UFCW Local 1500 Welfare Fund

Associated Administrators, LLC Report

December 12, 2017

Laura Walsh
Bill Jensen
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Agenda

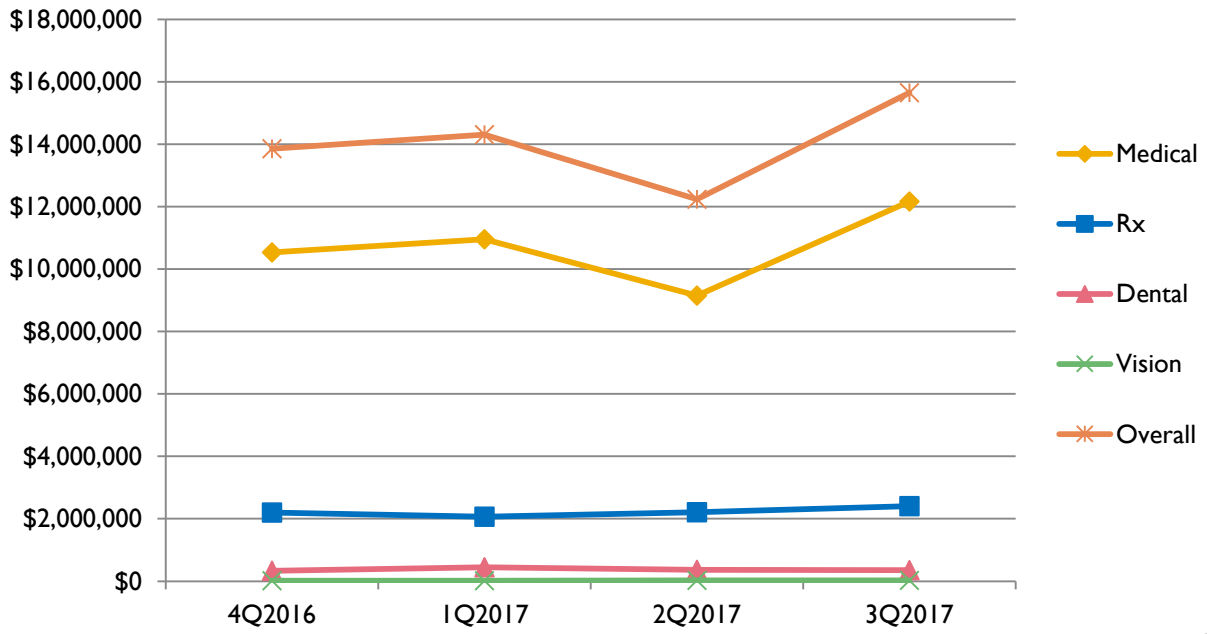
- AMR Summary and Claims Utilization Report 3Qtr 2017
  - Full Time
  - Special Part Time
  - Part Time ACA
  - Basic Part Time
  - Retiree
  - Summary and Reserve
- JAA Status Update
  - Snapshot
  - Top Five Health Conditions
  - Top Five Providers
- In-Network vs. Out-of-Network
- Out-Of-Network Discount Report
- Other Fund Business
- Tabled Appeals

AMR Summary : 3Q2017

Full Time Plan

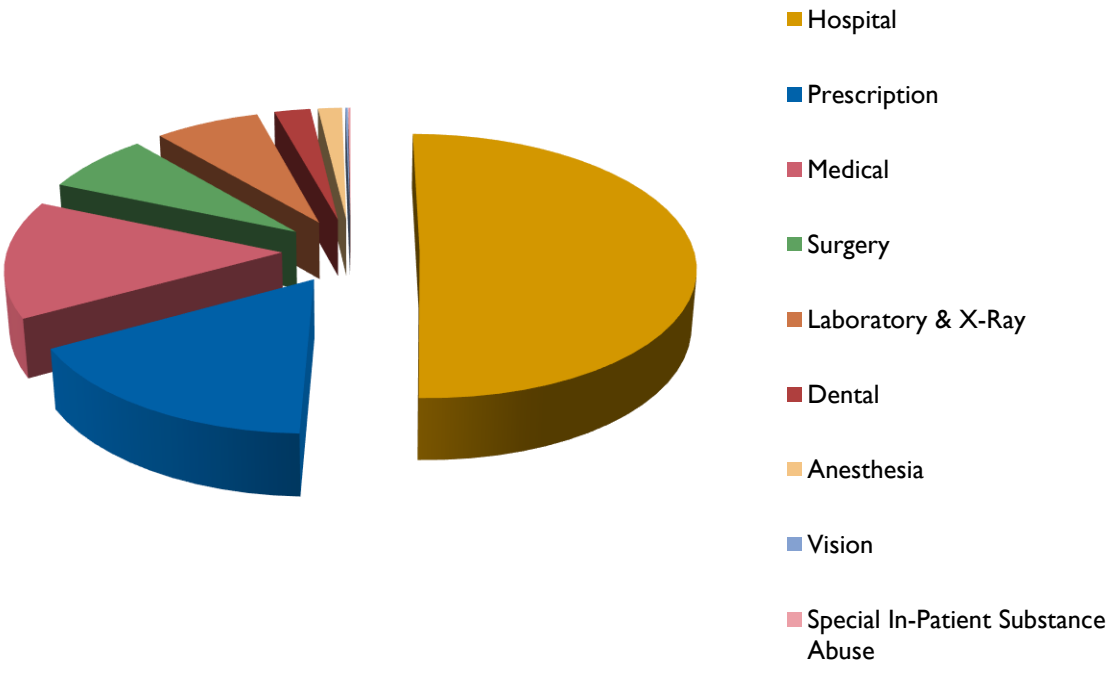
	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
Medical	$10,532,413	$10,954,802	$9,146,723	**$12,166,529**	$42,800,467
Rx	$2,195,829	$2,069,933	$2,213,682	**$2,403,177**	$8,882,621
Dental	$330,674	$445,263	$367,927	**$350,181**	$1,494,045
Vision	$19,124	$18,195	$23,563	**$22,974**	$83,856

