Fall River Consulting Group Health Care Recommendations for The University of Alaska, December 7, 2009

What Was Done With the Recommendations

Recommendations

1. **Retain a consultant who can provide quarterly updates to the JHCC about plan costs and utilization patterns.** The involvement of a knowledgeable consultant will help to ensure the regular and consistent reporting and analysis of data, allowing the JHCC and other groups to work more proactively with the University on plan issues.

   Adopted Recommendation: After a Request for Proposals for Consultant Services was completed, the University contracted with Lockton Dunning Benefits. Lockton provides quarterly reviews on the health plan and wellness program, and regularly attends JHCC meetings.

2. **Retain a consultant who can conduct a Return on Investment (ROI) analysis of the wellness programs.** A consultant with expertise in determining ROI will provide JHCC and University management with useful feedback on the performance of the current wellness programs and will aid decision-making regarding changes to that program.

   Adopted Recommendation: Lockton has been working with WIN for Alaska, Premera and Caremark to analyze claims data for wellness participants.

3. **Modify the eligibility provision of the UA Choice to require a 30 day waiting period prior to the effective of health care coverage for all new employees (this would include re-hired employees who have had over a one year break in coverage). This change would go into effect 7/1/10.** This change will permit more time for newly hired employees to receive orientations, complete their selection of benefits, and will greatly simplify administration of the plan for the University, Premera, Caremark, and VSP. The waiting period will also protect the plan to some extent from job applicants who seek UA employment primarily to obtain immediate health coverage because of a current condition.

   Adopted Recommendation: The 30 day waiting period was implemented July 1, 2010.

4. **Increase in the retail co-pay $5 for preferred (Tier 2) and non-preferred (Tier 3) name brand prescription drugs (with corresponding increases in mail order co-pays), and raise the Out of Pocket Limit on copays from $800 to $1000.** Caremark and Fall River have consistently stated that UA's generic utilization rate is less than optimal and just a 1% increase in the generic utilization rate can help UA Choice save $75,000 a year. Also, the $800 OOP limit on copays has been in place for a number of years and needs to be increased to $1,000 to keep step with inflation. This still provides very significant member protection.

   Adopted Recommendation: Copays and out-of-pocket maximums were adjusted.

EVF

5. **Eliminate the Dispense as Written provision and implement the Performance Step Therapy program.** The Dispense as Written provision currently allows any member to have their doctor write "DAW" on a brand name script and avoid a penalty for not using a generic drug. In order to create better incentives, the committee believes this penalty should apply to all members EXCEPT those for whom a medical necessity appeal is made by the doctor to Caremark to receive a 12 month exception. Performance Step Therapy will ask members to try a generic (Tier 1) or preferred (Tier 2) brand name drug first; prior to receiving a non-preferred (Tier 3) (an expensive brand name drug) in one of 12 targeted categories, Again, a medical necessity exception is available.

   Adopted Recommendation: These recommendations were accepted and put into place. Generic dispensing rate has increased from 54.7% in FY08 to 68.7% in FY11.

   In addition, we implemented the Incentivized Mail Order program in FY12 whereby a member can get their first two maintenance medications at the retail pharmacy, but then must use mail order to avoid the retail penalty (2x normal copay). The percent of prescriptions filled at mail order increased from 12.8% in FY11 to 20% in the first half of FY12.

6. **Implement Caremark's no cost items communication programs.** Caremark's no cost communications will educate and motivate employees and their dependents to review with their provider which medications are right for them.

   Adopted Recommendation: These services include safety programs. Where possible drug interactions are flagged for immediate or retrospective review, and a monitoring program where possible overuse or misuse situations are identified.

   Savings programs targeting generics and generic alternatives, including communications to members when brand name drugs they use become available as generics.

   Utilization management programs include dose optimization (using a single higher dose of medication vs multiple smaller dosages, when appropriate), Quantity Limits and Step Therapy, requiring a generic be used first before moving to higher cost brand name drugs.

   Health programs include those focusing on adherence and "gaps in care" problems. Communications are sent to members and their doctors when prescription fill patterns indicate a problem with the member taking their medication correctly and regularly (adherence).

