To: Interested colleagues  
From: Mary Shaw  
Date: November 15, 2005  
Subject: Barbara Smith’s Responses to 11/11 Remaining Health Care Questions 

This evening Barbara Smith sent responses to the questions I posed a few days ago. We discussed these questions on Monday afternoon, and I appreciate her written followup. Her responses are inset after the questions in a different font.

The University’s decision to restore alternatives for comprehensive and Highmark HMO is extremely welcome. However, a number of issues with our health care benefits remain. Here’s a list of my remaining questions, some of which have come up in the last week. It is followed by a list of issues people have mentioned to me in email (I’ve received email and phone calls from 45-50 colleagues about these issues).

My remaining questions related to this year’s election:

1. I still have not received an estimate of the fraction of an out-of-network provider’s charge that will be covered by the UCR. This is important, because the amount in excess of the UCR may be “balance billed” to me by the provider, with no insurance to help pay for it. I would accept an estimate of the corresponding fraction for in-network providers. We all need this number to understand our risk exposure. I realize that it varies from case to case, but we should be able to have some statistical approximation and an indication of how good an approximation it is. My own Highmark statements for the past two years show 50%. A colleague just told me that in a recent year he had significant expenses and the UCR was only 37% of the billed charges. This should be of interest to a lot of people -- the Highmark representative at the Health Fair said that 2% of their members (patients?) go out of network for care – that’s 1 in 50, which is quite a few people.

The term “usual, customary and reasonable (UCR)” is procedure, provider, vendor and geographically specific. It is a determination made by the third party administrator (Highmark, UPMC, HealthAmerica). Each administrator uses their database and considers the charges by the providers in their data base for each procedure in selected geographic locations. As a result there is not a practical way to estimate future risks for a specific situation. Because of the importance of the issue, I referred your question to our consultant, Hewitt Associates. They have indicated that they are not able to provide an experiential risk estimate. However, I have included below the specific responses related to UCR which we have received from Highmark and UPMC.

Highmark has provided the following explanation:

“Usual, Customary and Reasonable (UCR) reimbursement is based on the following factors:

- the actual cost of performing the procedure;
- the degree of difficulty and complexity, relative to other procedures;
- the competitive status of the product (i.e. keeping it affordable).

Both increases and decreases to UCR allowances are filed with the Insurance Department for approval. Highmark filings typically address the need to maintain inherently reasonable payments levels.

There are many UCR allowances today that are consistent across specialty or geographic region. For example, the allowances for clinical lab tests are established on a statewide, all-doctor basis. However, there are also procedures for which the UCR allowance may vary by specialty and/or geographic region. The difference between UCR and charges can vary greatly by region and even provider. Therefore, it is not possible to provide a meaningful estimated percentage of what Highmark would pay for an individual member seeking services out-of-network.

However, Highmark does offer a resource on our website that provides price estimates of what Highmark would typically pay a network provider for many procedures called “Price by Procedure Guide”. Members can use that information to estimate costs on a specific basis even when going out of network in the 29-county service area. In addition, members can
access their EOBs online through "My Expense Summary" as a way to estimate ongoing expenses. (Access to those portions of the website does require membership with Highmark)."

UPMC has provided this explanation:

"In order to price UCR, UPMC uses a software from Ingenix. This software gathers provider charges by zip code and comes up with an overall average by zip code for different procedures. UPMC uses this information to price UCR.

In general, UPMC finds the UCR tends to be about 65% of charges. Obviously, charges vary by county, with Allegheny being higher than Lycoming for example. However, in general, 65% seems to be a good rule of thumb."

2. Could we see the actual plan documents in time to use them for decision purposes? The HR web site for 2005 benefits has 70-80 page pdf documents for Highmark’s comprehensive and PPO plans, though they seem to be dated October 2003 and February 2004. I would like to see current documents.

The plan documents are prepared by the vendors; we have not received them from any of our vendors. Once received, they will be subject to Carnegie Mellon review before they are finalized. Since the Highmark Comprehensive Plan and Highmark HMO are continuations of existing plans we do not anticipate material changes in these plan documents.

3. The price for Comprehensive is surprising. In 2005 the monthly contribution for individual coverage on Comprehensive was $23 employee/$256 CMU and for PPO Blue (whose coverage was between the 2006 Highmark PPO3 and PPO3) was $59 employee/$252 CMU. This year individual coverage on Comprehensive is $104, Highmark PPO2 is $61, and PPO3 is $45; it does not show the 2006 CMU contribution. Why did the comprehensive premium increase by a factor of 4.5+ while the PPO premium fell a couple of dollars?

