "POS Plans" and POE Plans will continue, with both types of plans having the same network, POS plans allowing out of network coverage, and "POE plans" allowing coverage only in network. All of those choices remain exactly as described in the Health Care Planner that was mailed to employee's homes, and has been on the Comptroller's website since late April, except for the changes explained below.
2	So what does change?	There are some changes in pharmacy benefits, and some changes in medical benefits. We'll take them separately.
3	Okay, let's start with medical. What changes?	1. We have provided significant positive incentives for members to use the most high value, cost effective providers. These incentives come from Tiered Provider Networks and Smart Shopper, which are explained in more detail below. 2. We have a new network structure for outpatient laboratory services and diagnostic imaging called Site of Service (also explained below). 3. The co-pay for unnecessary emergency room visits is raised much higher – to $250. However, we continue to use the current definition of "unnecessary", which waives the co-pay if the patient is admitted to the hospital, or if the patient had no reasonable alternative to using the ER. (A link to the current waiver request form is here: ER Copay Waiver), 4. Finally, the Plan already requires medical necessity for physical or occupational therapy (PT/OT) but the vendors have had not had a clear and consistent structure of utilization management to review medical necessity. A consistent utilization standard will now be applied.

4	How do Tiered Provider Networks and Smart Shopper work?	Tiered Provider Networks waive the current $15 co-pay for a set of primary care providers, and specialists, who have been found to provide high quality, cost effective care. About 70% of primary care providers will be in the preferred Tier. Tiering of specialists will begin with 10 specialties for which there is currently good quality data, but may be expanded. Within these 10 specialties, about 60% of the doctors are in the preferred Tier. Finally, under the Smart Shopper Program, there are currently 9 medical procedures for which rebates will be made available to members based on data showing these procedures are provided in a way that is cost effective, and reduces secondary risks like hospital readmission, hospital acquired infection, etc. In each of these cases, if a member chooses a non-preferred provider, or not to use a Smart Shopper provider, the benefit remains precisely what it is now. These upsides to members may be expanded over time as more data becomes available with respect to other specialties and procedures.
5	How do these positive changes for members actually save the Plan money?	By encouraging members to use high quality, cost effective providers who have good results (e.g. avoid hospital readmission, have fewer complications, etc), the savings far exceed the cost of rebates or waivers.
6	Which specialties are going to be Tiered?	So far: • Allergy & Immunology • Cardiology • Endocrinology • ENT • Gastroenterology • OBGYN • Ophthalmology • Ortho/Surgery • Rheumatology • Urology
7	Which procedures will provide rebates to patients through Smart Shopper?	So far: Colonoscopy Hip Replacement (includes revision of total Hip) Knee Surgery Knee Replacement (includes revision of knee) Spinal Surgery (spinal fusion anterior/posterior) Shoulder Surgery (arthroscopy) Hysterectomy/Hysteroscopy Sigmoidoscopy Upper GI:

8	How does Site of Service work?	Site of Service is the name for the new network structure for outpatient laboratory services and diagnostic imaging (blood work, urine tests, stool tests, x-rays, MRIs, CT scans, etc.). Plan data has shown tremendous variation in the amount the Plan is charged for outpatient diagnostic tests such as blood tests, MRI, and CAT scans, even though the reading of those results is by the same doctors. The labs themselves charge prices that may vary by as much as 300% for exactly the same test. To encourage the use of the reasonably priced labs, about 60% of labs and imaging centers will be designated preferred labs and will continue to be 100% covered by the Plan. Of the remaining labs, most will be deemed "in network" and will have 80% coverage. The remainder will be deemed "out of network" and will be 60% covered. This a new restriction in the plan, but it is required that members always have convenient options of 100% covered facilities throughout the state. The Plan's savings comes from encouraging members to avoid the high price facilities which provide the same services as the reasonably priced ones.
9	What are the pharmacy changes?	There are two changes in pharmacy which save money mostly by encouraging members to use more cost effective pharmaceutical drugs. One is a change in co-pays, the second is a change in formulary. They are described separately below:
10	What is the change in pharmacy co-pays	For drugs not prescribed under the Health Enhancement program, pharmacy co-pays move from the current structure of $5/15/25 to a new structure of $5/10/25/40. The current structure has three prices: Generics are $5, Preferred Brand Names $10, and non-preferred are $25. The new structure has two Generic Prices -- $5 and $10 – to encourage members to use lower price generic drugs. This is because recent consolidation in the generic drug industry has allowed some manufacturers to price gouge while much more reasonably priced clinically equivalent generics are available elsewhere. The increase in the brand name pricing further incents members to use generics. Co-pays for drugs prescribed to treat chronic condition under the Health Enhancement Program (like insulin for Diabetes, or statins for High Blood pressure) will not change.
11	What is the change in pharmacy formulary?	Our plan will move to using the standard CVS/Caremark formulary which fights price gouging in the pharmacy industry by removing certain drugs from the standard prescription list where their price has become excessively high, and there are equally clinically effective alternatives available. If a doctor feels a non-formulary drug is medically necessary, a member may appeal any CVS/Caremark denial, and the ultimate determination will be made by the patient's doctor, not CVS/Caremark.

12	Why do all of these changes make sense?	In total, they save a lot of money, which is good for the plan, but also good for members who through their premium share currently pay an average of 12% of plan costs. Just as important, though, they save money primarily by keeping members healthier, or by encouraging members to avoid unnecessary costs rather than simply making members pay more. We think these kinds of changes are the best way to "bend the curve" of health care costs for the state and for the members.
13	When do these changes take effect?	For actives they should start around 7/1/17 or upon legislative approval of the agreement if that's after 7/1. The benefit enhancements that save money (Tiered Networks and Smart Shopper) or which are purely procedural (PT/OT) will apply to retirees on around the same date. The other changes (increased ER co-pay, the laboratory/imaging network change, and pharmacy changes) will apply only to new retirees who retire on or after October 2, 2017, or the 2nd of the month at least 60 days after legislative approval, whichever is later.
14	Are there any changes in the Health Enhancement Program (HEP)?	There are no new HEP requirements. However, the parties did agree to explore adding new HEP opportunities for members to choose to sign up for, or not sign up for, on a totally voluntary basis (choosing not to sign up would have no impact on whether a member can remain in the HEP). If new voluntary opportunities are created, they will be studied for cost-effectiveness to see if they should remain an option for members who choose them.
15	We heard something about a new Medicare Advantage plan. Why isn't that discussed here?	This Q%A is about Active and Future Retirees under 65. Medicare Advantage, which pertains to retiree healthcare for Medicare covered retirees, is describe in another Q&A put out by the Coalition -- Coalition Med. Ad. Q&A – and also one put out by the State Comptroller. Comptroller_FAQ.pdf
16	What happens if I live or move out of state – especially once I retire? Will I be charged out of network costs for lab work or tests because the "Site of Service" Network doesn't exist there?	No. If Anthem or United has an equivalent network in a given state, the same rules can be applied as do in Connecticut. But if no equivalent network exists, Plan rules require that out of state services be treated as in-network. In that case, labs and other diagnostic tests would continue to be 100% covered in those states regardless of which provider is chosen.