CITY OF HUNTINGTON BEACH

HEALTHCARE EDUCATIONAL FORUM

Alliant
Vickie West

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EMPLOYEE BENEFITS

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WHAT'S NEW IN 2016

WHAT'S NEW IN 2016

- Benefit Carriers for Medical, Dental, Vision, EAP, Basic Life/AD&D, Supplemental Life/AD&D and Long Term Disability will remain the same
- Employee contributions will change
- No plan changes for 2016

What Will Change on January 1, 2016 for MEO/NA) - Blue Shield

- Express Scripts will have a formulary change
- ACA change – an individual out of pocket maximum for in-network cannot exceed $6,850 (this will impact individuals who have family coverage on the HDHP plan only)

WHAT'S NEW IN 2016 – EXPRESS SCRIPTS PHARMACY CSAC-EIA PLANS WITH BLUE SHIELD

2016 Status Change Update

Our formulary development process ensures that clinically sound, cost-effective drugs are available to members and drive greater savings, in part by minimizing brand inflation and by reducing the use of nonpreferred brands. With our unmatched expertise and scale, we are uniquely positioned to manage the formulary in such a way that we ensure positive patient experiences and drive better outcomes.

New Exclusions			
Acuvail	National Medical Test Strips/Meters (Advocate Test Strips/Meters)	Asacol HD	Delzicol
Dipentum	Doxycycline 40mg capsules	Endometrin	Estrogel
Fluorouracil 0.5% cream	Ganirelix	Istalol	Kombiglyze XR
Onglyza	Qsymia	Synvisc/ Synvisc-One	Omnis Health Test Strips/Meters (Embrace/Victory Test Strips)
UniStrip Technologies Test Strips/Meters (UniStrip Test Strips)			

Preferred to Nonpreferred Changes			
Aczone	Besivance	Denavir	Estring
Evamist	MoviPrep	Nexium Packets	Pramosone
Transderm Scop	Treximet		

To view and download the full list of 2016 National Preferred Formulary exclusions and available alternatives, please visit www.express-scripts.com/2016drugs.

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HEALTHCARE MARKETPLACE UPDATE

So what's driving the high and rising cost of healthcare?

- Technology – more expensive, used more often
- Inflation – medical inflation outpaces general inflation
- Cost Shifting – when government programs like Medicaid and Medicare underpay for medical services, providers and hospitals make up for the losses by charging higher rates of reimbursement to commercial insurers
- Compliance with Government Regulations - $339 billion spent annually to cover mandated benefits and filing and reporting requirements
- Defensive Medical Treatment – oftentimes providers order tests or prescribe unnecessary treatments to avoid potential lawsuits
- Health Care Fraud and Abuse – National Health Care Anti-Fraud Association estimates 3% of all healthcare spending or $68 billion is lost to fraud every year

So what's driving the high and rising cost of healthcare?

- Prescription drug costs and usage
  - Specialty Drugs – ex. New cancer drugs can cost $100,000 per patient during the course of treatment
  - Half of all adults in the U.S. take at least one drug per day
  - 7% of adults in the U.S. take at least five drugs per day
  - 2/3 of people who walk into a doctor's office, walk out with a prescription

- Personal Lifestyles – we are getting unhealthier as a society
  - Obesity – the percentage of obese adults now exceeds the percentage of healthy weight adults
  - Tobacco use – one in five adults smoke
  - Sedentary Lifestyle – less than one third of adults report getting regular exercise
  - Poor Nutrition and Diet

Health Care Reform effects on Medical Trend:

- Health Care Reform mandates: Legislation dictates that more services will now be covered which will lead to higher claims cost; this is contributing to current medical trend in carrier renewal calculations.

