UFCW Local 1500 Welfare Fund

Associated Administrators, LLC Report

September 20, 2016

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Agenda

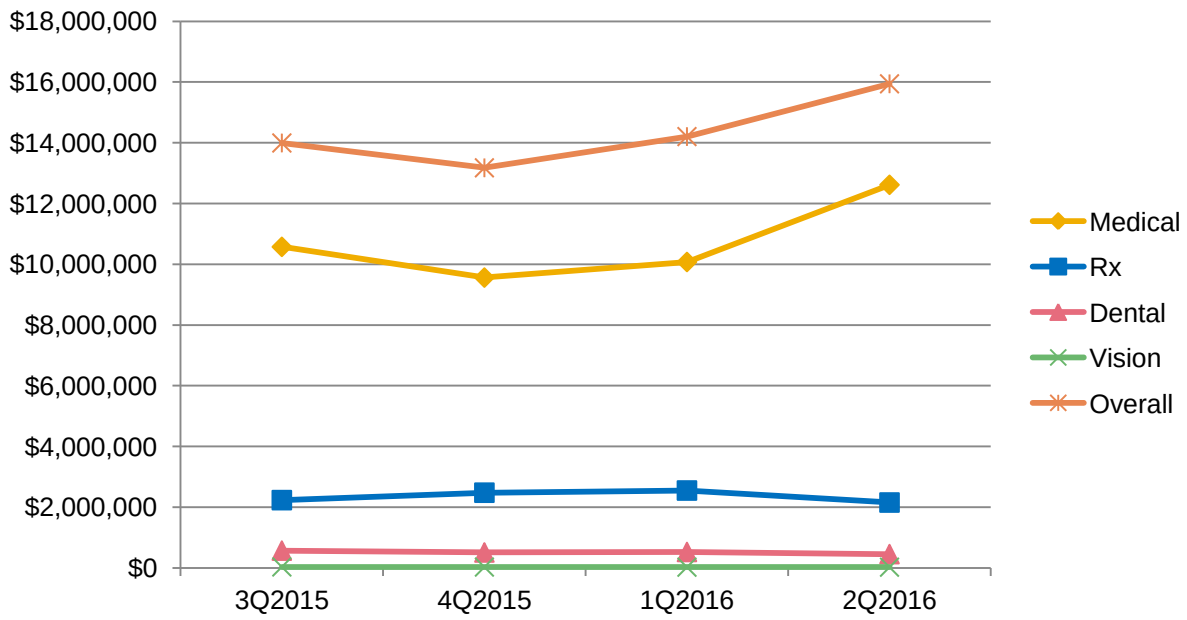
- AMR Summary and Claims Utilization Report 2Qtr 2016
  - Full Time
  - Special Part Time
  - Part Time ACA
  - Basic Part Time
  - Retiree
  - Summary and Reserve
- JAA Status Update
  - Snapshot
  - Top Five Health Conditions
  - Top Five Providers
- In-Network vs. Out-of-Network
- Out-Of-Network Discount Report
- Other Fund Business
- Tabled Appeals

AMR Summary : 2Q2016

Full Time Plan

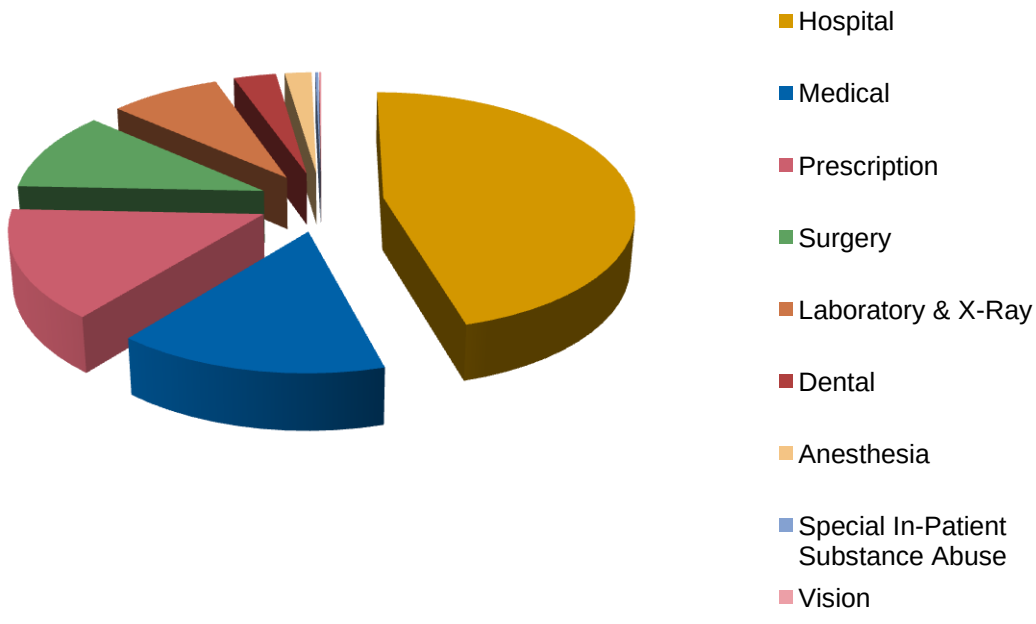
	3Q2015	4Q2015	1Q2016	**2Q2016**	Previous 4 Quarters
Medical	$10,572,710	$9,560,477	$10,073,968	**$12,616,112**	$42,823,267
Rx	$2,231,540	$2,476,566	$2,548,173	**$2,152,878**	$9,409,157
Dental	$569,540	$508,596	$524,745	**$454,884**	$2,057,765
Vision	$31,621	$27,499	$23,339	**$23,144**	$105,603

