

Health Care Questions
for
Faculty Senate Benefits Committee

March 21, 2008 meeting

Questions:

1. Why did the U of R choose to eliminate the flexible spending cards? We found them to be very convenient, and why weren't employees informed of change prior to the end of the enrollment period.

Answer: *In 2006 and 2007, the Flex Card feature was available to employees who elected Excellus as their TPA. In an attempt to have 2008 FSAs work in conjunction with the new University Health Care Plans, the decision was made to move from use of the Flex Card through Excellus to an Automatic Claims Transfer (ACT) process. (The University was advised that the Flex Card would not work with three of the four new health care plans, because of the deductible/co-insurance structure.) With the ACT feature, anytime a claim for medical or prescription coverage is submitted to Excellus by a provider/pharmacy, any amount that the member would be responsible for paying is automatically processed through the FSA account and a reimbursement is generated and either mailed or direct-deposited into a designated bank account. The FSA reimbursement process for both TPAs (third party administrator) was described in the Health Care Program Decision Guide on page 38. In addition, Excellus did a home mailing to 2007 FSA participants to advise them that the Flex Card was being discontinued as of 12/31/07.*

2. In 2007 and previous years, when an employee had health care coverage from outside of UR, they were still able to have FSA (flexible spending account) through the UR and every claim was automatically reimbursed. In 2008 when an employee has health care coverage from outside of UR and still have FSA with the UR, they have to manually mail in every claim to FSA to get reimbursed. Why the change?

Answer: *Automatic claim reimbursement applies to employees who are enrolled in the University Health Care Plans because the automatic feature is dependent upon claims submission to the TPA for payment. Without University health care coverage, the claims cannot bridge between the TPA and the FSA. This also was the case in previous years.*

3. I have looked through the Excellus site and the UR materials and haven't found any answers to how the high deductible plan is tracked. Do I keep track of expenditures ahead of meeting the threshold? Do providers (Drs. and pharmacy) communicate with Excellus? Better information on how it works would be useful, since the dollar amount is quite high (to me).

Answer: *The deductible and out-of-pocket maximums are tracked by the TPA (Aetna/Excellus). If a network provider is used, the provider or pharmacy will submit a claim to the TPA for payment when an expense is incurred. If a non-network provider is used, the provider may bill the member directly and the member will need to submit the claim to the TPA for reimbursement. The TPA will then determine the status of the deductible and what amount the plan will pay and what the out-of-pocket cost for the member will be. An Explanation of Benefits (EOB) is sent to the individual explaining the charges and payments.*

4. The date of withdrawal of funds from faculty paychecks and the deposit of funds into Aetna H.S.A. accounts differed by almost a week at the beginning of February. What happened? Will this be fixed (same day deposit) for future months?

Answer: *There was an error in the file transfer for the February monthly payroll that has been corrected. Future contributions should be credited to accounts as of the pay date.*

5. Are there any post-retirement health benefits remaining at UR? The website asks people to phone in person for a "packet." No information at all is given on the site.

Answer: *University retirees are eligible to enroll in retiree health plans. Information on the plans can be obtained by contacting the Benefits Office at either 275-4668 or 275-3292.*

6. Could the website provide more information regarding H.S.A. Versus F.S.A. expenses (what type of expenses qualify for each)?

Answer: *There is no difference in the types of medical and dental expenses that are considered to be eligible under Health Care FSAs and HSAs. The difference between the two is that, in addition to eligible medical and dental expenses, HSAs also may be used to cover additional costs including: long-term care premiums, Medicare premiums, COBRA premiums, and premiums while receiving federal unemployment compensation. Those enrolled in the University HSA-Eligible Plan who contribute to an HSA are eligible to contribute only to a Limited Purpose Health Care FSA. A Limited Purpose Health Care FSA can provide reimbursement only for qualified dental or vision expenses, but can not reimburse any out-of-pocket health care expenses until the health care plan deductible has been met.*

7. Those with H.S.A. Accounts pay full cost of prescription drugs until the deductible/co-insurance level is reached. Are prescriptions less expensive if we go to Strong Hospital to have them filled? Could the benefits office provide comparative costs for local vendors (Strong vs. Wegmans vs. Walmart vs. CVS vs. Rite Aid, for example) for certain common drugs? Or provide web links to sites where this information is available? This information is hard to come by (except for Walmart \$4 generics), and the full cost of some prescriptions is shocking.

Answer: *Each TPA negotiates their rates directly with their participating providers. Both the member sites for Aetna and Excellus include tools that will give general cost information on prescriptions based on zip code, as well as common generic alternatives for brand name drugs. The University does not have access to the rates charged by specific pharmacies for a particular drug.*

Comments:

1. It is a little early to comment, but one problem I have had is in determining what programs and which physicians are "in program" with the Aetna plan. This is important, since there are big differences in reimbursement depending on your selection. You can call Aetna, but there doesn't seem to be any comprehensive list. The "Find a Doc" on the Aetna web site does not allow searching by physician or program name. It simply lists PCPs or specialists by distance from you. Not helpful.

Answer: *You may search by provider name or facility name on Aetna's Doc Find by going to www.aetna.com and clicking "find a doctor" on the right side of the page. There is a check box that will allow searches to be narrowed by name, facility or various demographic features.*

2. Twice so far under the new health care plan Excellus has challenged prescription drugs that I have taken for many years to control well documented medical problems. In one instance, my physician's determination to go through several rounds of appeals ultimately led to approval; in the other, it has not to date. I don't know whether my difficulties are atypical or typical. If the latter, I would be very interested to learn why the university has adopted this policy. It is short-sighted with respect to the health of the employee and also with respect to the physician who in many instances is also a university employee who must now devote even more time to dealing with insurance companies.