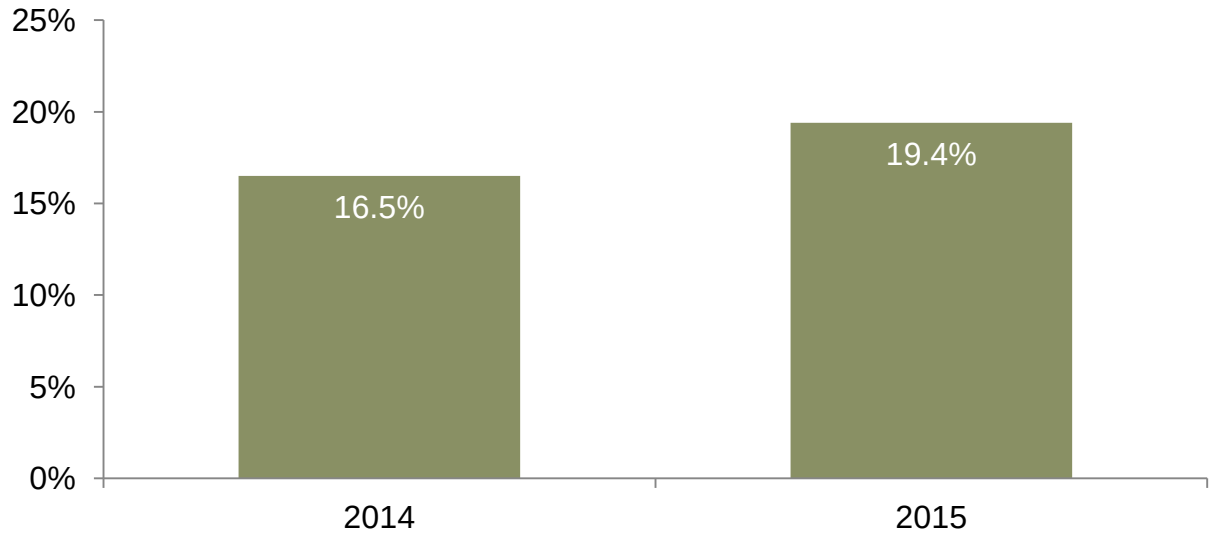
- Health Care Reform Taxes, Administrative and Compliance costs: Medical device makers, insurers, providers, hospitals and drug companies will pass these costs on to consumers; this will lead to higher medical trend in carrier renewal calculations over time.

- Cost Shifting: Medicaid will be the vehicle through which we provide coverage to the un-insured. Expect providers to demand higher rates of reimbursement from commercial insurers to make up for low Medicaid reimbursement rates; this will lead to higher medical trend in carrier renewal calculations over time.

SPECIALTY DRUG TRENDS

Projected Specialty Drug / Biotech Trend

- Typically, less than 1% of all prescriptions are specialty drug medications[1], survey respondents noted these drugs now account for more than 25% of total prescription drug cost trends



[1] 2013 Express Scripts Drug Trend Report
http::://lab.express-scripts.com/~/media/7f14884da6ef434dbf30abd82dd7e655.ashx

Source: 2015 Segal Health Plan Cost Trend Survey

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MEDICAL PLANS

TYPES OF MEDICAL PLAN OPTIONS

Managed Care **Freedom of Choice**

HMO

- Managed Care
- Primary Care Physician (Gatekeeper)
- Limited Network
- No Out-of-Network Coverage
- Capitation
- Negotiated Provider Rates
- Copays

High Deductible Health Plan (HDHP)

- Freedom of Choice
- Extensive PPO Network
- Out-of-Network Coverage
- Discounted Provider Rates (In-network only)
- Higher Deductibles
- Contribution to a pre-tax vehicle (HSA)
- Lower Cost

PPO

- Freedom of Choice
- Extensive Network
- Out-of-Network Coverage
- Discounted Provider Rates (In-network only)
- Deductibles & Coinsurance
- Higher Cost

HMO – Health Maintenance Organization (cont.)

