Benefit Plan Structures

**Topic for Committee’s consideration**
Review of current plan design and consideration as to whether to pursue any plan design changes.

**General Statutory Authority**
Sections 3, f(3) and (4) of the CHIP Act provides the Board with broad authority with respect to coverage and states in part:

f. The board may:

(3) Issue additional types of health insurance policies to provide optional coverages as are otherwise permitted by this Act including a Medicare supplement policy designed to supplement Medicare.

(4) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission certification, second surgical opinion, concurrent utilization review programs, and individual case management for the purpose of making the pool more cost effective.

Section 8 of the CHIP Act describes Board authority regarding minimum benefits in plan design. Section 8. a. and b. state in part:

Sec. 8. Minimum benefits.

a. Availability. The Plan shall offer in an annually renewable policy major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the Plan shall pay an eligible person’s covered expenses, subject to limit on the deductible and coinsurance payments authorized under paragraph (4) of subsection d of this Section ... Any person who otherwise would qualify for coverage under the Plan, but is excluded because he or she is eligible for Medicare, shall be eligible for any separate Medicare supplement policy or policies which the Board may offer.

b. Outline of benefits. Covered expenses shall be limited to the usual and customary charge, including negotiated fees, in the locality for the following services and articles when prescribed by a physician and determined by the Plan to be medically necessary for the following areas of services, subject to such separate deductibles, co-payments, exclusions, and other limitations on benefits as the Board shall establish and approve, and the other provisions of this Section:

Section 8. d. further addresses deductibles and coinsurance as follows:

d. Deductibles and coinsurance.

The Plan coverage defined in Section 6 shall provide for a choice of deductibles per individual as authorized by the Board. ... A mandatory coinsurance requirement shall be imposed at the rate authorized by the Board in excess of the mandatory deductible, the coinsurance in the aggregate not to exceed such amounts as are authorized by the Board per annum. At its discretion the Board may, however, offer catastrophic coverages or other policies that provide for larger deductibles with or
without coinsurance requirements. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.

Section 8(e) further addresses the scope of coverage as follows:

e. Scope of coverage.
   (1) In approving any of the benefit plans to be offered by the Plan, the Board shall establish such benefit levels, deductibles, coinsurance factors, exclusions, and limitations as it may deem appropriate and that it believes to be generally reflective of and commensurate with health insurance coverage that is provided in the individual market in this State.
   (2) The benefit plans approved by the Board may also provide for and employ various cost containment measures and other requirements including, but not limited to, preadmission certification, prior approval, second surgical opinions, concurrent utilization review programs, individual case management, preferred provider organizations, health maintenance organizations, and other cost effective arrangements for paying for covered expenses.

History of Plan Design:
CHIP first began providing coverage to Illinois residents on May 1, 1989. Originally, there were only two plans – a Medicare carve out for persons who were under age 65 but enrolled in Parts A and B of Medicare; and an indemnity policy that provided comprehensive major medical coverage available under Section 7 of the CHIP Act. At that time, there were only two deductible options: a $500 deductible option and a $1,000 deductible option. In February of 1994, the Board introduced a new $2,500 deductible option. In August of 1995, a new “hospital-only” PPO option was added -- if a non-PPO hospital was used, the member was subject to a non-PPO penalty. A new $1,500 deductible option was introduced in January, 1997. On July 1, 1997, CHIP introduced an identical comprehensive major medical policy and a “hospital-only” PPO option for HIPAA eligible individuals. In January, 1999, the option to use the Plan Administrator’s BlueScript program first became available (a program in which the member still paid for the prescription at time of service; but a discount was provided in exchange for the pharmacy submitting the claim electronically on behalf of the member). In April, 2001, no new indemnity major medical plans were issued. In May, 2001, the “hospital only” PPO plans were switched to full blown PPOs. In addition, the BlueScript Rx program became mandatory. On January 1, 2002, all existing indemnity plans were switched to the PPO option and a drug card program replaced BlueScript (member no longer had to pay for script in full up front and wait for reimbursement). In January, 2003, Plan 2 was changed to include a drug card benefit. On June 23, 2003, CHIP began issuing the first TAA/PBGC policies. The $5,000 deductible option was added January 1, 2005. The drug card program was discontinued for the Medicare carve-out members on January 1, 2006, due to the availability of Medicare Part D coverage. On January 1, 2008, High Deductible Health Plan (HDHP) deductibles of $1,200, $2,000 and $5,200 were first issued. On August 1, 2009, the maternity benefits were switched from an indemnity benefit that could be purchased in units of $500 benefit amounts to benefits being provided same as any other sickness. Benefits were still optional and had to be elected and paid for under Section 7; but automatic under the HIPAA pool.
A chart depicting these significant events is attached (Attachment A).