- **3Q17 deficit of $3,012,172**
- **PPPM Cost 3Q17 - $1,526**



Claims – 3Q2017

FULL-TIME PLAN		
Hospital	$7,341,853.19	50.49%
Prescription	$2,403,177.00	16.53%
Medical	$2,089,413.24	14.37%
Surgery	$1,060,375.41	7.29%
Laboratory & X-Ray	$1,020,161.32	7.02%
Dental	$350,181.37	2.41%
Anesthesia	$231,785.15	1.59%
Vision	$22,974.00	0.16%
Special In-Patient Substance Abuse	$21,310.00	0.15%
		100%

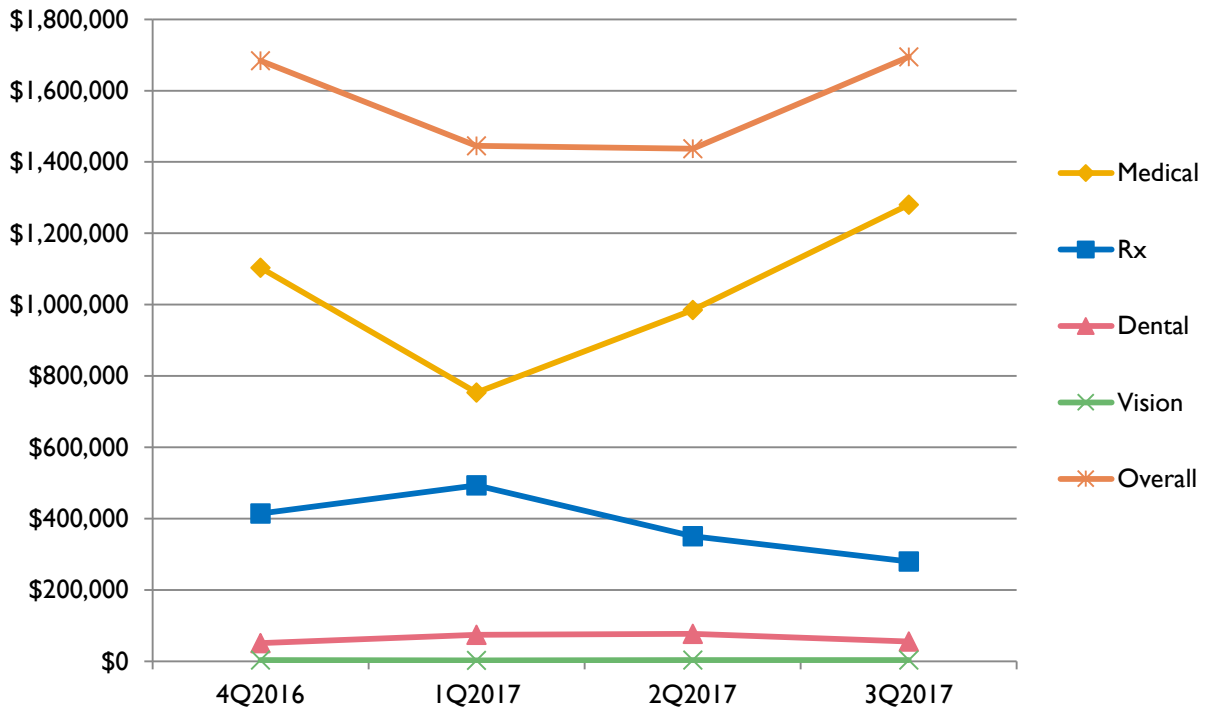


AMR Summary : 3Q2017

Special Part Time Plan

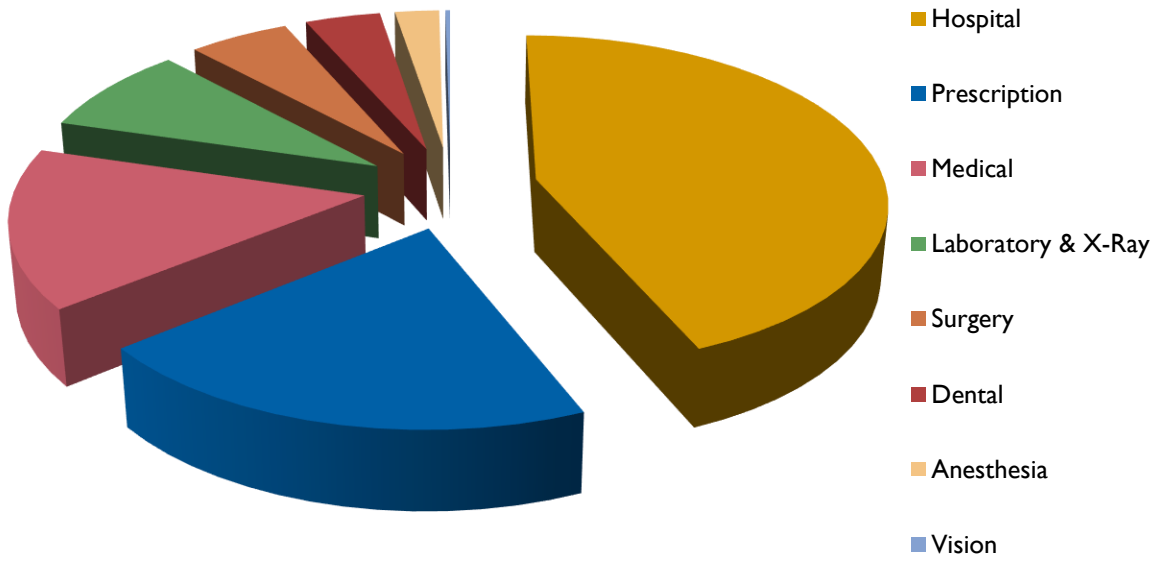
	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
Medical	$1,103,594	$753,701	$984,847	**$1,279,895**	$4,122,037
Rx	$413,834	$492,816	$350,286	**$279,925**	$1,536,861
Dental	$50,612	$74,131	$77,110	**$54,835**	$256,688
Vision	$3,110	$2,283	$3,263	**$3,438**	$12,094

