



# Open Forum

*For Retirees in the Commonwealth of Virginia's Health Benefits Program*

Published by the Virginia Department of  
Human Resource Management for Non-Medicare Retirees

April 2002

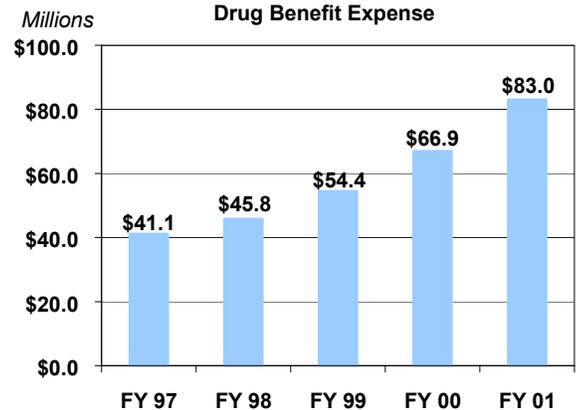
## Welcome To Our First Issue for Non-Medicare Retiree Program Members

Welcome to *Open Forum*, a newsletter for participants in the State Retiree Health Benefits Program. In meetings around the Commonwealth last fall, many retirees expressed a need for better communication of health benefit information. This newsletter is a direct result of comments and questions from meeting participants. We hope this format will be useful in providing information and serving as a true forum for your input and ideas. *Let us know what you think. E-Mail your comments and suggestions to [hbp@dhrm.state.va.us](mailto:hbp@dhrm.state.va.us).*

## Resources for Retiree Program Members

This newsletter is a part of your 2002 non-Medicare rate notification package. In addition to this and other enclosed reference materials, retirees have other resources available to them in order to seek information regarding their health plan choices, benefits and eligibility. The Department of Human Resource Management's Web site at <http://www.dhrm.state.va.us/services/health/retiree.htm> contains a wealth of information and provides links to all available health plans. A series of new Retiree Fact Sheets is now available to respond to many retiree questions. These subject-specific reference tools contain updated information formerly contained in the Retiree Sourcebook. If you do not have access to the Web, you may request fact sheets through your Benefits Administrator (VRS or your last employing agency).

Key Advantage and Cost Alliance Prescription  
Drug Benefit Expense



## Health Care Costs Keep Rising

Fueled by increasing medical costs, particularly prescription drugs, health plan premiums continue to rise nationwide, affecting employers such as the Commonwealth of Virginia.

For the State Health Benefits Program in fiscal year 2001, total claims expenses were up 17 percent for the Key Advantage and Cost Alliance health plans. Prescription drug costs rose 24 percent. As the chart above indicates, drug costs for state employees and non-Medicare retirees in these plans have increased more than 100 percent since 1997.

To fund these increasing plan expenses, the State Health Benefits Program will implement the copayment changes and premium increases outlined in your notification package. For additional information regarding premiums, please take a few moments to read the following article, "Why Did My State Retiree Health Plan Premium Increase?" which is provided in a Question and Answer format.



## Why Did My State Retiree Health Plan Premium Increase?

*Q. What are the statewide, self-funded plans?*

A. The Key Advantage and Cost Alliance plans are offered statewide to non-Medicare retirees. Key Advantage is also offered outside of Virginia. They are considered self-funded plans because the state assumes the full responsibility for all plan costs. One hundred percent (100%) of the premiums paid by non-Medicare retirees enrolled in these plans go toward paying plan expenses (claims and administrative costs).

Regional plans are underwritten by the individual insurance companies, who also determine their own premium levels.

### **The following information addresses only the statewide, self-funded plans.**

*Q. How are my monthly premiums determined?*

A. Each year, the Department of Human Resource Management reviews accounting, underwriting and actuarial information for its self-funded plans. The total amount paid for claims in the previous year is a significant part of the review. Premium levels are directly related to the expenses incurred by the plan since premium payments, paid in full by retirees and by agency/employee contributions on behalf of active employees, are the program's only source of revenue.

The total amount collected through premium payments must then pay the program's expenses. Increased claims equate to increased premiums. If the premiums collected are not enough to pay program expenses, an adjustment has to take place in the following year—in addition to any adjustments to reflect other projected increases (e.g., increasing medical and prescription costs). Unfortunately, without any state contribution, retirees realize the full impact of premium increases.