Answer: *The University's prescription coverage has not changed for 2008. Each TPA has their own pre-certification and claim review policies. Employees who are experiencing claim difficulties may contact the Benefits Office at 275-3779 or 275-8382 for follow up with the TPAs.*

3. The HSA plan is problematic because if you have serious expenses such as medications that you buy 3-months at a time, there are no funds available. This means that the subscriber has to "float" the money until it is funded. This should only happen the first year, but it is a burden, it is uncomfortable, and it is likely to make some people delay necessary care that could result in harm. It has been difficult for me personally.

Answer: *Contributions to HSAs are strictly regulated by the IRS, including provisions surrounding the type of health insurance a person must be covered by in order to contribute. The University offers the minimum deductibles allowed under IRS guidelines for the University HSA-Eligible Plan. This is one of the distinctions that define an HSA from an FSA. Unlike a FSA, HSAs do not allow access to the annual contribution election because it is a bank account with a rolling balance rather than an account based solely on calendar year. IRS guidelines regulate how HSAs are offered, including provisions dictating when account balances are accessible and what expenses can be applied. As the HSA is housed by a bank, the account is subject to the fee schedule determined by the bank (including monthly service fees and ATM withdrawal fees). The HSA debit card works like most other debit cards and only can be used to pay with money already deposited into the account or make withdrawals from the account balance at an ATM.*

4. It makes sense to me that the people who make less \$40,000 should get a break and that people who make more than \$100,000 should pay more than people who make between \$40,000 and \$100,000, however is not fair that someone who is making just more than \$100,000 pays the same as someone who is making many times that. The really well paid should pay a bigger share or the contribution should be on a more continuous sliding scale rather than 3 discrete scales.

Answer: *Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive.*

5. Part-time employees are relatively under-valued in this system by giving them substantially higher healthcare costs regardless of income. It is difficult to figure out how to reconcile this, but it makes it hard for someone to cut-back for personal or family reasons; it makes it hard to hire incremental by less than a full FTE.

Answer: *Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees remained competitive. Part-time contributions for 2008 are competitive with the University's local and national peer group. The University also has recognized that the part-time contributions were of great concern to employees and has instituted an additional salary band to reduce the contributions for part-time University employees with at least five years of University service as of the 1/1/08 effective date. Employees who reach five years of University service after 1/1/08 will be placed into the new salary band effect January 1st of the year after they reach the five-year service requirement.*

6. I have been with the university since May '04 and am part-time (.6). Though my previous five and half years of higher ed experience counts for many things, it does not count for me for my health benefits so I am paying an exorbitant proportion of my salary for health care for my husband and me. I find this to be extremely unfair and certainly not equitable based on what I make! I would appreciate this being taken up at the meeting.

Answer: *Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees remained competitive. Part-time contributions for 2008 are competitive with the University's local and national peer group.*

Comment 1

I would like to know how (why) they decided on the particular salary caps to 'scale' payments for insurance (i.e. those with income >\$100,000 pay more than those with income >\$40,000 etc.). It seems absurd that this salary 'cap' ends at \$100,000 such that the majority of the faculty are paying an amount similar to the small percentage of the faculty/administration whose incomes are much higher. If this is really to be a 'tiered' system, with the 'haves' supporting the 'have-nots' (which I am generally in support of, even though it is costing me considerably more) then this tiered system should be carried all the way to the top levels of income.

Answer: *Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive.*

Comment 2

Every time I have a question about the HSA account with Aetna and I ask at HR/Benefits, all they say is CALL AETNA. I spent 30 minutes on the phone during my lunch yesterday doing this. I wasn't all that bad but once I got to the correct person but I got transferred twice. I also was given a 4th number to call about the bank part of the Aetna/HSA benefits. I literally just did this on Monday.

I think it would be useful for the university to poll/survey/track the experiences of a number of faculty within each of the 4 options offered. It would need to have a nice number of faculty with differing backgrounds, enough people on the family plan in the HSA vs young single vs older adults with kids out of the home.

I'm sure like anything, it will take a couple of years to get enough experience as to what really works best for people. I'd like to see the university take a proactive approach to specifically inform it's employees as opposed to us finding out individually and only sharing by word of mouth. I did sign up for the On-line Navigator, which seems it will be helpful as I go.

Answer: *The University is not the plan administrator for a Health Savings Account (HSA). HSAs are private bank accounts regulated by the bank where the money is invested. As such, the Benefits Office is not always equipped to answer HSA-related questions, especially those that are specific to bank policies or have tax implications. The University recommends communicating with either the bank holding the HSA or your tax advisor to ensure that you receive accurate information regarding your HSA. Employees who are experiencing customer service issues may contact the Benefits Office at 275-3779 or 275-8382 for follow up with the TPAs.*

Comment 3

From all of the discussions that I've heard and the mass confusion, I can say that I am glad that I am on my husband's plan! I had more than one colleague call me up to see what I was going to choose.

Comment 4

My only comment is that the health care plan cost has increased dramatically for my family because of the changes – basically representing a significant decrease in take-home salary for us. I think many other faculty members felt the same way. Not fun!

Answer: *The changes were intended to spread the cost of health care more evenly among employees and promote healthy behaviors as a way to help faculty and staff more effectively manage personal health care costs. For employees with family coverage, in many cases, the monthly payroll deductions actually decreased for 2008 as the premiums are now more equitably distributed among coverage levels. Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive.*

Comment 5

In regards to conversations that I have had with peers and colleagues through out the University is that a break or reduced rate was given to those individuals making under \$40,000.00 per year. That said there are individuals who are single moms or dads with 3 children one in particular who has 4 children making \$41,000.00 per annual. \$41,000.00 is not a lot to support a family on.