- **3Q17 deficit of $509,187**
- **PPPM Cost 3Q17 - $631**



Claims cont'd – 3Q2017

SPECIAL PART-TIME PLAN		
Hospital	$597,762.93	43.70%
Prescription	$279,925.00	20.46%
Medical	$210,414.01	15.38%
Laboratory & X-Ray	$116,114.06	8.49%
Surgery	$73,227.17	5.35%
Dental	$54,834.65	4.01%
Anesthesia	$32,153.94	2.35%
Vision	$3,438.00	0.25%
		100%

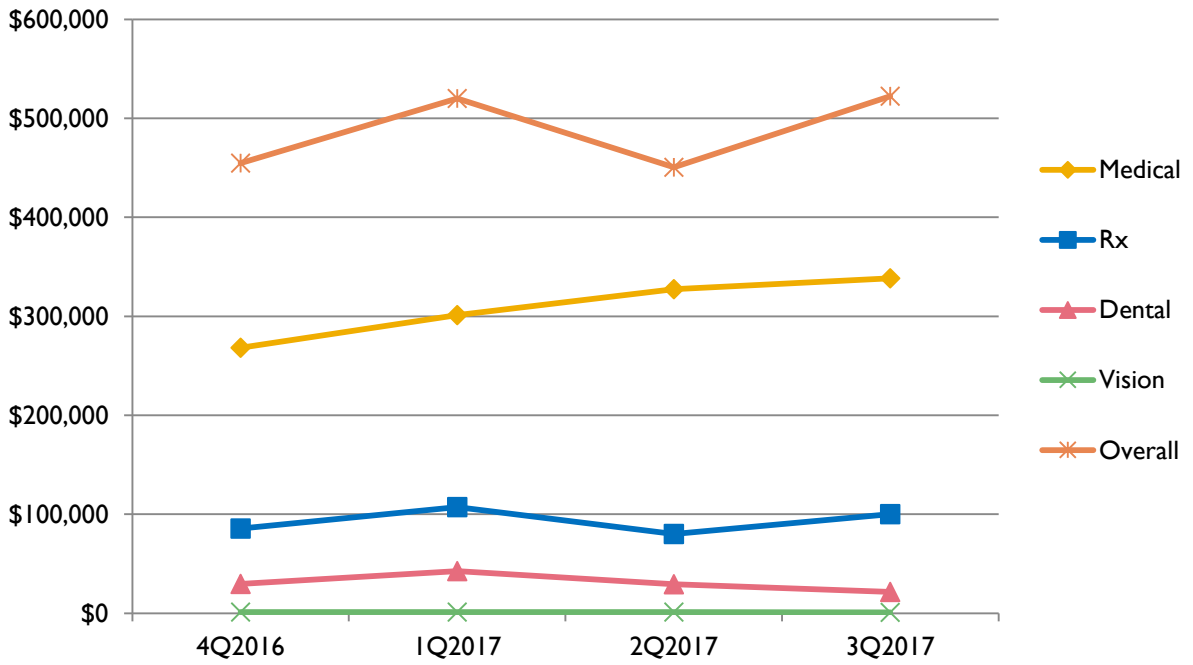


AMR Summary : 3Q2017

Part Time ACA Plan

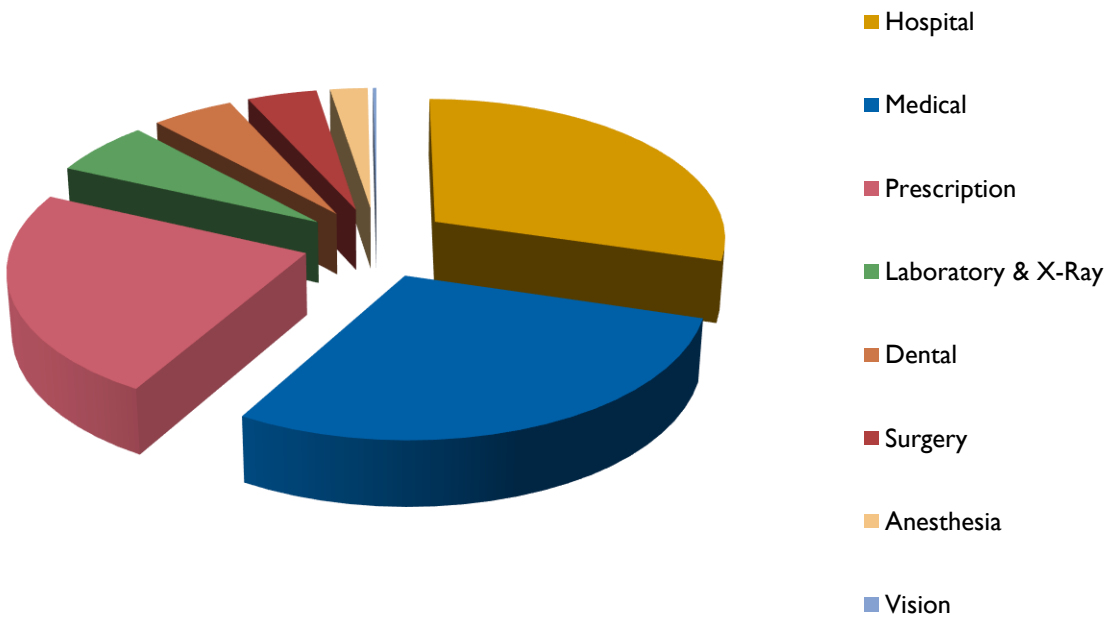
	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
Medical	$268,077	$301,031	$327,393	**$338,384**	$1,234,885
Rx	$85,391	$107,235	$80,157	**$100,091**	$372,874
Dental	$29,621	$42,642	$29,379	**$21,648**	$123,290
Vision	$1,317	$1,112	$1,162	**$900**	$4,491

- **3Q17 surplus of $223,166**
- **PPPM Cost 3Q17 - $292**



Claims cont'd - 3Q2017

PART-TIME ACA PLAN		
Hospital	$125,759.03	29.55%
Medical	$122,275.01	28.74%
Prescription	$100,091.00	23.52%
Laboratory & X-Ray	$26,595.16	6.25%
Dental	$21,648.15	5.09%
Surgery	$18,385.47	4.32%
Anesthesia	$9,868.60	2.32%
Vision	$900.00	0.21%
		100%