**Current Plan Design:**

The current standard Traditional and standard HIPAA and HCTC plans are 80%/20% PPO plans with a non-PPO reimbursement rate of 60%/40%. These plans have a drug card benefit of 80%/20% with a minimum of $5 per script ($10 for mail order) and a maximum of $100 per script ($200 for mail order). The deductible must be met before any benefits are payable except for prescription drugs, preadmission testing and second surgical options.

The current HDHP options for both Traditional and HIPAA have the same benefits structure as the standard plans, except there are no first-dollar benefits. The deductible must be met before any plan benefits are payable.

All plans cover most comprehensive major medical expenses due to illness or injury. There are very limited dental, vision and wellness benefits. Birth control and routine gynecological exams are excluded. Section 7 plans have a six month preexisting condition limitation while HIPAA plans do not. The only other difference between Section 7 plans and HIPAA pool coverage is that Section 7 covers in-patient mental health within the state for an unlimited number of days and the HIPAA pool limits in-patient mental health to 45 days per calendar year.

Currently, we offer five standard deductible options: $500, $1,000, $1,500, $2,500 and $5,000 And three HDHP deductible options: $1,200, $2,000 and $5,200

Historically and currently the most popular standard deductible continues to be our $500 deductible. See the table below for a breakdown of participation by plan choices (active count as of 8/14/2009):

<table>
<thead>
<tr>
<th>Deductible Option</th>
<th>Traditional</th>
<th>HIPAA</th>
<th>Total Count</th>
<th>Percentage by Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500</td>
<td>1,400</td>
<td>3,602</td>
<td>5,002</td>
<td>32%</td>
</tr>
<tr>
<td>$1,000</td>
<td>968</td>
<td>2,200</td>
<td>3,168</td>
<td>20%</td>
</tr>
<tr>
<td>$1,200 (HDHP)</td>
<td>92</td>
<td>303</td>
<td>395</td>
<td>3%</td>
</tr>
<tr>
<td>$1,500</td>
<td>538</td>
<td>1,533</td>
<td>2,071</td>
<td>13%</td>
</tr>
<tr>
<td>$2,000 (HDHP)</td>
<td>78</td>
<td>255</td>
<td>333</td>
<td>2%</td>
</tr>
<tr>
<td>$2,500</td>
<td>840</td>
<td>1,662</td>
<td>2,502</td>
<td>16%</td>
</tr>
<tr>
<td>$5,000</td>
<td>580</td>
<td>1,251</td>
<td>1,831</td>
<td>12%</td>
</tr>
<tr>
<td>$5,200 (HDHP)</td>
<td>128</td>
<td>313</td>
<td>441</td>
<td>3%</td>
</tr>
<tr>
<td>Total by Plan</td>
<td>4,624</td>
<td>11,120</td>
<td>15,744</td>
<td>100%</td>
</tr>
</tbody>
</table>

Deductibles can be increased every January 1st, but cannot be decreased. An exception is that we will allow someone on a $5,200 HDHP to revert back to the $5,000 standard plan. Deductibles accumulate during the calendar year and there is no carryover during the last months of the calendar year to the following year.
We continue to offer a Medicare carve out plan. But enrollment has dropped to less than 300 because of a change in Illinois law in May, 2008, which required Illinois carriers to guarantee issue Medicare Supplements to persons under age 65. This current Plan 2 is a Medicare carve out. Since Medicare D plans are available, prescription drugs are not covered unless they are payable under Part B of Medicare.

See Attachment B for benefit plan highlights.