Advantages

The most obvious advantage to belonging to an HMO is cost. First, the premiums of managed care are usually lower than traditional health insurance due to the high degree of management both caregivers and insurers exercise throughout the entire healthcare process. Second, HMOs and most other types of managed care do not require that you pay for your medical care up front, so there are no claim forms to fill out or waiting periods for repayment. Lastly, many HMOs require only a co-payment for a visit to the doctor, a hospital stay, or a prescription.

Disadvantages

The primary drawback to an HMO is that options for service providers are limited to network care providers only. Additionally, most HMO's have restrictive guidelines on how services are to be provided to the patient: courses of treatment are carefully managed by each patient's PCP. If a member seeks care outside of the HMO network, they are responsible for the entire cost of the service.

PPO – Preferred Provider Organization (cont.)

Advantages

In a PPO, the main advantage is the freedom to see any provider; there is no primary-care-physician who regulates the course of treatment. There are a larger number of in-network physicians to select from due to less stringent contracts between the medical insurer and the physician. PPO plans also provide a solution for groups with members in more rural areas who may not have easy access to an HMO network.

Disadvantages

The main drawback to a PPO plan is the cost to the employer and the employee. Premiums are traditionally higher for a PPO due to the types of contracts with hospitals and medical groups and the inability to control where a member seeks care. Out-of-pocket costs for members are also typically much higher due to deductibles and the cost sharing inherent with co-insurance. Furthermore, out-of-network co-insurance levels are lower and members may be subject to balance billing and greater out of pocket costs.

HIGH DEDUCTIBLE HEALTH PLANS

What is a Consumer Driven Health Plan Model?

This plan model combines a high-deductible health plan with an employee controlled spending account.

- HSA: Health Savings Accounts allow both employee and employer contributions. Individuals can make tax-deductible cash contributions that can then be used to reimburse the employee for qualifying medical expenses.

Advantages

incorporates all of the benefits of a PPO plan, but also provides the opportunity to put away tax free dollars to pay for out of pocket expenses. Premiums on this plan tend to be lower than the HMO and PPO plans.

Disadvantages

The main drawback to a HDHP plan is that every expense must accrue to the plan deductible. However, once the out of pocket maximum is met in-network, the plan pays 100% of the cost of care. Preventive care is also paid by the plan at 100%.

KEY TERMS YOU SHOULD KNOW

MEDICAL/GENERAL TERMS	
Allowable Charge	The negotiated amount that in-network providers have agreed to accept as full payment.
Balance Billing	A practice where out-of-network providers bill a member for charges that exceed the plan's allowable charge.
Coinsurance	The percentage cost share between the insurance carrier and a member.
Copay	The dollar amount a member must pay directly to a provider at the time of service.
Emergency Room	All members should go to any ER facility for emergency care when needed such as chest pains or heart attacks, stroke, fractures, severe bleeding, head injury or loss of consciousness, etc..
Explanation of Benefits (EOB)	The statement you receive from the insurance carrier that details how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay your provider until you have received this statement.
Family Deductible	The maximum dollar amount any one family will pay out in individual deductibles in a year.
Individual Deductible	The dollar amount a member must pay each year before the plan will pay benefits for certain services.
In-Network	Services received from providers (doctors, hospitals, etc.) who have agreed to limit their fees for health plan members to a negotiated allowable charge.
Out-of-Network	Services received from providers (doctors, hospitals, etc.) who have not agreed to limit their fees to a negotiated allowable charge. Out-of-network benefits are usually lower and additional balance billing charges often apply.
Out-of-pocket Limit	That maximum amount that you will pay each year for covered services.
Primary Care Physician (PCP)	Your PCP will be your primary healthcare provider. Primary care physicians include family medicine, general internal medicine, general pediatrics, combined internal medicine/pediatrics (med/ped) and general obstetrics and gynecology (ob/gyn), fulfilling the general medical needs of specific patient populations.
Preventive Care	Measures taken to prevent or detect common healthcare conditions when no symptoms are present. Services covered under preventive care include routine physical examinations, immunizations and routine tests for cancer.
Specialist	Specialists are medical providers who devote attention to a particular branch of medicine. HMO members must obtain a referral from their PCP to see a specialist unless you pay the higher Access+ copay.
Urgent Care	An urgent care center can provide many of the same basic medical services as your doctor's office – often with extended hours – and lower out-of-pocket costs than the emergency room. Staffed with licensed physicians, urgent care centers are ideal for non-emergency care when your doctor isn't available.