The topic of conversation is to change the reduced rate and to increase it \$50,000.00 or less.

There needs to be more discounts/PERKS YMCA, Health Clubs. There is not enough of that. I am on the BCBS CO PAY plan and it offers no discounts for health clubs.

The rates of the current coverage are just too expensive - they need to be reduced.

I have had a couple of visits and the PCP office has no idea what or how to bill not sure why it has been so confusing.

Just FYI - There is much conversation about not being able to contribute to the United Way this year not because individuals do not want to but because they can not afford it with the drastic increase in health care and they have to pull there funds from somewhere.

Answer: *Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive. Both the \$40,000 and the \$100,000 salary bands will be indexed annually based on national changes in average wages in the same increments used to increase the breakpoint established for the Retirement Program.*

Employees enrolled in the University Health Care Plans are eligible for the same discounts and incentives offered to any other Aetna or Excellus member with the exception of incentives tied to enrollment in specific plans (such as the Healthy Blue plans through Excellus).

Claims submission for the University Copay Plan should not be any different for in-network charges than the process providers used for the Quality and Enhanced Care Plans last year. If you are experiencing difficulties having a claim covered by insurance (for example the claim was denied), please feel free to contact the Benefits Office at 275-2779 or 275-8382.

Comment 6

I think it's great that there is a review of the new plans. Unfortunately, I don't have enough experience yet with the system to know how things are going to work. My husband took my youngest son to the pediatrician for fever and after the visit the office people didn't have the slightest idea how to bill the visit. We are still waiting for the bill from both the office and the lab for the throat culture. We have the high deductible/HSA eligible plan. I'm hoping it won't be too painful when it comes.

I have utilized my limited FSA (Excellus) to pay for an eye exam and new glasses for my oldest son and that was relatively painless.

Answer: *When an expense is incurred on a plan with a deductible and coinsurance structure, the provider will generally not know the amount to bill on the date of service. The claim must first be submitted to Aetna/Excellus to determine if the deductible has been met and to determine the negotiated charge for the service if provided by an in-network doctor/facility. The TPA will then notify both the provider and the member of what the appropriate charges will be. The provider can then use this information to bill the member accordingly. Please note that while this is the procedure that we understand most providers will use, neither the University nor the TPA can dictate the provider's billing practices. If a non-network provider is used, the provider may bill the member directly and the member will then need to submit the claim to the TPA for reimbursement.*

Comment 7

Boy did you ask the wrong person this new health plan is almost like having no coverage at all ... annual physicals are no longer annual ... but depending on age ... you have to be over 60+ something before you can get an annual physical (no one I spoke to knew that...) - all the preventive services which we were told would not go against the deductible - are subject to some limitation - which we were not told about at enrollment ... Rx coverage (which we were told would not change with the new plan) definitely did change cancer drugs which are waived by other insurers are the highest co-pay by Aetna's plan the dental plan - according to my dentist - is the worst one around (but I guess we are used to this one anyway) many I've spoken to (including nurses in the Medical Center) - think the medical plan coverage is terrible ... many have told me it is a disgrace that a medical institution would offer such a poor plan to its employees. Many individuals have stopped going to their doctors - they just can't afford it the rate range over \$40,000 - \$100,000 is a very BIG range ... and isn't at all realistic ... take-home pay from a \$40,000/yr salary is quite a bit less than from almost \$100,000 - there doesn't appear to be a savings in taking the high deductible over the low (from last year's plan rate - in my paycheck anyway) ... the copay plan is very expensive for the family plan for someone who is not close to

the upper end of the rate scale Hopefully, the Faculty Senate Benefits Committee will also consider staff in its recommendations on the health plan - we appreciate your help.

Answer: *Effective January 1, 2008, preventive services, as defined by the United States Preventive Services Task Force, are covered at 100%. The coverage frequency for routine preventive services, including physicals, has not changed from 2007 to 2008 except for the addition of 100% coverage for routine care received in-network within the frequency guidelines. As preventive services are covered at 100%, they are not applied to the deductible, because there is no out-of-pocket cost.*

Prescription drugs are covered under the same 3-tier system as last year (though there are some differences in the copay amounts for certain tiers).

The University did not change the Dental Plans for 2008. The Traditional Dental Plan continues to be offered to employees free of charge for both single and family coverage.

The Health Care Task Force established by President Seligman used benchmarking of the University's local and national peers to ensure that the 2008 plans are comparable in price and coverage to what is offered by other employers, both locally and nationally.

Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive.

Comment 8

I elected the co-pay plan. The questions I have are:

Why did the prescription co-pays increase? We were told the co-pays would remain the same as 2007.

What medical coverages have been reduced or eliminated since open enrollment? My colleagues tell me that they have found that services that were said to be covered in the new health plans have been eliminated or reduced.

Health care premiums for employees based on earnings is fair (over or under 40K). However, there is a huge gap between \$40,000 - \$100,000. Why aren't there a few more categories of contribution levels between this salary range?

What was administration thinking when they came up with the new health care plans communique? Many perceive the message as condescending and offensive. The message seems to be that you are solely responsible for the state of your health. You have developed a catastrophic illness, because of your unhealthy behaviors. News to "bean counters": people with healthy behaviors (normal weight range, plenty of exercise and a diet that includes plenty of fruits and veggies) may develop heart disease, autoimmune disease and cancer through no fault of their own. Yes, health care costs are escalating and it is in the University's financial interest to reduce their contribution to faculty and staff health care plans. Stating the facts without pointing fingers is preferable.

At times UR faculty and staff are collectively referred to as "leaders in the community". How can this collective group be leaders and imbeciles at the same time?