JAA Claims – 3Q2017
Part-Time ACA Plan Deductible/Out-of-pocket maximum

- **24 members met their $5,600 deductible for the 2017 plan year by the end of the 3rd quarter.**
- **Utilization below -- amounts shown include first $400 basic benefit.**

MEMBER	AMOUNT PAID THROUGH 3Q2017
1	$31,251.32
2	$7,319.79
3*	$14,383.42
4	$5,736.64
5	$163,511.37
6*	$2,997.78
7*	$800.03
8	$207,633.98
9*	$55,081.41
10	$4,815.75
11	$10,018.95
12	$64,661.51

MEMBER	AMOUNT PAID THROUGH 3Q2017
13	$54,887.96
14	$7,264.20
15	$16,137.90
16	$25,436.49
17	$4,459.18
18	$1,927.69
19	$10,589.58
20	$990.01
21	$8,752.01
22	$4,865.45
23	$2,419.71
24	$978.19

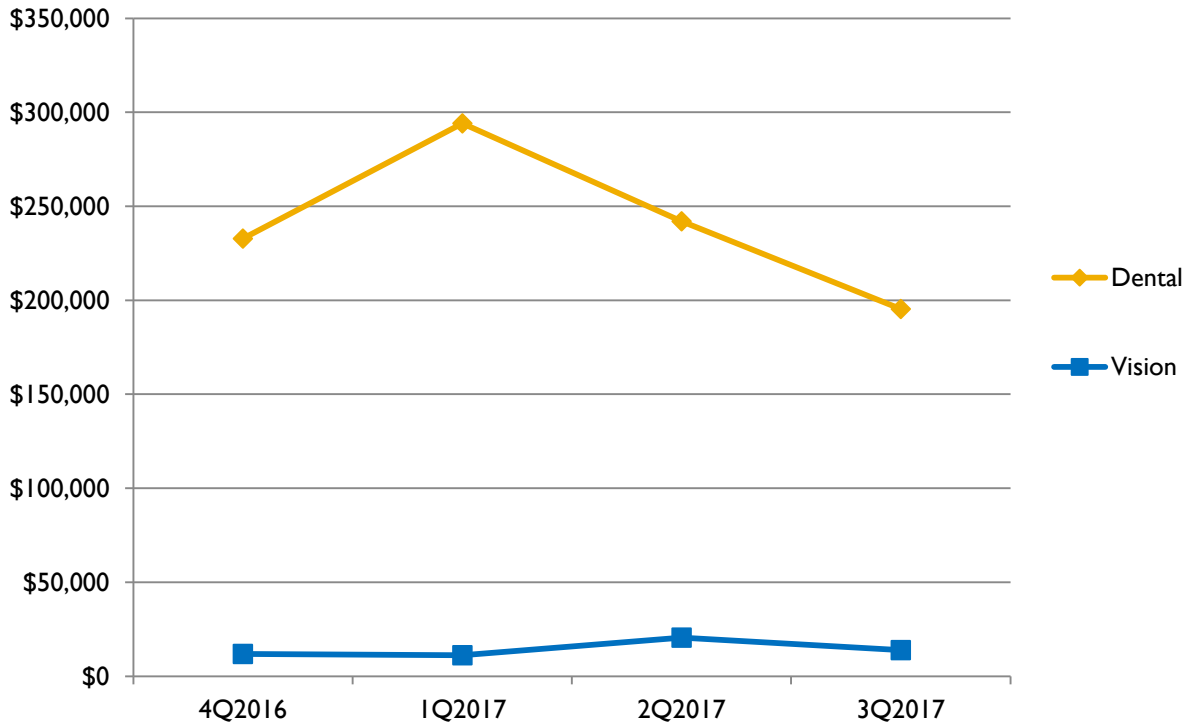
* Member's Part-Time ACA Benefits have terminated.

AMR Summary : 3Q2017

Part Time Plan

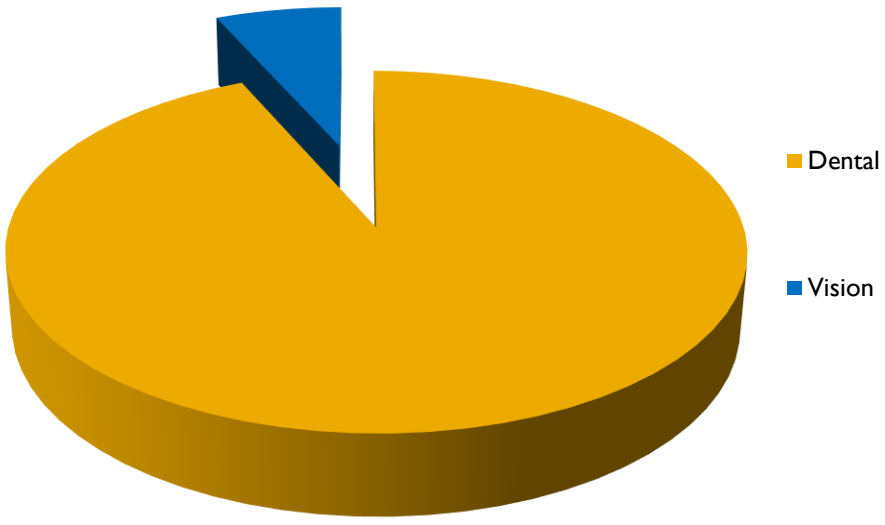
	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
Dental	$232,754	$294,169	$242,046	**$195,326**	$964,295
Vision	$11,829	$11,191	$20,603	**$13,870**	$57,493