- **2Q16 deficit of $4,614,026**
- **PPPM Cost 2Q16 - $1,599**



Claims – 2Q2016

FULL-TIME PLAN		
Hospital	$6,655,118.08	45.65%
Medical	$2,220,411.10	15.23%
Prescription	$2,152,878.00	14.77%
Surgery	$1,566,369.62	10.75%
Laboratory & X-Ray	$1,185,530.94	8.13%
Dental	$454,884.15	3.12%
Anesthesia	$286,738.16	1.97%
Special In-Patient Substance Abuse	$32,166.05	0.22%
Vision	$23,144.00	0.16%
		100%

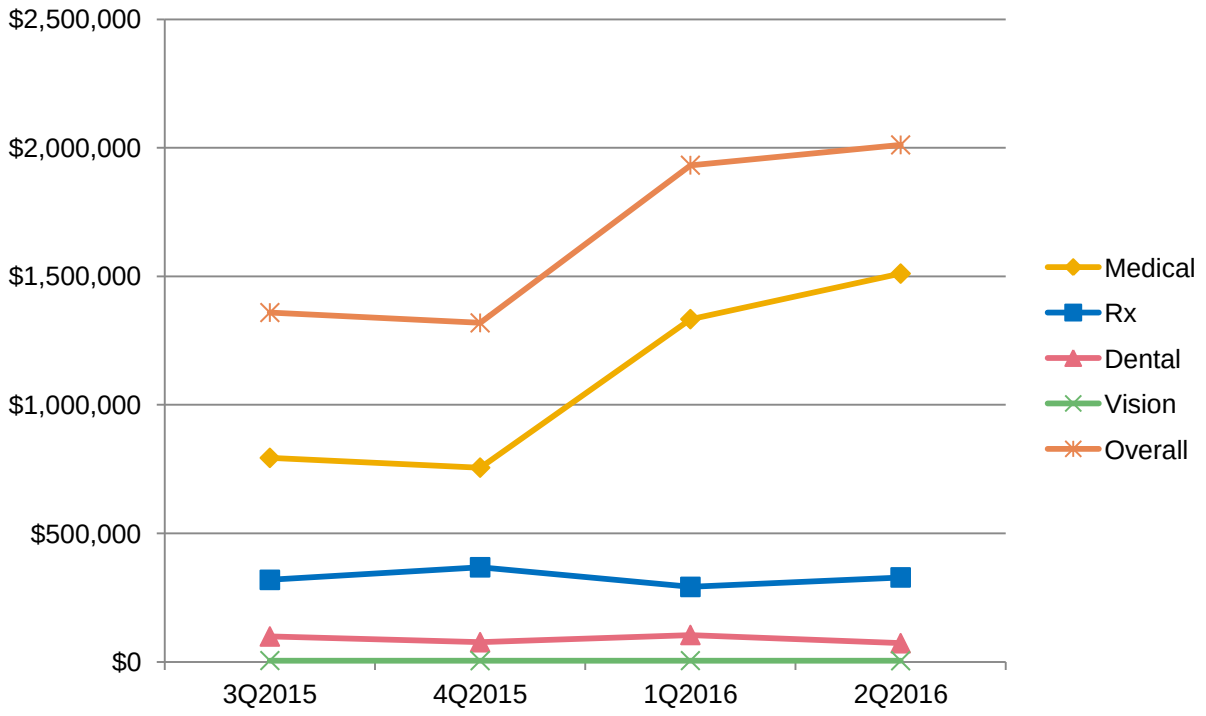


AMR Summary : 2Q2016

Special Part Time Plan

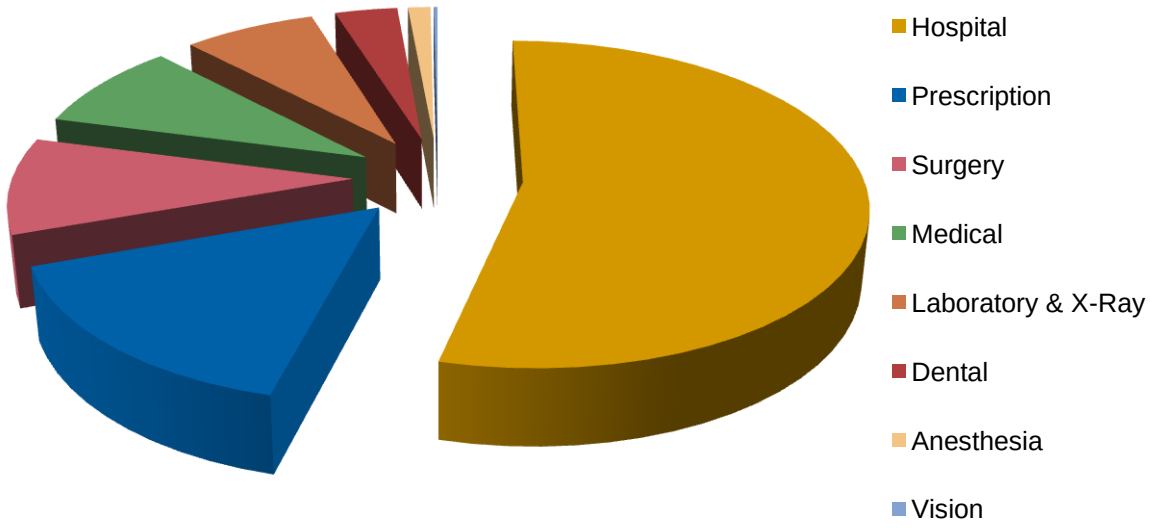
	3Q2015	4Q2015	1Q2016	**2Q2016**	Previous 4 Quarters
Medical	$793,825	$755,809	$1,333,520	**$1,510,718**	$4,393,872
Rx	$319,160	$368,109	$291,695	**$328,640**	$1,307,604
Dental	$98,930	$76,672	$104,773	**$72,682**	$353,057
Vision	$5,174	$4,694	$4,966	**$4,374**	$19,208

