REPORT OF THE
DEPARTMENT OF PERSONNEL AND TRAINING

A Review of the Efficacy and Administration of the Commonwealth's Employee Benefits Program

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT. 7

COMMONWEALTH OF VIRGINIA
RICHMOND
1992

COMMONWEALTH *of* VIRGINIA

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December 3, 1991

MEMORANDUM

TO: The Honorable L. Douglas Wilder
The Commission on Health Care for All Virginians
Members of the General Assembly

FROM: Dorthula H. Powell-Woodson DHPW

SUBJECT: House Joint Resolution 421

The 1991 General Assembly, by House Joint Resolution 421, requested the Department of Personnel and Training to study the administration and efficacy of the state's employee health benefits program.

Enclosed for your review and consideration is the report of the Department of Personnel and Training that has been prepared in response to this Resolution.

/pwf
Enclosure

cc: The Honorable Ruby G. Martin

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A REVIEW OF THE EFFICACY AND ADMINISTRATION OF THE COMMONWEALTH'S EMPLOYEE HEALTH BENEFITS PROGRAM

Department of Personnel and Training

November, 1991

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EXECUTIVE SUMMARY

I. INTRODUCTION

House Joint Resolution (HJR) 421 directed the Department of Personnel and Training (DPT) to study the administration and efficacy of the state's health benefits program. Specifically, HJR 421 required the Department to: 1) review the health insurance options currently available to state employees; 2) assess the advantages and disadvantages of the health insurance options; 3) examine the recent increases in premiums; and 4) evaluate the effectiveness of the program's administration.

To respond to the issues presented in HJR 421, DPT employed several major study methods. DPT analyzed historical data regarding premiums, procurement practices and program administration; surveyed state employees; surveyed other states and local employers; and requested its independent benefits consultant and actuary, William M. Mercer, Inc. (Mercer), to analyze and comment on various aspects of the program.

II. FINDINGS

A. Health Plan Options

1. Active Employees (see page III-1)

- The health benefits program is designed to provide every state employee, regardless of geographic location, a choice of at least two health plan options. The Basic plan is available statewide to all employees, at no cost to them.

- In addition to the Basic Plan, optional plans (KeyCare and Cost Awareness), which provide a higher level of benefits, also are made available to employees.

- In the Richmond, Tidewater, and Northern Virginia areas of the state, employees also have the option of obtaining coverage from private Health Maintenance Organizations (HMO's).

2. Retired Employees (see page III-6)

- Retirees under the age of 65, or who otherwise are not eligible for Medicare, may continue to participate in any of the options available to active employees.

- Retirees who are eligible for Medicare may enroll in an HMO, if they reside within the HMO's service area. DPT also provides two other Medicare complementary plans, Option I and Option II, on a statewide basis.

B. Relative Advantages and Disadvantages of Health Plan Options (see page IV-1)

- In any health benefits program, employees' views on the advantages and disadvantages of a particular benefit plan vary according to the medical needs of each employee.

- An analysis of the relative advantages and disadvantages of the state's health benefits plan options is presented on page IV-2.

C. Comparison of Virginia's Health Benefits With Other Employers

1. Comparison of Virginia's Health Benefits With Other Virginia Employers (see page IV-1)

- Mercer advised DPT that, overall, the Commonwealth's health benefits are comparable to other large Virginia employers.

- Mercer concluded that the structure of the program, which incorporates a variety of health plan options, is equal to or better than most large Virginia employers.

2. Comparison of Virginia's Health Benefits With Other States (see page IV-3)

- Unlike the Commonwealth's health benefits plan options, many states have instituted lower cost "comprehensive" benefit plans

(i.e. plans that require employees to pay a $100-$300 deductible and 20% co-insurance) as a means of holding down health insurance costs.

- In its 1991 Survey of State Employee Health Benefits Plans, the Martin E. Segal Company reported that 28 states had adopted comprehensive benefit plans. Virginia is one of 22 states which has retained a higher level of benefits as its statewide standard plan for employees.

3. Employees' Views About the State's Health Benefits Plans (see page IV-7)

   - Based on a survey of state employees, 43% of the Commonwealth's employees are "very satisfied" with their health benefits, and an additional 43% are "somewhat satisfied." Only 10% of employees reported being "somewhat dissatisfied" with their benefits, and 2% reported being "very dissatisfied."

D. Health Benefits Premiums

1. Premium-Setting Process (see page V-1)

   - For the Basic, KeyCare, and Cost Awareness plans offered to state employees, the premiums are based on two actuarial estimates, one by Mercer (DPT's independent consultant) and the other by Blue Cross and Blue Shield of Virginia (BCBSVA).

   - Premiums for HMO coverage are determined as part of the competitive procurement process used to select the HMO plans. Annual increases in the premiums charged by each HMO are limited to the percentage increase which the HMO files with the State Corporation Commission's Bureau of Insurance each year.

2. State and Employee Premium Contributions (see page V-2)

- o Section 2.1-20.1 of the Code of Virginia mandates that the Commonwealth pay the cost of employee-only coverage under the statewide plan (Basic). This same amount is paid toward the cost of the optional coverages (i.e. KeyCare, Cost Awareness, and the HMO's).
- o In addition to paying 100% of the cost of the employee's coverage, the Commonwealth also pays 52% of the cost of dependent coverage under the Basic plan.
- o Overall, the Commonwealth pays approximately 75% of the total cost of the health benefits program.

E. Recent Premium Increases

1. General (see page V-6)

- o The total amount paid by the Commonwealth for employee health insurance has increased from approximately $121.5 million in fiscal year (FY) 1988, to $228.9 million in FY 1991, an increase of $107.4 million.
- o The total amount paid by employees has increased from approximately $26.3 million in FY 1988, to $62.6 million in FY 1991, an increase of $36.3 million.
- o In 1990, the premium for employee-only coverage under the Basic plan increased 20%. In 1991, this premium increased another 30%. Premiums for family coverage and the optional plans also increased significantly in 1990 and 1991.

2. Reasons for Premium Increases (see page V-8)

- o Two key reasons for the Commonwealth's premium increases in 1990 and 1991 were medical cost inflation, and increases in the utilization of health care services by employees.

interest earnings on the balance of the health insurance fund. The health insurance fund earned approximately $11.2 million in interest income during fiscal years (FY) 1990 and 1991.

3. Managing Claims and Supplying Provider Networks for the Self-Insured Health Plans (see page VI-7)

   - DPT pays an administrative fee to its current program administrator, Blue Cross and Blue Shield of Virginia (BCBSVA), to manage claims and supply provider networks for the self-insured health plans.

   - The administrative fee paid to BCBSVA for these services is a fixed price per contract unit administered each month, and is not related to the number of claims processed, the amount of the claims, or the premiums charged to employees.

   - Approximately 97% of the premiums paid by the Commonwealth and employees are used to pay medical claims incurred by employees. Only 3% of the premiums are used to pay for administrative expenses.

III. RECOMMENDATIONS

A. Program Design and Cost Containment

1. DPT should continue to evaluate and implement effective cost containment programs to help control the rising cost of health insurance.

2. As required by Item 61 of the 1991 Appropriation Act, DPT will present a plan to the Governor and the 1992 General Assembly to revise the design of the health benefits program.

B. Program Administration

1. Prior to establishing new provider networks, particularly in rural areas, DPT should verify

that BCBSVA has met all of its criteria for ensuring that employees have adequate access to network providers.

2. DPT should implement the recommendations made by the Auditor of Public Accounts following its review of the health benefits program's financial controls and accounting procedures.

3. DPT should ensure that BCBSVA implements the necessary modifications to its claims processing systems such that all contractual performance standards are being met.

4. DPT should work with its consultant, William M. Mercer, Inc., and BCBSVA to revise the financial performance standards contained in its contract with BCBSVA to reflect more competitive performance levels.

5. The Commonwealth should increase the state's contribution to family coverage for those families with two state employees such that the contribution represents 100% of the cost of each employees' coverage plus 52% of the cost of the dependents' coverage.

C. Communications and Education

1. DPT should make available more information regarding the health benefits program so that employees and others understand the administration of the program, the procurement process, the premium-setting process, and other critical aspects of the program.

2. DPT should conduct an annual survey of employees to determine their views and satisfaction with the benefits and services provided through the program. DPT should give careful consideration to the results of the survey when changes to the program are being contemplated.

I. INTRODUCTION

A. Purpose of Study

The 1991 session of the General Assembly passed House Joint Resolution (HJR) 421 (see Appendix A). HJR 421 directed the Department of Personnel and Training (DPT) to study the administration and efficacy of the state's health benefits program. Specifically, HJR 421 required the Department to:

1. review the health insurance options currently available to state employees, including the equity of options offered to both married and single state employees;

2. assess the advantages and disadvantages of the health insurance options, particularly their impact on state workers in rural areas;

3. examine the recent increases in employee and state contributions toward the various options, and compare these increases with past adjustments; and

4. evaluate the effectiveness of the program's administration.

B. Study Methods

To respond to the issues presented in HJR 421, DPT employed several major study methods.

1. A review of the current literature on the administration and management of health benefits programs, including data on the increased cost of health care, was conducted.

2. Historical data maintained by DPT, as well as Blue Cross and Blue Shield of Virginia (BCBSVA) regarding premiums, procurement practices, program administration, and plan options, were reviewed and analyzed.

3. A survey of state employees regarding their satisfaction with the benefits and services

provided by the health benefits program was conducted.

4. A survey of the other 49 states, as well as 42 local governments, and 41 private employers, was conducted to obtain information regarding the administration of other health benefits programs.

5. DPT's independent consultant, William M. Mercer, Inc., was asked to analyze and comment on various aspects of the design, administration, and effectiveness of the health benefits program.

II. STATUTORY AUTHORITY AND ORGANIZATION OF HEALTH BENEFITS PROGRAM

A. Statutory Authority

Section 2.1-20.1 of the Code of Virginia (see Appendix B) establishes the state's health benefits program. Section 2.1-20.1 provides that the Governor shall establish a plan for providing health insurance coverage for state employees and retired employees, with the Commonwealth paying the cost thereof. Additionally, this section states that the health insurance plan shall provide a means by which coverage for families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost for dependents, and the employee must pay that portion of the cost not paid by the Commonwealth. Section 2.1-20.1 provides that DPT will administer the program.

Section 2.1-20.1 also states that all appropriations, premiums, and other payments shall be deposited into the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. This provision establishes the state's health insurance program as a "self-insured" program. (The advantages of the state program being self-insured are discussed in Section VI of this report.)

Section 2.1-20.1:01 of the Code of Virginia establishes the State Health Benefits Advisory Council. Three members of the Council are appointed by the Governor, two members are appointed by the Speaker of the House of Delegates, and two members are appointed by the President Pro Tempore of the Senate. The Council is comprised of representatives of active as well as retired employees. The Council advises the Secretary of Administration and DPT on issues pertaining to the administration of the program.

Section 2.1-20.1:02 of the Code of Virginia establishes the health benefits program for local governments, school divisions and constitutional

officers. In accordance with this section, DPT offers localities the same health benefits plans available to state employees and retirees. This statute provides that the income and expenses of the local plan shall be calculated independently from the plan established for state employees. As with the state employee health benefits program, an advisory committee has been statutorily created to assist DPT in the design and administration of the local program. The members of this advisory committee are appointed by the Governor.

Section 2.1-20.1:2 of the Code of Virginia establishes the retiree health insurance credit. State retirees with at least 15 years of creditable state service are provided a credit toward the cost of their health insurance of $1.50 per month for each year of service, up to a maximum of $45.00 per month. The Virginia Retirement System (VRS) assists DPT in the administration of this credit.

B. Program Regulations

As provided in section 2.1-20.1:02 of the Code of Virginia, DPT developed and published a set of program regulations which provide the administrative framework for administering the state and local health benefits programs. The regulations were developed and promulgated in accordance with the Administrative Procedures Act (APA). As required by the APA, draft regulations were published for public comment. In addition, a public hearing was held to obtain additional comment on the regulations. The final regulations were published in October, 1990.

C. Program Organization

The Office of State and Local Health Benefits Programs (OSLHBP) within DPT administers the health benefits program. This office is comprised of a Contracts Section and an Administration Section. The Contracts Section oversees the procurement of the health benefits plans, manages the contracts with the various health care vendors, and manages the income and expenses of the health insurance fund.

The Administration Section is responsible for the day-to-day administration of the program, including resolving claims payment problems, determining eligibility for benefits, and assisting employees to understand and utilize their health care benefits.

III. HEALTH PLAN OPTIONS AND TYPES OF MEMBERSHIP

A. Health Plan Options (Active Employees)

Section 2.1-20.1 of the Code of Virginia requires that a statewide health benefits plan be offered to all state employees. Under the statewide plan, the Commonwealth pays the entire cost of the employee's coverage and approximately 52 percent of the cost for dependents. In addition to the statewide plan, optional coverages, which provide a higher level of coverage, also are made available to employees. Finally, employees are provided the option of obtaining coverage from private Health Maintenance Organizations (HMO's) in those areas of the state where HMO services are available.

The state's health benefits program consists of insured health benefits plans (HMO's) and self-insured plans (i.e. the statewide plan and two optional coverage plans). (Section VI of this report provides more detailed information about the significance of self-insurance.) The health benefits program is designed to provide every state employee, regardless of geographic location, a choice of at least two health plan options. In the Richmond, Tidewater, and Northern Virginia areas of the state, employees have four plan options. Appendix C illustrates which plans are offered in each region of the state.

In Appendix D, a detailed comparison of the benefits of each plan is provided. The following information is a brief overview of the current plan offerings.

