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January 18, 2012

VIA EMAIL

Mr. Jim Puckett
Director
Division of Retirement and Benefits
State of Alaska
333 Willoughby Avenue
6th Floor State Office Building
Juneau, AK 99811-0208

RE: Information Regarding Financial Impact Due to House Bill No. 275

Dear Jim:

As requested, Buck is providing information regarding the potential impact of covering colorectal screenings, including colonoscopies and changes to the prescriptions drug benefit on the retiree health plan.

Calculation 1: "…group health insurance…include coverage for colorectal screening"

Currently, Medicare offers coverage for these services as described below:

Colorectal Screening	Frequency Allowed	Member payment
Fecal Occult Blood Test	Once every 12 months.	You pay nothing for the test, but you generally have to pay 20% of the Medicare-approved amount for the doctor visit.
Flexible Sigmoidoscopy	Generally, once every 48 months, or 120 months after a previous screening colonoscopy for people not at high risk.	You pay 20% of the Medicare-approved amount with no Part B deductible. If the test is done in a hospital outpatient department or an ambulatory surgical center, you pay 25% of the Medicare-approved amount.
Screening Colonoscopy	Generally once every 120 months (once every 24 months if you're at high risk), or 48 months after a previous flexible sigmoidoscopy.	You pay 20% of the Medicare-approved amount with no Part B deductible. If the test is done in a hospital outpatient department or an ambulatory surgical center, you pay 25% of the Medicare-approved amount.
Barium Enema	Your doctor can decide to use this test instead of a flexible sigmoidoscopy or colonoscopy. This test is covered every 24 months if you are at high risk for colorectal cancer and every 48 months if you aren't at high risk.	You pay 20% of the Medicare-approved amount with no Part B deductible. If the test is done in a hospital outpatient department or an ambulatory surgical center, you pay 25% of the Medicare-approved amount.

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Data

The data used in this analysis covers the period of December 2009 through November 2011, and was extracted from Verisk Health, Wells Fargo's online claims analysis provider. The data covers retirees and their dependents ages 50 and above. People who are 65 or over are assumed to have Medicare, and are entitled to the coverage listed above. The data extracted from Verisk includes all claims with a diagnosis of V76.51 – Colon Screening. If claims are coded correctly, this diagnosis code is common to all the procedures above, even though the CPT code for each procedure will vary.

Table 1 in the appendix contains a summary of the data in aggregate and split into claims that had non-zero paid amounts and those that had zero paid amounts. It is important to note that with this data we do not receive any information regarding why a claim was not paid, nor do we receive information regarding coordination of benefits with other insurance (if it occurred and what amount other coverage paid). Under the current plan, we would expect few, if any, of these claims to be paid by the State plan, as they are believed to be preventive care; however, almost 40% of the billed charges do show payments by the State. Of these charges, approximately 60% of the allowed amounts are for those who are 65 or older (assumed to be Medicare eligible), with 24% of the paid amounts falling to this same group. From this it can be assumed that Medicare is coordinating with the State plan according to the conditions listed above.

Perhaps the biggest issue uncovered by this data is the fact that the retiree plan is paying on claims that may not be covered, assuming the screenings are actually preventive in nature rather than diagnostic. In looking at the individual CPT and ICD-9 codes that can be used for any type of colorectal procedure, whether it's a screening or not, it was noted that 75% of the paid claims use non-screening procedure codes. Whether these procedures are legitimate services, or actual screenings coded to a non-screening code is not able to be determined from the data.

Table 2 in the appendix contains a summary of the data in aggregate, but assumes that all the current claims with no payments by the plan are treated as covered, with allowed and paid rates the same as the claims currently being paid. Comparing this table with Table 2 shows that for the 24 month period being examined, if colorectal screening was covered the same as any other illness, with no other changes to utilization, the annual plan paid amount would increase by approximately $700,000. According to this data, the plan is currently paying $532,000 per year ($1,064,000 for the 24 month data period), or $0.66 per member per month (PMPM), for these procedures. If the plan were to cover all the claims that fall under the diagnostic ICD-9 code, with no change to utilization, the additional cost to the plan would equate to $700,000 per year ($1,408,000 for the 24 month data period), or $0.88 PMPM, for a total cost of $1,236,000 per year ($2,472,000 for the 24 month data period), or $1.54 PMPM for the colorectal screening benefit.

In reality, if the State decided to cover colorectal screenings, the utilization would be expected to increase. We assume that due to pent up demand, the number of tests performed in the first year of coverage would be double the number currently performed, which would increase the aggregate costs for these tests substantially. Once the pent-up demand for these tests was met during the first few years, the number of additional screenings is assumed to stabilize, but at a level that is higher than the current testing rate.