- **3Q17 surplus of $2,514,562**
- **PPPM Cost 3Q17 - $25**



Claims cont'd – 3Q2017

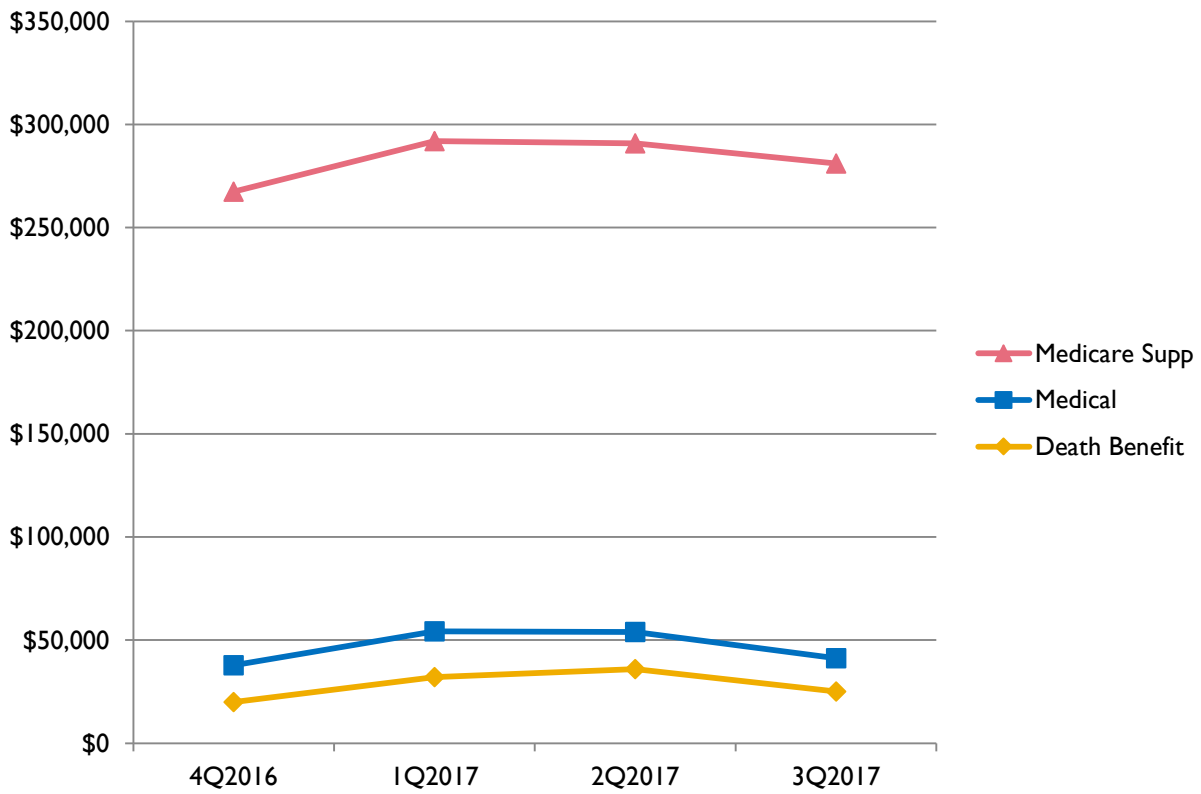
PART-TIME PLAN		
Dental	$195,326.10	93.37%
Vision	$13,869.91	6.63%
		100.00%



AMR Summary : 3Q2017

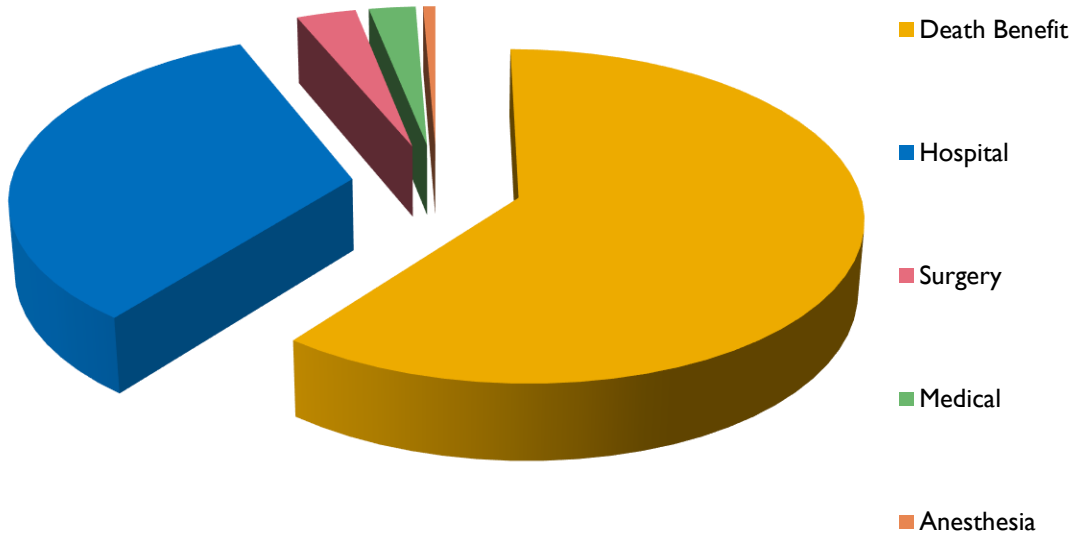
Retiree Plan

	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
Death Benefit	$20,000	$32,000	$36,000	**$25,000**	$113,000
Medical	$17,752	$22,166	$17,940	**$16,275**	$74,133
Medicare Supp Part B Reimbursement	$229,602	$237,824	$236,886	**$239,833**	$944,145