- **2Q16 deficit of $882,172**
- **PPPM Cost 2Q16 - $670**



Claims cont'd – 2Q2016

SPECIAL PART-TIME PLAN		
Hospital	$1,138,825.86	53.97%
Prescription	$328,640.00	15.58%
Surgery	$201,907.77	9.57%
Medical	$183,757.63	8.71%
Laboratory & X-Ray	$153,740.97	7.29%
Dental	$72,682.05	3.44%
Anesthesia	$26,069.74	1.24%
Vision	$4,374.00	0.21%
		100%

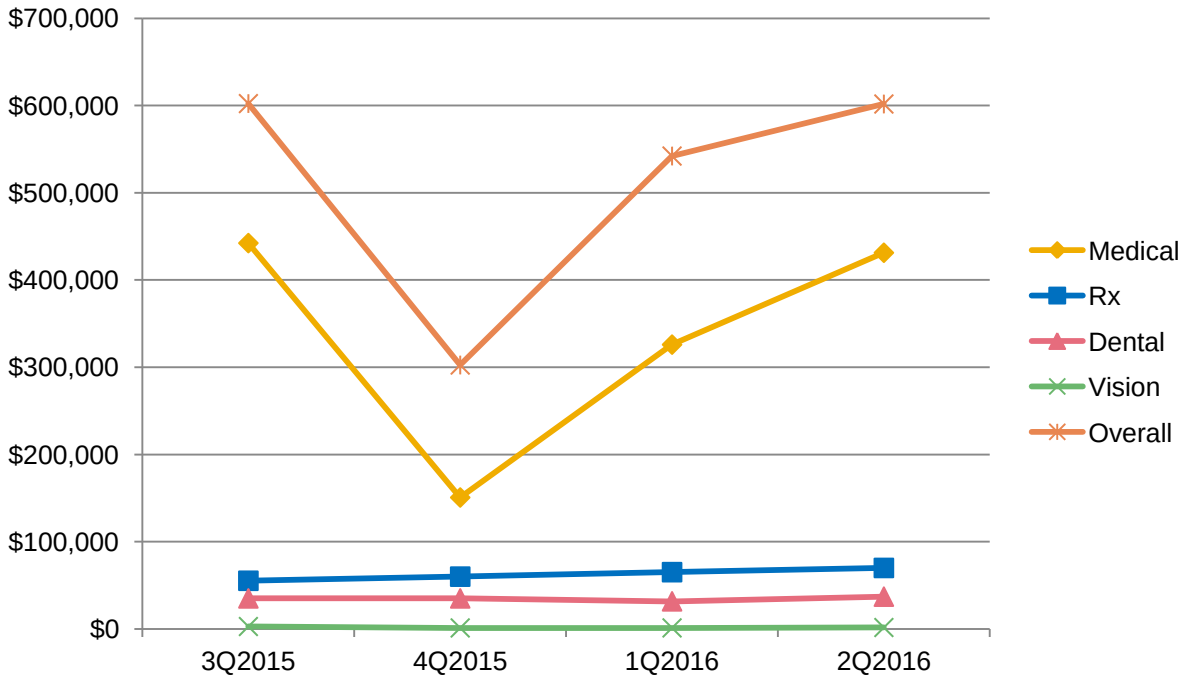


AMR Summary : 2Q2016

Part Time ACA Plan

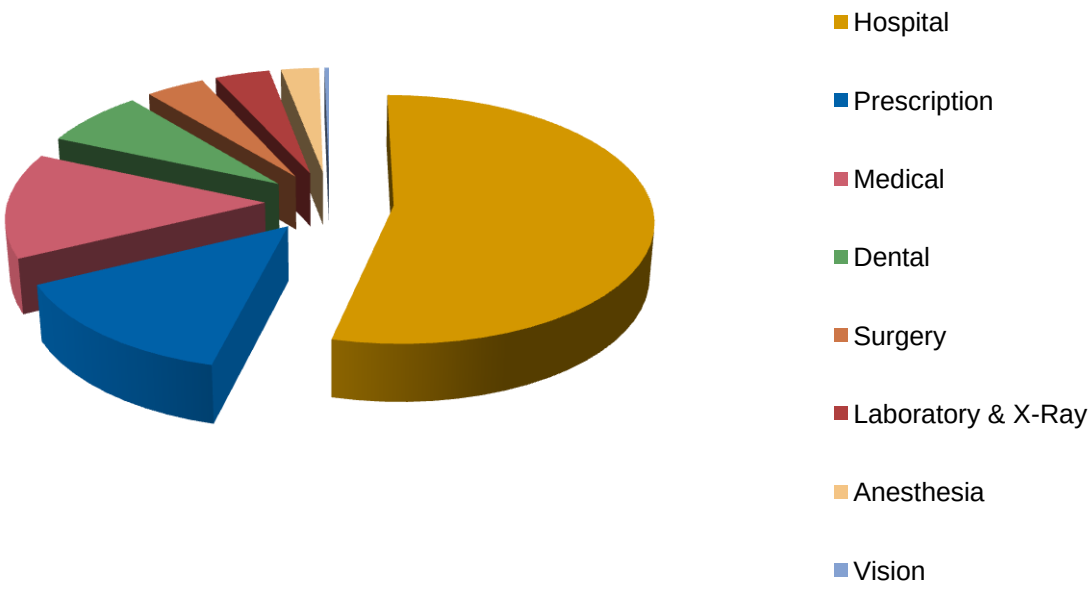
	3Q2015	4Q2015	1Q2016	**2Q2016**	Previous 4 Quarters
Medical	$442,296	$150,654	$325,919	**$431,225**	$1,350,094
Rx	$55,172	$59,912	$65,046	**$69,878**	$250,008
Dental	$34,973	$34,970	$31,597	**$36,976**	$138,516
Vision	$2,721	$1,097	$1,141	**$1,592**	$6,551