The price charged for comprehensive is the incremental cost of comprehensive relative to the other plans.

To provide a bit more context, however it should be noted that one of the dimensions of Carnegie Mellon’s response to rapidly growing health care costs is to provide a range of choices to employees. This does not eliminate the significant impact of these cost increases (to both the employee and the university) but it does allow employees who choose to pick plans with premiums that are lower. The way this is implemented is fairly straightforward. A default plan is identified, one that is in the "middle" in terms of plan features. This happens to be UPMC PPO2 RxB. Other plan’s costs are calibrated relative to this plan. Some plans have lower costs and we pass those costs savings fully on to the employee. Some plans have higher costs and we similarly pass those higher costs onto the employee.

The price increase in the comprehensive plan has three components. First, it is significantly more expensive, that is the expense per participant is higher than the expense per participant in other plans. This is due to experience, the facilities in the network and the level of discounts we receive compared to the UPMC default plan.

Second, as indicated, we have chosen this year to calibrate plans fully relative to the default plan. In the past, higher cost plans have been somewhat subsidized by more moderately priced plans. This is no longer the case.

Third, the reason that Carnegie Mellon is, we are told by Highmark, one of the last employers in Pittsburgh to offer a comprehensive option, is that adverse selection effects usually come to make comprehensive plans increasingly expensive. As an employer provides choice and has more offerings where employees have incentives to keep their health costs down (higher deductibles, more coinsurance, and in-network restrictions in exchange for premiums that are lower than they otherwise would be), employees migrate from comprehensive plans, leaving in the comprehensive plan individuals who generally have greater health risks. This leads to higher premiums, and that tendency is exacerbated over time. We do not know that that will occur at Carnegie Mellon but it well may.

4. What is the level of international coverage provided by the plans? I can’t figure out how much the BlueCard Worldwide program will actually reimburse, or even whether it’s still included this year. Will they cover all charges? If they apply a UCR, how do they determine it and how much of the
actual charges will it cover? Even the benefit plan on the 2005 pages (dated 2003 and 2004) just lists the type of assistance they provide, not the level of coverage. Without a current plan document I don’t know whether even that is still included. What’s the relation between this and the Aetna coverage? Does it depend on whether I’m on business? What if I’m traveling as a guest of a foreign university? What if I’m consulting?

The Aetna plan provides benefit continuity when traveling abroad on University business. It reimburses participants at the same benefit level had the service been provided in the United States in network. Specific services provided by the Aetna plan include a medical assistance line, medical evacuation, repatriation of remains, health care counseling, international EAP, direct claims payment, advance purchase of prescription drugs in the US before going abroad or on return trips to the US.

The Blue Card Worldwide coverage has not changed. It provides services to assist a person when traveling overseas. It enables participants to use Highmark’s expanded network of health care providers throughout the world and provides 24/7 assistance in locating providers when outside the US. Medical evacuation services and an international phone assistance line are included. To use this particular Highmark service, a person needs to specifically enroll for the coverage.

Because international coverage would be considered out-of-network, under Highmark’s comprehensive plan, 80% of the UCR would be paid by the plan; the faculty or staff member would be responsible for 20% of the UCR, as well as any charges above the UCR without the Aetna coverage. The Aetna plan provides reimbursement as if the service had been provided in network, and so would pick up the expenses above UCR.

In addition to the specific services identified above, the university’s Aetna plan provides the same services as the Blue Card Worldwide for faculty and staff whose plan networks would not otherwise offer these benefits.

5. Similarly, what is the level of out-of-area emergency service coverage (as distinguished from planned medical care outside the Pittsburgh area)? We hear that all plans cover emergency medical care, at least in the US, but the comparison tables are unclear and (see #2) I can’t find the detailed plan documents. Is the coverage just for emergency room and ambulance? What if I don’t need an emergency room but I need care before I get home? For example, while traveling a couple of years ago my husband was sick for several days, and I took him to the only clinic within 40 miles of where we were staying. Would that be covered as an emergency, or would it be out-of-network service if the clinic didn’t happen to be in my plan’s network?