**Modifications to Plan Design:**

At the September 11, 2009 Joint Underwriting and Finance meeting, members directed staff to explore what is currently available in both the group and individual market in Illinois. An internet search was done to determine benefit designs in Illinois. Attachment C describes staff efforts in this regard.

In addition, John Ahrens, our outside actuary reviewed deductible, coinsurance, out-of-pocket and lifetime maximums and drug benefits of the carriers that we routinely survey. Attachment D is the result of his survey. The following are our observations:

- There are plans available that offer separate office visit copays
- There are plans available that provide drug tiers.
- Coinsurance of 80%/20% is still common.
- Our lifetime maximum is at the low end. (It appears all of the Blue Cross plans have $5,000,000
- Our out-of-pockets look to be within range, although $3,000 is also common for the Blue Cross Plans.
## Timetable of Significant Plan Design Changes

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/1/1989</td>
<td>CHIP first began providing coverage to Illinois residents. Two Plans were available: the Medicare carve out for persons who were under age 65 but enrolled in Medicare Part A &amp; B; and a comprehensive major medical indemnity policy. Each option had two deductibles to choose from: $500 and $1,000</td>
</tr>
<tr>
<td>2/1/1994</td>
<td>New $2,500 deductible option</td>
</tr>
<tr>
<td>8/1/1995</td>
<td>Added hospital only PPO option to existing plans.</td>
</tr>
<tr>
<td>1/1/1997</td>
<td>New $1,500 deductible option</td>
</tr>
<tr>
<td>7/1/1997</td>
<td>HIPAA policies first made available</td>
</tr>
<tr>
<td>1/1/1999</td>
<td>Optional use of BlueScript program (discounted prescriptions available; pharmacy filed claims electronically on behalf of member)</td>
</tr>
<tr>
<td>4/1/2001</td>
<td>Discontinued issuing indemnity plans - only option available was PPO</td>
</tr>
<tr>
<td>5/1/2001</td>
<td>Hospital-only PPO plans switched to full blown PPOs; Bluescript mandatory</td>
</tr>
<tr>
<td>1/1/2002</td>
<td>All existing indemnity plans switched to PPO option and drug card replaced BlueScript--member no longer had to pay for script in full up front and wait for reimbursement</td>
</tr>
<tr>
<td>1/1/2003</td>
<td>Plan 2 (Medicare carveout) modified to include drug card benefits</td>
</tr>
<tr>
<td>6/23/2003</td>
<td>HCTC polices offered</td>
</tr>
<tr>
<td>1/1/2005</td>
<td>New $5,000 deductible option</td>
</tr>
<tr>
<td>1/1/2006</td>
<td>Drug benefits removed from Plan 2 (Medicare carveout) due to federal Medicare Part D</td>
</tr>
<tr>
<td>1/1/2008</td>
<td>HDHPs offered: $1,200; $2,000 and $5,200 deductibles</td>
</tr>
<tr>
<td>8/1/2009</td>
<td>Maternity benefits switched from incremental benefits to same as any other sickness. Coverage optional for Section 7 and automatically included in the HIPAA pool</td>
</tr>
</tbody>
</table>
Plan 5, Plan P and Plan T Benefit Highlights
(Revised Effective August 1, 2009)

Your health care benefits for all Covered Services are highlighted below. However, to fully understand Your
benefits, it is very important that You read Your entire Benefit Plan Booklet, including any amendments thereto.
Refer to the Schedule Page for specific information about the Deductible and other options which apply to Your
CHIP Coverage. All benefits described in this Benefit Highlights are subject to all of the terms and conditions
of Your Benefit Plan Booklet.

The HIPAA CHIP Plan You have qualified for contains a Preferred Provider Organization (PPO) benefit level
and a Non-Preferred Provider Organization (Non-PPO) benefit level. This means that different benefit levels
apply, depending on whether You use a PPO Provider or a Non-PPO Provider. To receive the maximum
benefits allowed under Your HIPAA CHIP coverage, always make sure that You use a PPO Provider. Visit the
Plan Administrator’s website at www.bcbsil.com or call 1-800-810-2583 (1-800-810-BLUE) to find out which
Providers are in the PPO network, or check with Your Physician to see if he/she is a PPO Provider.