- **2Q16 surplus of $13,181**
- **PPPM Cost 2Q16 - $332**



Claims cont'd - 2Q2016

PART-TIME ACA PLAN		
Hospital	$270,595.53	53.88%
Prescription	$69,878.00	13.91%
Medical	$69,056.36	13.75%
Dental	$36,976.45	7.36%
Surgery	$21,015.19	4.18%
Laboratory & X-Ray	$19,557.42	3.89%
Anesthesia	$13,556.50	2.70%
Vision	$1,592.00	0.32%
		100%



JAA Claims – 2Q2016
Part-Time ACA Plan Deductible/Out-of-pocket maximum

- **11 members met their $5,600 deductible for the 2016 plan year by the end of the 2nd quarter.**

- **Utilization below -- amounts shown include first $400 basic benefit.**

MEMBER	AMOUNT PAID THROUGH 2Q2016
1	$13,645.24
2	$29,084.54
3	$41,010.32
4	$15,182.49
5	$6,502.47
6	$18,613.44
7	$59,817.69
8	$7,070.87
9	$889.92
10	$1,495.11
11	$186,932.01

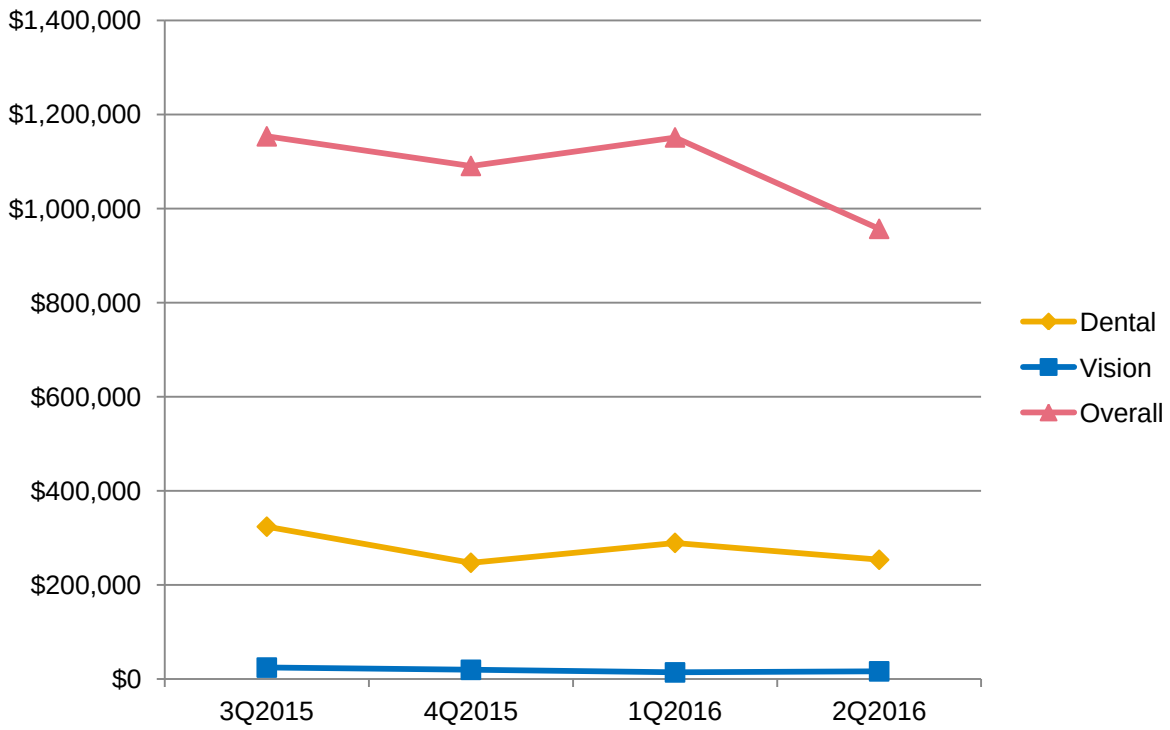
All members listed are currently active.

AMR Summary : 2Q2016

Part Time Plan

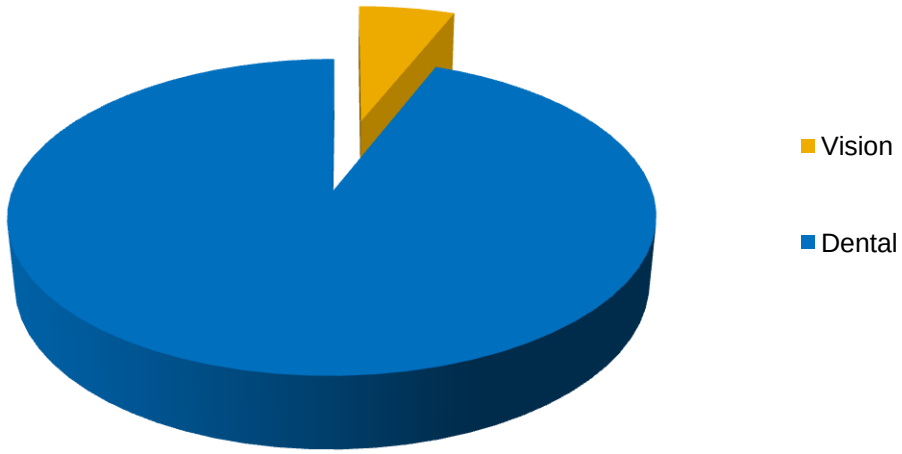
	3Q2015	4Q2015	1Q2016	**2Q2016**	Previous 4 Quarters
Dental	$323,604	$246,897	$289,190	**$253,272**	$1,112,963
Vision	$24,061	$19,274	$13,807	**$16,028**	$73,170