Premium payments are directed into the Health Insurance Fund, which pays the claims and administrative costs incurred by the self-funded plans. Ninety-five percent (95%) of premium payments go directly toward paying the claims expense incurred by the plan. Only five percent (5%) of the premium is used to pay the program's administrative costs (program oversight, data processing, communication, reporting, analysis, etc.).

*Q. Does the state contribute toward the cost of my health plan premium?*

A. Retiree plan members pay the full cost of their health plan coverage. While some members are eligible for the Health Insurance Credit Program (separate from the State Retiree Health Benefits Program and administered by the Virginia Retirement

System), the full amount of the premium is collected from the retiree plan member and deposited into the Health Insurance Fund. Remember:

- The fund must pay all claims and administrative costs incurred by the plan.
- Premiums, collected from retirees and through agency/employee contributions for active employee coverage, are the only source of revenue for the program.

The total amount of the agency and employee contribution for active employee coverage is equal to the premium paid by retirees for the same membership level.

To their benefit, non-Medicare retirees share the same plans with active employees. This is beneficial because claims experience is pooled with a larger group, thereby spreading the program's risk over more premium payers. This is particularly significant since the average annual cost per active employee contract in fiscal year 2001 was \$4,327, while the average annual cost per non-Medicare retiree contract was \$6,194.

*Q. Do I have any control over premium increases?*

A. While the cost of medical care is often outside of the control of individual consumers, plan members can take steps to contain plan costs. A few things to keep in mind:

- Be sure to remove ineligible dependents immediately upon their loss of eligibility. Covering ineligible dependents can result in unnecessary claims expense—which affects all plan members and can also result in members' suspension from the program.
- Check your hospital and doctors' bills for accuracy. Report any discrepancies to the Member Services number listed on your membership card.
- Take advantage of the second surgical opinion option under the self-funded plans. These are covered up to the allowable charge (and with applicable copayments). Remember, a referral will be required from your primary care physician. While obtaining a second opinion is optional, it might prevent an unnecessary surgical procedure and the associated expenses.
- Avoid duplication of laboratory tests and x-rays. Ask your physician to forward your records to any other consulting physicians so that they can take advantage of results that are already available. Be sure to advise your plan of any other coverage that may be available to you or your covered dependents. This ensures that the member gets all benefits to

## Retiree Premium Q&A (continued)

which he or she is eligible, but it helps to avoid duplication of benefits or payment of benefits by the state program that may be appropriately paid by another plan.

*Q. If I am healthy and wish to cancel my coverage, why can't I come back into the plan at a later date?*

A. The State Retiree Health Benefits Program has very strict eligibility guidelines in place to protect the program and its members. In only very limited circumstances, a participant may leave the program and return at a later date.

If participants were allowed to drop out of the program and return at will, many would cancel coverage until they anticipated medical expenses—then all plan members would be incurring expenses, and the cost of the plan would skyrocket. That contradicts the very concept of an insurance program in which group members pay a fixed amount to protect them from paying a potentially larger amount in the future. It is a risk-sharing arrangement in which all members contribute to the pool from which all expenses are paid. Some members will receive more in benefits than they have paid into the program, and some will pay more in premiums than they will receive in benefits. However, everyone is protected from incurring catastrophic medical expenses.

*Q. Is the state doing anything to help keep costs down?*

A. The State Health Benefits Program has consistently implemented innovative health plan provisions in an effort to keep plan costs under control. The implementation of managed care has resulted in improvements to some areas, such as the number of inpatient days and average length of inpatient admissions. Unfortunately, these savings have often been offset by the increasing costs per day of hospital care. Also, outpatient facility expenses increased during fiscal year 2001. The Department of Human Resource Management reviews and adjusts the plan to balance premium costs with copayment levels. Higher copayments allow for some relief in premiums, and they shift the costs to those who are using the plan to a greater extent. However, the goal of the program is to keep out-of-pocket expenses affordable for all participants, so determining a manageable balance is an ongoing challenge.

*Q. Do I have alternatives to the State Retiree Health Benefits Program?*

A. Participation in the State Retiree Health Benefits Program is not mandatory. All plan members may

choose to shop for plans outside of the state program that might better meet their needs. The Department of Human Resource Management works diligently to keep the retiree program effective and affordable for its participants. However, health plan needs are individual. Not every individual need can be met through the state program. Your participation in the state program is greatly valued, but your top priority should be to achieve your own health plan and financial goals. If you can find a better product to meet those needs, you may leave the retiree program at any time, but remember, once you cancel your coverage, you cannot return in the future. Be sure to check into the long-term implications of enrollment in any new plan.