LIFETIME MAXIMUM BENEFIT
DEDUCTIBLES ($500, $1,000, $1,500, $2,500 or
$5,000 per Calendar Year)

$2,000,000 (decreases to $1,500,000 on 8/29/20 10)
Your Individual and Family Deductible amounts
depend on which option You selected and are
specified on the Schedule Page

* HOSPITAL ADMISSION DEDUCTIBLE (per
admission, per individual in addition to Your
calendar year deductible)

For each admission to a PPO Hospital, $0
For each admission to a Non-PPO Hospital, $300

CO-INSURANCE

80/20 for Participating Providers up to Out-of-Pocket
Expense Amount (60/40 if Non-PPO Providers are
used)

OUT-OF-POCKET EXPENSE AMOUNT (does not
apply to all services)

$1,500 Per Calendar Year Plus the Amount of
the Calendar Year Deductible Option You Selected (for
Yourself) or $3,000 Per Calendar Year Plus Two
Times the Amount of the Calendar Year Deductible
You Selected (for Your Family)

OUT-OF-NETWORK EXPENSE LIMIT (applies
ONLY if Non-PPO Provider is used and is in
addition to any Out-Of-Pocket Expense Amount
applicable)

$4,500 Per Calendar Year Plus the Amount of the
Calendar Year Deductible Option You Selected and
any Additional Deductibles that apply (for Yourself) or
$9,000 Per Calendar Year Plus Two Times the
Amount of the Calendar Year Deductible You
Selected and any Additional Deductibles that apply
(for Your Family)

PREEXISTING CONDITION LIMITATION

None

BENEFIT PAYMENT LEVELS
Hospital Benefit

For each admission to a PPO Hospital, $0
For each admission to a Non-PPO Hospital, $300*

Hospital Admission Deductible (per admission,
per individual in addition to Your calendar year
deductible)

Inpatient (Illinois and Border Hospitals)

Provided Precertification Is Obtained, 80% of Eligible
Charge for PPO Hospitals and 60% of Eligible Charge
for Non-PPO Hospitals

Attachment #B, page 1
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Out of State Hospitals)</td>
<td>Same as for Illinois and Border Hospitals, but Limited to a Combined Total of 45 Days per Calendar Year (Including Hospital Confinements for Mental Illness Treatment and Substance Abuse Rehabilitation Treatment Programs)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% of the Eligible Charge for PPO Hospitals 60% of the Eligible Charge for Non-PPO Hospitals</td>
</tr>
<tr>
<td><strong>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment Program</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Same as for Illinois Hospitals, but Limited to a Combined Total of 45 Days per Calendar Year For All Hospital Confinements (See Hospital Benefit, above)</td>
</tr>
<tr>
<td>* Outpatient</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td>* Limited to 50 visits Per Calendar Year</td>
<td></td>
</tr>
<tr>
<td><strong>Physician Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Surgical Services</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td>Other Professional Medical Services Including Office Visits</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Care</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 120 Days Per Calendar Year Pre-certification Required</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 270 Visits Days Per Calendar Year Prior Approval Required</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td><strong>Hospice Care Program</strong></td>
<td></td>
</tr>
<tr>
<td>Limited to 180 Days Per Calendar Year Prior Approval Required</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td><strong>Specified Organ Or Tissue Transplant Benefit</strong></td>
<td>Provided Prior Approval is Obtained, a Participating Transplant Center is Used for the Specified Organ or Tissue Transplant Approved by CHIP, and all other benefit plan requirements are satisfied. Maximum is the Transplant Payment Allowance</td>
</tr>
</tbody>
</table>

AS05PT (Page 2 of 3) (REV 8/09)
### Other Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Prescription Drugs</strong></td>
<td>80% of Eligible Charge (show Pharmacy Your CHIP ID card) provided a Participating Pharmacy Is Used and the Claim is submitted electronically to the Plan Administrator (20% Co-pay applies to all covered Outpatient prescriptions, subject to $5 minimum, $100 maximum for retail; $10 minimum, $200 maximum for mail order and a separate $2,500 maximum out-of-pocket per calendar year)</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>To Nearest Hospital Qualified to Treat Condition, 80% of Usual and Customary Fee</td>
</tr>
<tr>
<td>Physical, Speech and Functional Occupational Therapy</td>
<td>80% of Eligible Charge or Maximum Allowance for Participating Providers. 60% of Eligible Charge or Maximum Allowance for Non-Participating Providers</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Provided Prior Approval is Obtained for Items Costing $500 or more, 80% of Usual and Customary Fee</td>
</tr>
</tbody>
</table>