- **2Q16 surplus of $1,769,687**
- **PPPM Cost 2Q16 - $29**



Claims cont'd – 2Q2016

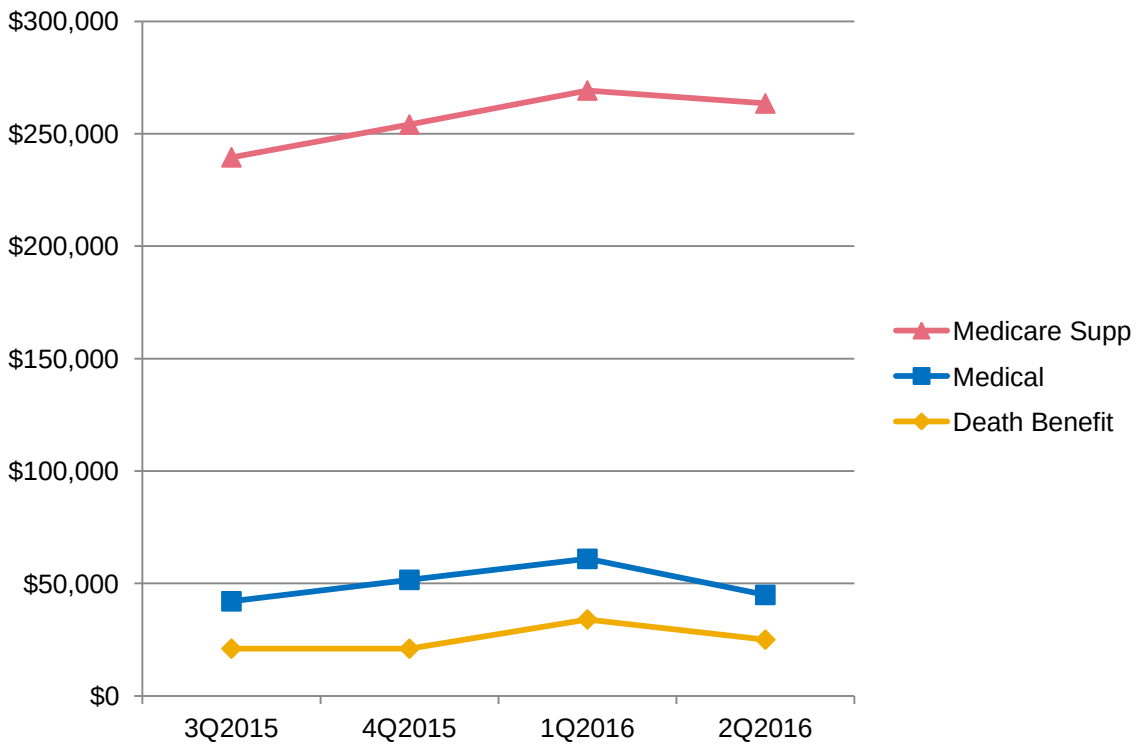
PART-TIME PLAN		
Dental	$253,272.05	94.05%
Vision	$16,028.00	5.95%
		100.00%



AMR Summary : 2Q2016

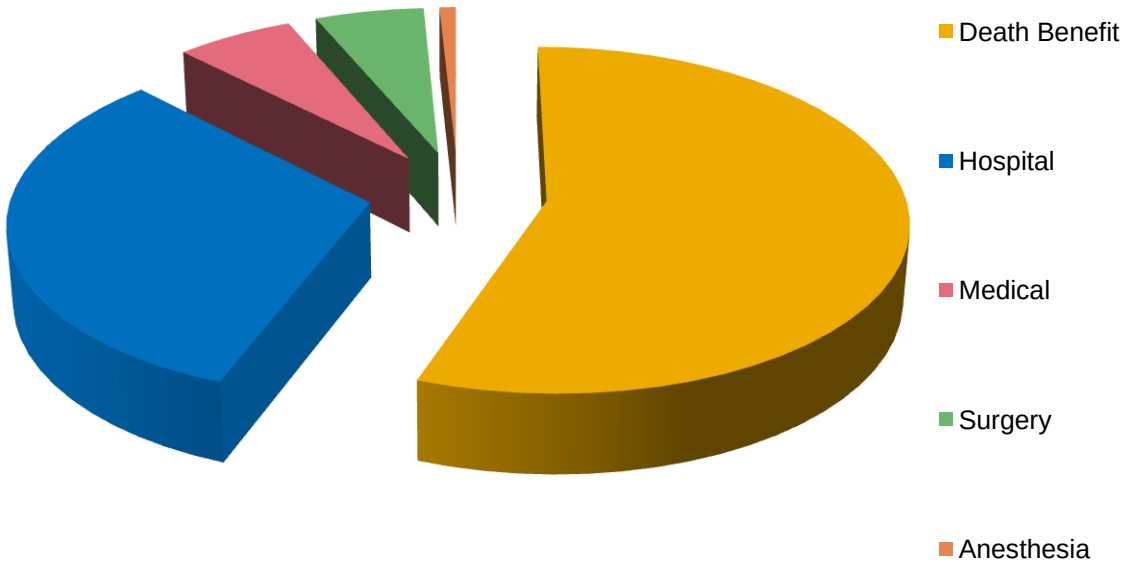
Retiree Plan

	3Q2015	4Q2015	1Q2016	**2Q2016**
Death Benefit	$21,000	$21,000	$34,000	**$25,000**
Medical	$21,082	$30,607	$26,941	**$19,911**
Medicare Supp	$197,422	$202,457	$208,300	**$218,546**