1. Plan Descriptions (Self-Insured Portion of the Program)

a. Basic Plan

The Basic plan is administered by BCBSVA as part of the self-insured component of the overall program. The Basic plan is offered statewide. Under this plan, employees and their dependents have the freedom to choose or change their physicians and to seek the

services of a specialist without referral from a primary care physician. Employees are free to select any hospital appropriate for the type of care needed. (Employees receive maximum benefits if care is received from hospitals and physicians which contract with BCBSVA.) Benefits are provided for hospital and physician services, with no deductible or copayment for outpatient hospital surgery, diagnostic tests, and immediate treatment of accidental injuries. The Basic plan provides 120 days of inpatient hospital care per confinement and 120 days of inpatient care per calendar year for psychiatric conditions. For both types of inpatient hospital care, the employee pays a $100 deductible.

Physician services (doctors' office visits) are paid at 80% under the major medical portion of the plan after the enrollee has satisfied a $200 deductible. Once the enrollee has incurred $1,160 in out-of-pocket expenses, the plan pays 100% of physician services.

b. KeyCare and Cost Awareness

KeyCare and Cost Awareness are Preferred Provider Organization (PPO) health benefits plans. PPO's require enrollees to receive care from "preferred" providers (hospitals and physicians) in order to receive the maximum level of benefits available through the plan. These plans, which are the optional coverages offered under the self-insured component of the overall program, are administered by BCBSVA.

The benefits of KeyCare and Cost Awareness are identical. The only difference is that KeyCare is offered in those areas of the state where BCBSVA has established networks of providers who agree to receive a lower reimbursement in return for increased patient flow. Cost Awareness is offered where KeyCare networks have not been established. (The establishment of KeyCare

networks is discussed later in this section of the report.)

Under KeyCare and Cost Awareness, employees receive 365 days of inpatient hospital care (employees pay a $100 deductible). The plans provide 30 days of inpatient psychiatric care per calendar year. Doctors' office visits and "well-baby" visits are paid at 100% with the enrollee paying a $10 deductible for each visit. The plans also provide up to $1,000 per year in dental benefits.

In order to receive the full benefits of KeyCare, enrollees must receive services from a KeyCare participating provider. The KeyCare provider network is a subset of the overall group of providers who contract with BCBSVA. When services are received from a non-KeyCare provider, the enrollee is responsible for paying 25% of the KeyCare allowable charge, plus any balance between the provider's charges and the plan payment.

Because Cost Awareness is offered in areas where BCBSVA has not established a KeyCare provider network, enrollees need only receive their services from any BCBSVA contracting provider to receive the full benefits of the plan.

c. Prescription Drug Benefit

DPT contracts with PCS, Inc. to administer the outpatient prescription drug benefit. Baxter Healthcare Corporation provides the mail order drug services through a subcontract with PCS, Inc. The PCS/Baxter prescription drug benefit is included in each of the BCBSVA plans and the CIGNA HMO plan.

Through the outpatient prescription drug program, employees can purchase up to a 34-day supply of a covered drug for $8.00 at any pharmacy which participates in the PCS,

Inc. program. (All pharmacies are eligible to participate in the PCS, Inc. program. Currently, approximately 95% of all Virginia pharmacies participate in the PCS, Inc. program.) Employees also can purchase long term or maintenance prescriptions (in amounts greater than a 34 day supply) through the Baxter mail order pharmacy for a $6.00 copayment for each such prescription. Additionally, there are approximately 130 local pharmacies throughout the state which are classified as "walk-in maintenance" pharmacies. Employees can purchase their maintenance prescriptions at these pharmacies for the same $6.00 copayment.

2. Health Maintenance Organizations (HMO's)

DPT first offered HMO's to employees in 1985. HMO's are classified as either an Independent Practice Association (IPA) model HMO or a Group/Staff model HMO. IPA type HMO's contract with numerous physicians to provide services to enrollees in their individual practice settings. Group/staff model HMO's either employ or contract with a specific group of doctors to provide care to enrollees at a centralized location. In both types of HMO's, enrollees must choose a "primary care physician" who manages the enrollee's health care services. To access care, enrollees must receive care from the primary care physician or be referred by the primary care physician to a specialist.

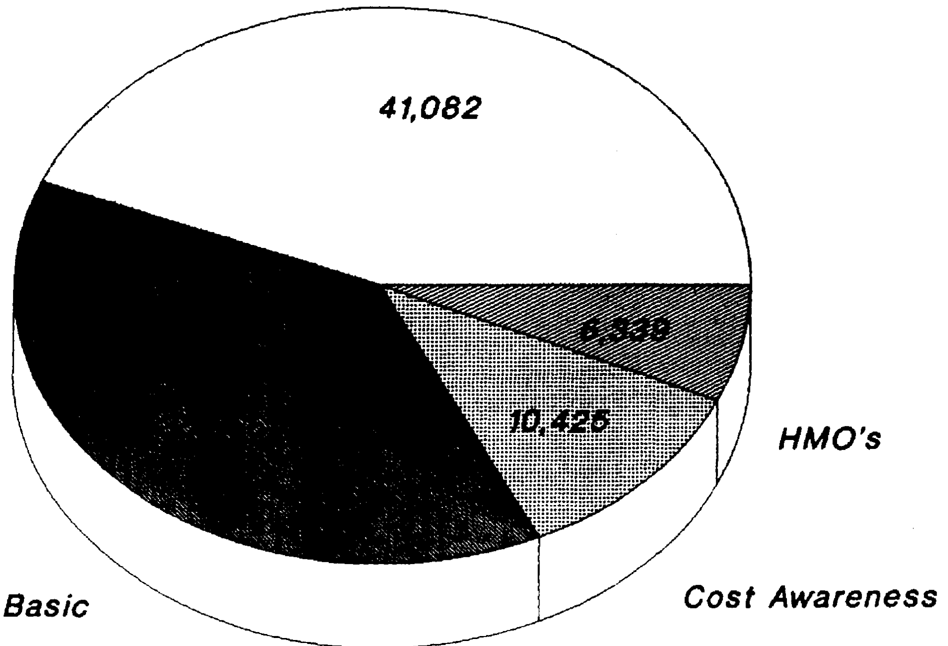
In those areas of the state where HMO's are available (see Appendix C), DPT offers one IPA model HMO and one Group/Staff Model HMO. In Richmond and Tidewater, the IPA model HMO is CIGNA (formerly EQUICOR). In Northern Virginia the IPA model HMO is M.D. IPA. The Group/Staff model HMO's are PruCare in Richmond, Sentara in Tidewater, and Kaiser Permanente in Northern Virginia.

The benefits are similar in all of the HMO's offered. (A detailed description of each HMO benefit is presented in Appendix D.) With each

HMO, all necessary inpatient hospital care is paid at 100% with no deductible. Inpatient psychiatric care is limited to 30 days per year. Doctors' office visits, including preventive care, are covered at 100% with the employee paying a copayment, ranging from $5 to $10, depending on the type of care received. All HMO's, except CIGNA, provide their own coverage for outpatient prescription drugs. (The PCS/Baxter drug benefit is incorporated in the CIGNA HMO benefits.) Copayments for prescription drugs range from $3 to $10, depending on the type of drug prescribed, and whether the drug is purchased at one of the HMO's participating pharmacies.

Table III-1 illustrates the number of employees enrolled in each of the health benefit plan options available to active employees.

Table III-1
Enrollment in Health Benefits Plans - June, 1991



Source: DPT

B. Health Plan Options (Retired Employees)

Retirees under age 65, may continue to participate in any of the options described above. Of those under 65 or not eligible for Medicare, approximately 5,700 retirees are enrolled in the Basic plan; 1,500 retirees are enrolled in KeyCare and Cost Awareness; and approximately 290 retirees are enrolled in the HMO plans.

Retirees who are eligible for Medicare may enroll in one of several plans designed to complement their Medicare coverage. Retirees eligible for Medicare may enroll in an HMO, if they reside within an HMO's service area. In addition, DPT provides two other plans, Option I and Option II, on a statewide basis. Both plans provide coverage for the Medicare Part A inpatient hospital deductible (except $100) and Medicare's inpatient coinsurance requirement. Other key provisions of these two plans are as follows:

- o Option I: Option I provides coverage for the Medicare Part B (physician services) deductible and coinsurance, after $1,000 in out-of-pocket expenses for physician services has been incurred. The PCS/Baxter outpatient prescription drug benefit is included in Option I, as well as vision care and dental benefits. Approximately 8,000 retirees are enrolled in Option I.

- o Option II: Option II provides full coverage of the Medicare Part B deductible and coinsurance requirements. There are no dental or vision care benefits. Outpatient prescription drugs are covered under the Major Medical portion of the plan. Approximately 9,000 retirees are enrolled in Option II.

Appendix D contains a complete description of the Option I and Option II benefits.

C. Membership Options

Currently, there are three primary membership options available to state employees:

- o Employee-Only - This membership provides coverage solely for the employee. No dependents can be covered under this membership option.
- o Dual - This membership was instituted January 1, 1991, and provides coverage for the employee and one eligible dependent (i.e. a spouse or child).
- o Family - This membership provides coverage for the employee and all other eligible family members (i.e. spouse and/or children).

In addition to the primary membership options, several Medicare "carve-out" options are available for employees or dependents who are eligible for Medicare due to "end stage" renal disease. A "carve-out" membership provides the same level of benefits as provided through the three primary membership options. However, the employee's Medicare coverage is the primary payor of claims, and the state plan coordinates its payments with Medicare.

The state's contribution toward the cost of each employee's health benefits coverage depends on the type of membership the employee selects. Detailed information on the state's contribution to employees' health benefits coverage is presented in Section V-B of this report.

IV. QUALITY OF THE STATE'S HEALTH BENEFITS PLANS

A. Advantages and Disadvantages of Health Plan Options

In any health benefits program, the advantages and disadvantages of a particular benefit plan to employees vary according to the needs of each employee. For instance, an employee who is in need of psychiatric services will view the inpatient psychiatric benefit available through the Basic plan (120 days) as a significant advantage over that provided under KeyCare (30 days). However, employees who do not need such extensive psychiatric services perhaps would view the benefit as unnecessary. Similarly, employees who are enrolled in a benefit plan which offers a "well-baby" benefit may view the benefit as an advantage or disadvantage, depending on whether the employees have children.

Because there is a finite amount of funding available for benefits, some employees who do not utilize a certain benefit may view the benefit as a disadvantage because they believe that the funding could be used to purchase another benefit that they can utilize. While some individuals may have different views on the advantages and disadvantages of each health benefits plan, Table IV-1 (page IV-2) presents an analysis of the relative advantages and disadvantages of the state's health benefits plan options.

When employees choose among various health benefit plans to take advantage of specific benefit levels, "adverse selection" occurs. Adverse selection increases the overall cost of a health benefits program because employees "select" the benefit plan they can use the most. As a result, utilization of services increases which leads to increased program costs.

B. Comparison of Virginia's Health Benefits With Other Employers

1. Comparison of Virginia's Health Benefits With Other Virginia Employers

TABLE IV-1

STATE HEALTH BENEFITS PLANS

ADVANTAGES AND DISADVANTAGES

	BASIC	KEYCARE	COST AWARENESS	HMOs*	OPTION I (RETIREES)	OPTION II (RETIREES)
ADVANTAGES	- lowest premium of available plans - coverage is free to employees with single coverage - freedom to choose and change physicians, and select hospitals - 120-day inpatient psychiatric benefit - available statewide	- 365-day inpatient hospital benefit - physician services covered after $10 deductible - well-baby care through age 5 - dental coverage (maximum $1,000 per year)	- same as KeyCare - enrollees can access care from any BCBSVA participating provider	- highest level of benefits - preventive care for all enrollees - dental coverage** - low deductibles and copayments	- low premium ($52.00/month) - PCS/Baxter prescription drug benefit - dental benefit - vision care benefit	- Medicare Part B (physician services) deductibles and co-insurance is paid in full
DISADVANTAGES	- 120-day inpatient hospital benefit is less than other plans - no coverage for preventive care - no dental benefit - physicians' office visits subject to deductible and co-insurance	- in order to receive full benefits, enrollees must receive care from KeyCare participating physician - employee share of premium greater than Basic plan	- enrollees must pay a greater share of premium than with Basic or KeyCare	- generally, HMO premiums are higher than BCBSVA plans - enrollees must access care through a primary care physician - HMO plans provide no coverage unless care is provided by or approved by primary care physician***	- physician services are not covered until retiree has incurred $1,000 in out-of-pocket expenses	- higher premium ($100.75/month) - no dental or vision benefits - prescription drugs are paid at 80% through Major Medical rather than PCS/Baxter benefit

*While HMO benefits vary somewhat among the five HMO plans, the advantages and disadvantages of HMO coverage apply to each.
**Except Kaiser and MD IPA.
***Except in emergencies.

DPT requested its benefits consultant, William M. Mercer, Inc. (Mercer), to compare the state's health benefits program with the programs offered by other large employers in Virginia.

A synopsis of Mercer's comparative analysis is presented below:

- Overall, the state's health benefits are comparable to those of other large Virginia employers. The structure of the health benefits program, which incorporates several different plan options (i.e. Basic, KeyCare, Cost Awareness, and HMO's), is equal to or better than most large Virginia employers.

- The Commonwealth's health care utilization control efforts are similar to those that have been implemented by other large employers. However, the Commonwealth instituted its controls several years prior to most other employers.

- The dental benefits offered through the Commonwealth's plans are not as extensive as those of many large Virginia employers. However, the Commonwealth's medical reimbursement account program enables employees to pay for additional dental services, as well as other eligible medical expenses, on a tax-free basis.

- The Commonwealth's initiatives in health promotion (i.e. CommonHealth wellness program) ranks the state with the best of private sector employers in Virginia.

2. Comparison of Virginia's Health Benefits With Other States

As employers wrestle with the rapidly increasing cost of health care, one of the

more common means of reducing employers' health insurance costs is to shift costs to employees and, in some cases, also reduce benefits. Unlike the Commonwealth's health benefits plan options, many states have instituted "comprehensive" benefit plans as a means of holding down costs. Under a typical comprehensive plan, the employee pays a deductible totalling between $100 and $300 before the plan pays for any services. Once the employee has met the deductible, the plan pays 80% of the costs, while the employee pays the other 20%. Once the employee has reached a "stop-loss limit" (generally between $1000 - $2000) the plan begins paying 100% of the employee's health care costs. The actuarial value to employees of a comprehensive benefit plan is approximately 18-20 percent lower than the Commonwealth's Basic plan.