Dental care, vision care (except for cataracts), and hearing care are not covered. Refer to Part M, Exclusions – What is Not Covered, for a complete listing of non-covered items.

All Benefits are subject to Eligible Charges, Maximum Allowances, medical necessity, standards of practice, and all other terms, conditions, limitations and exclusions as described in the Benefit Plan Booklet for Plan 5, Plan P and Plan T (Rev 1/08), and any amendments thereto.

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* Does not apply to Out-of-Pocket Expense Amount.

** Does not apply to Deductible. A separate Prescription Drug maximum out-of-pocket applies.
MEMORANDUM

To: Tim Sullivan

From: Cheryl Meisenheimer

RE: Internet Research – Plan Designs

The Joint Underwriting and Finance Committee met on September 11, 2009, and directed staff to conduct internet research to see if we could determine benefits/plan design in Illinois. The request was to look for both group and individual plan design.

I contacted Mercer and AHIP to see if they could provide any information and have yet to hear back from them, so I doubt that they will be of assistance. I was able to obtain and review Kaiser Family Foundation’s Employer Health Benefits report for both 2008 and 2009. These reports are the result of an annual survey that they conduct of employer health benefit plans, which would include both insured and self-funded plans. It is not specific to Illinois, but does contain regional data which includes a category of “Midwest”, that includes Illinois. With respect to plan design, the following are the pertinent highlights of their report:

- The majority of covered workers are enrolled in preferred provider organizations (PPOs). Compared to other regions, workers in the Midwest are more likely to be enrolled in PPOs than other types of coverage. (Enrollment in HDHPs is also highest in the Midwest over other regions)
- The average general annual deductible for single coverage was $560 for workers in PPOs in 2008; $634 in 2009
- The majority of workers have to pay a portion of the cost of physician office visits, with an average copayment of $19 for primary care and $26 for specialty physicians in 2008 and $20 and $28 respectively in 2009. For workers with coinsurance, the average coinsurance for office visits was 17% in 2008 and 18% in 2009
- Most plans have 3 or more levels or tiers of cost sharing for prescription drugs; with $10 for the first tier, $27 for the second and $46 for the third level. The average coinsurance is 20%, 26% and 37% respectively
• Most covered workers have hospital cost sharing when they are admitted or they have cost sharing when receiving outpatient surgery, in addition to the general plan deductible.
• Out-of-pocket maximums vary considerably. For 2009, 42% of workers with an out-of-pocket maximum for single coverage have an out-of-pocket (OOP) maximum of less than $2,000 – (the percentage was 50% in 2008). Twenty-six percent had OOPs of $3,000 or more (with a specified limit).
• Annual deductibles for HDHPs averaged $1,922 in 2009) ($1,911 for the Midwest).
• The average annual OOP for HDHPs in 2009 was $2,976.
• 43% of covered workers have a specified limit of $2 million dollars or more, up from 2007 (32%).
• 58% of firms offering health benefits also offer at least one of the following wellness programs:
  o Weight loss
  o Gym membership discounts or off-site exercise facilities
  o Smoking cessation
  o Personal health coaching
  o Nutrition or healthy living classes
  o Web-based resources for healthy living
  o Wellness newsletter
• Plans for next year include increasing deductible amounts, office visit copays or coinsurance, and increased prescription drug share (same as in 2008).