Claims cont'd - 2Q2016

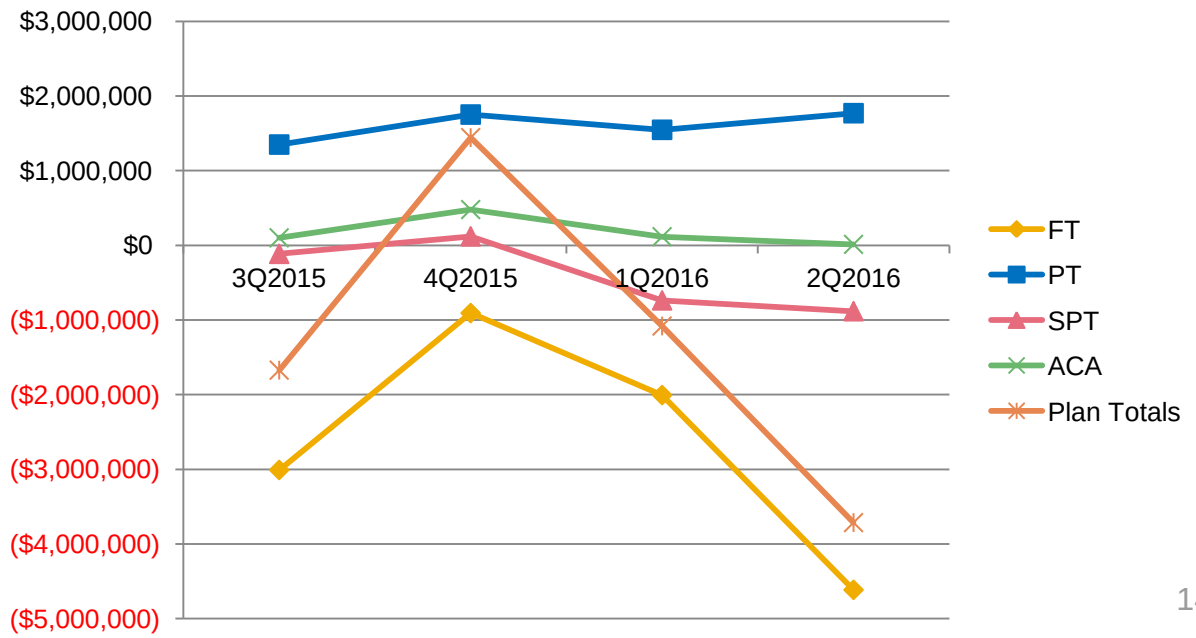
RETIREES		
Death Benefit	$25,000.00	55.67%
Hospital	$14,320.40	31.89%
Medical	$2,714.08	6.04%
Surgery	$2,500.86	5.57%
Anesthesia	$375.65	0.84%
		100.00%



AMR Summary : 2Q2016

All Plans: Surplus/Deficit

	3Q2015	4Q2015	1Q2016	**2Q2016**	Previous 4 Quarters
FT	($3,008,605)	($907,592)	($2,005,852)	**($4,614,026)**	($10,536,075)
PT	$1,349,668	$1,751,322	$1,547,162	**$1,769,687**	$6,417,839
SPT	($113,634)	$120,135	($737,215)	**($882,172)**	($1,612,886)
ACA	$100,611	$478,849	$116,032	**$13,181**	$708,673
Plan Totals	($1,671,960)	$1,442,714	($1,079,873)	**($3,713,330)**	($5,022,449)



AMR Summary : 2Q2016 Fund Reserve

- Average monthly expense January 2015 – June 2016 is **$5,563,929**

- Fund reserve amount is **$33,669,734**, as reported by Fund Auditor 6/30/16

6/30/16 – Fund reserve is 6.1 months

Monthly reserve at past quarterly meetings:

3/31/16	6.6 months
12/31/15	6.5 months
9/30/15	6.0 months

JAA Status Update

Snapshot

Month	Claims Processed	Billed Amount	Paid Amount	Discount Percentage
January	9,281	$10,469,728.75	$3,013,434.40	71.22%
February	9,792	$12,387,203.78	$3,138,723.91	74.66%
March	12,231	$14,310,165.18	$4,407,803.83	69.20%
April	9,902	$13,623,160.66	$4,331,560.72	68.20%
May	9,517	$13,325,150.03	$4,337,767.62	67.45%
June	9,843	$10,866,929.35	$3,523,081.31	67.58%
July	8,296	$10,623,757.02	$3,234,747.43	69.55%
August	9,377	$15,392,103.45	$5,000,520.26	67.51%
Totals	**78,239**	**$100,998,198.22**	**$30,987,639.48**	**69.32%**

JAA Claims – 2Q2016

- Top 5 Diagnoses By Plan

FULL-TIME	
Amount Paid	**Diagnosis**
$377,149.92	Myelodysplastic syndrome, unspecified
$214,161.54	Acute and subacute infective endocarditis
$191,423.18	End stage renal disease
$169,871.63	Sepsis, unspecified organism
$162,193.94	Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

PART-TIME ACA	
Amount Paid	**Diagnosis**
$177,205.51	Nontraumatic intracerebral hemorrhage, intraventricular
$30,866.87	Encounter for antineoplastic chemotherapy
$25,648.37	Sepsis, unspecified organism
$25,359.28	Crohn's disease of small intestine without complications
$12,852.69	Deformity of reconstructed breast

JAA Claims – 2Q2016

- Top 5 Diagnoses By Plan

SPECIAL PART-TIME	
Amount Paid	**Diagnosis**
$189,076.57	Sepsis, unspecified organism
$115,383.29	Thoracic aortic aneurysm, without rupture
$107,273.70	Type 2 diabetes mellitus with other specified complication
$99,551.20	Atrioventricular block, complete
$57,833.91	Cerebral infarction, unspecified