Answer: *The prescription coverage continues to be offered as a 3-tier copay structure on the 2008 plans. There were some changes to the copays for certain tiers based on benchmarking data of the plans offered by the University's local and national peers.*

The 2008 plans cover all services that were previously covered in 2007. Depending on the specific plan, coverage for a service may be different in 2008, but none of the services previously covered have been eliminated.

Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees, including those that earn \$100,000 or greater, remained competitive.

The intention of the communication materials was to help employees to understand each of the four new plans, so that educated enrollment decisions would be made. The new plans have a strong emphasis on the importance of healthy behaviors because the University recognizes that the most effective means to reduce and contain escalating health care costs for both the employer and employee is through healthy lifestyles and preventing or reducing the risk of expensive chronic conditions through the use of preventive care and a focus on wellness. The message was not intended to be condescending or accusatory, but rather empowering as a commitment to providing employees with the tools and support needed to live healthy lifestyles.

Comment 9

I changed from Aetna to Excellus (similar plan and cost, so it said) and from holding my own insurance to joint healthcare insurance with my husband who is a professor on River Campus.

First complaint is that Excellus has a list of drugs they approve and do not approve, however, this information is obscured to the patient/client and doctor. My doctor has been prescribing Prevacid and I called in for a refill to Wegman's. I went to pickup my refill and was told my healthcare insurance would not pay for the medicine which was \$278.00. Aetna had always co-paid for the prescription. Wegman's contacted my physician and Excellus and my physician filled out forms and yet Excellus wanted him to try 3 different drugs, have evidence they did not work and then Excellus would approve the use of Prevacid. Needless to say this was making my ulcer worse, this took over a week and so I paid for the Prevacid and used it until a new Excellus approved drug was prescribed. (No refund of course was given). Needless to say I am always a little cautious and fearful that Excellus will do this again on other prescriptions without advance notice. I feel like I was ambushed by them.

Second complaint, Excellus also issues cheap antiquated paper identification cards that are not easy to carry in your wallet (they do not fit the card slots) and worse are issued in my husband's name (okay don't laugh or be offended but if it were you wouldn't you be upset?), and not mine own name (I do not hold my husband's name legally or socially), Aetna did not do this. In the U of R in the Health Care plan packet grid it stated that these plans were similar to Aetna, but clearly are not.

Answer: *The University Health Care Plans cover the same services and expenses regardless of whether Aetna or Excellus is the TPA. However, there are slight differences in the means in which the plans are administered.*

The University Health Care Plans have a mandatory generic provision that requires that if a generic drug is available, it be used instead of a brand name drug unless the generic has been proven to be ineffective or causes dangerous side effects in the user. Drug approvals that may have been on file with one TPA would not be transferred to the new TPA, meaning that the new TPA would require evidence to waive the mandatory generic provision.

The University does not have the authority to determine the type of ID card offered by each of the TPAs, so we were unable to make changes to the format of the card or the materials used.

Comment 10

I have chosen the High-Deductible Family Plan with an FSA option, both via Aetna.

Of course the costs (premium and total) are significantly higher than previous plans, but that was expected.

My analysis / estimates prior to choosing a plan indicated there was little difference in cost between the plans. Comparing an average year of health care procedures, the costs were ultimately going to be similar, barring a catastrophic / major health situation.

One criticism ... It is difficult to determine the cost of a test / procedure prior to performance and submission for payment. Aetna has a Cost Estimator on their website, but I have yet to find a single test or procedure that is even close to what the estimate indicates. There is considerable price differences for procedures depending on the provider (blood tests at various hospital labs for example), so shopping around can save some serious money. It is a very time-consuming, labor intensive process to call Aetna, provide the procedure code (CPT code) and the provider name, to enable Aetna to look up the negotiated cost of a test prior to performance.

I do like the Auto Debit / Auto Deposit Reimbursement features of Aetna's FSA program.

I did not choose the Health Savings Account option because of service fees on the "checking-like" account.

Answer: *Unfortunately, negotiated rates vary from provider to provider and the information is generally considered to be proprietary. Both Aetna and Excellus have cost estimating tools on their websites that should be based on the regional data of the zip code used to search, but we are unable to verify how closely these estimates reflect what will be the true cost from a particular provider for a specific service. You also may contact your provider to obtain pricing for a service.*

The HSA is a personal bank account which is subject to the fee structure implemented by the bank holding the account. The University is unable to modify these fees.

Comment 11

Meds are a lot more expensive!

Answer: *Prescription coverage continues to be based on a 3-tier copay system in 2008. There have been some slight changes to the specific copays for certain tiers. Please note that prescription coverage on the University HSA-Eligible Plan is subject to the deductible and out-of-pocket maximum, meaning prescription costs must be paid in full until the plan's deductible has been met. IRS regulations require that "HSA-Eligible" plans make all coverage under the plan be subject to the deductible, including prescription costs.*

Comment 12

The major question I have is about price. We are supposed to be making service-use decisions based on "price" -- or at least we are supposed to become more aware of price.

It is a significant problem that there is no way for anyone in the three deductible-based plans to:

--> know what they should be charged for a visit or --> know whether they have been charged *correctly* once they do receive a bill.

Physicians do NOT know what to charge us. I have asked all of my docs and a few others. Repeatedly. Colleagues who have used services have been met with blank stares @ the check-out desk: "how would we know what to charge you?" That is true -- they deal with thousands of permutations of thousands of plans -- they do not have a list of negotiated rates for UR Aetna or Excellus beneficiaries in their offices.