In its 1991 Survey of State Employee Health Benefits Plans, the Martin E. Segal Company (an international benefits consultant) reported that 28 states had adopted comprehensive benefit plans. Virginia is one of 22 states which has retained a higher level of benefits as its statewide plan for employees.

C. Impact of Health Benefit Plan Options on Employees Living in Rural Areas

As noted earlier, all state employees, regardless of where they reside, have at least two health plan options available to them. In 1985, DPT began offering HMO plans for employees living in the Richmond, Tidewater and Northern Virginia areas. Prior to 1986, the only health benefits plan available to state employees residing in areas other than Richmond, Tidewater and Northern Virginia was the Basic plan. In 1986, DPT established the KeyCare and Cost Awareness benefit plans. One key reason for implementing the KeyCare and Cost Awareness plans was to provide an enhanced benefit option to employees living outside of the three major metropolitan areas.

1. General Comparison of KeyCare and Cost Awareness

   KeyCare was implemented in those areas of the state where BCBSVA had negotiated discounts with physicians and hospitals (i.e. had developed provider networks). However, there still were many rural areas of the state where BCBSVA was unable to institute KeyCare networks. As a result, DPT established the Cost Awareness program for employees living outside of the KeyCare areas. As noted earlier, the benefits of Cost Awareness are identical to KeyCare. The only difference in the plans is that employees living in a KeyCare area must receive care from a KeyCare participating provider in order to receive the full benefits of the plan. Because there were no networks to utilize in the non-KeyCare (rural) areas, employees were allowed to access care from any BCBSVA participating provider. The Cost Awareness plan was implemented as an interim measure until BCBSVA could develop KeyCare networks.

   As BCBSVA expands the KeyCare network, Cost Awareness areas become KeyCare areas. Establishing new KeyCare areas is a critical and necessary step in holding down the rising cost of health care. The KeyCare plan generates significant provider discounts for the state program. Reimbursements to hospitals are 3-4% less under KeyCare than through Cost Awareness. Reimbursements for physician services are approximately 6% less than those provided through the Cost Awareness plan. These discounts translate into substantial savings for the Commonwealth and employees.

2. Comparison of Costs of KeyCare and Cost Awareness

   Because of the provider discounts that are generated through the KeyCare program, the KeyCare benefit has an actuarial value approximately 5% less than the Cost Awareness plan. Despite the difference in value, employees living in the rural areas and participating in Cost Awareness, were charged

the same premium as KeyCare enrollees. Thus, employees in the rural areas were subsidized by the provider discounts generated by KeyCare. As part of the Department's response to a 1990 General Assembly requirement to reduce program costs by $9.4 million, the Department began charging Cost Awareness enrollees a higher premium that more accurately reflects the true cost to deliver the Cost Awareness benefits to employees living in areas where provider discounts are not available. The Cost Awareness premium change became effective January 1, 1991.

3. Provider Networks in Rural Areas

BCBSVA, as well as all other insurance companies and HMO's, have had difficulty establishing provider networks in rural areas of the state because of less competition among providers due to their scarcity, and less incentives to offer providers due to the scarcity of patients to direct to them.

Currently, there are no HMO's operating outside of the Richmond, Tidewater and Northern Virginia areas that DPT can offer to employees. Further, due to the difficulty in establishing effective provider networks in rural areas, there are no additional provider discounts that can be passed on to employees in the form of lower premiums.

The difficulty in establishing effective provider networks in rural areas was evidenced by the recent expansion of the KeyCare network that became effective January 1, 1991. In order to take advantage of the provider discounts available through KeyCare, DPT expanded the KeyCare network in Northern Virginia and the Roanoke and New River Valley areas of the state. In several rural areas of the network, BCBSVA was unable to establish a sufficient number of providers to ensure reasonable access to care. As a result, DPT arranged with BCBSVA to provide a waiver that allowed the employees living in these areas to

receive care from non-KeyCare providers without penalty.

D. Use of Zip Codes to Denote Health Benefit Plan Service Areas

DPT historically has used zip codes to denote the service areas for KeyCare, Cost Awareness, and the HMO's. The use of zip codes followed the federal government's practice of using zip codes to define service areas for federally-qualified HMO's.

However, today, federal regulations permit the use of city and county boundaries to define HMO service areas. The Department currently is converting its computerized employee eligibility files from zip code designations to city and county designations. This conversion process is expected to be completed by the October, 1991, enrollment period.

The Department's practice of defining service areas by zip codes has caused isolated instances where employees, who live in an area intended to be designated as a Cost Awareness area, fall within a KeyCare service area. In these isolated instances, some employees have expressed dissatisfaction about having to utilize the KeyCare network because they live in an area intended to be designated as a Cost Awareness area. By utilizing city and county boundaries to define service areas, this issue will be resolved.

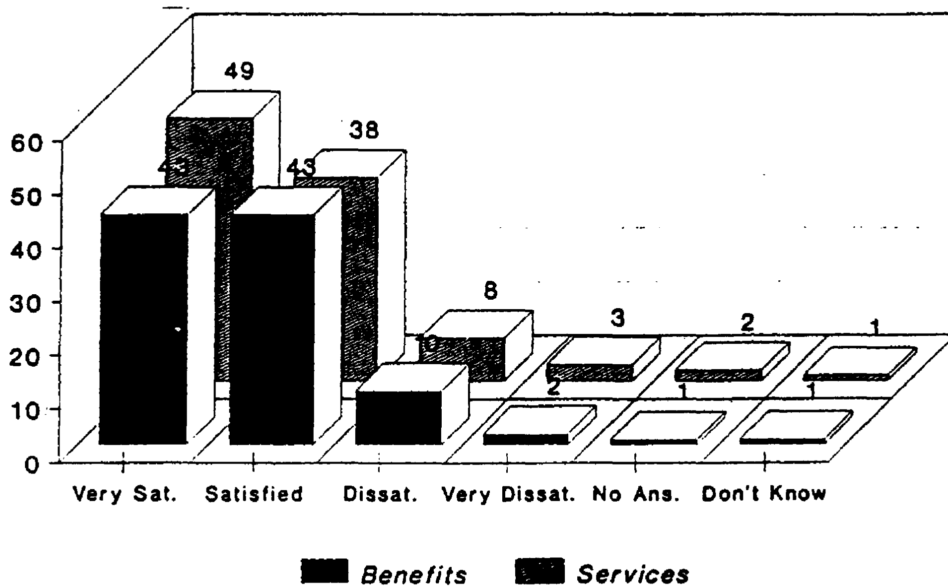
E. Employees' Views About the State's Health Benefits Plans

In order to assess employees' views about the state's health benefits plans, DPT contracted with the Survey and Research Laboratory of Virginia Commonwealth University (VCU) to conduct a telephone survey of state employees. VCU surveyed 1,129 employees. The survey sample was selected randomly from DPT computer files. The survey was developed to provide specific information for this study as well as general information for other health benefits projects.

The two survey questions most pertinent to this study asked employees how satisfied they were with the services and the benefits of the health benefits plan (BCBSVA Basic, KeyCare, etc.) in which they currently are enrolled. As seen in Table IV-2, overall, 43% of employees are "very satisfied" with their health benefits, and an additional 43% are "somewhat satisfied." Only 10% of employees reported being "somewhat dissatisfied" with their benefits, and 2% reported being "very dissatisfied." Similarly, 49% of employees indicated they are very satisfied with the services (i.e. claims payments, customer service) of their health benefits plan, and 38% stated they are somewhat satisfied with the services. Eight percent of employees reported they are somewhat dissatisfied with the services, and 3% stated they are very dissatisfied.

Table IV-2

Employees' Satisfaction with Benefits and Services



Source: Employee Survey by DPT

Employees' responses also were analyzed with respect to each of the three BCBSVA plans. (The number of responses from employees enrolled in the HMO plans was not large enough to make definitive statements regarding employees' satisfaction with each HMO plan.) Regarding the overall satisfaction with the benefits provided by the BCBSVA Basic plan, 34% of the employees were very satisfied and 50% were somewhat satisfied. For KeyCare, the survey showed that 51% were very satisfied and 37% were somewhat satisfied. For Cost Awareness, 50% were very satisfied, and 40% were somewhat satisfied.

With respect to the services of the BCBSVA Basic plan, 43% of the employees were very satisfied, and 43% were somewhat satisfied. For KeyCare and Cost Awareness the ratings were identical, 53% indicated they were very satisfied, and 35% indicated they were somewhat satisfied.

Employees' satisfaction with the health benefits plans also was analyzed by geographic region of the state to ascertain if there were significant differences among employees living in rural areas. Appendix E contains a map of the state which illustrates how employees' responses were analyzed by regions of the state. While there are some differences by region, the large majority of employees in all regions are satisfied or very satisfied with their benefits. The overall satisfaction rating (very satisfied, somewhat satisfied) concerning the benefits provided, ranged from 76% in the Northern region to 88% in the Northwest, Central, and Eastern regions. The overall satisfaction rating in the Southwest region was 81%.

Employees' satisfaction with the services of their health benefits plan also was analyzed by region. The overall satisfaction ratings (very satisfied, somewhat satisfied) were as follows: Southwest-79%; Northern-81%; Central-88%; Northwest-89%; and Eastern Region-91%.

F. Conclusions

The state's health benefits program provides employees in all areas of the state with at least two benefit plan options. While there are relative advantages and disadvantages to each plan, employees are free to select which plan offers them the most advantages and least disadvantages, depending on their individual circumstances.

Virginia's health benefits program is comparable to the health benefits programs of other large employers in Virginia. Nationally, Virginia's health benefits program provides a higher level of benefits than 28 other states.

Based on the results of the employee survey, a large majority of employees are satisfied with their health benefits plan, both in terms of the level of benefits and the services provided. Employee satisfaction rates are consistently high throughout all areas of the state, including employees who live in rural areas.

In light of the significant provider discounts that are generated through restricted network plans (i.e. KeyCare), DPT broadened the KeyCare network to maximize program savings, and hold down future premium increases. However, due to the fewer number of providers (hospitals and physicians) in rural areas, the KeyCare provider networks may be insufficient for employees living in these areas. In these instances, DPT should continue its practice of providing employees with a waiver that allows them to receive care from a non-KeyCare provider without penalty. When developing new KeyCare areas, DPT should verify that BCBSVA has met all of the criteria for ensuring employees have adequate access to network providers prior to broadening the KeyCare network.

V. HEALTH BENEFITS PREMIUMS

A. Premium-Setting Process

Premiums are the only source of income for the health benefits program. Premiums paid by the Commonwealth and employees are needed to pay the claims costs and administrative expenses of the program.

The premiums for HMO coverage are determined by each HMO as part of the competitive negotiation process outlined in Section III of this report. Annual increases in the premiums charged by each HMO are limited to the percentage increase which the HMO files with the Bureau of Insurance each year.

For the Basic, KeyCare, and Cost Awareness plans offered to state employees, the premiums are based on two actuarial estimates, one by Mercer (DPT's independent consultant) and the other by BCBSVA. The actuarial estimates project, based upon recent claims history and anticipated claims costs, the amount of income that will be needed by the program to pay claims and administrative expenses for the ensuing fiscal year. Approximately 97% of the premiums paid by the Commonwealth and employees goes to pay the medical claims incurred by employees. Only 3% of the premiums pays for administrative expenses.

Included in each actuarial analysis is an estimate of a reserve for claims which have been incurred but not reported (IBNR) during the year. This reserve ensures that the program will have sufficient cash balances on hand to pay all claims incurred in a given year.

DPT reviews the two actuarial estimates, and together with the two actuaries, establishes the recommended premiums. DPT then provides the Department of Planning and Budget (DPB) the recommended premiums for the budget. The premiums, including the amounts paid by the Commonwealth and employees, are reviewed by the legislature as part of the overall budget process.

The actuarial estimates project the expected cost of the premium for employee-only coverage under the BCBSVA Basic plan. Because the benefits of the KeyCare plan have an actuarial value 5% greater than the Basic plan, the KeyCare premium is set at 1.05 times the cost of Basic. Similarly, the actuarial value of Cost Awareness is 10% greater than Basic, and thus, the Cost Awareness premium is set 1.10 times the cost of Basic.

The premium for dual membership (two persons) under each plan is calculated to be two times the employee-only premium. The premium for family coverage is calculated to be 2.8 times the employee-only premium. (This factor can change from time to time based on the actual cost of claims of family members.)

When the program expenses for a given year exceed the premium income, the reserve fund (IBNR) must be used to pay the unanticipated expenses. However, in order to replenish the IBNR, the deficit amount must be factored into the calculation of the following year's premium. Likewise, if the premium income exceeds program expenses, the surplus is factored into the actuarial estimate of the premium income needed for the following year.

B. State and Employee Premium Contributions

1. Cost-Sharing Formula

Section 2.1-20.1 of the Code of Virginia mandates that the Commonwealth pay the cost of employee-only coverage under the statewide plan (Basic). This same amount is paid toward the cost of the optional coverages (i.e. KeyCare, Cost Awareness, and the HMO's). Any difference between the state's contribution and the total premium for these optional coverages is paid by the employee.

There is no statutory requirement that the Commonwealth pay any portion of the cost of dependents' coverage. However, since 1982, in addition to paying 100% of the cost of the

employee's coverage, the Commonwealth also has paid 52% of the cost of dependent coverage under the Basic plan. As a result, the Commonwealth traditionally has paid approximately 70%-71% of the total cost of Basic family coverage. The amount of the Commonwealth's contribution toward the cost of Basic family coverage is applied to the cost of family coverage for the optional plans. Employees pay the remaining cost of their dependents' coverage under the optional plans.