JAA Claims – 2Q2016

- Top 5 Providers By Plan

FULL-TIME	
Provider	**Amount Paid**
LIJ MEDICAL CENTER	$752,211.49
STONY BROOK UNIVERSITY HOSPITAL	$549,367.61
JOHN T. MATHER MEMORIAL HOSPITAL	$500,232.89
STATEN ISLAND UNIVERSITY HOSPITAL	$363,749.89
GOOD SAMARITAN HOSPITAL/MEDICAL CENTER	$283,930.77

PART-TIME ACA	
Provider	**Amount Paid**
BRONX LEBANON HOSPITAL CENTER	$177,432.95
THE STAMFORD HOSPITAL	$35,519.77
VASSAR BROTHERS MEDICAL CENTER	$34,445.92
HACKENSACK MEDICAL CENTER	$26,835.37
NORTH SHORE LIJ MEDICAL	$14,086.26

JAA Claims – 2Q2016

- Top 5 Providers By Plan

SPECIAL PART-TIME	
Provider	**Amount Paid**
MONTEFIORE MEDICAL CENTER	$285,137.70
JOHN T MATHER MEMORIAL HOSPITAL	$222,419.73
LENOX HILL HOSPITAL	$108,679.46
MEMORIAL HOSPITAL FOR CANCER	$71,082.55
WHITE PLAINS HOSPITAL/MEDICAL CENTER	$62,362.47

In-Network vs. Out-of-Network : 2Q2016

- **Inpatient Facility Utilization**
  - **In-Network Total: $6,010,571.88**
    - Full-Time: $4,861,815.59
    - Part-Time ACA: $211,218.80
    - Special Part-Time: $937,537.49
  - **Out-of-Network Total: $0.00**
- **Outpatient Facility Utilization**
  - **In-Network Total: $2,038,641.37**
    - Full-Time: $1,785,477.57
    - Part-Time ACA: $56,816.73
    - Special Part-Time: $196,347.07
  - **Out-of-Network Total: $6,930.00**
    - Full-Time: $6,930
    - Part-Time ACA: $0.00
    - Special Part-Time: $0.00
- **Inpatient & Outpatient Professional Fees**
  - **In-Network Total: $4,859,616.76**
    - Full-Time: $4,328,749.31
    - Part-Time ACA: $125,745.47
    - Special Part-Time: $405,121.98
  - **Out-of-Network Total: $1,128,656.91**
    - Full-Time: $963,361.48
    - Part-Time ACA: $0.00
    - Special Part-Time: $165,295.43

Out-Of-Network Discounts HRGi Savings

- April 2016 Invoice – Total billed $1,388,983.50
  - Savings: $582,502.48
  - Average: 42% per claim
- May 2016 Invoice – Total billed $627,208.11
  - Savings: $297,820.08
  - Average: 48% per claim
- June 2016 Invoice – Total billed $843,950.39
  - Savings: $397,953.34
  - Average: 47% per claim
- July 2016 Invoice – Total billed $327,760.67
  - Savings: $144,794.58
  - Average: 44% per claim
- August 2016 Invoice – Total billed $470,429.16
  - Savings: $170,017.00
  - Average: 36% per claim

April through August – Total billed $ 3,658,331.63

Total saved: $1,593,087.48

Average: 43.5%

Other Fund Business

- Full-Time Spousal Questionnaire mailed to 1,364 members on 8/5/16
  - As of 9/14/16, we have received 593 responses
    - 70 spouses are currently covered by their employer's plan
    - 28 spouses will be covered by future enrollment
  - A second letter was mailed on 9/16/16 to 771 members

- Transitional Reinsurance Fee
  - 2nd payment due 11/08/16
  - Transaction amount: $122,045

- Subrogation Recovery 2Q2016
  - Full-Time Plan: Total medical liens were $14,370.27 (100% recovered)

- Creditable Coverage Notice will be mailed by 10/15/16

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Hospital/Medical – Preventive Services #M16/194-1455

FUND RULE:
"**Preventive Care Services Benefits**
The UFCW Local 1500 WELFARE Fund provides coverage for certain preventive services, as required by the Patient Protection and affordable Car Act of 2010 (hereinafter "ACA"). Coverage is provided with no cost sharing (for example, no deductibles, coinsurance, or copayments), on an in-network basis only."
(Quoted from, UFCW Local 1500 Welfare Fund Preventive Care Service Benefits Revised as of January 1, 2015)

SUMMARY:

Date(s) of Service:	June 10, 2016
Claim Received:	July 5, 2016
Claim Denied:	July 6, 2016
Appeal Received:	August 10, 2016

The **participant** is appealing for additional payment of a claim that was paid at 80%. The participant states, "Quest Diagnostic charged me for a test that is supposed to be covered at 100% under the preventive benefit. I spoke to a representative at the Fund office on June 3, 2016 before I had that test included in my bloodwork. I gave her the code that the doctor gave me, it was a test deemed necessary because of a vitamin D deficiency. The representative told me the vitamin D test was covered. "

Fund records indicate Quest Diagnostics submitted a claim for a blood draw, calcifediol (25-oh vitamin D-3), general health panel and lipid panel" with the diagnoses "encounter for general adult medical examination and vitamin D deficiency." The testing for the calcifediol (25-oh vitamin D-3) was processed and paid at 80% under the medical benefit. This test is not covered under the Preventive Care Service Benefit.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Prescription Benefit – Drug Quantity Management #Rx16/131-1219

FUND RULE:
"**Effective October 1, 2015 –** The Prescription Drug Benefit is amended to include Utilization Management (hereinafter 'UM') administered by Express Scripts, Inc. (hereinafter 'ESI'). The Plan's UM program will consist of 3 components: (1) Prior Authorization (hereinafter 'PA') of medications, (2) Step Therapy and (3) Drug Quantity Management.