I have asked Benefits for the lists (knowing what the answer would be) and --of course--- they are proprietary and 'cannot be shared'. We can guesstimate based on EOB's from prior years, but that is crude-- at best -- and is useless to anyone who is seeking a new service for the first time (with no EOB history to reference). It also has limited relevance for those who changed TPA's -- because the negotiated prices *are* different. Theoretically similar, yet in reality -- different.

The consequences of that are that patients are wide open to financial consequences: we can't determine what "price" is appropriate, therefore, we cannot advocate for ourselves to be charged correctly. Docs can therefore pursue any charges they choose to -- appropriate or otherwise -- all the way through collections or beyond -- and we have absolutely NO INFORMATION on which to refute a charge, correct a charge, or recognize and refute a reimbursement error {that results in additional charges to the patient}. Since claims processing, billing and reimbursement *all* have their well-documented sources of error, this is an important thing for us to be able to monitor for ourselves. It is one thing for a claim to be denied or underpaid -- in the co-pay plans, that is between the docs and TPA's. In the deductible-based plans, that is between providers and the insured -- the bills land in our laps and we don't know thing #1 to start with what the 'price' *should* be.

This is important in the event of a dispute about claims or coverage. I had an outpatient procedure last year, for which the provider was reimbursed a small fraction (in the hundreds of dollars) of what was billed (in the high thousands). Under last year's plan setup, that is between the doc and the TPA. Under the three consumer-directed plans this year, that dispute would be between the physician and ME. I would have no way to check any of the numbers (from any source that does not have a stake in the matter, let alone ANY source). The doc could come after me for thousands of dollars - to collections, etc -- and I would be both uninformed about the (financial) facts and unprotected from large financial liability and risk.

If price is the fulcrum, then it has to be transparent. It is not.

Feel free to call me if you'd like to chat further. I sent questions about this the first time around. Their "answers" the first time were useless.

Answer: *The TPA is responsible for adjudicating the health care expense submissions. Anytime a provider submits a claim to the TPA, an Explanation of Benefits (EOB) will be sent to the member informing him/her of the correct out-of-pocket cost. If the provider is an in-network provider, then he/she cannot charge beyond the established negotiated rate for a particular service and a member should not pay any amount billed beyond what is indicated as the member's out-of-pocket costs on the EOB. Any bill from an in-network provider that does not match the EOB sent from the TPA should be directed to the TPA for follow-up. If the TPA does not adequately address the claim, please contact the Benefits Office (275-3779 or 275-8382) for additional review of the situation.*

Comment 13

I am signed up for the health savings plan/high deductible option with Aetna as the administrator. We have been with Aetna since the University adopted their plans some years ago and I have been pleasantly surprised with the experience. Under the new plan, however, there is a major frustration having to do with the health savings account.

Like the FSA, which we have had in the past, money is taken pretax from monthly pay and put into the account for appropriate allocation. Unlike the FSA, however, money from the HSA is only available as per the realtime balance of the account. In other words, the balance is \$0.00 until the first paycheck at the end of January, and then accrues monthly. With the FSA account, the annual total contribution was available throughout the year and "overdraws" were covered by the administrator, and then paid back as subsequent paycheck deductions hit the account. The high deductible plan results in upfront expenses early in the year that far outstrip what is in the HSA such that I am paying for this now (typically prescriptions and some doctor visits and testing) and have to later, as dollars accumulate in the account, reimburse myself from the account using the card that was issued by Aetna as an ATM card, for which there is a per transaction charge (which I don't remember seeing any information about in the materials distributed when we were making our new health plan decision). So, there is the hassle of keeping track of qualified expenses, and then going to an ATM repeatedly to get the money as it becomes available. And, Aetna (or more likely, the bank housing the ATM) is charging a service fee each time!

I can understand why the system does not want to "front" the money earlier in the year before it has been deposited from my paycheck, but this was the procedure with the FSA in the past, and it is much preferred. Even if the administrator is not prepared to credit the money before it has been deposited, a system whereby the card can be presented with the purchase of each qualified expense and then these expenses are cumulatively monitored and a check is automatically generated and mailed to the home as funds accrue to the HSA would be a big improvement. As it is now, if I present the card to the pharmacy, for example, all it does is indicate that there is no money in the account. There is no submission of the expense figure to my subscriber specific database for later automatic allocation.

Answer: *The Health Savings Account (HSA) is a private bank account established with a bank (JP Morgan Chase for Aetna and HSA Bank for Excellus). Unlike a FSA, HSAs do not allow access to the annual contribution election because it is a bank account with a rolling balance rather than an account based solely on calendar year. IRS guidelines regulate how HSAs are offered, including provisions dictating when account balances are accessible and what expenses can be applied. As the HSA is housed by a bank, the account is subject to the fee schedule determined by the bank (including monthly service fees and ATM withdrawal fees). The HSA debit card works like most other debit cards and only can be used to pay with money already deposited into the account or make withdrawals from the account balance at an ATM. The Health Care Program Decision Guide references some of the fees associated with the HSA and the online enrollment tool included fee schedules for both banks.*

Comment 14

I am writing with a couple of comments/queries regarding the changeover to the new health care plan.

First, as you may be aware, part time employees earning anything less than \$100,000 are required to make a far higher contribution than either full time employees earning less than \$40,000 and even full time employees earning \$40,000 - \$100,000.

A change was made in December reducing the contribution required of part time employees who have worked at the university for more than five years.

Although this was a step in the right direction, those part time employees whose annual earnings are under \$40,000 and whose term at the university is less than five years are greatly penalized. I don't believe the term of service is a factor for the contribution amount for full time employees and in addition, they are given two tiers (under \$40,000 and \$40,000 -100,000) of contribution levels.

As a single parent, part time employee with a term of service under 5 years, I would like to see some consideration of this issue.

Second, I have a question with regard to the cost reduction for part time staff earning less than \$100,000 with at least five years of university service.