Claims cont'd - 3Q2017

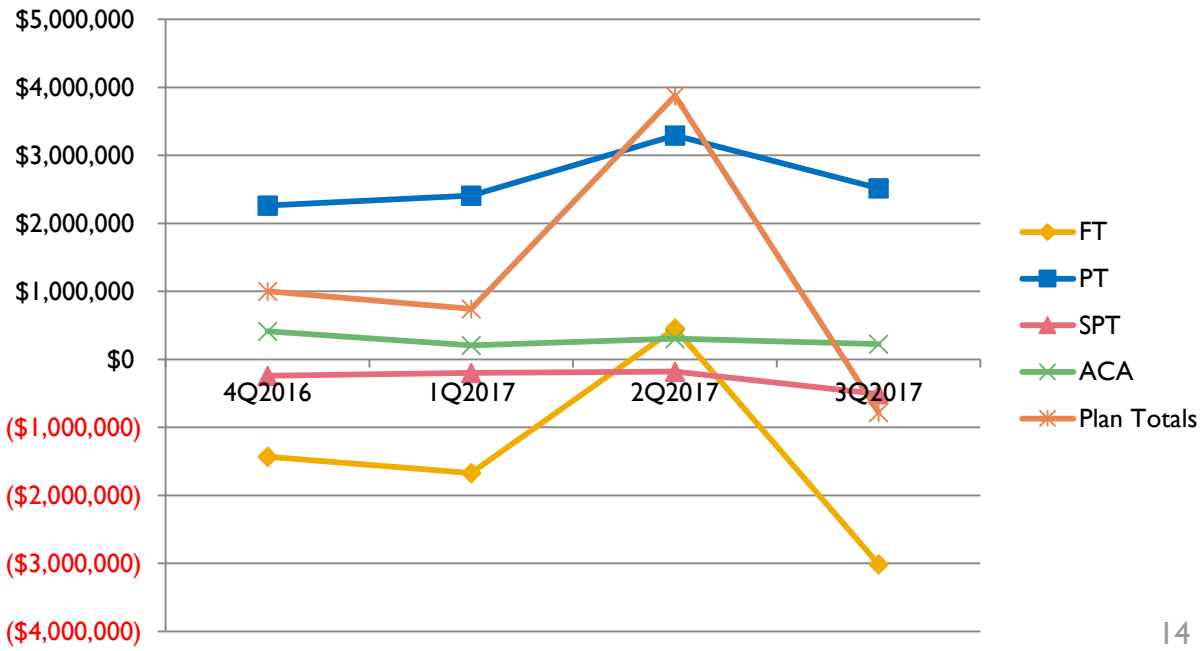
RETIREES		
Death Benefit	$25,000.00	60.57%
Hospital	$13,658.52	33.09%
Surgery	$1,316.74	3.19%
Medical	$1,030.56	2.50%
Anesthesia	$269.32	0.65%
		100.00%



AMR Summary : 3Q2017

All Plans: Surplus/Deficit

	4Q2016	1Q2017	2Q2017	**3Q2017**	Previous 4 Quarters
FT	($1,433,785)	($1,669,922)	$456,000	**($3,012,172)**	($5,659,879)
PT	$2,262,950	$2,407,933	$3,291,115	**$2,514,562**	$10,476,560
SPT	($241,653)	($199,792)	($178,298)	**($509,187)**	($1,128,929)
ACA	$411,666	$203,114	$306,572	**$223,166**	$1,144,518
Plan Totals	$999,179	$741,333	$3,875,389	**($783,631)**	$4,832,270



AMR Summary : 3Q2017 Fund Reserve

- Average monthly expense April 2016 – September 2017 is **$5,853,152.86**

- Fund reserve amount is **$41,731,308**, as reported by Fund Auditor 9/30/17

9/30/17 – Fund reserve is 7.1 months

Monthly reserve at past quarterly meetings:

6/30/17	7.0 months
3/31/17	6.1 months
12/31/16	5.8 months
9/30/16	5.5 months
6/30/16	6.1 months

JAA Status Update

Snapshot

Month	Claims Processed	Billed Amount	Paid Amount	Difference
December ’16	7,582	$11,001,605.35	$3,233,256.63	70.61%
January ’17	9,329	$11,563,874.47	$3,280,264.98	71.63%
February ’17	8,498	$10,225,760.58	$3,395,888.02	66.79%
March ’17	9,417	$11,745,209.64	$3,830,420.07	67.39%
April ’17	7,629	$8,228,666.63	$2,730,832.01	66.81%
May ’17	8,706	$10,407,457.51	$3,487,994.80	66.49%
June ’17	9,272	$10,022,797.65	$3,095,844.26	69.11%
July ’17	7,517	$11,719,690.72	$3,188,647.56	72.79%
August ‘17	8,841	$18,706,067.83	$5,883,489.39	68.55%
September ’17	7,424	$8,687,002.26	$2,897,887.00	66.64%
October ’17	8,301	$9,966,285.42	$2,983,095.78	70.07%
November ’17	7,742	$9,841,280.16	$3,505,561.71	64.38%
Totals	**100,258**	**$132,115,698.22**	**$41,513,182.21**	**68.58%**

JAA Claims – 3Q2017

- Top 5 Diagnoses By Expense By Plan

FULL-TIME	
Amount Paid	**Diagnosis**
$2,248.698.15	Sepsis due to Enterococcus
$232,505.42	Other streptococcal sepsis
$187,774.78	Major depressive disorder, recurrent severe without psychotic features
$178,618.07	End stage renal disease
$165,530.24	Acute disseminated encephalitis and encephalomyelitis, unspecified

PART-TIME ACA	
Amount Paid	**Diagnosis**
$85,597.21	Malignant neoplasm of endometrium
$35,001.80	Other acute osteomyelitis, right ankle and foot
$18,189.00	Crohn's disease, unspecified, with fistula
$18,055.23	Crohn's disease of large intestine with other complication
$17,018.61	Encounter for antineoplastic chemotherapy

JAA Claims – 3Q2017

- Top 5 Diagnoses By Expense By Plan

SPECIAL PART-TIME	
Amount Paid	**Diagnosis**
$103,343.70	Hypertensive heart and chronic kidney disease with heart failure
$101,509.57	Spinal stenosis, cervical region
$49,850.89	End stage renal disease
$45,064.64	Encounter for other specified surgical aftercare
$42,124.38	Malignant neoplasm of unspecified site of left female breast

JAA Claims – 3Q2017

- Top 5 Providers By Expense By Plan

FULL-TIME	
Provider	**Amount Paid**
LIJ MEDICAL CENTER	$2,457,480.31
WINTHROP UNIVERSITY HOSPITAL	$539,798.59
STONY BROOK UNIVERSITY HOSPITAL	$370,477.31
NORTH SHORE UNIVERSITY HOSPITAL	$289,762.84
MONTEFIORE MEDICAL CENTER	$277,438.95

PART-TIME ACA	
Provider	**Amount Paid**
MONTEFIORE MEDICAL CENTER	$90,837.32
HACKENSACK MEDICAL CENTER	$67,939.93
ARDEN HILL HOSPITAL	$36,180.51
PENNSYLVANIA PSYCHIATRIC INSTITUTE	$12,051.98
ST. JOHNS RIVERSIDE HOSPITAL	$9,556.44