Drug Quantity Management (DQM). DQM is a program that is designed to make use of prescription drugs safer and more affordable. It provides the medication you need while making sure you receive it in the amount (or quantity) considered safe.

There are certain medications in this program. For those medications, you may only receive a specified amount. The quantity dispensed allows you to receive medication (1) in the daily dose considered safe and effective by the U.S. Food & Drug Administration (hereinafter "FDA") (i.e., for a medication you take once a day, the Plan will allow you to fill a prescription for 30 pills/capsules) and/or (2) in a more cost effective manner (i.e., if a prescription is available in different strengths, sometimes you can take a higher strength pill rather than 2 smaller strength pills). In that way, you would have one co-payment instead of two.

The ESI DQM program follows guidelines developed by the FDA. These guidelines recommend the maximum quantities considered safe for prescribing certain drugs. The DQM program includes drugs which might be unsafe if the quantity you receive is larger than the guidelines recommend (i.e., it includes medications that are not easily measured like nose sprays and inhalers).

DQM works as follows: When you submit your prescription, your pharmacist's computer system will note that the prescription is for a non-covered amount of medication. This could mean that you have asked for a prescription too soon or your doctor wrote the prescription for a quantity larger than the Plan covers. If the quantity on your prescription is too large, you can ask the pharmacist to fill the prescription as written, but for the amount allowed under the DQM guidelines. You will pay the appropriate co-payment. This may mean you will have to fill the prescription more frequently which, in turn, could end up costing you additional co-payments OR you can ask the pharmacist to contact your doctor to discuss changing the prescription (for example if the issue is the strength of the medication and your physician is prescribing a low dosage medication, the pharmacist and doctor can discuss the possibility of having a higher strength medication dispensed) OR **your doctor can contact ESI and request a PA for the medication as written.** If the request is denied, you can still get the medication, however, it will be dispensed in the quantity recommended by the DQM. In those cases, you will continue to pay the Plan's co-payment each time you get a refill.

The DQM program applies to the Plan's Mail Order option as well. In those cases, ESI will try to contact your doctor to suggest either changing your prescription or asking for a PA. If your doctor is unavailable at the time ESI contacts him/her and ESI does not hear from him/her within 2 days, ESI will fill your prescription for the quantity covered under the DQM.

PLEASE NOTE: The DQM program does not deny you access to your needed medication. It simply ensures that the Plan provides the prescription drugs you need in the quantities that follow the Plan's guidelines for safe and economical use, as determined by the FDA."
(UFCW Local 1500 Full Time Employees Benefit Plan Summary of Material Modifications, July 21, 2015)

SUMMARY: Appeal Received: March 10, 2016

The **participant** is appealing to be allowed coverage of Depro Provera 150mg/mL (medroxyprogesterone 150mg/mL) once every 60 days as opposed to the Plan limit of once every 68 days. It was noted that Depro Provera is a birth control medication. The participant states she has been using Depro Provera since 2012 for a medical condition (endometriosis) and not for birth control purposes. Included with the appeal, was a letter of medical necessity from Dr. Alex G. Hirsch. Dr. Hirsch states that the participant has been prescribed Depro Provera 150mg/mL once every two months to control this condition.

After the appeal was received, Associated Administrators contacted Express Scripts. Express Scripts advised that pharmacy claims for medroxyprogesterone 150mg/mL (generic Depro Provera) were paid on April 21, 2015, June 16, 2015, and August 12, 2015 (between 56 and 57 days apart, respectively). The Plan implemented a Drug Quantity Management (DQM) program effective October 1, 2015. Pharmacy claims for this medication were denied on October 7, 2015, October 12, 2015, and October 15, 2015 because the Plan limit was exceeded. A pharmacy claim was paid on October 20, 2015 (69 days from the last successful claim). A pharmacy claim was denied again on December 26, 2015 and then paid on December 28, 2015 (again at an interval of 69 days from the last successful claim). Pharmacy claims were denied again on March 2, 2016 and March 3, 2016. A pharmacy claim was then paid on March 9, 2016 (at 72 days).

Note: Express Scripts advises that Depro Provera 150mg/mL does not require a Prior Authorization and therefore, no Prior Authorization process is available at their firm.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

NAME: **SS#:**
REGARDING:

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Dental – Excluded Services #D16/147-5769

FUND RULE:
"Dental Expense Benefit

Any service or supplies not specifically listed are not covered by this benefit."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Page 75)

SUMMARY:

Date(s) of Service:	January 15, 2016
Claim Received:	March 14, 2016
Claim Denied:	March 14, 2016
Appeal Received:	April 18, 2016

The **participant** is appealing for payment of a general anesthesia charge on a dental claim for her daughter (DOB: 11-2-1991) that was denied. The participant states that her daughter "was very anxious about the procedure and would not have been able to tolerate the extractions and the removal of the impacted teeth if it were to be done with only local anesthesia. It was necessary to remove the teeth due to discomfort of the areas and to prevent infections and damage to the teeth adjacent to the impacted third molars. Under these circumstances, I feel general anesthesia should be a covered procedure."

David Miller, DDS submitted a claim (for secondary payment) for the surgical extraction of four (4) teeth under general anesthesia performed on January 15, 2016. The charges for the extractions were paid, up to the limits of the Dental Plan. The general anesthesia charge was denied because it is not a benefit of the Dental Plan.

Note: Aetna paid this claim on January 21, 2016. The participant's daughter has primary coverage with Aetna through her father's employment which has been in effect since January 1, 2013. The Fund is secondary.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS:

Conclusion

- Thank You
- Questions?