For the purposes of determining the five years of service, does that mean five years worked at the Univ. of Rochester or is the intent to give credit for additional years worked at another university? Specifically, in my case when I began work here 2 1/2 years ago, my three years of work at another university counted toward the time requirement for purposes of retirement and some other benefits.

I have directed this inquiry to the benefits office but have received no response.

Answer: *Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees remained competitive. The University also has recognized that the part-time contributions were of great concern to employees and has instituted an additional salary band to reduce the contributions for part-time University employees with at least five years of University service as of the 1/1/08 effective date. Employees who reach five years of University service after 1/1/08 will be placed into the new salary band effect January 1st of the year after they reach the service requirement. The service requirement will only take into account University service, which is employment in a benefits-eligible position at the University of Rochester.*

Comment 15

With a new infant, I have to say this new healthcare plan has caused me considerable stress. I will admit upfront that I am quite naïve to the intricacies of healthcare coverage and I'm sure it's been a difficult struggle to find a good solution. However, as the largest employer and provider of high-quality medical services in this region, the University of Rochester should be able to offer it's employees a better plan. I chose the HSA plan and on the positive side, I do like the flexibility of this savings account, the ability to carry over unused funds at the end of the year, and the removal of the least amount of fees out of my paycheck. However, when the University announced new plans, I and others did not expect that we would have to pay 2-3 times more this year for healthcare, causing significant financial strain. This has forced me to make difficult decisions balancing costs of care versus need for care. I've bulleted below my concerns with this plan and questions for the committee. Thank you for taking the time to consider them.

Prescriptions: Costs are very high and must be paid at the time of pickup. We already have at least one prescription that has increased in cost since January (\$115 to \$130, and wonder what it will be next month). Will it be possible for prescriptions to return to the co-pay system instead of applying to the deductible first? Or, would it be possible to lock in the price of a maintenance prescription for the 12 month term of the insurance?

- Estimating costs upfront: I have been unable to obtain costs of care upfront from doctor offices and have been very surprised by some of the costs. We had one charge of \$380 for a specialist consultation. Offices claim that there are too many variables to give an estimate of charges. My son will be having surgery at the end of the year and I have no idea what it will cost, I just have to assume that I will be paying our entire deductible by then. Will anything be done to mandate or at least strongly encourage that offices must be able to at least give a reasonable estimate of cost?
- UR Benefits department: There was a problem with the initial setup of my HSA account and needed information from UR Benefits before I could finish the setup in time for the first deposit. I left 2 voicemails at the main #, 2 emails to the main email, an email to the director and asst. director. None of these were answered. I sent 2 emails to the healthcare specialist and 3 days later finally got an incomplete answer...I gave up trying to get more information. What will be done to increase the quality of services of the Benefits dept? I have heard this same complaint from many people in my dept.

- Preventative care coverage: Would it be possible to add some sort of tracking system to the Aetna web service that will track your preventative care coverage and/or alert you to when it's time for it. The list on the Benefits website is difficult to find. There also seem to be unusual "loopholes", i.e. for the Pap Smear, Screen annually until 3 consecutive normal pap smears, then every 3 years. Every doctor I've gone to has done this annually. How is someone supposed to know when something's covered??? There needs to be an easier way to keep track otherwise it's of little benefit.

In addition, I think a bigger benefit for long-term health may be to cover more individualized preventative care. I have a thyroid condition so for me the lab tests every other month and doctor consultations a few times per year are preventative maintenance. However, because I am paying for these out of pocket, I'm finding that I am not following the recommended schedule. I know that it's affecting my overall health but my son's healthcare comes first so the money goes to his health bills before mine or my husbands. I am constantly struggling with the question of what healthcare services we can afford versus what services we need. This is a big adjustment for me since I've always had a co-pay plan, and it saddens me that due to variable financial restraints, I am unable to care for my health the way I used to.

Answer: *Prescription coverage continues to be based on a 3-tier copay system in 2008. There have been some slight changes to the specific copays for certain tiers. Please note that prescription coverage on the University HSA-Eligible Plan is subject to the deductible and out of pocket maximum, meaning prescription costs must be paid in full until the plan's deductible has been met. IRS regulations require that "HSA-Eligible" plans make all coverage under the plan be subject to the deductible, including prescription costs.*

Unfortunately, negotiated rates vary from provider to provider and the information is generally considered to be proprietary. Both Aetna and Excellus have cost estimating tools on their websites that should be based on the regional data of the zip code used to search, but we are unable to verify how closely these estimates reflect what will be the true cost from a particular provider for a specific service. You also may contact your provider to obtain pricing for a service.

The Benefits Office has made every effort to meet the customer service needs of the University during the open enrollment period and into the new year. In addition to individual questions, members of the office were available at open enrollment sessions, the health and wellness fair, and individual departmental sessions. Response times during the end of the year were delayed due to the high volume of requests. Please be assured that the Benefits Office continues to work to improve the quality and speed of customer service.

The preventive service coverage in 2008 is based on recommendations from the United States Preventive Services Task Force (USPSTF). The USPSTF guidelines were developed by an independent panel of experts in primary care and prevention that reviewed evidence on effectiveness in developing the recommendations. The guidelines refer to other sources for some services including the Centers for Disease Control for immunization schedules. The guidelines also refer to increased risk factors for certain services including osteoporosis screening for women under 65 and for HIV testing. The guidelines are reviewed and updated on a regular basis. In any situation where the guidelines offer a lower frequency than what was covered under the University Health Care Plans in 2007, the frequency will remain at the 2007 levels ensuring that there is no reduction in the benefit.