The Commonwealth makes a special contribution toward the cost of family coverage when the family includes two state employees married to each other. This contribution is calculated to be two times the employee-only premium under the Basic plan. This special contribution is always greater than the contribution for family coverage when only one employee is in the family.

2. Increases in State and Employee Contributions

Table V-1 (page V-4) illustrates the total premium for the Basic plan, the state's contribution, and the employees' share during the period 1988-1992. Prior to fiscal year (FY) 1990, increases in the premiums paid by both the Commonwealth and employees became effective in July of each year. However, in FY 1990, employee increases scheduled to begin in July, 1989, were not implemented until January, 1990. In each succeeding year, the state share of the premiums has increased in July of each year, while any increase in the employees' share has taken effect in January. Thus, in the first six months of the fiscal year (July-December), the state's contribution represents a greater percentage of the total premium. However, for the last six months of the fiscal year (January-June), after the employees' premium increase takes effect in January, the state's contribution represents a smaller percentage of the total premium.

As seen in Table V-1, the state's share of the cost of family coverage remained constant at

Table V-1

Premiums for BCBSVA Basic Plan

Fiscal Years (FY) 1988-1992

	FY 1988	FY 1989	FY 1990[1]		FY 1991		FY 1992[2]	
			JUL-DEC '89	JAN-JUNE '90	JUL-DEC '90	JAN-JUNE '91	JUL-DEC '91	JAN-JUNE '92
EMPLOYEE-ONLY Total Premium Amt. Pd. by Employee Amt. Pd. by State	 $82.28 $ 0.00 (0%) $82.28 (100%)	 $92.00 $ 0.00 (0%) $92.00 (100%)	 $110.40 $ 0.00 (0%) $110.40 (100%)	 $110.40 $ 0.00 (0%) $110.40 (100%)	 $143.00 $ 0.00 (0%) $143.00 (100%)	 $143.00 $ 0.00 (0%) $143.00 (100%)	 $164.00 $ 0.00 (0%) $164.00 (100%)	 $164.00 $ 0.00 (0%) $164.00 (100%)
DUAL Total Premium Amt. Pd. by Employee Amt. Pd. by State	 N/A	 N/A	 N/A		 N/A	 $286.00 $ 69.00 (24%) $217.00 (76%)	 $318.00 $ 69.00 (22%) $249.00 (78%)	 $328.00 $ 79.00 (24%) $249.00 (76%)
FAMILY Total Premium Amt. Pd. by Employee Amt. Pd. by State	 $206.38 $ 58.86 (29%) $146.52 (71%)	 $230.00 $ 66.70 (29%) $163.30 (71%)	 $262.66 $ 66.70 (25%) $195.96 (75%)	 $298.08 $102.12 (34%) $195.96 (66%)	 $378.12 $102.12 (27%) $276.00 (73%)	 $423.00 $147.00 (35%) $276.00 (65%)	 $447.00 $147.00 (33%) $300.00 (67%)	 $459.00 $159.00 (35%) $300.00 (65%)

NOTES:

1. Beginning in FY 1990, increases in employees' share of the premiums were implemented in January, while the increase in the State's share was implemented in July. Thus, for FY 1990 and each succeeding fiscal year, the State's percentage share of the premiums during the first six months (Jul-Dec) is greater than the last six months (Jan-June).

2. The premiums for FY 1992, including amounts paid by the State and employees, were established by the 1991 General Assembly (Item 764 of 1991 Appropriation Act).

71% through 1989. In FY 1990, the state's contribution toward family coverage during the first six months of the fiscal year amounted to 75% of the total premium, and, during the last six months, the state's contribution represented 66% of the total premium. Over the course of the full year, the state's contribution averaged 70.5%. In FY 1991, the state's contribution toward family coverage averaged 69% of the total premium.

The 1992 total premiums, (i.e. amounts paid by the Commonwealth and employees), were established by the General Assembly in the 1991 Appropriation Act. Based on these premiums, the state's contribution to family coverage during FY 1992 will average 66%.

3. Increase in State's Contribution for Families With Two State Employees

One issue concerning the state's contribution to employees' health insurance premiums that DPT has analyzed critically is the amount contributed to family coverage when the family includes two state employees.

As previously stated, the state's current contribution to family coverage when the family includes two state employees is calculated to be two times the employee-only premium under the Basic plan. The current state contribution for families with two state employees is greater than the contribution for families with one state employee (i.e. 100% of the employee's coverage, plus approximately 52% of the additional cost of dependents' coverage). However, DPT has concluded that the state should pay the full cost of each employee and the 52% share of their dependents' cost, which represents a more logical and equitable application of the current funding formula.

C. Employer Contributions in Other States

Based on the 1991 benefits survey of all 50 states conducted by the Martin E. Segal Company, the

Commonwealth is one of 21 states that pays the entire cost of employee-only coverage. The other 29 states require employees to pay a portion of the cost of employee-only coverage. The maximum contribution required of employees was 50% of the total premium, with most states requiring between 5% and 20%.

Thirty-one states contribute a greater percentage of the cost of family coverage than does the Commonwealth. However, because many states offer a lower level of benefits than Virginia (i.e. 28 states offer comprehensive benefit plans), the cost of the benefits are lower. Thus, in such situations, the employer could be contributing less dollars per employee than Virginia, while contributing a greater percentage of the total premium. However, the dollar amount paid by the Commonwealth for family coverage ($276.00 in 1991) is greater than 32 of the 49 other states (i.e. 32 states contribute less than $276 per month, for their employees' family health insurance).

D. Recent Premium Increases

The total amount spent on health care in the United States in 1990 was estimated to be $671 billion, approximately 12% of the nation's gross national product.[1] Health care expenses are increasing twice the rate of general inflation.[2] The primary reasons for the rapid rise in health care costs are general medical cost inflation, an increase in the utilization of services by employees, expensive new technology and malpractice insurance costs.

Like all other employers trying to maintain the same level of health benefits for employees, the Commonwealth has had to spend ever-increasing same level of health benefits for employees, the

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[1]United States Office of National Health Statistics, Annual Report, 1990.
[2]Consumer Price Index figures reported in Monthly Labor Review, February, 1991.

Commonwealth has had to spend ever-increasing amounts. Similarly, state employees have had to pay increased premiums to provide coverage for their family members.

Under the current cost-sharing formula, the Commonwealth pays approximately 75% of the total cost of the program. Thus, when premiums increase, the Commonwealth absorbs most of the additional cost. Based on figures from the Department of Planning and Budget (DPB), in FY 1991, the total amount paid by the Commonwealth for employee health insurance was approximately $228.9 million. DPT records indicate that employees contributed approximately $68 million. In FY 1992, DPB estimates that the Commonwealth will spend approximately $248.9 million on employee health insurance.

Based on DPB records, the total amount paid by the Commonwealth for employee health insurance has increased from approximately $121.5 million in FY 1988 to $228.9 million in FY 1991, an increase of $107.4 million. Based on enrollments in BCBSVA plans (approximately 94% of total enrollments), the total amount paid by employees has increased from approximately $26.3 million in FY 1988 to $62.6 million in FY 1991, an increase of $36.3 million.

Table V-2 displays increases in premiums for the Basic Plan that have been instituted during the past five years (1988-1992).

Table V-2
Premium Increases: 1988 - 1992
Basic Plan[1]

	JANUARY 1988		JANUARY 1989		JANUARY 1990		JANUARY 1991		JANUARY 1992	
	Premium	% Inc.	Premium	% Inc.	Premium	% Inc.	Premium	% Inc.	Premium	% Inc.
loyee - Only Total Premium	$ 82.28	5%	$ 92.00	12%	$110.40	20%	$143.00	30%	$164.00	15%
l[2] Total Premium	N/A		N/A		N/A		$286.00	N/A	$328.00	15%
ily Total Premium	$206.38	5%	$230.00	11%	$298.08	30%	$423.00	42%	$459.00	9%

[1]Because the premiums for KeyCare and Cost Awareness are based on the Basic plan, only the Basic plan's premiums are presented. MO premiums are set independently by each HMO plan.
[2]Dual membership was instituted in January, 1991.

Source: DPT

1. Reasons for Premium Increases

In calendar year 1990, the Commonwealth paid $238.9 million in medical claims, and $7.2 million in administrative fees to BCBSVA. As such, approximately 97% of the premiums paid by the Commonwealth and employees goes to pay medical claims incurred by employees. Only 3% of the premiums pays for administrative expenses. Thus, virtually all of the recent premium increases were needed to pay employees' medical claims.

As seen in Table V-2, there were significant premium increases in the Basic plan in 1990 and 1991. The premiums for KeyCare and Cost Awareness also increased considerably during these same years. Two key reasons for the Commonwealth's premium increases in these years were medical cost inflation, and increases in the utilization of health care services by employees. For example, program

expenses for FY 1990, compared to FY 1989, increased as follows:

- o covered charges for Hospital Inpatient services increased 21%;
- o the cost per inpatient hospital day increased 17%;
- o covered charges for Hospital Outpatient services (e.g. x-rays, diagnostic tests) increased 39%;
- o covered charges for Physician Outpatient Services (doctors' charges for diagnostic tests, outpatient surgery, etc.) increased 32%; and
- o the number of physician services per 1,000 enrollees increased 17%.

Another major reason why the Commonwealth's premiums have increased is that there have been <u>no</u> benefit reductions. In recent years, many employers have reduced benefits as a means of controlling health care costs. Not only has the Commonwealth not reduced benefits, but there have been benefit enhancements, including the outpatient prescription drug program. In order to retain the high level of benefits offered to Virginia state employees, premiums had to be increased accordingly.

2. Employees' Views on the Value and the Cost of Their Health Benefits

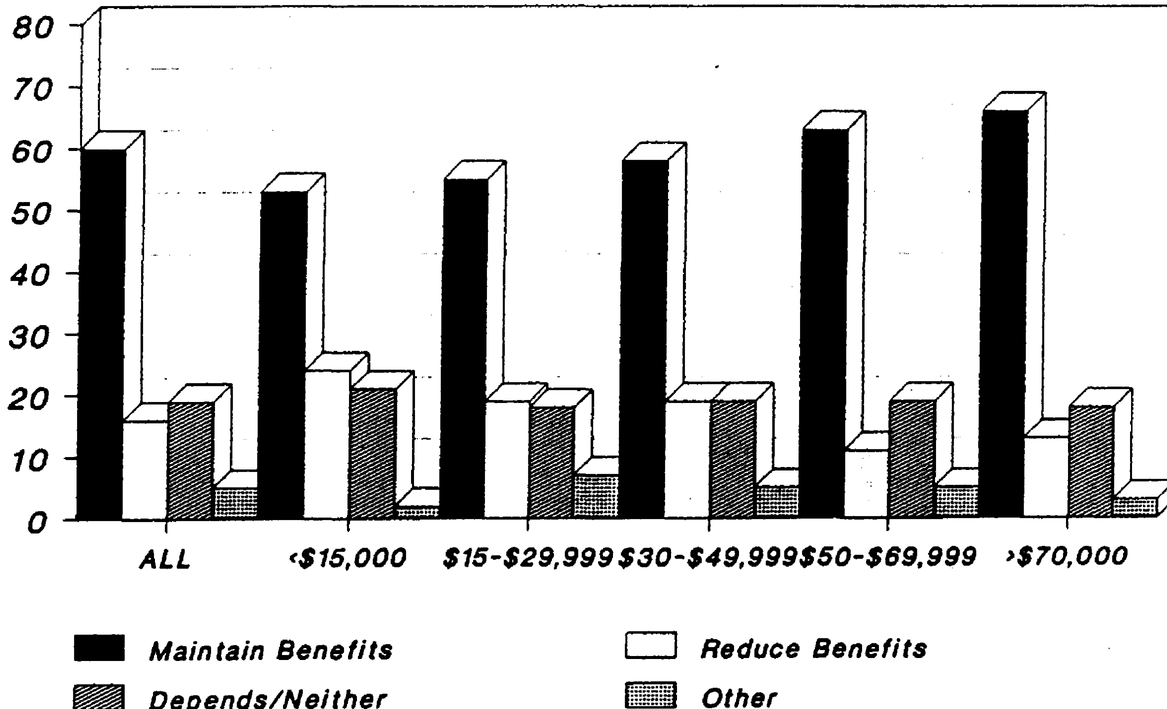
Based on the results of the survey of state employees, the Commonwealth's actions in not reducing health benefits are supported by the majority of employees. In the survey, employees were asked whether they would prefer to keep their current benefits, and pay a higher premium, or have benefits reduced and continue to pay the same premium. As illustrated in Table V-3, 60% of all employees indicated that they would prefer to maintain benefits, and pay a higher premium. Only 16%

indicated that they would prefer the Commonwealth to reduce benefits in order to hold premiums constant. Nineteen percent of respondents stated that their decision would depend on which benefits were reduced.

Table V-3 indicates that employees' responses to the issue of maintaining benefits are consistent when analyzed according to family income. While the percentage of lower paid employees who prefer to maintain benefits is somewhat less than the percentage of higher paid employees, a substantial majority of these employees also would prefer to maintain benefits and pay a higher premium.

Table V-3

Employees' Views: Maintain Benefits and Pay Higher Premiums vs. Reduce Benefits and Hold Premiums Constant



Source: Employee Survey by DPT

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3. Measures to Lessen the Impact of Recent Premium Increases

The impact of the 1990 and 1991 premium increases was softened by three cost-saving measures implemented by the Commonwealth. First, in July, 1990, DPT implemented the "premium conversion" program. The premium conversion program, which is authorized by section 125 of the Internal Revenue Code, allows employees to pay their share of the health insurance premiums on a tax-free basis. Employees who participate in premium conversion reduce their payroll taxes, and increase their spendable income. For example, an employee at step 1 of salary grade 7 who is married with two children, and who pays $147 each month for family coverage under the Basic plan, saves approximately $488 annually through premium conversion.

