To: Interested colleagues  
From: Mary Shaw  
Date: November 11, 2005 (revised November 12)  
Subject: Remaining Health Care Questions

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.

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.

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?

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?

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?

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.

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?

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 web site 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?

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.

- 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”.

- The descriptions of Highmark alternatives given in the original HR materials did not exactly match the plan names on the Highmark web site 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.

- 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).

- 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.
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.

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).

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.

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.

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.

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.

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.

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