Savings

The main purpose for covering colorectal screenings would be for the plan to reduce its costs related to colon cancer. According to the Verisk data, there were 246 individuals that had a diagnosis of colon cancer, with medical and Rx claims under the same ICD-9 code totaling $2.7 million. A study performed by the American Medical Association in 2000 found that compliance with routine testing (every 5 years from ages 50-85) could reduce the incidence of colon cancer by up to 60%. For the purpose of this analysis, we assumed a minimum incidence reduction of 40% and a maximum of 60%.

Projection

Based on the cost data and savings assumptions, the following table shows a ten year projection of costs and potential savings, using an assumed 2013 effective year for the screenings being covered:

		Aggregate				PMPM		
Year	Membership (50+)	Total Tests	Total Testing Cost	Minimum Plan Savings	Maximum Plan Savings	Total Testing Cost	Minimum Plan Savings	Maximum Plan Savings
2013	73,559	2,882	$ 3,194,893	$ 67,553	$ 101,330	$ 3.62	$ 0.08	$ 0.11
2014	77,237	2,275	$ 2,723,543	$ 40,920	$ 61,380	$ 2.94	$ 0.04	$ 0.07
2015	81,099	2,196	$ 2,839,056	$ 37,273	$ 55,909	$ 2.92	$ 0.04	$ 0.06
2016	85,154	2,101	$ 2,933,543	$ 30,150	$ 45,225	$ 2.87	$ 0.03	$ 0.04
2017	89,412	2,211	$ 3,334,807	$ 36,635	$ 54,952	$ 3.11	$ 0.03	$ 0.05
2018	93,883	2,328	$ 3,792,348	$ 44,633	$ 66,949	$ 3.37	$ 0.04	$ 0.06
2019	98,577	2,450	$ 4,310,354	$ 54,270	$ 81,406	$ 3.64	$ 0.05	$ 0.07
2020	103,506	2,579	$ 4,900,574	$ 66,134	$ 99,201	$ 3.95	$ 0.05	$ 0.08
2021	108,681	2,715	$ 5,570,816	$ 80,590	$ 120,885	$ 4.27	$ 0.06	$ 0.09
2022	114,115	2,858	$ 6,334,042	$ 98,367	$ 147,551	$ 4.63	$ 0.07	$ 0.11

As is shown in this table, the cost of providing the tests exceeds the potential savings due to a reduction in colon cancer diagnoses. In considering whether to cover colorectal screenings, Buck recognizes that cost is as important as emphasizing a focus on prevention and wellness with the membership

Calculation 2: "...group health insurance…allow retirees to choose between brand-name and generic drug products, and limit certain prescription drug benefit payments to an amount based on the cost of the generic drug product."

Currently, the retiree health plan provides the following prescription drug benefit:

Prescription Drug Copayments

You pay for the amounts listed below for each prescription up to a 90-day or 100-unit supply.

Brand Name/Participating Pharmacy	$ 8
Generic/Participating Pharmacy	$ 4
Brand Name/Mail Order	$ 0
Generic/Mail Order	$ 0

Buck interprets the bill language to reflect the same basic principles as the standard industry program known as "Mandatory Generic Substitution", wherein, when an equivalent generic drug is available it is substituted for a brand-name drug. Exception to the substitution is allowed when the prescription notes "Dispense as Written" or when there is, in fact, no generic equivalent available. Should a participant choose not to purchase a generic equivalent when available outside the exception, the participant is to pay the difference in the cost of the generic and brand-name drugs. The impact of potential generic drug substitutions on the health plan is an estimated $3.2 in savings.

Because Buck did not have the necessary data in house to perform the actual analysis, we relied on Envision, the Pharmacy Benefit Manager for the health plan, to gather and assemble the appropriate data.

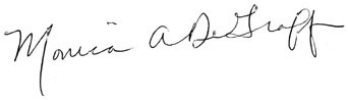
Table 3 below highlights the following data points impacted by bill language using CY 2011 data:

- Number of Rx
- Total Rx cost
- Participant copays
- Plan cost
- Adjusted copays
- Adjusted Plan cost
- Estimated Plan Savings before DAW exception
- Estimated Plan Savings less DAW prescriptions

The financial impact of HB 275 as a whole (Calculations 1 & 2) net an amount near zero for the health plan.

Please let us know if you need any further information.

Sincerely,



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c: Ms. Julie Wilson, State of Alaska
Mr. Dave Slishinsky, Buck Consultants

Appendix

Table 1: Summary Statistics for Actual Colorectal Screening Data (Calculation 1)

Alaska Care Medical Claim Data, 12/2009 through 11/2011 (excludes Rx)

	Records for Claimants with Colon Screenings (ICD9 V76.51)								
Aggregate	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Retirees Age 50-64	1,204	$ 3,499,011	$ 1,151,710	$ 808,238	$ 2,906	$ 957	$ 671	$ 2.16	$ 0.92
Retirees over Age 65	1,397	$ 4,917,073	$ 2,007,023	$ 255,940	$ 3,520	$ 1,437	$ 183	$ 0.54	$ 0.35
Retirees	2,601	$ 8,416,084	$ 3,158,733	$ 1,064,179	$ 3,236	$ 1,214	$ 409	$ 1.26	$ 0.66