Second, in January, 1991, DPT instituted the new dual membership for employees who wish to provide coverage for only one dependent. Eligible employees who would have paid $147 each month for Basic family coverage now pay only $69 per month, a savings of $78 per month. Approximately 13,500 employees were able to reduce their health care costs as a result of the dual membership.

Third, in May, 1991, DPT implemented the "flexible reimbursement accounts" program. This program, which is authorized by section 125 of the Internal Revenue Code, allows employees to reduce their taxable income by setting aside a portion of their salary in a medical reimbursement account or a dependent care reimbursement account. The amounts set aside are not taxed. The medical reimbursement account enables employees to pay for certain medical expenses not covered by their health insurance with non-taxed funds. Similarly, by enrolling in a dependent care reimbursement account, employees can pay for day care expenses with non-taxed funds. By participating in either account, employees

reduce their taxes, and increase their spendable income.

4. Virginia Premiums Compared to Other Employers

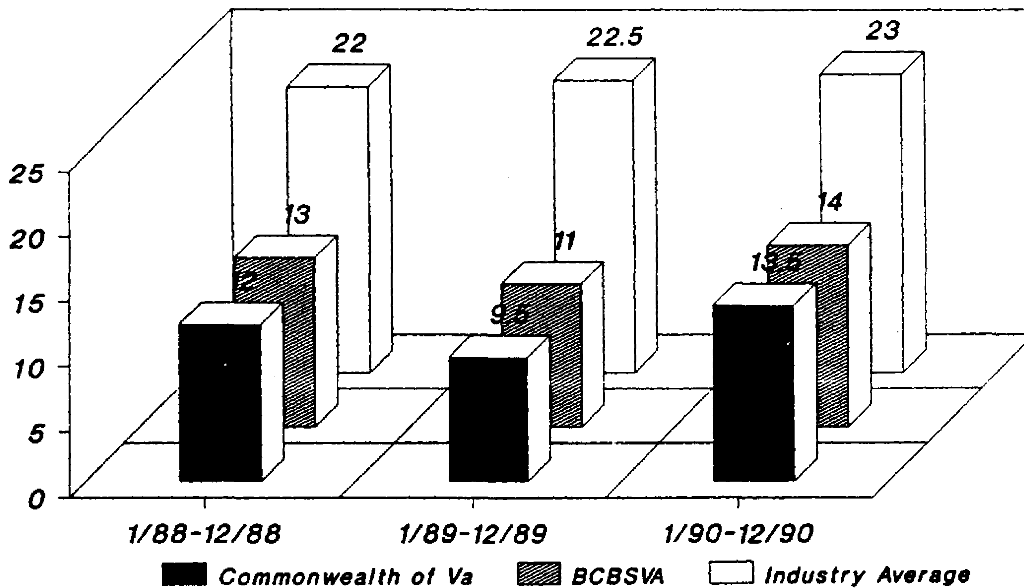
Making direct comparisons of the premiums for various health insurance programs is very difficult, and sometimes misleading, due to the numerous factors which influence the cost of health care coverage. The cost of health insurance is determined by the level of benefits offered, the number of plans offered, the level of employer and employee contributions, and the design of the program (e.g. does the plan require deductibles and co-insurance). Because rarely, if ever, would all of these factors be the same for two groups, comparison of premiums between different groups does little to indicate which group has a more attractive, or better managed health insurance plan.

A more appropriate analysis compares the growth in per capita claims expenditures among groups. This measure of the increase in costs for a health insurance group is referred to as the group's "trend." A lower than average trend, often is indicative of health plans which are better managed, or are better designed to combat medical inflation.

The Commonwealth's "trend" has been consistently lower than the average trend for other groups insured by either BCBSVA or the major commercial insurance companies in Virginia. Table V-4 illustrates the Commonwealth's trend since 1988, as compared to: 1) a composite trend of all groups for which BCBSVA insures or provides administrative services, and 2) the average trend for groups insured by the major commercial insurance companies in Virginia.

Table V-4

Trend Comparison: State of Virginia
Compared to BCBSVA Groups and Industry Average



Source: BCBSVA, William M. Mercer, Inc.

E. Conclusions

The rising cost of health care is a problem affecting employers nationwide. Health care costs are rising twice as fast as the cost of other services. The Commonwealth's health benefits program has not been insulated from this phenomenon.

The state's health insurance premiums increased substantially in 1990 and 1991. While there are many factors which contribute to higher health care costs, two key reasons for the increases in 1990 and 1991 were the general inflation in medical costs and an increase in the utilization of health care services by employees. Retaining a high level of benefits also contributed to the increases. Nonetheless, a majority of employees prefer to maintain a high level of benefits, and

pay higher premiums, rather than reduce benefits in order to hold premiums constant.

The percentage of health insurance premiums paid by the Commonwealth for employees for the various types of membership (i.e. employee-only, dual, and family) has remained constant over time, with only minor variations. DPT has concluded that the state's contribution to family coverage when the family includes two state employees should be increased such that the state pays 100% of the cost of each employee <u>and</u> the 52% share of their dependents' cost.

The implementation of premium conversion, the new dual membership, and the flexible reimbursement account program, helped to ease the impact of the increased premiums in 1990 and 1991.

While there have been significant premium increases in 1990 and 1991, the Commonwealth's growth in per capita claims expenditures (trend) over the past several years has been lower than the average trend for other groups insured by either BCBSVA or the major commercial insurance companies in Virginia.

VI. ADMINISTRATION OF THE HEALTH BENEFITS PROGRAM

A. DPT's Administrative Functions

1. General

The Department of Personnel and Training's administration of the health benefits program includes the design of health insurance plans, the procurement and administration of the health benefits contracts, promulgation of regulations, budgeting, containment of costs, and establishment of financial controls.

As the state agency responsible for the administration of the health benefits program, DPT provides day-to-day management and oversight of the program. Due to the large number of employees located throughout the state who are enrolled in the program (approximately 100,000), benefits administrators in each agency assist DPT in administering the health benefits program. Agency benefits administrators disseminate information to employees, provide policy guidance (based on DPT regulations and policy manual), process employees' enrollment forms, and respond to employees' questions regarding various benefits issues.

DPT provides annual training to agency benefits administrators just prior to the October enrollment period. The training sessions are held at several locations around the state. During these sessions, DPT reviews any recent policy revisions, provides instruction on new enrollment procedures, reviews any changes in the benefits plans, and provides other pertinent information.

In addition to the annual training program, DPT currently is developing a "basic" training program for new benefits administrators. Once completed, DPT will offer the training several times throughout the year at various locations across the state.

In administering the state's health benefits program, DPT utilizes the expertise of several different entities, including independent actuaries, consultants, and advisory groups. As previously stated, William M. Mercer, Inc. (Mercer), provides actuarial and other consultative services to DPT on a wide range of topics, including benefits design, premium calculations, procurement of the insurance carriers and program administrator, and other projects requiring technical expertise.

DPT consults with the State Health Benefits Advisory Council (SHBAC) on various policy issues which affect the program. The SHBAC was established pursuant to section 2.1-20.1:02 of the Code of Virginia to advise the Secretary of Administration on the administration of the program. In addition, DPT formed the Benefits Advisory Committee (BAC) to assist in the day-to-day administration of the program. The BAC is comprised of human resources personnel from state agencies and employee representatives. The BAC provides guidance and assistance to DPT in the daily administration of the program, such as communicating with employees, developing administrative policies, and revising enrollment forms.

2. Cost Containment

One of the most important administrative functions of DPT is controlling the cost of health insurance. In this capacity, DPT has instituted a number of cost containment programs which play an integral role in the cost-effective administration of the health benefits program, including:

- o pre-admission hospital review,
- o concurrent review while in the hospital,
- o hospital discharge review,
- o second surgical opinion,
- o case management of large claims,
- o mail order prescription drug program,
- o mandatory generic drug substitution (when generic drugs are available, the

program pays the cost of the generic only), and

- o a wellness program (the CommonHealth wellness program provides health risk appraisals, intervention programs, and wellness education to employees and their dependents).

DPT has implemented 20 separate cost containment measures to help hold down the cost of health insurance. According to the 1991 Martin E. Segal survey of all 50 states, no state reported implementing more cost containment programs than Virginia.

3. Financial Controls

A critical part of DPT's administrative responsibility is managing the health insurance fund, and maintaining appropriate financial and accounting controls. To ensure that adequate controls are in place, DPT requested the Auditor of Public Accounts (APA) to review DPT's financial management of the program, and recommend any necessary changes. (DPT's request for an APA review of the program was made prior to the 1991 session of the General Assembly.)

In its review, the APA examined the procedures used to enroll employees in the various health benefit plans; evaluated the procedures for making claims payments to BCBSVA and the HMO's; examined financial controls which ensure that only eligible employees are receiving benefits, and that the correct premiums are being paid by the Commonwealth and employees; and reviewed how DPT coordinates the administration of the program with other central agencies, such as the Department of Accounts (DOA) and the Virginia Retirement System.

At the time this report was completed, the APA had not completed its review. However, during the course of the review, the APA has recommended that DPT follow through with its plan to implement several enhancements to the

Department's Benefits Eligibility System (BES). The BES is a computerized system which contains records of employees enrolled in the health benefits program. The APA recommended that DPT implement, as soon as possible, modifications so that the system has more effective controls to ensure only eligible employees are receiving benefits, and that the proper premium amounts are being deducted from employees' paychecks. The APA also recommended that DPT improve its control over agencies' access to the BES. Currently, in some agencies, the same person who enters health benefits information into the BES also enters payroll information into DOA's payroll system. Thus, there is the potential for agency personnel to improperly reduce payroll deductions for health benefits coverage without detection. The APA recommended that DPT and DOA implement procedures to prevent circumvention of the BES and payroll systems.

Once the review is completed, the APA will submit a report to DPT outlining its findings and recommendations.

4. Overall Management of the Self-Insured Plans

Among the major administrative responsibilities of DPT are the design, planning and oversight of the state's self-insured plans. Section 2.1-20.1 of the Code of Virginia, which became effective July 1, 1989, established the state's health benefits program as a "self-insured" program for all plans except the Health Maintenance Organization (HMO's) plans.

Being self-insured means that the group (e. g. the Commonwealth) retains the "risk" of making certain that there is sufficient income (premiums) to pay program expenses (claims, administrative expenses, etc.). Self-insurance is very common, particularly among larger groups. According to the 1991 Martin E. Segal survey, 34 of the 50 states are self-

self-insured only 16 are insured.[3] Moreover, there is a growing trend of more states becoming self-insured. Eight states, including Virginia, self-insured their employee health insurance programs within the past three years.

Self-insurance offers a number of advantages to the group. The primary advantages to the Commonwealth by being self-insured are:

- Interest income and tax savings: A significant advantage that accrues to the Commonwealth as a result of being self-insured is the interest income that the health insurance fund earns. Section 2.1-20.1 of the Code of Virginia requires that any interest on unused balances in the state's health insurance fund reverts back to the credit of the fund. The health insurance fund earned approximately $11.2 million in interest income during fiscal years (FY) 1990 and 1991. The Department of Treasury estimates that the fund will earn approximately $6.3 million in interest income in FY 1992. For every dollar earned in interest income, the program requires one less premium dollar. Thus, the Commonwealth and state employees save money.

  Insurance companies operating in Virginia must pay a premium income tax, based on the amount of insurance premiums collected by the insurer. Insurers recover these taxes by factoring them into the insurance

[3] Only the HMO portion of the health benefits program is administered on an insured basis. HMO's are paid a premium which is used to pay the medical claims incurred by employees and the administrative expenses of operating the plan. Because only 6% of employees are enrolled in HMO plans, virtually the entire state program is self-insured.

premiums paid by their insured groups. Because self-insured groups do not pay premiums to an insurer, these groups do not have to pay this additional charge.

- Lowest possible cost: Insurers do not assume insurance risks without compensation. Thus, any group that is insured will be rated conservatively (i.e. insurer includes contingency amounts that inflate the needed premium), which means higher premiums. Thus, insurers establish premiums for insured groups to minimize their risk and to make a profit. If the premium income exceeds expenses, the insurer retains any remaining balances. If the claims exceed the premium income, the insurer absorbs these costs. However, the loss is factored into the group's premium for the next year.

  For self-insured groups, premiums are set to cover only claims payments and administrative expenses. Since there are no additional contingency fees (i.e. no built in factor to inflate premiums above the needed amount), premiums can be held to the lowest possible rate.

- Greater control over reserves and timing of payments: Under an insured arrangement, the insurer has the right to set premiums. Even when claims reserves are adequate, insurers tend to rate conservatively (i.e. charge higher premiums), which can result in unnecessarily high reserves.

  Self-insured groups have far greater control over how the program's finances are handled, including the calculation of premiums, the timing of payments, and the level of claims reserves.

In implementing the self-insured arrangement,

the Commonwealth accepted the financial risks and rewards ordinarily retained by private insurance companies. However, the technical aspects of claims management are handled by a third party administrator for a number of reasons.

First, large insurance companies maintain the advanced claims processing systems necessary to assure the eligibility of services, the eligibility of the individual receiving the services, and the balance of available benefits for the services. Second, large insurance companies are able to develop the effective networks of providers (i.e. hospitals and physicians) and sufficient discounts from them which are necessary to maintain a high quality program. Third, large insurers maintain the cadre of medical professionals which is an essential element in determining medical necessity and appropriateness of services for which claims are filed.

One major factor which makes it cost effective to obtain these services privately stems from the fact that private insurers develop their systems and provider networks for numerous clients. For example, the Commonwealth's large employee group constitutes only 11% of the "book of business" of the current third party administrator.

Accordingly, the Commonwealth, in essence, shares the costs of the systems and networks with numerous other groups. Similarly, the Commonwealth benefits from the additional bargaining leverage possessed by the insurers of many groups when the insurer negotiates discounts from providers.