JAA Claims – 3Q2017

- Top 5 Providers By Expense By Plan

SPECIAL PART-TIME	
Provider	**Amount Paid**
MONTEFIORE MEDICAL CENTER	$219,391.32
WESTCHESTER COUNTY HEALTH CARE	$142,293.90
LIJ MEDICAL CENTER	$60,020.47
HUDSON VALLEY HEMATOLOGY-ONCOLOGY	$55,406.26
NEW YORK HOSPITAL MEDICAL CENTER – QUEENS	$46,917.26

In-Network vs. Out-of-Network : 3Q2017

- **Inpatient Facility Utilization**
  - **In-Network Total: $6,085,746.85**
    - Full-Time: $5,586,676.01
    - Part-Time ACA: $88,440.91
    - Special Part-Time: $410,629.93
  - **Out-of-Network Total: $0.00**
- **Outpatient Facility Utilization**
  - **In-Network Total: $1,841,006.12**
    - Full-Time: $1,629,247.96
    - Part-Time ACA: $35,907.18
    - Special Part-Time: $175,850.98
  - **Out-of-Network Total: $112,935.70**
    - Full-Time: $112,935.70
    - Part-Time ACA: $0.00
    - Special Part-Time: $0.00
- **Inpatient & Outpatient Professional Fees**
  - **In-Network Total: $4,324,868.95**
    - Full-Time: $3,744,582.96
    - Part-Time ACA: $178,535.18
    - Special Part-Time: $401,750.81
  - **Out-of-Network Total: $732,896.07**
    - Full-Time: $691,455.68
    - Part-Time ACA: $0.00
    - Special Part-Time: $41,440.39

HRGi
Out-Of-Network Discounts

- July 2017 Invoice – Total billed $95,111.25
  - Discount: $51,632.08 – net of fees
  - Average: 54% per claim
- August 2017 Invoice – Total billed $1,299,057.39
  - Discount: $759,771.63 – net of fees
  - Average: 58% per claim
- September 2017 Invoice – Total billed $497,340.45
  - Discount: $160,960.30 – net of fees
  - Average: 32% per claim
- October 2017 Invoice – Total billed $99,564.26
  - Discount: $44,437.52 – net of fees
  - Average: 45% per claim

July 2017 through October 2017

Total billed: $1,991,073.35

Total discount: $1,016,801.53 – net of fees

Average: 51.07%

Other Fund Business

- Subrogation Recovery 3Q2017
  - Full-Time Plan: Total medical liens were $31,087.38 ($26,603.52 recovered due to trustee approved lien reduction) – Maria Maloney assisted in recovery

- Plan Reporting – ACA sections 6055 and 6056
  - Forms 1094-B/1095-B due 2/28/18

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Prescription Benefit – Prior Authorization #Rx17/206-9515

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.

Prior Authorization. PA is a program that monitors certain prescription drugs for safety and cost. PA reviews are done before the medication is dispensed to ensure the necessity of the drug. The ESI PA program was developed under the guidance and direction of independent, licensed physicians, pharmacists and other medical experts utilizing the most current research on the medication. These experts recommend prescription drugs that are appropriate for the PA program and ESI chooses the drugs that will be covered. Drugs which may require pre-authorization include those prescribed for conditions other than the conditions for which the FDA has approved the drug and drugs which might be used for non-medical purposes.

The PA program works as follows: when your pharmacist tries to fill a prescription, the computer system will indicate 'prior authorization required'. This means that information is needed to determine if the Plan covers the drug. You can then ask your doctor to contact ESI or prescribe another medication that does not require PA. ESI's PA phone lines are open Monday – Friday, 8am to 9pm Eastern Time. The number to call is (800) 417-1764.

If the doctor provides information sufficient to establish that the medication is medically necessary, ESI will allow the prescription to be processed. Thereafter, you only pay the applicable co-payment at the pharmacy. If the medication is not deemed medically necessary, it will not be covered and your physician has the option of prescribing another medication. If a medication is deemed not medically necessary and you choose to fill the prescription anyway, you will be responsible for the full cost of the drug."
(UFCW Local 1500 Full Time Employees Benefit Plan Summary of Material Modifications, July 21, 2015)

SUMMARY: Appeal Received: September 29, 2017

The **provider,** Dr. David D'Agate, is appealing on behalf of the participant for coverage of injectable Praluent. It was noted that a prior authorization for Praluent was denied by Express Scripts on May 23, 2017 because it did not meet their criteria for coverage. Express Scripts advised, **"Coverage is provided in situations where the patient has documentation of a trial of one high-intensity statin therapy (that is, atorvastatin 40 mg or greater daily: rosuvastatin 20 mg or greater daily [as a single-entity or as a combination product] and Zetia (ezetimibe tablets) [as a single-entity or as a combination product] in combination for at least eight (8) continuous weeks and there is documentation that the patient's low-density lipoprotein cholesterol (LDL-C) level after this treatment regimen remains greater than or equal to 70 mg/dL or the patient has been determined to be statin intolerant by documentation that they have experienced statin-related rhabdomyolysis or skeletal-related muscle symptoms and documentation has been provided that the patient's skeletal-related muscle symptoms (for example, myopathy or myalgia) occurred while receiving separate trials of both atorvastatin and rosuvastatin (as single-entity or as combination products). Coverage cannot be authorized at this time."** Documentation of a trial for one high-intensity statin therapy was not supplied.

After the prior authorization was denied, Dr. D'Agate sent a fax to Express Scripts on August 7, 2017 indicating Zetia 10mg was prescribed daily with the patient's maximum dose Pravastatin 80mg for eight (8) weeks. Labs drawn on July 24, 2017 reported an LDL of 155 while on the max dose statin therapy in combination of Zetia. According to Dr. D'Agate, "The patient's LDL remains too high on combination max dose statin with Zetia. We feel the addition of Praluent will be necessary to reduce his LDL to an optimal level."

Express Scripts states there is no further review available at their firm for this prior authorization.