Non-Zero Paid	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Retirees Age 50-64	501	$ 1,122,068	$ 992,958	$ 808,238	$ 2,240	$ 1,982	$ 1,613	$ 2.16	$ 0.92
Retirees over Age 65	675	$ 1,581,724	$ 1,553,127	$ 255,940	$ 2,343	$ 2,301	$ 379	$ 0.54	$ 0.35
Retirees	1,176	$ 2,703,792	$ 2,546,085	$ 1,064,179	$ 2,299	$ 2,165	$ 905	$ 1.26	$ 0.66

Zero Paid	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Retirees Age 50-64	703	$ 2,376,944	$ 158,752	$ -	$ 3,381	$ 226	$ -	$ -	$ -
Retirees over Age 65	722	$ 3,335,348	$ 453,897	$ -	$ 4,620	$ 629	$ -	$ -	$ -
Retirees	1,425	$ 5,712,292	$ 612,649	$ -	$ 4,009	$ 430	$ -	$ -	$ -

Table 2: Summary Statistics for Colorectal Screening Data, Assuming All Claims Are Paid (Calculation 1)

Alaska Care Medical Claim Data, 12/2009 through 11/2011 (excludes Rx)

	Records for Claimants with Colon Screenings (ICD9 V76.51)								
Aggregate	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Retirees Age 50-64	1,204	$ 3,499,011	$ 1,151,710	$ 1,942,354	$ 2,906	$ 957	$ 1,613	$ 5.18	$ 2.22
Retirees over Age 65	1,397	$ 4,917,073	$ 2,007,023	$ 529,702	$ 3,520	$ 1,437	$ 379	$ 1.13	$ 0.73
Retirees	2,601	$ 8,416,084	$ 3,158,733	$ 2,472,055	$ 3,236	$ 1,214	$ 950	$ 2.93	$ 1.54
Non-Zero Paid	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Retirees Age 50-64	501	$ 1,122,068	$ 992,958	$ 808,238	$ 2,240	$ 1,982	$ 1,613	$ 2.16	$ 0.92
Retirees over Age 65	675	$ 1,581,724	$ 1,553,127	$ 255,940	$ 2,343	$ 2,301	$ 379	$ 0.54	$ 0.35
Retirees	1,176	$ 2,703,792	$ 2,546,085	$ 1,064,179	$ 2,299	$ 2,165	$ 905	$ 1.26	$ 0.66
Zero Paid	**# Claimants**	**Total Billed**	**Total Allowed**	**Total Paid**	**Average Billed Per Claimant**	**Average Allowed Per Claimant**	**Average Paid Per Claimant**	**Cost PRPM**	**Cost PMPM**
Estimated Paid Amounts									
Retirees Age 50-64	703	$ 1,574,478	$ 1,393,312	$ 1,134,115	$ 2,240	$ 1,982	$ 1,613	$ 3.02	$ 1.30
Retirees over Age 65	722	$ 1,691,859	$ 1,661,270	$ 273,761	$ 2,343	$ 2,301	$ 379	$ 0.58	$ 0.38
Retirees	1,425	$ 3,266,337	$ 3,054,582	$ 1,407,877	$ 2,292	$ 2,144	$ 988	$ 1.67	$ 0.88

Table 3: Summary Analysis for Prescription Drugs (Calculation 2)

Envision Pharmaceutical Services
ALASKACARE - Retiree Groups
Copay Conversion - DAW Analysis
Utilization January 1, 2011 to December 31, 2011

Summary

	Cost	Per Rx	Savings	Per Rx
Current	$ 10,212,395.77	$ 281.72		
Scenario 1	$ 3,751,578.61	$ 103.49	$ 6,460,817.16	$ 178.23

	Net Rx	Total Drug Cost	Current Copays	Current Cost to Plan	Converted Copays *	Converted Cost to Plan	Plan Savings
Brands with Generics Available	**36,250**	**$ 10,409,235.15**	**$ 196,839.38**	**$ 10,212,395.77**	**$ 6,657,656.54**	**$ 3,751,578.61**	**$ 6,460,817.16**

Estimated % of "Dispense as Written" prescriptions **50%**

Estimated Plan Savings less DAW Rx **$ 3,230,408.58**

Scenario 1 assumes member selects a generic drug equivalent product as substitute for brand drug product where available - essentially a standard industry practice known as "Mandatory Generic Substitution". Should the member choose not to select a generic equivalent in place of the brand, the member is subject to pay the drug price difference as well as the appropriate co-pay. Scenario 1 excludes the member from choosing a brand drug product as substitute for generic drug product prescribed.

The Estimated Plan Savings excludes Brand drug prescriptions noted as "Dispense As Written" according to HB 275, 14,B i, therefore reducing potential savings.

* Copays calculated by member paying the DAW difference