B. Managing Claims and Supplying Provider Networks for the Self-Insured Health Plans

1. Procurement of Services

The services of managing claims and supplying of provider networks for the self-insured

plans are procured from a private vendor in accordance with the Virginia Public Procurement Act (VPPA). The VPPA requires the purchasing agency to define the product or services sought; advertise in order to secure adequate competition; include in its solicitation the criteria to be used in making an award; and award the contract according to the evaluation criteria. The Department follows all of these provisions under the competitive negotiation provisions of the VPPA. The Department procured the administrative services associated with its health benefits plans in 1987 and again in 1989. (The benefits plans procured in 1989 became effective January 1, 1991.)

Since the administrative services to be procured are not commodities that can be purchased through a bidding process (i.e. contract is awarded according to price alone), the Department solicits competitive offers (rather than bids) through a Request For Proposals (RFP).

Requests for Proposals are drafted by DPT, and reviewed by the Office of the Attorney General (OAG) to ensure that all provisions are in accordance with state law and the VPPA. RFP's are advertised in the Richmond Times Dispatch, the Washington Post, and the Virginia Business Opportunities.

In addition to the advertising requirements of the VPPA, the Department generally takes additional steps to secure competitive offers. During the development of the most recent RFP (1989) for health benefits plan administration services, the Department requested potential offerors to provide comments on what should be included in the RFP, what the evaluation criteria should be, and what would be a reasonable schedule for preparing offers. Also, the Department provided draft copies of the RFP to interested parties for comment prior to publication. In addition, DPT's independent consultant, William M. Mercer,

Inc. (Mercer) also contacted offerors, and encouraged them to submit a proposal. Proposals submitted in response to an RFP are reviewed by the Department for compliance with the technical requirements of the RFP (e.g. proper form, timely submission, etc.). Proposals which meet the technical requirements of the RFP then are evaluated by Mercer based on the evaluation criteria established as part of the RFP. The Department, with assistance from Mercer, negotiates with the finalists to obtain the best possible products, services and price.

During the 1989 procurement of administrative services for the health benefits plans, two incumbent contractors, the prescription drug contractor and one of the health maintenance organizations (HMO) were replaced as a result of the Department's procurement process. The current program administrator is Blue Cross and Blue Shield of Virginia (BCBSVA).

There is no requirement that the term of any contract be for only one year. The initial term of the health benefits contracts typically is for two years. There are provisions for automatic one year extensions at the discretion of the Department.

Records pertaining to both the 1987 and 1989 health benefits procurements, as well as other procurements, are maintained by the Department, and may be inspected upon request to the Department.

2. Services

The administrative services provided by BCBSVA include:

- processing claims,
- providing claims information and other services to employees,
- providing utilization review services,
- providing actuarial estimates used in calculating premiums,

- assisting in program and benefit design,
- administering cost containment programs (e.g. pre-admission review and medical necessity determinations),
- enforcing coordination of benefits provisions (ensures the Commonwealth does not duplicate claims payments received by an employee from another source of health insurance), and
- developing provider networks, and negotiating provider discounts on behalf of the Commonwealth.

One of the most important services provided by the program administrator (BCBSVA) is the negotiation of discounts from the ordinary fees of providers (i.e. hospitals and doctors). In calendar year 1990, program savings from provider discounts amounted to almost $31 million. The state's contract with BCBSVA guarantees hospital discount savings of at least 8%. However, the actual discount approximated 11%, due, in large part, to additional hospital discounts that the KeyCare program generates.

Physician reimbursements and discounts are more complex. Some savings are generated from the usual, customary, and reasonable (UCR) fee limitation on fees that physicians can charge. Under the UCR system, the health benefits program pays the lesser of the physician's billed charge or the prevailing charge in the provider community. On average, the UCR allowable charge is approximately 10% below physicians' actual charges. Participating physicians agree to accept this allowance as payment in full, and the employee, by contract, is protected against having to pay the balance (balance billing). As with hospital discounts, the KeyCare program generates additional discount savings inasmuch as the KeyCare allowances are approximately 6% lower than the standard BCBSVA allowances.

3. Fees

The Commonwealth pays BCBSVA an administrative fee for the services it renders. The fee is a fixed price per contract unit administered each month. (A contract unit is defined as an enrolled employee, regardless of membership type.) For instance, if BCBSVA administers a benefit plan for 20,000 employees in a given month, the payment to BCBSVA is the "per contract unit" price times 20,000. Accordingly, the administrative fees paid to BCBSVA are not related to the number of claims processed, the amount of the claims, or the premiums charged to employees.

The per contract unit fee for the Basic plan is $3.60 per month; the monthly fee for KeyCare and Cost Awareness is $5.46; and the fees for the Option I and Option II retiree plans are $6.25 per month.

The administrative fees paid to BCBSVA are governed by contract. Any increases in the fees must be approved by the Commonwealth, and must be based on actual cost increases incurred by the administrator. Increases may not exceed the percentage increases reported in the medical care component of the consumer price index (CPI).

DPT maintains a separate contract with the administrator of the outpatient prescription drug program, PCS, Inc. Under this contract, an administrative fee is paid for each claim processed by the administrator. As a result of the most recent competitive procurement of these services, DPT negotiated a fixed cost per claim, guaranteed for three years, with no increases.

4. Contract Performance Requirements

In both the BCBSVA and PCS, Inc. administrative services contracts, DPT includes specific performance requirements that the contractor must meet or exceed. For

the program administrator (BCBSVA), specific performance standards must be met. There are administrative standards regarding response times to, for example, telephone and written inquiries, and the dissemination of information to employees. The most critical performance standards pertain to the processing of claims. DPT's contract with BCBSVA requires that BCBSVA meet or exceed the following claims processing standards:

- 90% of routine claims must be processed within 14 calendar days, and 100% must be processed in 30 days;

- 90% of developed claims (claims which require follow-up processing) must be processed in 45 days, 99.5% in 60 days, and 100% in 90 days;

- total payment accuracy rate (number of claims processed correctly) must be at least 93%; and

- total financial accuracy rate (dollar amount of claims processed correctly as compared to the total dollar amount of claims processed) must be at least 97%.

William M. Mercer, Inc. (Mercer), the Department's independent consultant, performs annual audits of the program administrator's performance. These audits are conducted to ensure that contract performance requirements are being met. Mercer's most recent audit, which was completed in June, 1991, indicated that all claims processing standards were met, except the standard requiring that 90% of routine claims be processed within 14 days, and that 100% of routine claims be processed in 30 days. Mercer's analysis indicated that 82.1% of claims were processed in 14 days, and 92.5% of claims were processed in 30 days. DPT has instructed BCBSVA to implement system improvements such that all standards are being met.

One of Mercer's 1991 audit recommendations was that the Commonwealth should tighten the financial performance standard (i.e. increase the current total financial accuracy rate of 97%) to reflect more competitive performance levels. As a result of Mercer's recommendation, DPT currently is re-negotiating this performance standard with BCBSVA.

The Commonwealth's contract with PCS, Inc. (outpatient prescription drug program administrator) also includes specific performance standards, including:

- 90% of all properly completed claims must be processed within 14 calendar days, 100% must be processed in 30 calendar days;
- all claims must be paid correctly, all erroneous payments must be corrected;
- all mail order prescriptions must be dispensed within seven calendar days; and
- all mail order drugs must be dispensed in conformance with every aspect of the prescription involved.

Mercer also audits the outpatient prescription drug contractor. The current contractor, PCS, Inc., began providing administrative services in January, 1991. Thus, Mercer has not yet conducted an annual audit. However, an audit is scheduled to be conducted in late 1991.

Because the HMO portion of the health benefits program is insured, the Commonwealth does not assume the same risks associated with the self-insured program. The Commonwealth contributes a set amount (based on the self-insured Basic plan) to the cost of HMO coverage. The HMO retains the financial risks of insuring state employees. Thus, annual financial audits of the HMOs are not conducted.

C. Conclusions

The Commonwealth's health benefits program is managed effectively, and is administered in accordance with applicable state and federal laws. DPT makes appropriate use of actuaries, consultants and advisory groups in the administration of the program.

Self-insurance provides several advantages to the state's health benefits program. The most important advantage is the cost saving features of self-insurance, particularly the interest earnings on the balance of the health insurance fund. Based on national surveys, large employers increasingly are becoming self-insured to take advantage of the significant benefits of self-insurance.

The administrative fee paid to BCBSVA to administer the state's health benefits program is a fixed fee per contract unit. The fees paid to BCBSVA are not based on the number or amount of claims paid, nor are the fees based on the premiums. In return for the administrative fees, BCBSVA provides a wide range of services. As reported in Mercer's 1991 independent audit, BCBSVA is meeting the claims processing standards required by the Commonwealth, except that 82.1% of routine claims are being processed within 14 days, and 92.5% are being processed within 30 days. The performance standards require that 90% of claims be processed in 14 days, and 100% be processed in 30 days. DPT should ensure that BCBSVA makes the necessary modifications to the claims processing system such that all contract provisions are met.

Also, DPT should continue to work with BCBSVA to develop more stringent financial performance standards to be included in the state's contract for program administration services.

While health insurance premiums have increased substantially over the past two years, DPT has implemented numerous cost-containment programs. DPT should continue to identify and implement new effective measures which can help control the rapid rise in health care costs.

DPT should implement the preliminary recommendations made by the APA regarding the program's financial controls and accounting procedures. Once the APA's final report is issued, DPT should implement any additional APA recommendations.

VII. CHANGES IN HEALTH BENEFITS PROGRAM DESIGN

In order to respond to the increasing cost of health insurance, the state's health benefits program must be designed to be as efficient as possible. An "efficient" program means one where the maximum level of benefits is offered for the lowest possible cost.

Item 61 of the 1991 Appropriation Act directs DPT "to revise the design of the employee health insurance plan in order to maximize the economic leverage of a very large employer health insurance group, and, to the maximum extent possible, to avoid widespread reductions in benefits and unnecessary cost shifting to employees."

As required by the legislation, DPT has worked with the Governor's Personnel Advisory Board and staff members of the House Appropriations and Senate Fiance Committees in developing the revised plan.

Since Item 61 requires DPT to recommend a new plan for consideration by the Governor and the 1992 session of the General Assembly, the analysis, conclusions, and recommendations regarding the future design of the health benefits program will be presented to the Governor and the General Assembly as part of the report required by Item 61.

VIII. RECOMMENDATIONS

Based on the information provided in this review, the following recommendations are offered:

A. Program Design and Cost Containment

1. DPT should continue to evaluate and implement effective cost containment programs to help control the rising cost of health insurance.

2. As required by Item 61 of the 1991 Appropriation Act, DPT will present a plan to the Governor and the 1992 General Assembly to revise the design of the health benefits program.

B. Program Administration

1. Prior to establishing new provider networks, particularly in rural areas, DPT should verify that BCBSVA has met all of its criteria for ensuring that employees have adequate access to network providers.

2. DPT should implement the recommendations made by the Auditor of Public Accounts following its review of the health benefits program's financial controls and accounting procedures.

3. DPT should ensure that BCBSVA implements the necessary modifications to its claims processing systems such that all contractual performance standards are being met.

4. DPT should work with its consultant, William M. Mercer, Inc., and BCBSVA to revise the financial performance standards contained in its contract with BCBSVA to reflect more competitive performance levels.

5. The Commonwealth should increase the state's contribution to family coverage for those families with two state employees such that the contribution represents 100% of the cost of each employees' coverage plus 52% of the cost of the dependents' coverage.

C. Communications and Education

1. DPT should make available more information regarding the health benefits program so that employees and others understand the administration of the program, the procurement process, the premium-setting process, and other critical aspects of the program.

2. DPT should conduct an annual survey of employees to determine their views and satisfaction with the benefits and services provided through the program. DPT should give careful consideration to the results of the survey when changes to the program are being contemplated.

APPENDIX A

GENERAL ASSEMBLY OF VIRGINIA--1991 SESSION

HOUSE JOINT RESOLUTION NO. 421

Requesting the Department of Personnel and Training to study the administration ar. efficacy of the State Health Benefits Program.

Agreed to by the House of Delegates, February 22, 1991
Agreed to by the Senate, February 21, 1991

WHEREAS, health care costs are currently an eminent concern among consumers, employers, third-party payors, and national and state governments; and

WHEREAS, the Commonwealth's role in health care encompasses that of provider, regulator, licensor, and consumer; and

WHEREAS, the Commonwealth began administering its own health insurance program for state employees in 1989; and

WHEREAS, the present fiscal climate demands that all means possible to enhance cost effectiveness be examined to produce the greatest utilization and benefit of available dollars; and

WHEREAS, the Commission on Health Care for All Virginians has cited its mission as ensuring that the Commonwealth adopts the most cost effective and most efficacious means of delivery of its health care services so that the greatest number of Virginians may be served; and

WHEREAS, an examination of the Commonwealth's Health Benefits Program could effect greater cost containment initiatives; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Personnel and Training be requested to study the administration and efficacy of the State Health Benefits Program. The Department should include, but not be limited to, in its deliberations (i) a review of the health insurance options currently available to state employees, including the equity of options offered to both married and single state employees; (ii) an assessment of health insurance options' advantages and disadvantages, particularly their impact on state workers in rural areas; (iii) an examination of the recent increases in employee and state contributions toward the various options and comparison these with past adjustments; and (iv) an evaluation of the effectiveness of the prograr. administration.

The Department shall complete its work by November 30, 1991, and submit its findings and recommendations to the Commission on Health Care for All Virginians and the Governor and the 1992 Session of the General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

§ 2.1-20.1. Health and related insurance for state employees. — A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. Notwithstanding the provisions of § 38.2-3419, the plan shall include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law.

Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance program. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund.

D. For the purposes of this section, the term "state employee" means state employee as defined in § 51.1-101, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, and interns and residents employed by the Medical College of Virginia of Virginia Commonwealth University and the School of Medicine and Hospital of the University of Virginia.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof. (1970, c. 557; 1972, c. 803; 1973, cc. 69, 297; 1978, c. 70; 1984, c. 430; 1988, c. 634; 1989, cc. 559, 664; 1990, c. 607.)

