**Plan Year 2013: PEIA Public Hearing Information**

***Overview and 2013 Plan Proposal***

* There were no additional state dollars from the Governor for PEIA in plan year 2012, but there was a premium increase for employees that did not participate in the wellness program ($10) and/or complete the living will ($4).
* Governor Tomblin has said he will increase the PEIA budget with state dollars by 4%, or $25 million, for plan year 2013.
* Medical rate of inflation is about 6.5% and Rx inflation is around 10%.
* As a result of no additional money from the Governor/Legislature last year and only a 4% increase this year, PEIA finds itself in a pretty big hole.
* The 80/20 rule prohibits a premium increase in plan year 2013 because of last year’s premium increase with no additional state dollars (It actually threw us out of 80/20 for the year).  The difference is made up in plan year 2013 by not increasing employee premiums, which bring us back to 80/20.

***Benefit reductions and increased participant costs proposed:***

* As a result, the board needs to “eliminate $42 million in benefits”.  The proposals can be piecemealed and amended, but the cuts will be substantive.
* The proposals are broken down by what each will save the plan, they are (for actives and retirees pre-65):
  + Capping the Pay Go Premium, aka the retiree subsidy, at $162 million with an escalator of $5million per year.  In the most recent legislative session, we agreed to a cap, but only if the escalator was a percentage and not a fixed dollar amount; and the subsidy was broken down by a per member per month calculation. **The cost to retirees under this proposal is off the charts.**
  + Close Tier 3 of the Rx formulary, which would change the formulary to look like $5 for Tier 1, $15 for Tier 2, 100% for all other drugs and $50 for specialty drugs.  It essentially means no coverage at all for Tier 3 drugs.  **It would affect 22,000 participants and cost participants about $24 million**.
  + Increase co-pay in the Rx formulary.  Instead of it looking like it does today, which is $5/$15/$50/$50 Sp., it would look like $8/$50/$85/$100 Sp.  **It would affect everyone and cost participants about $20.5 million**.
  + Eliminate PPI (proton-pump inhibitor) coverage, which are the gastric acid drugs.  Examples of PPIs include Nexium, Prevacid, Prilosec, and Aciphex.  According to PEIA’s medical doctor, the over-the-counter medications for PPIs have the same ingredients and make-up as the Rx medications.  **The cost to participants would be $6 million.**
  + Open a new West Virginia Only plan.  The new plan would only allow participants to use West Virginia providers.  It is anticipated this will save the plan about $5.4 million.
  + Eliminate coverage for the $4 Wal-Mart drugs.  **Not sure of the details on this, but the cost for participants is $4.5 million.**
  + Increase family out-of-pocket max from 1.5x to 2x for single coverage.  **The cost for participants is $3.8 million.**
  + Introduce imaging co-pay of $50.  **The cost is $3.4 million.**
  + Increase emergency room co-pay from $50 to $100. **The cost is $2.4 million**.
  + Make physical, occupational and speech therapy a medical necessity for coverage, with a $10 co-pay. **The cost is $1.8 million**.
  + The list goes on and on with savings under a million for each proposal.  **Some examples include introducing $500 co-pays for procedures like Hysterectomy, Knee Replacements, Hip Replacements, Gastric Bypasses, etc.**

***Recommendations/Talking Points***

# *General*

* School employees were given health benefits *in lieu* of a pay raise several years ago. Each year that premiums, co-pays, and out-of-pocket expenses are increased results in a *pay cut* for employees.
* In 1988, the employee share of PEIA was ZERO.
* State law mandates that PEIA should have an 80/20 premium split by 2007.
* Employees are paying *more money* for *fewer benefits*.
* West Virginia already faces a teacher shortage, particularly in critical need areas such as science, math, and foreign language. It will be difficult to attract and retain quality teachers with salary and benefit packages that are inferior to surrounding states. This will erode the quality of education delivered to WV children.
* The philosophy of these proposals flies in the face of what insurance is all about, which is about all participants sharing costs, not financially penalizing the sick.
* We should continue to strive to find innovative ways to expand the program and/or develop networks in/out of West Virginia to provide relief for active and retiree enrollees within PEIA.
* There is no reason for substantial benefit reductions when there is an excess reserve.  At the end of the 2012 fiscal year, the reserve is expected to be at $187 million. The PEIA Finance Board should use more of the excess reserve to offset at least some of the proposed benefit reductions.
* Of course, the traditional public hearing statements apply.  Some are:

o   The Board shouldn’t balance the state budget on the backs on actives and retirees.