All plans will cover "emergency" medical services in or out of the network. Emergency services are typically described as life threatening or potentially disfiguring. Another parameter used to determine if the service is an emergency is if the patient is admitted to the hospital. If admitted, all university plans provide coverage for the emergency treatment at 100% except for the Comprehensive Plan that reimburses 80% after the deductible is met. Services with a lesser intensity would not be considered emergency services. The situation you referenced, of your husband contracting the flu, exemplifies the difficulty of making generalizations. Depending on your husband’s overall health status and the severity of his condition, the flu could be considered an emergency, although, in other circumstances, it would not.

6. How much difference is there among the Highmark networks? I know from experience that the PPO network is not exactly the same as the Comprehensive network, and you can see on the Highmark pages for finding providers that some providers are in a few plans but others are in many (on one search I saw one single provider with four offices, and the four offices participated in 6, 7, 14, and 28 named plans!!). However, I can’t tell how large the differences between Highmark’s plans are or whether they are systematic.

In the Western Pennsylvania area there are 14,158 providers in the PPOBlue network and 14,196 providers in the Comprehensive network. A provider can be in both or either network. Network participation is physician determined and changes constantly. There are also network changes from time to time as Highmark develops new products, and phases out old products.
7. Health Savings Accounts (HSAs) are new, but some companies appear to be offering them already. They seem like a better deal than the Flexible Spending Accounts because they allow rollover. What’s the obstacle to CMU offering this alternative?

A limited number of organizations offered HSAs at the time our changes were being developed. Although our high deductible plan met the deductible 2005 requirements for HSAs, the minimum deductible for an HSA has been since indexed at $1050 for an individual and $2100 for a family for 2006. We will review our plan design for 2007 and consider whether to offer an HSA at that time.

8. One of the two most popular optometrists among faculty and staff of the School of Computer Science has decided that participating in the Davis Optical plan would unacceptably lower quality. A quick check of providers on the Davis website suggests that the other of SCS’s two favorite optometrists is not a Davis provider, either. A colleague just told me about two providers he has found not accepting Davis. This is going to leave a lot of CMU people in a bind – change their long-time trusted provider, or pay out of pocket. Is it too late to provide coverage that will allow people to stay with an outstanding optometrist? Can you at least provide the option of a one-year election so you can resolve the problem and let people switch back next year?

It was not Carnegie Mellon’s decision to change vision plans; Highmark did not make Optichoice, the current vision plan, available to Carnegie Mellon for 2006. The Davis Vision plan does provide out of network benefits which could be applied toward the cost of services rendered by an out of network provider, such as Dr. Mallinger.

Concerns that should be addressed for next year, since it’s too late to fix them this year:

9. The vocabulary of the benefits plans is confusing. For example:

- An astonishing number of people think that “out of pocket maximum” means “the most I will have to spend on health care” rather than “the total of deductible and copayments I make before the health provider starts paying the entire UCR, leaving me responsible for balance-billed charges for amounts above the UCR if I get services outside my network”. Even the UPMC representative at the Health Fair was confused about this and had to check with the UPMC claims processing office to get a clear answer.

  I agree that there is confusion about “out-of-pocket maximum” and its implications. We have made efforts to clarify how this feature works in our presentations and in meetings with faculty and staff. Out-of-pocket is defined as “The highest amount you are required to pay in coinsurance and deductibles for any covered expenses in a calendar year. Using non-participating providers may result in additional costs not included in your out-of-pocket maximum.”

- The label “preventive care” is also misleading. Most people think it covers a baseline of routine medical care such as periodic physical exams. However, the Highmark representative at the Health Fair told me that if your annual physical results in a diagnosis (e.g., in order to renew a maintenance prescription) it is no longer preventive care. So either call this “physical exam is covered if it turns out that you didn’t need one” or change the coverage to include the physical exam in either case – isn’t the idea to catch problems early and monitor them rather than letting them get out of hand? After all, Barbara Smith’s message at the beginning of September said CMU is “encouraging preventive care coverage, such as regular physicals”.

  Preventative Care: we have posted the preventative care schedules for all the carriers on our web site. Preventative care is usually limited to routine exams. The exams for a person with a health condition, i.e., diabetes, would not fall under preventative care.

- The descriptions of Highmark alternatives given in the original HR materials did not exactly match the plan names on the Highmark website for finding participating providers. This year it took me two tries to get a confirmation from HR that I should look for “PPO Blue” among
the two dozen or so plans that my Highmark providers may or may not participate in. The HR web pages now say the plans are PPOBlue and ClassicBlue, and I’m relying on that.