KEY TERMS YOU SHOULD KNOW - CONTINUED

PRESCRIPTION DRUG TERMS	
Brand Prescription Drug	A drug which is produced and distributed under patent protection with a trademarked name from a single drug manufacturer. A generic drug may be available if the patent has expired.
Dispense as Written (DAW)	A prescription that does not allow for substitution of an equivalent generic or similar brand drug.
Maintenance Medications	Medications taken on a regular basis for an ongoing condition. Examples of maintenance medications include oral contraceptives, blood pressure medication and asthma medications.
Non-Preferred Brand Drug	A brand drug for which alternatives are available from either the insurance carrier's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.
Preferred Brand Drug	A brand drug that an insurance carrier has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of their clinical effectiveness and their cost.
Specialty Pharmacy	Provide special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/AIDS.
Step Therapy	The practice of beginning drug therapy for a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

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HOW TO BE BETTER HEALTHCARE CONSUMERS

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Save money with discount drug programs

Many retail pharmacies offer 30-day supplies of generic drugs for $4. These programs can help you save money on your medicine.

If you take a generic prescription drug, check if it's included in the discount programs. If you take a brand-name drug, ask your doctor if a generic is available for it.

- Make sure you talk to your doctor if you need a new prescription.
- When picking up and paying for your generic drug, be sure to show your health plan ID card. Why? Your ID card is proof that you're insured.
- Showing your ID card also helps ensure that your prescription history is complete and correct.
- Unreported drugs leave gaps in your history and can even lead to drug safety problems.
- Using your ID card helps protect you, and it helps you and your doctor have a good understanding of your health.

Why choose generics?

- Generics are safe and effective. Generic drugs are copies of brand-name drugs. Brand and generic drugs have the same active ingredients, strengths and dosages.
- The Food and Drug Administration (FDA) requires generics to go through the same strict testing as brand drugs. This makes sure they meet the same high standards for purity, quality and safety.
- Generics may look different, but they work just as well. Even though the active ingredients in a brand and generic drug are the same, the company that makes the generic may use different inactive ingredients. This could change the color, shape and size of the drug. But, because generics must meet the same standards as brand drugs, you can be sure the generic works just as well.
- Generic drugs usually cost 30% to 60% less than brand drugs. And with the discount programs offered by many retailers, it's just $4 for a 30-day supply of lots of generic drugs.

Many generic drugs are on the market today, and new ones become available all the time. Ask your doctor if a generic is right for you. If one isn't available for a brand-name drug you take, your doctor may suggest another drug that works well. Don't switch or stop taking any drugs before you talk to your doctor.

HOW TO BE BETTER HEALTHCARE CONSUMERS

HOW TO TALK TO YOUR DOCTOR AND WHAT TO ASK?

- Have you ever found yourself drawing a blank when it comes time to ask your doctor important questions about your health? You're not alone. It helps to take some time before your visit and write down all of the medicines, vitamins, nutritional supplements and other treatments you use. Then think through anything else you might want to tell your doctor about your health. Finally, write down any questions you have. This list will get you started:
  - Do I need to come back for another visit?
  - Can I call for test results?
  - What should I do to prevent or delay health problems?
  - Are there changes I should make to improve my health?
  - Are there tests or screenings I should have, based on my age or other risk factors?
  - Am I due for any vaccines?
  - ***Is this visit preventive or diagnostic?***

Get healthy. Stay healthy.