The 2009 report (233 pages) can be found at http://www.kff.org/insurance/employer.cfm. There is also a historic link to previous reports. Let me know if you have any questions or concerns.
<table>
<thead>
<tr>
<th>%</th>
<th>0/08</th>
<th>1/08</th>
<th>2/08</th>
<th>3/08</th>
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<tr>
<td>Blue Edge</td>
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<tr>
<td>Total</td>
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<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
<td>12,000</td>
</tr>
</tbody>
</table>

**Note**: The table represents the monthly premium for different percentage values and series. The data is effective for the period from 7/1/2008 to 6/30/2009.
Preexisting Condition Exclusions for Rxs

**Topic for the Committee’s Consideration**
Whether to implement a preexisting condition exclusion for prescription drugs under Section 7 coverage.

**Background**
For Section 7, we have a 6 month preexisting conditions limitation. After moving from a back-end adjudication system to the point-of-service method, we have encountered administrative difficulty with trying to enforce the preexisting condition exclusion.

**Issues to Consider**
We have been meeting with our PBM consultant and our current PBM and Plan administrators to determine if and how we can better administer our Section 7 prescription drug claims. Additional research is needed in order to answer administrative and cost estimates.

**Implementation Recommendations**
Staff recommends that the Board approve going forward with development of a method that would more accurately allow administration of our preexisting conditions exclusion.

**Cost and Enrollment Estimates**

Another risk pool has been able to implement a process and they describe a general impression that costs are down, with little member noise. There is a fair amount of administrative involvement.
Got this from Texas yesterday. We might want to include some of the info.

Mindy, here's the update for 2009. Our average plan pay cost per script is $105, so the direct savings from the program for Y09 was $65,000, based on 619 denied script appeals. Of course, many more scripts are denied without the member bothering to file an appeal. Hope this helps,
Steve

Thanks~

David Fuentes
GSD Senior Supervisor
325-793-4476
Fax 325-793-4134
David, I'm not finding a more recent Rx preex analysis. Please send a summary of your Rx preex investigation stats for last year. Thanks, Steve

-----Original Message-----
From: Wanda_Gutierrez@BCBSTX.COM [mailto:Wanda_Gutierrez@BCBSTX.COM]
Sent: Wednesday, January 24, 2007 6:58 AM
To: browning@txhealthpool.org
Cc: Jackson_Boen@BCBSTX.COM
Subject: 2006 Summary Preex drug investigation review

Attached is a summary of the first year of the drug preexisting review. There will be some information in the board book but this is a little more detailed that we thought you would like to have for your records.

If you have any questions about the information, please let me know.

Thanks,

Wanda Gutierrez
Sr. Manager, Claims & Customer Service
Texas Health Insurance Risk Pool
325-793-4365
Fax: 325-793-4134
(See attached file: Preex drug investigation review.doc)

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[attachment "Preex drug investigation review.doc" deleted by David Fuentes/TX/HCSC]

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Oklahoma; or (972) 766-6900 in Texas. Preex drug investigation review 2009.doc
Pre-existing Prescription Drug Summary
Texas Health Insurance Pool
February 22, 2010

The Board of Directors for the Texas Health Insurance Pool (the “Pool”) elected to implement pre-existing condition limitations on prescription drugs. This benefit limitation applies to new members with effective date of January 1, 2006 or after.

The Pharmacy Benefit Manager (PBM) placed a flag on certain classes of drugs that would require investigation of a pre-existing condition. BCBSTX implemented a process to identify for the PBM all members who were subject to pre-existing condition limitations. When these members submitted a prescription to the pharmacy for a drug that was subject to pre-existing conditions limitation, the pharmacy received a prompt that benefits would be denied by the Risk Pool pending investigation of pre-existing condition. Members were instructed to contact Blue Cross Blue Shield (BCBSTX) in order to initiate a review. For those members choosing to appeal, BCBSTX requested information concerning the condition the drugs prescribed from the treating physician. Once the investigation was completed, notification was sent to the member and to the PBM as to whether or not the condition was pre-existing. If the research determined that the condition was not pre-existing, the PBM flagged all classes of drugs that would treat the condition to allow future prescriptions and issued a refund to the member if needed.

For 2009, there were appeals received from 564 members and investigation was done on 955 prescriptions. The following information was determined from the information received from the providers:

Pre-existing condition limitation applied: 619
Pre-existing condition limitation did not apply: 229

There are currently 107 scripts considered incomplete because information from the prescribing physicians has not been returned.

This service is included in the PMPM administrative fee.