The 1989 amendments. — The 1989 amendment by c. 559 added the present third paragraph, and inserted "the" following "under" in the first sentence of the last paragraph.

The 1989 amendment by c. 664, effective Jan. 1, 1990, in the first paragraph, combined the former first and second paragraphs into the present first paragraph, in the first paragraph inserted "and retired state employees" in the first sentence, added the present second sentence, and deleted "chosen" following "The plan" in the third sentence; and deleted the former fourth paragraph, which read "The Governor shall designate the Department of Personnel and Training as his agent to administer such plan as may be approved by him."

The 1990 amendment designated the first paragraph as subdivision A 1; designated the second paragraph as subdivision A 2; added subsection B; and designated the third, fourth and final paragraphs as subsections C, D and E.

§ 2.1-20.1:01. State Health Benefits Advisory Council. — There is hereby created a State Health Benefits Advisory Council. The Council shall advise the Secretary of Administration on issues and concerns of state retirees and active employees regarding health insurance coverage and other health related benefits. The Council shall consist of seven members, two of whom have retired from state service. Three members two of whom have retired from state service shall be appointed by the Governor; two members shall be appointed by the Speaker of the House of Delegates; and two members sha'' be appointed by the President Pro Tempore of the Senate. Appointees shall subject to confirmation by the General Assembly. Members shall serve t. two-year terms and no member shall serve for more than two full successive terms. Initial appointments to the Council shall be as follows: three for a term of one year, and four for a term of two years. A chairman shall be elected annually. (1989, c. 636.)

§ 2.1-20.1:02. **Health insurance program for employees of local governments, local officers, teachers, etc.; definitions.** — A. The Department of Personnel and Training shall establish a plan or plans subject to the approval of the Governor, for providing health insurance coverage for employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, officers, teachers and retirees. The plan or plans shall be rated separately from the plan established pursuant to § 2.1-20.1 to provide health and related insurance coverage for state employees. Participation in such insurance plan or plans shall be (i) voluntary, (ii) approved by the participant's respective governing body, or by the local school board in the case of teachers, and (iii) subject to regulations promulgated by the Department.

B. The plan established by the Department shall satisfy the requirements of the Virginia Public Procurement Act, Chapter 7 (§ 11-35 et seq.) of Title 11, shall consist of a flexible benefits structure which permits the creation of multiple plans of benefits and may provide for separate rating groups based upon criteria established by the Department. The Department shall promulgate regulations regarding the establishment of such a plan or plans, including, but not limited to, requirements for eligibility, participation, access and egress, mandatory employer contributions and financial reserves, and the administration of the plan or plans. The Department may engage the services of other professional advisors and vendors as necessary for the prudent administration of the plan or plans. The assets of the plan or plans, together with all appropriations, premiums and other payments, shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance fund. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund. The State Treasurer shall charge reasonable fees to recover the actual costs of investing the assets of the plan or plans.

In establishing the participation requirements, the Department may provide that those employees, officers, and teachers without access to employer-sponsored health care coverage may participate in the plan. It shall collect all premiums directly from the employers of such employees, officers, and teachers.

C. In the administration of the plan or plans, the Department shall take into consideration the recommendations made by an advisory committee. Such advisory committee shall be composed of at least five members to be appointed by the Governor, with at least one member representing each of the following groups: local governments, local officers, local school boards, teachers, and retirees. Committee members shall be reimbursed for the expenses incurred by them as members of the committee but shall not be otherwise compensated for their services. The terms of service for the advisory committee members shall be established by the Department.

D. In the event that the financial reserves of the plan fall to an unacceptably low level as determined by the Department, it shall have the authority to secure from the State Treasurer a loan sufficient to raise the reserve level to one which is considered adequate. The State Treasurer is hereby authorized to make such a loan, to be repaid on such terms and conditions as established by him.

E. For the purposes of this section, the following terms shall have the meanings indicated:

"Employees of local governments" shall include all officers and employees of the governing body of any county, city or town, and the directing or governing body of any political entity, subdivision, branch or unit of the Commonwealth or of any commission or public authority or body corporate created by or under an act of the General Assembly specifying the power or powers, privileges or authority capable of exercise by the commission or public authority or body corporate, as distinguished from §§ 15.1-20, 15.1-21, or similar statutes, provided that the officers and employees of a social services department, welfare board, mental health, mental retardation and substance abuse services board, or library board of a county, city, or town shall be deemed to be employees of local government.

"Local officer" means the treasurer, registrar, commissioner of the revenue, attorney for the Commonwealth, clerk of a circuit court, sheriff, or constable of any county or city or deputies or employees of any of the preceding local officers.

"Teacher" means any employee of a county, city, or other local public school board. (1989, c. 475.)

The number of this section was assigned by the Virginia Code Commission, the number in the 1989 act having been 2.1-20.1:01.

§ 2.1-20.1:2. Health insurance credits for retired state employees. — A. The Commonwealth shall pay the cost of coverage for state employees retired under the Virginia Retirement System, State Police Officers Retirement System, Judicial Retirement System or any retirement system authorized pursuant to § 51.1-126 who (i) served no less than fifteen years of creditable service as regularly employed full-time employees of the Commonwealth or (ii) rendered service as a temporary employee of the General Assembly in 1972 and became a member of the retirement system from 1972 to 1985 immediately following such temporary service. An amount of one dollar and fifty cents per year of creditable service not to exceed a maximum monthly allowance of forty-five dollars shall be credited monthly to any retired state employee participating in the state health plan established by § 2.1-20.1; however, such credit shall not exceed the health insurance premium for retiree-only coverage as provided under such plan. Any retired state employee retired under the provisions of §§ 51.1-156 and 51.1-307, shall receive the maximum credit provided by this section.

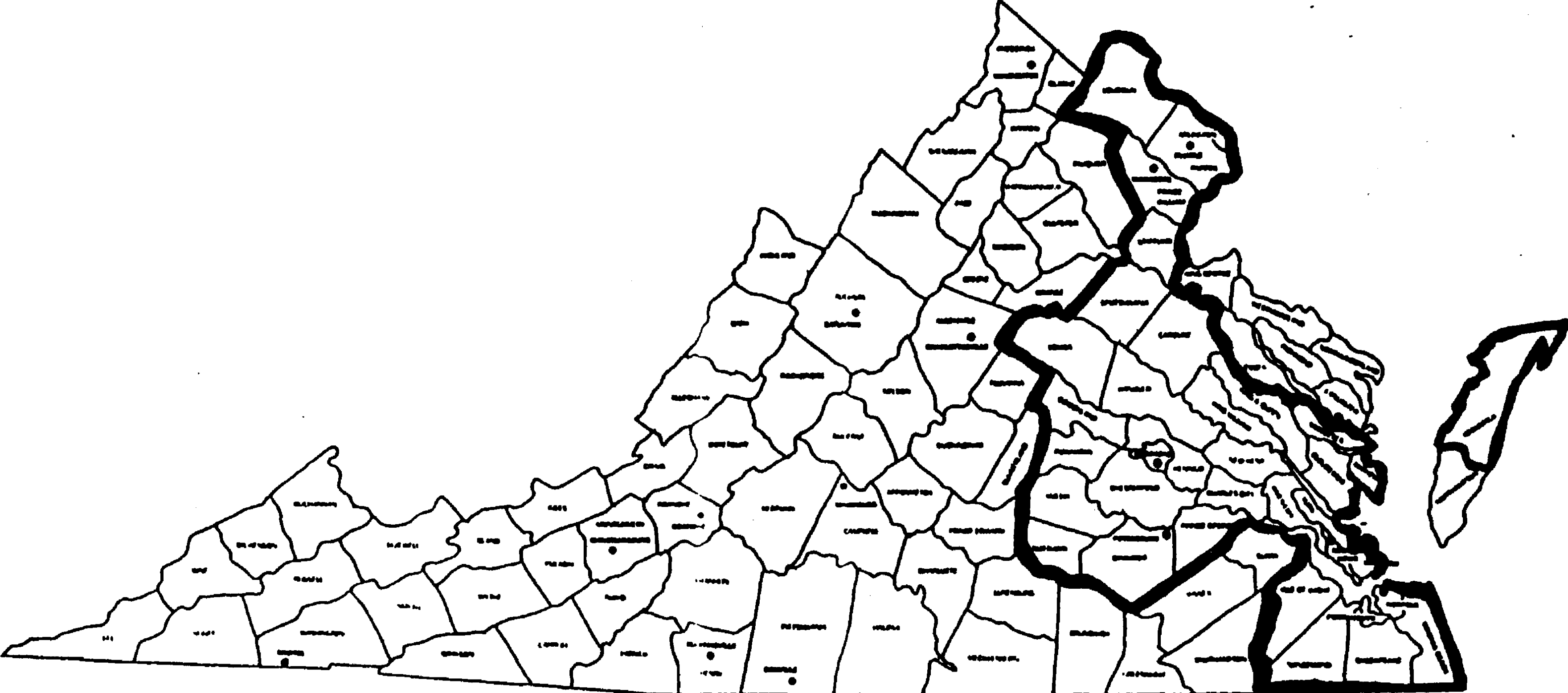
B. Such credit shall be applied to the monthly premium deducted from benefits payable to retired state employees in accordance with Chapters 1, 2 and 3 of Title 51.1. In the event that either no benefit is payable or the benefit payable is insufficient to deduct the entire health care premium, the Virginia Retirement System shall transfer funds in an amount equivalent to the credits that would otherwise have been payable to the Department of Personnel and Training.

C. The Virginia Retirement System shall actuarially determine the amount necessary to fund all credits provided by this section; and shall reflect the cost of such credits in the employer contibution rate pursuant to § 51.1-145. (1989, c. 664.)

Effective date. — This section is effective Jan. 1, 1990.

HMO Service Areas

HMO plan(s) are available in areas designated by the darker lines.



APPENDIX D

COMPARISON OF HEALTH BENEFITS

Benefits	BC/BS Basic Plan	BC/BS KeyCare	BC/BS Cost Awareness	PruCare
Inpatient Care: Pre-admission Review is required. Hospital Care in Semi-Private Room for Illness (including Surgery), Injury or Pregnancy	120 days per confinement after $100 deductible.	365 days per confinement after $100 deductible.	365 days per confinement after $100 deductible.	All medically necessary care.
Hospital Care in Semi-Private Room for Mental and Nervous, Alcohol or Drug Abuse	120 days per calendar year after $100 deductible per confinement. (90-day lifetime benefit for inpatient substance abuse treatment).	30 days per calendar year after $100 deductible per confinement. (90-day lifetime benefit for inpatient substance abuse treatment).	30 days per calendar year after $100 deductible per confinement. (90-day lifetime benefit for inpatient substance abuse treatment).	30 days per calendar year. No deductible.
Skilled Nursing Home Care in Semi-Private Room	120 days per confinement, payment limited to $65 per day.	180 days per confinement.	180 days per confinement.	180 days per calendar year.
Inpatient Professional Services for Illness, Surgery, Injury, Pregnancy, Mental Illness and Skilled Nursing Care	120 days per confinement (except up to 45 days for psychiatric and substance abuse).	365 days per hospital and 180 days per skilled nursing home confinement. Psychiatric and substance abuse covered up to 30 days per calendar year.	365 days per hospital and 180 days per skilled nursing home confinement. Psychiatric and substance abuse covered up to 30 days per calendar year.	All medically necessary care, subject to day limits for mental and nervous illness and skilled nursing care.
Outpatient Institutional Care Hospital Care for Accidental Injuries and Medical Emergencies	Accidental injuries: Covered at UCR if treated within 72 hours.	Covered after $30 deductible.	Covered after $30 deductible.	Covered if life-threatening or approved in advance; $25 copayment per visit if not admitted to hospital.
Home Health Care Visits	Covered at UCR for 90 approved visits per calendar year.	Up to 90 approved visits per calendar year. $10 deductible only for visits by a doctor.	Up to 90 approved visits per calendar year. $10 deductible only for visits by a doctor.	All medically necessary care when approved in advance.
Outpatient Physician & Professional Services Illness or Injury	Accidents, surgery and diagnostic tests: covered at UCR. Other conditions, including medical emergencies, covered at 80 percent UCR after deductible.	$10 deductible per visit and 10 percent copayment for X-rays, lab tests and certain shots.	$10 deductible per visit and 10 percent copayment for X-rays, lab tests and certain shots.	$5 copayment per visit to primary care. $10 copayment to specialist.
Preventive Care	Not covered.	Well-baby care through age 5. 100 percent for common immunizations; $10 deductible per office visit and 10 percent copayment for diagnostic tests.	Well-baby care through age 5. 100 percent for common immunizations; $10 deductible per office visit and 10 percent copayment for diagnostic tests.	$5 copayment per visit to primary care physician.
Dental Care	Not covered.	Diagnostic and preventive services covered in full up to 2 visits annually. Routine at 80 percent. No deductible. $1,000 annual limit.	Diagnostic and preventive services covered in full up to 2 visits annually. Routine at 80 percent. No deductible. $1,000 annual limit.	Under traditional fee-for-service plan, payment based on a schedule after $50 deductible for basic and major services. See Employee Handbook for the schedule.
Diagnostic Tests & Laboratory	100 percent UCR.	90 percent.	90 percent.	100 percent.
Outpatient Psychiatric Services	First 50 visits covered at 80 percent UCR after deductible and visits 51-70 covered at 50 percent.	$10 deductible per visit, up to $2,000 in benefits per calendar year.	$10 deductible per visit, up to $2,000 in benefits per calendar year.	Upon referral, $15 per session for the first 25 sessions, $25 per session for sessions 26-50.
Outpatient Prescription Drug Plan	PCS—$8 for 34-day supply at participating pharmacies. $16 deductible for over a 34-day supply. $6 for 90-day supply through mail order.	PCS—$8 for 34-day supply at participating pharmacies. $16 deductible for over a 34-day supply. $6 for 90-day supply through mail order.	PCS—$8 for 34-day supply at participating pharmacies. $16 deductible for over a 34-day supply. $6 for 90-day supply through mail order.	Drugs are included as part of HMO benefits. $5 copayment per prescription.