Fall River Consulting Group Health Care Recommendations for The University of Alaska, December 7, 2009

What Was Done With the Recommendations

7. **Implement Caremark's Specialty Guideline Management program.** Although the savings from this change will be modest, this program is primarily focused on quality of life issues for members. It is designed to assist employees, dependents and their medical providers with issues that arise from the treatment of their condition.

   Adopted Recommendation: This program was implemented. As noted, it is not primarily a cost control item, but increases quality of care.

8. **Modify plan coverage by implementing a plan year maximum of 26 visits per year/per enrollee for Chiropractic care and 26 visits per year/per enrollee for Physical and Massage Therapy, with a recertification process for enrollees requiring additional treatments beyond this limit.** The high utilization rates presented to the committee by Fall River and Premera demons6trated a need for greater management of this benefit. Premera will be engaged to perform the medical necessity review/recertification process for visits over 26.

   Adopted Recommendation with subsequent modification: This change was made to the UA Choice plan design. However, we modified it this year (FY12) because it proved to be too restrictive for physical therapy. Members who had a clear need for physical therapy after severe accidents or surgeries had unnecessary delays in receiving care while exceptions were processed. We have since increased the physical therapy limit to a more standard 45 visits per plan year, with medical exceptions available for more as needed. Chiropractic care and massage therapy are each still limited to 26 visits per plan year.

9. **Adjust the employee contribution rate on the Deluxe Plan to more closely represent the value of the plan.** Both Premera and Fall River's data demonstrated the employee rates for those selecting the Deluxe plan need to be adjusted to better reflect the high costs of this plan.

   Adopted Recommendation: The employee contribution to the Deluxe Plan was increased by 10% for FY11 open enrollment, with minor reduction in the charge for the lower plans. This changed the value tier ratio between the plans to better reflect plan value.

10. **Implement a Value Based Benefit program that coordinates with the disease management vendor's programs.** Both the health plan and individuals benefit when those with chronic conditions remain current with their drug regimens. As a first step, the JHCC would like to see co-pays waived for generic and the cost of name brand medications set at $5 for qualifying employees and dependents who actively participate in the disease management program.

EVF

What Was Done With the Recommendations

Adopted Recommendation: The zero copay program was implemented. Active participants in the disease management program receive generic medications for their covered condition with no copay at the time of service. The $5 brand name copay program was not implemented.

11. **Authorize WIN for Alaska to share Health Risk Assessment and bio-metric data collected by WIN with the disease management vendor. This step would be premised on employee knowledge and consent. Confidentiality and security of this information would be strictly maintained.** JHCC believes that by allowing health care professionals in UA's disease management (DM) program to access this information, there would be greater ability to identify employees who could benefit from DM programs.

    Adopted Recommendation with subsequent modification: The University of Alaska has not conducted the health risk assessment since 2010. In 2012, we are offering it again (called the Personal Wellness Profile, or PWP) but with no financial incentive. WIN for Alaska is providing participant information to our consultants, Lockton, as is Alere, our disease management vendor. In addition, WIN for Alaska is referring participants in the Individual Health Planning (IHP) sessions who would qualify for the DM program to Alere.

12. **The University needs to boost its leaders' involvement in and support for Wellness activities. A leadership conference is recommended, along with periodic meetings of leaders that would focus on the importance of Wellness efforts and their role in supporting this UA system initiative.** The purpose of the conference would be to demonstrate to University executives, including Chancellors, Vice Chancellors, Vice Presidents, Provosts, Deans and Department Heads the additional impact their active and open support of the wellness programs could have on overall employee health, productivity, employee charges and the budget. For example, the lack of meeting space has presented limitations on growth of the Individual Health Planning (IHP) sessions offered as a part of the current wellness program. Meeting space is within the control of campus departments and this situation will not be solved unless senior management takes a more supportive role in prioritizing the need for space to hold these sessions.

    Not Adopted: We have not conducted a leadership conference. We have, however, held vendor summits to address the need for increased integration between our benefit plan vendors to provide more comprehensive coverage to employees and dependents. We have held two vendor summits to date, with the next tentatively scheduled for fall 2013. The plan is to invite leadership and governance groups to the 2013 vendor summit.