*Q. Are increasing premiums a problem in all retiree programs?*

A. Increasing medical costs are a national problem in health plans for active and retired employees. Unfortunately, this rise in costs coupled with projected future increases has led to a reduction in the number of large employers providing retiree health benefits coverage. According to the Henry J. Kaiser Family Foundation, 80% of large employers offered retiree health benefits in 1991, compared to only 62% in 2000.

*Q. What types of medical expenses are the biggest contributors to higher premiums?*

A. Despite the implementation of a generic-only program, the biggest single driver of increased health plan expenses is prescription drug cost. Costs for prescription drugs have more than doubled since 1997. According to *Business and Health* magazine, this can be attributed to overall price increases (22%), increased numbers of higher priced drugs (36%), and a higher volume of prescription drugs (42%). The volume of drugs dispensed in the United States has increased from 1.9 billion in 1992 to 2.9 billion in 2000, and increases are expected to continue. To illustrate this point, Medicare, with its huge buying power, continues to be unable to offer a prescription drug benefit under its original plan.

*Q. Can I expect to see continued increases in the future?*

A. According to the Henry J. Kaiser Family Foundation, annual growth percentages in national health expenditures are projected to continue this upward trend in the areas of hospital care, physician services and prescription drugs until at least 2010. This is likely to have a continuing impact on premium levels.

## Fall 2001 Retiree Meetings

Last fall more than 200 retirees took the opportunity to gain additional insight into their health benefits by attending one of 13 meetings held around Virginia. Participants were enthusiastic and provided useful, constructive input regarding the program. Due to current budget restraints, we do not anticipate additional meetings in the near future. However, your comments and suggestions are important to us and may be sent by e-mail to [hpb@dhrm.state.va.us](mailto:hpb@dhrm.state.va.us) or through regular mail.

## A Question From Retirees: How Are Retiree Health Benefit Plans Procured?

The Request for Proposal (RFP) process is complicated, but is set up to provide an opportunity for any qualified offeror to submit a proposal and to ensure that the best offeror is awarded the contract. The process works like this: Generally every five years (depending on one-year renewal options), an RFP for state health benefits is published per the Virginia Public Procurement Act (VPPA) as defined in the Code of Virginia. The RFP is advertised in newspapers and posted on the Department of Human Resource Management's Web site. An RFP for state health benefits was published most recently on July 21, 2000. Anyone (company or individual) who wishes to submit a proposal may do so within the defined time limits. The specifications within the RFP are very specific and define requirements such as claims processing, system capabilities, plan inquiries, benefits administration, accounting, standards of performance, reports and deliverables.

## Prescription Drugs and Mail Service: Myth and Reality

If you are a participant in Key Advantage or Cost Alliance, take a few minutes to review the enclosed flyer which dispels a number of myths regarding your Prescription Drug Program. In a time of soaring prescription drug costs, it pays to understand your plan and to utilize its highest benefit level.

The selection of qualified offeror(s) is based on the evaluation factors included in the RFP, including the offeror's organization and financial stability, qualifications of staff, member services, administrative capability, administrative costs, and utilization of small, women-owned and minority business. The proposals are scored (based on the factors contained in the RFP) and negotiations are conducted with the selected offerors. Price is a consideration when selecting finalists for negotiation, but it is not the sole determining factor.

The Department of Human Resource Management, Office of Health Benefits, selects the offeror who has made the best proposal and awards the contract. Proposals must be submitted in writing and must provide complete and accurate information which is subject to verification. The format of the proposal is very specific and must be in compliance with the VPPA. In addition, all contractors must agree to assist the Department of Human Resource Management and its auditors in conducting audits and providing an annual report.

---

## Attention Tidewater Area Participants!

Effective January 1, 2002, Atlantic Anesthesia, a practice that provides a significant level of anesthesia services in the Tidewater area, resigned from the major portion of the Trigon provider networks.

If you require anesthesia services, you may choose to:

- Use Atlantic Anesthesia at a network hospital. Your claim will be paid at the full allowable charge under either Key Advantage or Cost Alliance; however, members may be billed for

any amount that Trigon does not pay. Also, the claim payment will be mailed to the member, not the provider.

- Ask your referring physician to request a Trigon-participating anesthesiologist.

All other plan provisions and benefit levels will apply to services received in settings other than network hospitals. Please contact your Member Services representative if you need additional information.

---