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

NAME: **SS#:**
REGARDING:

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Prescription Benefit – Coverage of Brand Name Drug #Rx17/217-9555

FUND RULE:
"Prescription Drug Benefit
When a brand name drug has a generic equivalent, you may get the brand name, but you will be responsible for the difference between the cost of the brand name drug versus the cost of its generic equivalent, plus the co-payment."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Page 69)

SUMMARY: Appeal Received: October 27, 2017

The **participant** is appealing for her son (DOB: 6-20-1989) to be allowed coverage of Depakote ER, which is a brand name drug. The participant states that her son "has been taking Depakote ER for many years and it has worked well to keep the seizures under control. In the past we tried the generic brand, but it did not agree with him." Included with the participant's appeal is a letter of medical necessity from Dr. Sean T. Hwang. Dr. Hwang states, "It is my medical opinion for seizure control and hematological reasons, [the participant's son] should remain on the brand [name] version of [Depakote ER]."

Note: The Fund's medical consultant determined in 2013 that brand name Depakote ER **was medically necessary**, and the participant's son was granted coverage for one year at the co-payment level (without responsibility for the difference between the cost of the brand name drug versus the cost of its generic equivalent). The participant's son was granted coverage again, upon appeal, in 2016. That approval expires on December 31, 2017.

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

NAME: **SS#:**
REGARDING:

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Hospital/Medical – Experimental/Investigational #M17/204-7261

FUND RULE:
"Medical Limitations and Exclusions
Technology including treatments, procedures, drugs, biological, and medical devices that, in [the Fund's] sole discretion, are not medically necessary in that they are one of the following:
- Experimental
- Investigational

Experimental or investigational means either of the following definitions:
- The technology is not of proven benefit for either the particular diagnosis or the treatment of your condition.
- The technology is not generally recognized by the medical community (as reflected in the published peer-review medical literature) as either effective or appropriate for the particular diagnosis or treatment of your particular condition.

[The Fund] may apply any or all of the following… criteria when determining whether a technology is experimental, investigational, obsolete, or ineffective:
- Any medical device, drug, or biological product must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular diagnosis or condition."
(UFCW Local 1500 Full Time Employees Benefit Plan SPD, Pages 47-48)

SUMMARY:

Date(s) of Service:	May 15, 2017 and May 24, 2017
Claim Received:	May 22, 2017 through May 30, 2017
Claim Denied:	May 30, 2017 through June 8, 2017
Appeal Received:	September 27, 2017

The **provider,** Omni Eye Services, is appealing for payment of claims for the participant's spouse that were denied.

Omni Eye Services submitted claims for intravitreal Avastin (generic bevacizumab) injections with the diagnosis "Type 2 diabetes mellitus with severe nonproliferative retinopathy." The claims were denied because Avastin has not been FDA-approved for the treatment of this diagnosis.

After the appeal was received, it was sent to HealthLink for review. HealthLink advised Associated Administrators, LLC that the treatment **is medically necessary**.

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

NAME: **SS#:**

UFCW LOCAL 1500 WELFARE FUND

LOCAL: 1500
STATUS: Full Time

ISSUE: Prescription Benefit – Prior Authorization #Rx17/205-7931

FUND RULE:
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Prior Authorization. PA is a program that monitors certain prescription drugs for safety and cost. PA reviews are done before the medication is dispensed to ensure the necessity of the drug. The ESI PA program was developed under the guidance and direction of independent, licensed physicians, pharmacists and other medical experts utilizing the most current research on the medication. These experts recommend prescription drugs that are appropriate for the PA program and ESI chooses the drugs that will be covered. Drugs which may require pre-authorization include those prescribed for conditions other than the conditions for which the FDA has approved the drug and drugs which might be used for non-medical purposes.

The PA program works as follows: when your pharmacist tries to fill a prescription, the computer system will indicate 'prior authorization required'. This means that information is needed to determine if the Plan covers the drug. You can then ask your doctor to contact ESI or prescribe another medication that does not require PA. ESI's PA phone lines are open Monday – Friday, 8am to 9pm Eastern Time. The number to call is (800) 417-1764.

If the doctor provides information sufficient to establish that the medication is medically necessary, ESI will allow the prescription to be processed. Thereafter, you only pay the applicable co-payment at the pharmacy. If the medication is not deemed medically necessary, it will not be covered and your physician has the option of prescribing another medication. If a medication is deemed not medically necessary and you choose to fill the prescription anyway, you will be responsible for the full cost of the drug."
(UFCW Local 1500 Full Time Employees Benefit Plan Summary of Material Modifications, July 21, 2015)

SUMMARY: Appeal Received: September 29, 2017

The **provider,** Patricia Melville, RN, is appealing on behalf of the participant for coverage of injectable Avonex. It was noted that a prior authorization for Avonex was denied by Express Scripts on October 6, 2017 because it did not meet their criteria for coverage. Express Scripts advised, **"The requested drug is non-preferred and coverage is not authorized under the plan. However, coverage has been approved for the preferred drug based on the information provided. The preferred drug approved is Glatopa. The non-preferred drug is covered when the patient has tried Glatopa and was unable to administer it, according to the prescribing physician."** Ms. Melville states, "[The participant] has been using Avonex to control her Multiple Sclerosis since 1999. Avonex has successfully controlled her MS exacerbations and slowed progression of her disease. Failure to approve continued use of Avonex may result in progression of disease and worsening symptoms."

After the appeal was received, Associated Administrators contacted Express Scripts. Express Scripts advised that a prior authorization for Avonex was previously approved on October 3, 2016 which was valid for one year. However, effective January 1, 2017, Glatopa became the preferred covered alternative. When a prior authorization renewal for Avonex was submitted by the prescribing physician on September 28, 2017, it was denied in accordance with the above. The participant advised Associated Administrators by telephone on November 13, 2017 that she has not tried treatment with Glatopa and is unwilling to do so.

According to the Food and Drug Administration (FDA), Avonex is an injection administered once weekly. Glatopa is an injection administered once daily. According to the Glatopa website, there is a Glatopa Nurse line available to assist patients with injection training online and over the phone.

Express Scripts states there is no further review available at their firm for this prior authorization.

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

Conclusion

- Thank You
- Questions?