13. **Open up IHPs to employees located at rural campuses if sessions offered at the main campuses are not filled by January 1, 2010.** JHCC supports the use of video and telephonic to offer IHP sessions to the rural campuses. JHCC agrees with Fall River's conclusion that the IHPs

need to reach more employees, and ideally, spouses/partners as well. Emphasis should be placed on trying to reach more high risk individuals.

Adopted Recommendation: Rural Individual Health Planning (RIHP) sessions were implemented, utilizing telephonic coaching and using the available sessions leftover from the regular IHPs. The RIHP program began in February 2010 as a pilot, based on IHP numbers and a purpose to fill the IHP goal. We offered 40 slots, and filled with 41.

In addition, individuals with high risk scores from the last PWP were sent advance notice of the IHP enrollment opportunity, and their enrollment was tracked. Referred to as the "305 Group" (there were 305 identified individuals), almost all of them signed up for IHPs in 2011.

14. **Contract with a vendor for a monthly healthcare/wellness newsletter that can be posted on the web, email to employees and sent home to each employee in print form.** JHCC agrees with Fall River's conclusions that employees and dependents need more communications about life style issues and how to be a better health care consumer. Also, these communications need to be sent via as many modes as possible and targeted at spouses as well as employees.

    Adopted Recommendation: The JHCC reviewed a couple of different newsletter offerings, and selected the "Personal Best" newsletter that has space for two 200-word articles provided by the university. This newsletter is sent bi-monthly to all employees eligible for the health plan.

15. **Conduct further analysis of the concept of "medical tourism."** The cost and access to health care in Alaska is a problem and to address it, JHCC would like to see Systemwide Benefits Department present its ideas for a domestic medical tourism program. Also, it has been suggested that an alternate name be used to avoid confusion with an international medical tourism program.

    Not Adopted: This benefit plan design has been looked at and continues to be under review. Several complicating factors include the question of how much to cover in addition to medical costs: airfare, lodging, per diem, etc. Also a concern is the question of follow-up care if a patient traveled to another state for surgery or care. Finally, we must be careful to balance the needs for cost control with the desire to encourage the medical community to develop and expand available services in Alaska.

16. **Send an annual mailing to each employee containing a list of currently enrolled dependents whom the employee has enrolled in the health plan.** The committee discussed the recommendation of hiring a vendor to do a full dependent eligibility audit. However, for current employees, JHCC would rather see an annual mailing used for verification of enrolled dependents. As part of that mailing there needs to be a clear statement of the employee's responsibility to notify the University of ineligible dependents and the actions of the University

will take if an employee fails to notify UA when dependents become ineligible or misstates the eligibility status of covered dependents.

Adopted with modifications: The annual mailing was not done, primarily because it would be too hard to track who had completed it and would increase workload at the campus HR offices. The University did conduct a full dependent audit beginning in January 2011 and concluded in August. In addition, during open enrollment for FY12, employees were encouraged to make a positive election and choose a plan, rather than default to the new 750 Plan. Positive enrollment included listing all dependents and signing to certify that they were eligible dependents.

17. **Require proof of dependent's eligibility as of July 1, 2010 for all new employees, ex-employees re-enrolling in the plan and when life events occur that cause dependents to be added to the plan.** JHCC is of the opinion that this action, in conjunction with an annual mailing used for the verification of eligible dependents, should minimize the number of ineligible dependents of the plan.

    Adopted Recommendation: Effective July 1, 2010, all dependents must be verified at the time of enrollment.

18. **Authorize WIN for Alaska to begin additional messaging (email and mail only, no calls) to members with high risk scores, to encourage them to sign up for IHPs and to participate in additional health screenings, etc.** JHCC is of the opinion this action will help reach more employees who have not sought needed health care or who are in need of life style changes. WIN for Alaska, and Fall River if desired, can help the University design the optimal strategy in this area.

    Adopted Recommendation: High risk individuals are sent advance notice of the availability of IHPs through the use of post card mailings and e-mail. This has resulted in increased enrollment for these individuals.

19. **Switch Disease Management vendors from Premera/Healthways to Caremark/Accordant effective 7/1/2010.** The JHCC has reviewed a full comparison of the two vendors and an analysis of DM offerings by Fall River. Due to more favorable pricing, better and more timely reporting and the ability to access real-time pharmacy data, it is expected that Accordant can deliver more value to the University.