Highmark name alternatives: There are 2 PPO choices on the Highmark website.

- Even the tag “Healthy Solutions” is overblown. It suggests new alternatives for healthy living, such as improved menu choices for campus dining, extended open swimming hours, or parking passes tailored for people who would mostly walk but need to drive a couple of days a week (the garage plan doesn’t solve that problem).
  
  Healthy Solutions: We are looking at various healthy solutions both within our plans (i.e., the use of health risk assessments) as well as on campus (i.e., offering free after hour fitness classes and as a participant in the Student Health “Healthy Campus” initiative)

- The definition of “provider’s reasonable charge” and “UCR” is confusing, especially since they tend to be used in different places for approximately the same thing.

10. We need some kind of coverage for the out-of-network balance-billing problem. See #1 above – I’m still trying to understand my risk exposure. The HR Q/A document of last September said, “we’re enabling employees to choose and manage the level of health care coverage that best meets their needs” and the HR email of 9/7 said, “Our goals are to … offer meaningful choices that fit the varying health care needs and finances of faculty and staff”. Many of us are most concerned about managing the risk of low-probability but high-cost problems. Please help us, too.

The university will investigate whether any optional insurance protection is available to limit this risk in the future. Currently, the health care flexible spending account may be used to cover these expenses. With the continuation of the Highmark Comprehensive Plan and the Highmark HMO, there is no greater exposure for out of network balance billing than in the past.

11. If it’s too late to repair the optical plan problem this year, find out what the specific problems with Davis Optical are and resolve them.

See #8 above

12. We need good access to HSAs, if that can’t be done this year. I think the FSAs have restrictions on deductibles and out-of-pocket maximums, so there should be a version of the comprehensive plan that qualifies (I think that would raise the deductible and presumably lower the premium).

See #7 above

Here are some other issues people have described in email:

13. Some people who are self insured would like to be reimbursed for the costs that CMU is not incurring on their account – that is, they think there should still be an opt-out alternative.

Opt out credits were discontinued so that those funds could be available to meet plan costs. Opt out credits were introduced at a time when some health plans offered by Carnegie Mellon had no cost to participate. That is no longer the case, so the intended purpose, incenting faculty and staff not to elect free coverage, no longer exists. This change has made opting out of health care consistent with opting out of other benefit programs, none of which offer an incentive in the case of non-participation.

14. Some people would like more transparency in the analysis and accounting. CMU is now self-insured, so the payments to providers should balance the premiums. Given the intensity of feelings, people would like a more public accounting of the costs and payment balances.

The university’s health plans are self-insured. Payments to providers are made when expenses are incurred.

15. Some people are concerned about the prescription coverage. For example, “two of my maintenance prescriptions are off-formulary, so I will be paying for those, and my nearest pharmacy, which is open 24/7, is off the providers list, so I can’t use them any more either”. Also, there’s concern about people who aren’t already on PharmaCare having to visit doctors to get new prescriptions.

Drug formularies are not a new feature of this year’s prescription program. Faculty and staff may choose any pharmacy, but their choice impacts the expense associated with the drug. If they elect to use a non-preferred provider the prescription may not be covered under the plan
or may be covered at a lower level. These provisions are intended to help manage the
dramatic increase in the cost of prescription drug coverage. Physicians are frequently willing to
write new prescriptions for a drug a patient is currently taking in order to allow the person to
take advantage of a mail order plan. The person would have to contact their physician to see if
this is an alternative.

16. The plans are so complicated and confusing that people find it hard to get clear, correct answers.
Several people have reported getting different answers (or what they think are different answers)
on different occasions, for example one interpretation at the public meeting and a different one
when they called to confirm.

It is probably inevitable that some confusion would result from the number of changes being
made this year in the complex area of health care. Every effort has been made to
communicate clearly and openly with faculty and staff about the changes. Benefits Office
Specialists are willing to discuss either in person or over the phone any questions faculty and
staff may have concerning the plans.

17. Some people would like more visibility into the decision process so their concerns could be
reflected better in the plans that are made available.

As metrics become available they will be shared with the campus community.

18. A student suggested that there are concerns about the student health coverage.

The student health program is separate from the program for faculty and staff. Student health
issues should be directed to Anita Barkin, Director of the University Health Service.