Getting the most of your preventive care coverage

Preventive care at no additional cost keeps you healthy at every stage

Your first step in a healthier direction starts with prevention. Good prevention starts early and continues throughout your entire life. Even if you feel fine, going to the doctor for **health tests and checkups** is part of living a healthy life. These screenings check for problems early, before you feel signs of sickness. Finding problems early often gives you more care choices with better results.

With your Blue Shield health plan, **preventive care services are covered at no cost, even before you meet the plan's deductible**. This healthcare flier provides a summary of these preventive care services. For more details on preventive services and to find out what's right for you, visit the *Health & Wellness* section of our website at **blueshieldca.com**.

Adult preventive care

In addition to routine physical exam, the following is a partial list of covered screenings, immunizations, and counseling/services:

Screenings	Immunizations	Counseling/services
Blood pressure	Hepatitis A[1]	Domestic violence
Cholesterol	Hepatitis B[1]	Family planning and select contraceptive drugs and devices
Diabetes	Human papillomavirus (HPV)[2]	Breast-feeding support
Colorectal cancer[2]	Meningococcal[1]	
Colonoscopy screening; polyp removal if found during colonoscopy screening[2]	Measles, mumps, rubella (MMR)	
Breast cancer[2]	Pneumococcal (pneumonia)[1]	
Cervical cancer[2]	Tetanus, diphtheria, pertussis (Tdap)	
Prostate cancer[2]	Varicella (chicken pox)	
Sexually transmitted infections	Influenza (flu)[2]	
Weight, height, and BMI	Zoster (shingles)[2]	
Vision and hearing tests		
Osteoporosis[1]		
Abdominal aortic aneurysm (AAA)[1,2]		
HIV[3]		
Gestational diabetes		

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blueshieldca.com

Urgent Care Versus Emergent Care: Did you know that an emergency room visit is 8 – 11 x's more expensive than an office visit or urgent care visit. If it's not an emergency and you can't get to your regular doctor, you may be able to get the care you need -- and save time and money with other types of quick-care options.

Urgent Care

Call NurseHelp 24/7 or visit an Urgent Care Center

NurseHelp 24/7SM – talk to a registered nurse 24 hours a day

- Call **(877) 304-0504** for immediate and reliable health advice and information.

Urgent Care Centers (UCCs)– save time for non-emergencies

- Quality care in less time—average ER wait is 4 hours, 34 mins, while UCC is usually under 1 hour.
- UCC's treat a variety of conditions, such as coughs, colds, flu, rashes, minor cuts/scrapes, back pains, and body aches.
- Learn more and find an Urgent Care provider by going to **blueshieldca.com/csac**.

Remember: If you believe you need an emergency care, always call 911 immediately or go to the nearest ER.

Prevention Program

Be proactive about your health

- Download recommendation for preventive health screenings, immunizations and more.
- Guidelines available for:
  - Children
  - Men
  - Women
- Go to **blueshieldca.com/csac.**

