EGYPTIAN AREA SCHOOLS
EMPLOYEE BENEFIT TRUST

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TO: **All Executive Committee, Board of Managers Members, District Superintendents and Bookkeepers**

FROM: Jeff Dosier, Chair, Matt Klosterman, Vice-Chair
Tom Dahncke & Leo Hefner, Consultants to the Trust

RE: **Actions of the Board of Managers**

The Egyptian Trust's Board of Managers took the following actions at their May 10th meeting:

Changed Premium Increases to a Tiered Model

Managers voted to initiate a Tiered Premium Increase model for the 2017-18 plan year, with premium increases corresponding to a member district's most recent 2.5-year loss history. The Tiered model accompanies this memo.

Adopted Reference Based Pricing Model for Hospital Services

With a PPO network, the network sponsor negotiates discounts with network hospitals off their billed charges. Those billed charges continue to increase, eroding the value of the discounts.

In contrast to the traditional PPO network model, with the RBP model, the Plan determines the amount it is willing to pay for any hospital service using a company specializing in pricing hospital and medical services. All hospitals are required to report their costs to CMS (Centers for Medicare & Medicaid Services) so CMS can determine appropriate reimbursements under Medicare and Medicaid. The RBP pricing vendor has access to the CMS information and uses the hospital's own reported cost information and other information to determine a reasonable price for the service at a level greater than allowed by Medicare, but below the typical network discounted allowed amounts.

Under the RBP model, members may go to any hospital, since there is no longer a network of hospital providers. All care involving a hospital facility (except emergency care) must be pre-certified. When the procedure or admission is pre-certified, the hospital is notified in advance of the amount the Plan will allow for the specific service, absent complications.

The Plan will continue to use a PPO network, PHCS, for physician charges since it is not practical to pre-certify all physician services. If your physician is in the network, the claim is paid in accordance with the terms of the network contract. If the physician is not in the network, the allowed amount is determined by the RBP repricing vendor.

An important plan design change with the RBP model is that there will be only one benefit level – all hospital and medical claims in all plans will be paid at the current in-network benefit level. Members will have the same in-network deductibles, copays, coinsurance and out of pocket amounts, regardless of provider. This should be a benefit for members in areas which have not had good access to network providers.

Changed TPA and UM Vendors

Unfortunately, Meritain was unable to administer the RBP model. While Meritain has been an excellent partner to the Trust for most of its history, and Quantum has provided excellent customer service since 2012, the savings to districts and members from changing to the RBP model were compelling. Therefore, the Managers decided to change to a different TPA and to a different utilization management (UM) firm.

- TPA: HealthSCOPE Benefits
- UM Vendor: MedWatch
- Repricing Vendor: HST

These firms all have considerable experience with reference based pricing. The change to these new vendors is also expected to reduce the Trust's annual administrative costs for these services. As in past years, there will be one telephone number to call for questions, pre-certification or other issues.

Discontinued Healthcare Blue Book

The comparison pricing services provided by HCBB were not as valuable with RBP. The Managers voted to drop this program to obtain additional savings in administrative costs.

Other programs currently offered by the Trust, such as Teladoc and LabCard, will continue in effect.

Mental Health/Substance Abuse Benefits Increased

The Managers voted to improve the Mental Health/Substance Abuse Benefits in two respects.

- Paying for outpatient office visits like other medical office visits with a $30 co-pay, instead of subject to deductible and co-insurance as in the current plans.
- Increasing the hospital in-patient lifetime maximum benefit from 50 days currently to 80 days.

All the above changes become effective September 1, 2017.

ED Medications

Managers also voted another change to be effective June 1, 2017 in connection with the change to the new Keenan/Express Scripts pharmacy program. Currently medications such as Viagra and Cialis are not covered by the pharmacy benefit but are covered instead by the medical benefit after preauthorization. These drugs will now be covered under the prescription drug card benefit. Preauthorization through Express Scripts will be required, but these drugs will be covered with the applicable prescription drug copays instead of after deductible and coinsurance under the medical benefit.

Reduced Claim Filing Period from 12 Months to 6 Months

The Plan currently allows members to submit claims as late as 12 months after an expense is incurred, which is a much longer period than most plans allow. Managers voted to reduce the claims filing period to 6 months, as is common in the health insurance industry. This will also be effective June 1, 2017. Claims for all expenses incurred prior to June 1, 2017 must be submitted by December 31, 2017.

End Trust Sponsored Wellness Benefit

The Managers voted to end the current Trust sponsored wellness benefit where a $100 deductible credit (10% increase in co-insurance after the deductible is met in a High Deductible Health Plan) was earned by a covered member completing a biometric screening. HealthSCOPE has other wellness models the committee will study for possible implementation. Members who qualified for 2017 will have the benefit through calendar year 2017.

Comments or questions about this information may be directed to Trust consultants Tom Dahncke, tdahncke@charter.net, 618-791-5541 or Leo Hefner, lhefner@htc.net, 618-973-8221.