Under the USPSTF guidelines, preventive services are those that prevent or detect serious illness early. They do not include services intended to treat or monitor an existing recognized condition, though these services may be covered under other portions of the University Health Care Plans.

Premium Burdens (3 respondents)

1. As a part time employee I feel that I am being asked to take an unfair share of the cost burden. I understand that it costs just as much to cover my health care as it does for a full time employee, but we part-time employees are paying much more in terms of absolute dollars – I don't even want to think about how much it is in proportion to salary.

I had to minimize my coverage in order to be able to afford it – I can only hope that I do not get sick. I never thought I would find myself in this position after working continuously at a professional level for 28 years.

Answer: *Salary banding was implemented to more equitably distribute health care cost-sharing across all faculty and staff. Those who earn more, as well as part-time faculty and staff, pay a greater share of the health care premium. Part-time contributions were set higher than active faculty and staff contributions to reflect the greater contribution full-time faculty and staff make to the University. Benchmarking data from the University's local and national peer group also was reviewed to ensure that contributions for all employees remained competitive. Part-time contributions for 2008 are competitive with the University's local and national peer group. The University also has recognized that the part-time contributions were of great concern to employees and has instituted an additional salary band to reduce the contributions for part-time University employees with at least five years of University service as of the 1/1/08 effective date. Employees who reach five years of University service after 1/1/08 will be placed into the new salary band effect January 1st of the year after they reach the service requirement. The service requirement will only take into account University service, which is employment in a benefits eligible position at the University of Rochester.*

2. I'm pleased that I still had an option to choose a co-pay plan; I'm not so happy that my take home pay is substantially less than in 2007. I do realize that the high deductible plans would not have such a negative impact on my take home pay but I'm not so sure I would keep all my doctor appointments (follow-up appointments to unexpected surgery I had last year) if I knew I would have to pay a hefty bill. Maybe for those with a higher household income this is not an issue.

Answer: *The new Health Care plans were designed to help control the rate of increase in the University's health care expenditures going forward, while continuing to serve as an attraction and retention tool for the University. The Health Care Task Force established by President Seligman reviewed survey information on the University's local and national peer group while developing the new plans to ensure that the new plan designs and contribution schedule remain competitive with the University's peer group. . Contributions will be higher for plans that have lower deductibles, coinsurance and out-of-pocket maximums.*

3. I have worked at the U or R for over 10 years. When [the UR became self-insured], we were told as employees that with this new insurance coverage, we as employees would see the benefit with decreased costs for health coverage and policies offered for free. After many years of paying nothing for health coverage, I shocked at the amount we now have to pay for good, practical insurance, roughly \$83 per month. I realize there was a need for increasing out of pocket costs, but this goes against what we were told when we went to [self-insurance]. And going from paying \$0 per year to over \$1,000 seems to be a very high increase. As a healthy, young woman, I rarely use the health care system other than yearly OB/GYN visits and physicals every 5 years. I now

feel however that because I have to pay over \$1,000 per year for medical coverage, that I am now going to start using the health care system as much as I can.

Every year in June we get a cost of living increase, my question is for this year, are we going to get an additional increase to pay for these health care costs? Basically, the cost of health care will knock out my raise this year.

Answer: *The new Health Care plans were designed to help control the rate of increase in the University's health care expenditures going forward while continuing to serve as an attraction and retention tool for the University. The Health Care Task Force reviewed survey information on the University's local and national peer group while developing the new plans to ensure that the new plan designs and contribution schedule remain competitive with the University's peer group.*

Mental Health Coverage Parity (2 respondents)

1. The University's right to exemption from Timothy's Law (described below) seems illegal. This is a law passed based on dedication, sacrifice and substantial evidence. For this University to decide on its own that the law is unnecessary suggests to me they do not care for their employees or community. Given that we as employees have assumed a large responsibility for our healthcare costs, we should be able to use that healthcare as the laws have seen fit. Will the University notice our rights if something tragic happens, as it did in Timothy O'Clair case?!

"Timothy's Law goes beyond the Federal Mental Health Act, enacted in 1996 and renewed again in 2002, to completely eliminate discriminatory and unequal insurance coverage for mental health and substance abuse services by insurance companies. Timothy's Law mandates that insurance providers covering any health care services must also provide coverage for mental health and substance abuse services, and that coverage and cost must be 'on par' with all other health care services covered under such policy." (<http://www.timothyslaw.org/whatis.htm>). The University of Rochester should not be allowed to behave in a manner above the law.

Answer: *The new 2008 plan designs comply with Timothy's Law. Coverage for eligible mental health services, covered by Timothy's Law, is the same as for any other equivalent service.*

2. [abbreviated from 2-page response] As a dedicated staff member of nearly 10 years with a mentally ill family member, I am asking you to address the severe restriction in mental health services available to covered individuals under all current health plans. This restriction results in potentially devastating financial and emotional consequences to employees and families and a financial toll to the University in lost employee productivity, due not only to missed work days while caring for and seeking services for the ill family member, but also due to constant worry and distraction while at work. I have on at least 4 occasions contacted Aetna seeking help for my child and have been told that the University is exempt from Timothy's Law because it is self-insured. This may be a legal option but it is an unconscionable ethical violation of the University's mission.

Answer: *The new 2008 plan designs comply with Timothy's Law. Coverage for eligible mental health services, covered by Timothy's Law, is the same as for any other equivalent service.*

Burden on Consumers to Make Judgments Beyond Their Ability; Lack of Research Support for Cost-Sharing (1 response)

The burden to stay “healthy” and decrease costs by shifting financial burdens to the consumer is fundamentally flawed, since the consumer does not have the ability to make informed decisions whether to “invest” in either a treatment or a particular provider. The University HR Representative cited the study by The Commonwealth Fund as evidence to support the University’s new Health Plan – results that have NOT been replicated by others – in fact, other studies reveal contradictory results. As a university and health care institution, how can we promote health when cost, not health, drives our decisions?