    Adopted Recommendation: The University of Alaska switched Disease Management vendors effective July 1, 2010, to Alere (formerly Accordant). This change has resulted in increased participation and better reporting than we had with the former vendor.

Fall River Consulting Group Health Care Recommendations for The University of Alaska, December 7, 2009

What Was Done With the Recommendations

20. **Expand the requirements for the $100 Wellness Incentive.** The JHCC recommends that $100 incentive amount now provided for each member who completes the HRA, should have additional requirements: that the employee be willing to undergo a biometric screen, and consent to have both the HRA and the biometric information released to the DM vendor. Currently, an employee or covered spouse/partner each receives $100 just for completing the Health Risk Assessment. JHCC is of the opinion that the current incentive does not yield enough in terms of employee engagement. The final strategy can be developed in conjunction with WIN for Alaska, and if desired, Fall River.

    Adopted recommendation with modification: We did not conduct the health risk assessment (called the Personal Wellness Profile, or PWP) in 2011. We are offering it this year (as of April 1), but with no financial incentive. WIN for Alaska is also holding the "Know Your Numbers" biometric screenings at multiple locations, dates and times in Fairbanks, Anchorage and Juneau in conjunction with the PWP.

    For the future, we will be looking at requiring the PWP and other wellness participation (such as biometric screenings) in order to qualify for a reduced charge (or credit) for health care benefits.

There are several other ideas discussed during the earlier meetings that the JHCC does not support recommending at this time:

A. Adding a $25 per pay period charge to the employee for having his/her spouse or partner on UA's health plan, if that person has other available health care coverage. This would be enforced on the honor system with caveat language stating that if false information is provided it could result in the denial of claims. While JHCC considered this suggestion, the committee does not support it.

   Follow-up: this has not been considered further, although as part of the dependent audit employees were asked if their spouse had other coverage through their work. Of the 1900 respondents, 876 stated no their spouse did not have access to coverage through their employment, 873 stated yes their spouse did have access, and 151 stated they were not sure.

B. Fall River presented to JHCC a number of programs that would entail using incentives for outcome based wellness behaviors (BioMetrics, tobacco, etc.). The committee is not ready to take action on those at this time.

   Follow-up: These programs will be looked at for implementation in FY14. JHCC had moved to not implement this type of program for FY12 or FY13, and management agreed. But we

EVF

now believe these types of programs will be key to driving engagement in the wellness program to help control health plan costs.

C. The committee does not recommend the hire of a vendor to conduct a dependent eligibility audit at this time. Recommendations 16 & 17 above are viewed to be sufficient protection against ineligible dependents.

Follow-up: We did conduct a full dependent audit in addition to positive enrollment for FY12 and dependent verification at the time of enrollment.

D. Possible pharmacy plan designs, using either coinsurance in place of co-pays and/or a highly incentivized mail order design, were considered. The committee does not recommend these changes right now, but agrees they may need to be looked at in the future.

Follow-up: Incentivized mail order was implemented for FY12, resulting in a 56.7% increase in the use of mail order (from 12.8% of prescriptions to 20%). In addition, plans to move forward with a qualified High Deductible Health Plan with an HSA for FY14 will require integration of the pharmacy benefit into the medical plan, subject to deductibles and coinsurance.

E. Plan changes such as eliminating the deluxe plan, or creating a new plan tier using Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) were discussed and considered by the JHCC. The committee does not want to eliminate the deluxe plan in FY11, although the plan cost needs to be better matched to value. (See 9 above) Also, HRAs may be attractive in the future, but HSAs will be unworkable as long as the medical and pharmacy claims adjudication are performed by separate vendors.

Follow-up: The Deluxe Plan and the Standard Plan were eliminated in FY12, with the "Economy Plan" becoming the new top level plan, and two new higher deductible plans added (the 750 Plan and the High Deductible Health Plan). Plan changes being considered for FY14 include eliminating the top tier plan (currently the 500 Plan), and implementing a new (additional) qualified High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) that would have an embedded pharmacy plan subject to the deductible and coinsurance.