Benefits	EQUICOR*	M.D. IPA	Kaiser Permanente	Sentara Health Plan
Inpatient Care: Pre-admission Review is required. Hospital Care in Semi-Private Room for Illness (including Surgery), Injury or Pregnancy	All medically necessary care.	All medically necessary care.	All medically necessary care.	All medically necessary care.
Hospital Care in Semi-Private Room for Mental and Nervous, Alcohol or Drug Abuse	30 days per calendar year. No deductible.	30 days per calendar year. No deductible.	30 days per calendar year. No deductible.	30 days per calendar year. No deductible.
Skilled Nursing Home Care in Semi-Private Room	180 days per calendar year.	180 days per contract year.	180 days per calendar year.	180 days per calendar year.
Inpatient Professional Services for Illness, Surgery, Injury, Pregnancy, Mental Illness and Skilled Nursing Care	All medically necessary care, subject to day limits for mental and nervous illness and skilled nursing care.	All medically necessary care, subject to day limits for mental and nervous illness and skilled nursing care.	All medically necessary care, subject to day limits for mental and nervous illness and skilled nursing care.	All medically necessary care, subject to day limits for mental and nervous illness and skilled nursing care.
Outpatient Institutional Care Hospital Care for Accidental Injuries and Medical Emergencies	Covered if life-threatening or approved in advance; $25 copayment per visit if not admitted to hospital.	Covered if life-threatening or approved in advance; $25 copayment per visit if not admitted to hospital.	Covered if life-threatening or approved in advance; $25 copayment if not admitted to hospital.	Covered if life-threatening or approved in advance; $25 copayment per visit if not admitted to hospital.
Home Health Care Visits	All medically necessary care when approved in advance.	All medically necessary care when approved in advance.	All medically necessary care when approved in advance.	All medically necessary care when approved in advance.
Outpatient Physician & Professional Services Illness or Injury	$5 copayment per visit to primary care physician. $10/after 5 p.m. and weekends/holidays $10/specialist visit.	100 percent.	100 percent for all medically necessary care.	$5 copayment per visit to primary care physician. $10 per specialist visit.
Preventive Care	$5 copayment per visit to primary care physician.	100 percent.	100 percent.	$5 copayment to primary care physician.
Dental Care	Diagnostic and preventive services at 100 percent after deductible; 70 percent out-of-network. $25 deductible per individual, $75 deductible per family applies to out-of-network services.	Not covered.	Not covered.	Diagnostic and preventive services at 80 percent; basic services at 50 percent; complex and restorative services at 30 percent.
Diagnostic Tests & Laboratory	100 percent.	100 percent.	100 percent.	100 percent.
Outpatient Psychiatric Services	First visit at 100 percent upon referral from primary care physician. Visits 2-50, $15 copayment per visit.	Upon referral, for up to 50 visits; $15 copayment.	Upon referral, for up to 50 visits. Visits 1-25, $15 copayment per visit. Visits 26-50, $25 copayment per visit.	Upon referral, from primary care physician, up to 50 visits. $15 copayment per visit.
Outpatient Prescription Drug Plan	PCS—$8 for 34-day supply at participating pharmacies. $16 deductible for over a 34-day supply. $6 for 90-day supply through mail order.	Drugs are included as part of HMO benefits. $4 copayment per prescription.	Drugs are included as part of HMO benefits. $3 copayment at Kaiser Pharmacies; $10 copayment at participating pharmacies.	Drugs are included as part of HMO benefits. $5 copayment per 34-day supply (oral contraceptives per 3-cycle supply.) $5 copayment per vial of insulin.

* Now part of CIGNA Employee Benefits.

MEDICARE COMPLEMENTARY PLAN (OPTION I) FOR RETIREES ELIGIBLE FOR MEDICARE

Administered by Blue Cross and Blue Shield of Virginia.

SERVICE AREA

Wherever State retirees reside.

FOR QUESTIONS OR SERVICE CALL

355-8506 in the Richmond dialing area, 1-800-552-2682 in Virginia, or 1-800-368-5024 outside of Virginia.

Questions about prescription drugs should be directed to PCS. Please see the Outpatient Prescription Drug Program information on page 10.

GENERAL DESCRIPTION

The Medicare Complementary Plan allows Medicare beneficiaries the opportunity to select unique benefits to help in areas where Medicare offers little or no assistance and to provide nearly full coverage of the Medicare Part A inpatient deductibles. The Medicare Complementary Plan also pays 20% of approved charges for Part B doctors' care and medical services once the participant meets a $1,000 calendar year out-of-pocket expense limit. The Part A and Part B benefits, vision benefits, and dental services are administered by Blue Cross and Blue Shield of Virginia. The Outpatient Prescription Drug Program provision of the Medicare Complementary Plan is administered by PCS, Inc.

BENEFITS

Hospital Inpatient

- Medicare Part A hospital deductible *less $100* per benefit period, days 1-60 — in full
- Medicare Part A daily hospital copayment amount, days 61-90 — in full
- 100% of hospital's reasonable charges, days 91-120 — in full
- Copayment amount for Medicare Lifetime Reserve Days (60 days available) — in full

Skilled Nursing Facility

- Medicare Part A skilled nursing home copayment, days 21-100 — in full
  (Medicare covers days 1-20 in full.)
- A daily amount equal to Medicare skilled nursing home copayment, days 101-180 — in full
  (Medicare provides no coverage beyond 100 days.)

Doctor's Care And Medical Services

(after $1,000 out-of-pocket expense limit)

Enrollees in the Medicare Complementary Plan are responsible for the first $1,000 in covered expenses for Part B doctors' care and other medical services. Expenses which apply to the $1,000 out-of-pocket expense limit include the Part B $75 calendar year deductible and 20% of Medicare-approved charges for Part B services. After the $1,000 out-of-pocket expense limit is met during a calendar year, the Medicare Complementary Plan pays:

- Physicians' care — 20%*
- Diagnostic x-ray and lab tests — 20%*
- Ambulance service — 20%*
- Durable medical equipment and supplies — 20%*

*Of Medicare-approved charges

Vision Care Benefits *(once every 24 months)*

maximum allowance:

- Examination — $40
- Frames — $50
- Lenses (one of the following)
  Single lenses — $35
  Bifocal lenses — $50
  Trifocal lenses — $70
- Contact Lenses: *(in place of frames and lenses)* — $100

Dental Service Benefits

- Annual maximum — $1,000
- Twice yearly visits to dentist: *(Benefit includes oral examinations, X-rays, cleaning, scaling, and polishing).* — 100% AC**
- As needed services: *(Benefit includes emergency treatment of toothaches, space maintainers, biopsies of oral tissue, and pulp vitality tests).* — 100% AC**
- Full mouth X-rays: *(Benefit available every 36 months)* — 100% AC**
- Primary services: *(Benefit includes fillings and simple extractions; endodontics; repair of removable dentures, recementing of crowns and inlays and bridges; excision, drainage or removal of cysts, tumors, and abscesses; preparation of gum ridge for dentures).* — 80% AC**
- Periodontic services: *(Benefit includes gingivectomy and gingivoplasty; gingival curettage; osseous surgery; surgical periodontal examinations; mucogingivoplastic surgery; treatment of acute infections).* — 80% AC**

**The Blue Cross and Blue Shield of Virginia Allowable Charge (AC) is the usual, customary, and reasonable allowance for a specified covered service or the provider's charge for that service, whichever of the two amounts is less. Blue Cross and Blue Shield of Virginia sets the usual, customary, and reasonable allowance for covered services.

Outpatient Prescription Drug Program

Outpatient prescription drugs are available to Medicare Complementary Plan enrollees through the PCS plan described on page 10.

MAJOR EXCLUSIONS

- Physician services, up to the $1,000 calendar year out-of-pocket expense limit, except those provided by an employee of the hospital or nursing home and billed to Medicare as part of the inpatient charge.
- Services and supplies for an admission not approved by Medicare, including care in a psychiatric hospital beyond the 190-day lifetime limit set by Medicare.
- Vision services for tinted contacts only for the purpose of changing eye color.
- Vision services for any amount more than the actual charge for the vision services.
- Vision services for tests associated with the fitting of contact lenses.
- Vision services for sunglasses of any type.
- Vision services required for employment or rendered through a facility maintained by your employer.
- Dental services rendered to an inpatient in a facility by a dentist paid by that facility to perform such services.
- Dental services for gold foil restorations.
- Dental services for instructions in personal hygiene and care, including plaque control.
- Dental services rendered as part of optional plans of treatment, personalized restorations, or special techniques, unless approved by Blue Cross and Blue Shield of Virginia in advance.

DEDUCTIBLES AND COPAYMENTS

- $100 deductible per benefit period for the first 60 days of hospital inpatient care.
- 20% of Medicare allowable charge as copayment on Part B services, up to the $1,000 out-of-pocket expense limit each calendar year.
- Copayment equal to any balance between the allowance paid for vision services and the provider's charge for the covered service.
- 20% copayment for dental services paid at 80% of the allowable amount.

PROVIDERS OF SERVICE

Hospitals which participate in the Medicare program are covered. Admissions not approved by Medicare are excluded.

Vision services may be provided by an optometrist or ophthalmologist. Benefits cover a major portion of the cost of the services. However, you are asked to share in the cost of vision services. Therefore, ask the cost of each service before you make your appointment to have your eyes examined or buy your glasses or contacts.

Dental services described in this summary are available from Blue Cross and Blue Shield contracting dentists. Contracting dentists accept the Allowable Charge as the maximum amount they can receive for the covered service. If you visit a non-contracting dentist, you have to pay any amount more than the Allowable Charge maximum.

SPECIAL INFORMATION ABOUT MEDICARE PROVIDERS

Doctors have the option to sign a participating agreement with Medicare. When a doctor signs this agreement, he or she will "accept assignment" for all services furnished to Medicare patients. This means he or she will file your Part B claims for you and accept Medicare's allowable charge for covered services. It also means that your copayment is limited to a percentage of the Medicare-approved charge. Your Social Security office can give you more information about Medicare participating physicians.

Appeals Procedures—Claims appeals should be addressed to "Medicare Complementary Plan Claims Appeals Coordinator" and mailed to Blue Cross and Blue Shield of Virginia, P. O. Box 27401, Richmond, Virginia 23279. Please follow the PCS Appeals Procedures for prescription drug claims appeals.

NOTE: This is only a brief summary of your Medicare Complementary Plan benefits. For a complete description of the benefits, limitations, terms, and conditions, refer to the Medicare Complementary Plan Member Handbook and the Outpatient Prescription Drug Program Member Handbook. You may also refer to the group contract between Blue Cross and Blue Shield of Virginia and the State, and the group contract between PCS and the State.

Important: Option I and Option II enrollees *must* also be enrolled in both Medicare Parts A and B. Retirees or family members eligible for Medicare who wish to enroll in a Blue Cross and Blue Shield of Virginia plan may enroll only in an Option I or Option II health benefits plan. This type of membership covers only the individual who is eligible for Medicare. Other family members, not eligible for Medicare, may enroll in full coverage through another State health benefits plan.

MAJOR EXCLUSIONS

- Services and supplies for an admission not approved by Medicare, including care in a psychiatric hospital beyond the 190-day lifetime limit set by Medicare.
- Routine physical examinations.
- Services rendered by chiropractors.
- Dental services, except Major Medical benefits for the correction of accidental injury sustained while enrolled under this program or removal of impacted teeth on an outpatient basis.
- Eyeglasses and hearing aids, including examinations for prescription or fitting.
- Services or supplies that are not medically necessary.

DEDUCTIBLES AND COPAYMENTS

- $100 deductible per benefit period for the first 60 days of hospital inpatient care.
- $200 Major Medical calendar year deductible.
- 20% copayment for Major Medical (until Stop-Loss Limit is reached).

PROVIDERS OF SERVICES

Your first choice for Part B services should be a Medicare participating physician. Doctors have the option to sign a participating agreement with Medicare. When a doctor signs this agreement, he or she will "accept assignment" for all services furnished to Medicare patients. This means he or she will file your Part B claims for you and accept Medicare's allowable charge for covered services. It also means that your copayment is limited to a percentage of the Medicare-approved charge. Your Social Security office can give you more information about Medicare participating physicians.

Blue Cross and Blue Shield participating professional providers may or may not file claims on your behalf, but your financial responsibility is limited to the Allowable Charge maximum. The difference between the Medicare Allowable Charge and the Blue Cross and Blue Shield of Virginia Allowable Charge maximum may be filed under Major Medical. If you select a physician who does not participate in either Medicare or with Blue Cross and Blue Shield of Virginia, you must pay any balance between the Blue Cross and Blue Shield Allowable Charge and the charge for the covered service.

Appeals Procedure—Claims appeals should be addressed to "Medicare Supplemental Plan Claims Appeals Coordinator" and mailed to Blue Cross and Blue Shield of Virginia, P. O. Box 27401, Richmond, Virginia 23279.

NOTE: This is only a brief summary of benefits of your Medicare Supplemental Plan. For a complete description of the benefits, limitations, terms, and conditions, refer to the Medicare Supplemental Plan (Option II) Member Handbook or the group contract between Blue Cross and Blue Shield of Virginia and the State.

Important: Option I and Option II enrollees *must* also be enrolled in both Medicare Parts A and B. Retirees or family members eligible for Medicare who wish to enroll in a Blue Cross and Blue Shield of Virginia plan may enroll only in an Option I or Option II health benefits plan. This type of membership covers only the individual who is eligible for Medicare. Other family members, not eligible for Medicare, may enroll in full coverage through another State health benefits plan.

APPENDIX E

Virginia Health Planning Regions

Regions used in analyzing VCU Employee Survey Responses.