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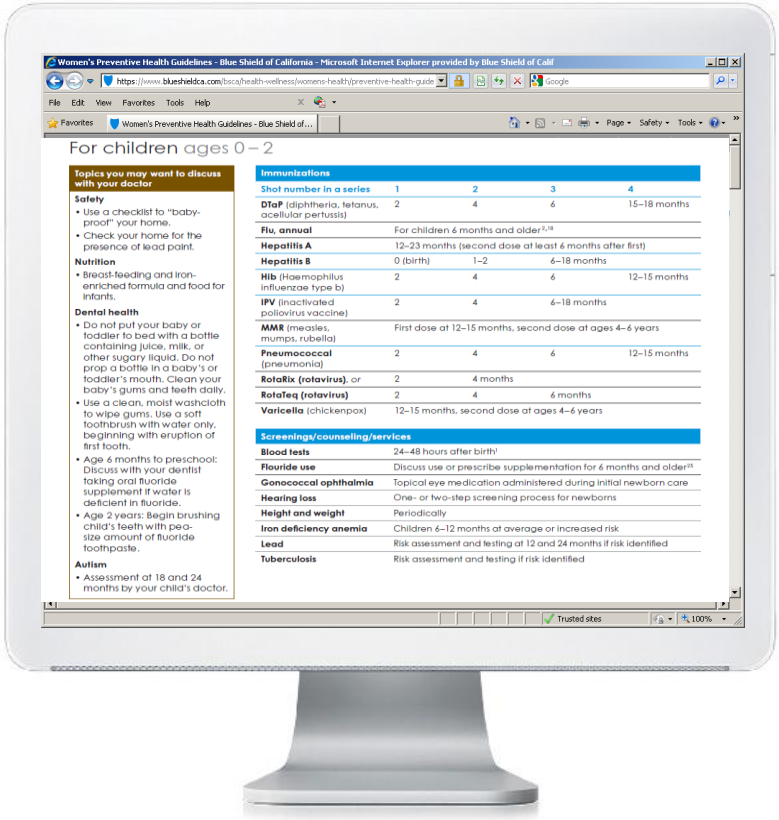
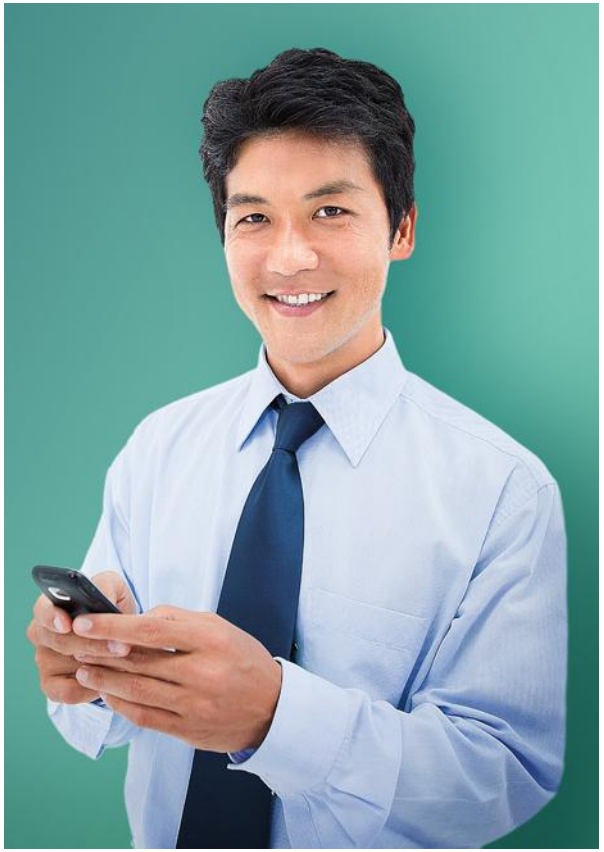


Good health on the go

Mobile apps

Use your smartphone or mobile device to fit wellness into your schedule.

- Manage your care, find nearby facilities, and more
- Stay fit with the free Every Body Walk! app—a fun, interactive tool to help you create and maintain a daily walking routine
- Just download our free apps from the App Store℠ or Google Play*



*App Store is a service mark of Apple Inc.

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WHAT YOU NEED TO KNOW

Blue Shield Facets System change

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- Blue Shield – New Facets System Change
  - On 11-1 new Blue Shield ID cards will be sent to all City of Huntington Beach members who are currently enrolled
  - ID cards will reference 2015 benefits
  - Members will receive a 2nd ID card in December/January if a plan change if made for 2016
  - Customer service and group numbers will change
    - New: 855-256-9404 (7-7 M-F PST hrs)
  - Please do not throw away the new cards and begin using them right away

QUESTIONS?