o   The Governor should come up with more money to help offset the benefit reductions.

o   This is taking back PEIA benefits at its worst.

o   These proposals will increase the financial burden on the sickest participants of PEIA.

o   It is important to offer the Board solutions.  Most speakers complain without offering suggestions.  The Board is willing to consider options, provided they are offered.

***Specific Issues*:**

        The first, and possibly most important, issue is the Pay Go Premium.  As mentioned earlier, AFT-WV has agreed to a cap, but only if the escalator is a percentage and not a fixed dollar amount, as well as a per member per month calculation.  Here is why:  In year 1, if the cap is $5 million of $162 million (this is the cost of today’s retiree benefits) that represents a 3% increase.  In the following year, the cap is $167 million ($162 plus the $5).  If a flat dollar escalator is used, the percentage increase falls below 3%.  The difference really starts to show in the out years, let’s use year 10 as example:  The cap would be $212 million in year 10 ($162 plus 10 years of $5 million increases).  Moving to year 11, a $5 million increase amounts to a 2.3% increase.  As you can see, the further along we go, the lower the percentage increase, which amounts to additional costs placed on the backs of retirees.  That is why must ask the Board to use a percentage escalator instead of a fixed dollar amount escalator.  A supportive statement would be that health care costs are always broken down and based on percentages; the Board should not change the rules midstream in order to penalize retirees.   Additionally, we must break down the subsidy to a per member per month calculation.  The rationale is simple; each member is entitled to fair subsidy no matter the number of retirees.  Here is why:  If there are 10,000 retirees in year 1, each retiree would receive an annual subsidy of $16,200.  In year 2, without a per member per month adjustment, the retiree number increases to 11,000, which equates to an annual subsidy of $15,180, an amount that is $1,000 less than the previous year.  If a per member per month calculation is used, the subsidy is broken down individually and the increase of retirees does not affect the benefit.  Ted Cheatham is supportive of this, but we should remind him and the Board that this is the only fair way cap a benefit.

        There is no excuse for substantial benefit reductions when there is an excess reserve.  At the end of the 2012 fiscal year, the reserve is expected to be at $187 million, or 25% of the plan.  If the reserve is reduced to only 15%, which is still 5% higher than the statute says, that would free up roughly $80 million to offset benefit reductions.  Under the proposal, $17 million is removed from the reserve to offset benefit reductions, but it still leaves the reserve at 21% at the end of plan year 2013, which is well above the recommended amount.  We should encourage the Board to use more of the excess reserve to offset at least some of the proposed benefit reductions.

        There are 2 big ticket items related to Rx coverage.  One benefit change is worth $24 million and the other is worth $20 million.  It seems the trend under all of the proposals is that the participants who utilize more of the care should be paying more.  This is a slippery slope.  On one hand, I think utilizers should pay a little more for the coverage they receive; this is applied now in the form of co-pays.  On the other hand, that philosophy flies in the face of what insurance is all about, which is about sharing costs, not penalizing the sick.  A major plan change like one of these two options will be detrimental to those requiring 3rd Tier drugs.  If changes are made to the formulary, exceptions should be made for cases in which there is no Tier 1 or Tier 2 alternative.

        Offering a West Virginia Only plan may be a viable option for those that live in West Virginia’s “major” cities, but for many plan participants, it would simply not be an option.  In fact, the majority of West Virginians live in rural parts of the state within 50 miles of the border.  As a result, many folks can’t get the care they need in West Virginia.  This new plan would be attractive, at a 5% discount off of the Plan A rate, but it would decrease the pool of Plan A participants, resulting in increased costs for those that remain.  Note:  PEIA reimburses providers in WV less than 20 cents on the dollar.  Conversely, out-of-state providers are reimbursed at 93 cents on the dollar.  Hence, the trigger!