My own experience as a provider, and consumer, is similar to the statements made in the following editorial by UR faculty, Peter G. Szilagyi, MD, MPH, who wrote the following in an editorial: “...Evidence from the RAND Health Insurance Experiment, fielded from 1974 to 1982 to specifically study the effects of different levels of cost-sharing, found that adult patients were not able to make distinctions between care that was necessary vs. care that offered little benefit: participants in the higher cost-sharing group made more careful financial choices and used less medical care overall, but they did not choose well between care that was important and effective and care that was not. The RAND study also found that lower-income families reduced their care use more than wealthier families did, with poor children less likely than any other age or income group to get even the most basic necessary services... More recent evidence demonstrates that patients still do not choose well—that higher cost-sharing reduces use of high-value and low-value services alike.”

Answer: *We agree that cost sharing is a significant issue to be considered as part of a comprehensive strategy to achieve behavior change, health status improvement and, ultimately, improved financial outcomes. There is evidence in the literature that supports both the advantage of cost sharing and potential downsides of cost sharing. Many factors need to be considered in determining the specific areas for which cost sharing can provide the appropriate impetus for encouraging and/or reinforcing a behavior. Socioeconomic status is a significant factor to be considered, as there is evidence that cost sharing (if too dramatic) can lead to lower compliance with pharmacy treatment, as an example. This is one reason that the University decided to incorporate salary-based contributions as part of the new program. Employees who earn less, have the option of electing the University Copay Plan, which has lower cost sharing features, at a lower cost than employees who earn more.*

It is also important to note that studies also have shown that individuals who share in the cost of a program (as an example) have higher levels of participation as compared to those for whom the program is free.

In summary, we believe that individuals can, and have, become better healthcare consumers if explained the "why" of taking personal responsibility for their health and are provided the tools, education and support to do so. Many companies and organizations have taken the proactive step to help their employees/spouses in this area by implementing broad-based care management programs that provide them with the tools they need to maintain/improve their health (regardless of their current health status) and educational resources to learn more about their health. These two areas show the most promise for success when bundled together as part of a comprehensive care management strategy that includes incentives for program participation and ongoing communications campaign to develop a "culture of health".

The evidence is strong that unless an organization undertakes a proactive approach of educating their employees on the importance of taking responsibility for their health and providing the tools to do so, there's relatively no opportunity of reversing the less than optimal health status of many in their population and thus the upward trend of medical costs. Organizations that make a strong and sustained commitment to developing a comprehensive, multi-year care management strategy supported by an ongoing communication campaign have had success in reducing medical and pharmacy cost trends.

More Financial Support for Healthy Behavior (1 response)

Another comment, since the emphasis is on promoting wellness it would make sense that employees receive a reimbursement on fees paid to Health Clubs (of their choice) and/or businesses offering health related services i.e. yoga classes. This would certainly help offset some of the fees for insurance plans for those who chose to be proactive about their health.

Answer: *Employees enrolled in the University Health Care Plans are eligible for the same discounts and incentives offered to any other Aetna or Excellus member, with the exception of incentives tied to enrollment in specific plans (such as the Healthy Blue plans through Excellus). A list of the incentives can be found on the Aetna/Excellus websites or by contacting the customer service for your administrator.*

FSA Reimbursement Process unclear (1 response)

I switched to the UofR BlueCross from Aetna...in the past, when there was a charge...like a pharmacy charge, the amount was just taken out of the FSA automatically...this one seems to require copying receipts, submitting and waiting...is this a growing pain? ...or do they think the Strong Health systems will eventually be coordinated?

Answer: *FSA reimbursement through EBS (the Excellus FSA administrator) offers a feature called "Automatic Claims Transfer" or ACT to any FSA user who is enrolled in a University Health Care Plan. With the ACT feature, anytime a claim for medical or prescription coverage is submitted to Excellus by a provider/pharmacy, any amount that the member would be responsible for paying is automatically processed through the FSA account and a reimbursement is generated and either mailed or direct-deposited into a designated bank account.*

I checked the Aetna Navigator site, and noticed that my daughter was listed as covered, but not my son. I called Aetna. They told me that his coverage had been terminated in January. No one contacted me to tell me his coverage was terminated -- it just happened.

They said it was because of his birthday; he turned 19. BUT he is a full-time college student, and I filed the correct paperwork with UR to keep his covered (submitted paperwork last September).

During the course of this conversation, Aetna told me (by the way) that MY coverage was going to be terminated on March 1, and therefore coverage of my entire family as well. I asked why -- they said that this was information that had come to them from UR and they had no other explanation.

But as of the next day (I called on Friday, insurance was due to terminate Saturday), I was uninsured. By the way, it's only "luck" that I happened to call them. No one at Aetna was going to bother to contact me to let me know that my health insurance was being terminated.

I called UR, and had many phone calls and call-backs. Finally I was told that it was Aetna's mistake and that UR DOES have the paperwork for my son, and that my insurance would not be terminated March 1. They said they would e-mail Aetna with the correct information.

I checked Aetna Navigator again today. There is a "temporary insurance card" posted online for myself, my husband, and my daughter. As of this morning, my son is still uninsured. I still don't know why Aetna was apparently notified by UR that my termination date was March 1.

Answer: *For the 2008 enrollment, we requested employees to validate their dependents including students. To validate a student, we requested the employee file an updated Full-time Student Verification Form for 2008. Employees who are experiencing customer service issues may contact the Benefits Office at 275-3779 or 275-8382 for follow up with the TPAs.*