June 2014

NYC PBA HEALTH & WELFARE Retiree Bulletin

www.nycpba.org

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IMPORTANT CHANGES > > >

Plan design updates for better benefits, lower costs

Over the past few years, a number of prescription drug industry trends have impacted employer- and union-sponsored health benefits plans, including the Retiree Health and Welfare Fund of the PBA (the Fund). These trends include the introduction of new high-cost specialty drugs, the introduction of oral versions of drugs previously only available as injectibles, and the overall increase in prescription drug prices. Together, these trends have resulted in significantly increased costs to health plans.

In addition to the factors outlined above, the federal government's Retiree Drug Subsidy (RDS) Program, which reimburses retiree drug plans for a portion of their costs, has initiated a 2% subsidy reduction which applies to drug claims on or after April of 2013. The RDS Program has been vital to the financial stability of the Fund and this subsidy reduction will add further cost pressures.

Other plans have addressed these added cost pressures in a variety of ways, including increasing copayments, eliminating benefits, and requiring or increasing member premium contributions. Striving to avoid shifting costs to our Members, the Retiree Health and Welfare Fund has explored ways to address these cost concerns with the following goals in mind:

- *Ensure the long-term financial stability of the Health and Welfare Fund.*
- *Continue to provide comprehensive prescription drug, dental, and vision benefits.*
- *Maintain current copayment levels.*
- *Adopt cost-saving initiatives that result in minimal disruption to Members.*
- *Expand and improve benefits when possible.*

After careful consideration, the Fund will implement the following three plan design changes in the coming months:

- *Step Therapy Program*
- *CVS/Caremark Pharmacy Savings Program*
- *Adoption of Dental Implant Pilot Program as a Permanent Benefit*

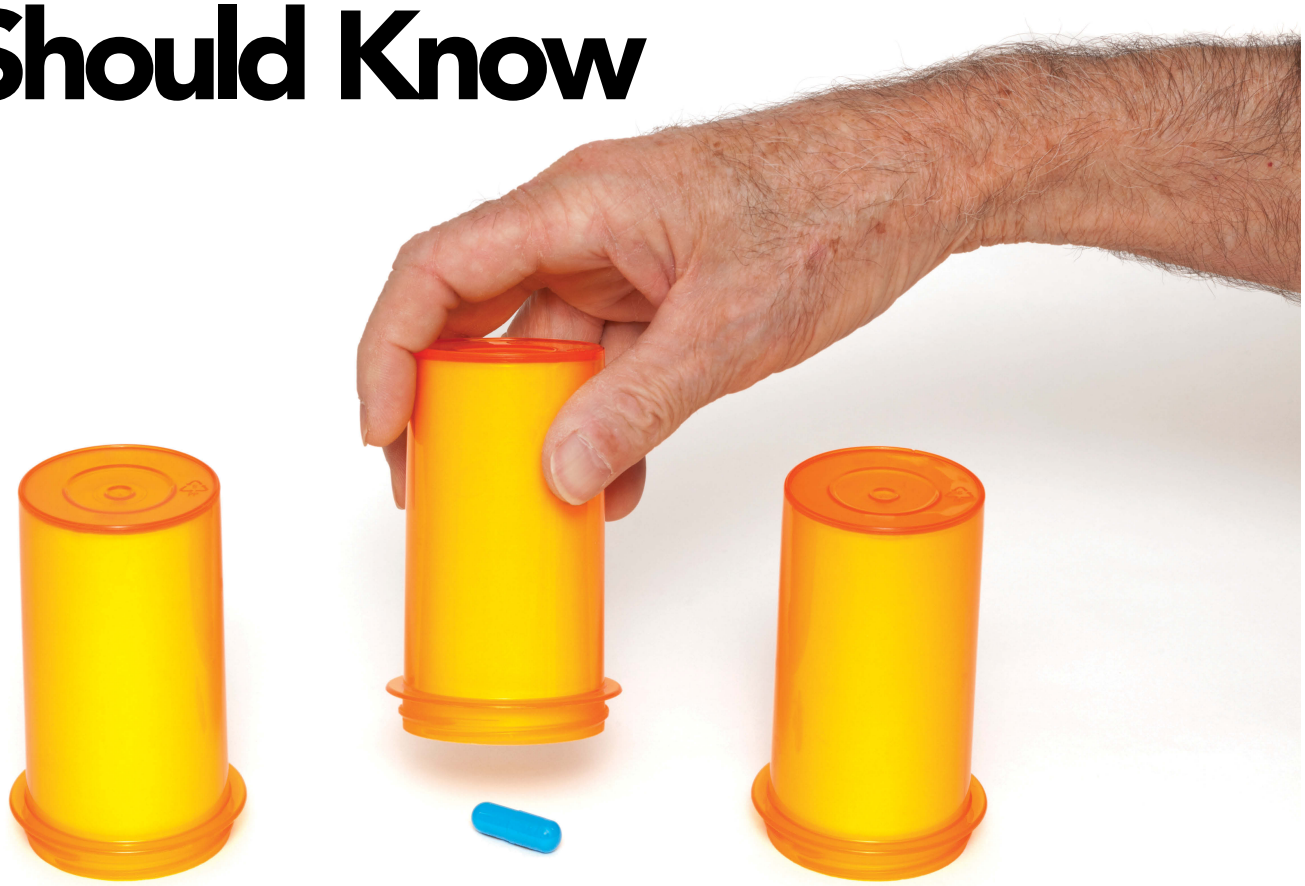
Each of these plan design changes are described in detail in this Benefits Bulletin. ■

Dental Implant Program Has Been Expanded

As you know, the PBA Health and Welfare Fund launched a pilot program to cover a portion of the cost of dental implants in 2009. The implant benefit, which requires pre-authorization, pays $600 toward the cost of an implant and is limited to one implant per arch in a twelve-month period. The pilot program was limited to a list of six pre-approved providers.

The Health and Welfare Fund is pleased to announce that the Dental Implant Pilot Program has been made a standard Dental Plan benefit. In addition, the initial list of six approved providers has been expanded to over 40, and we expect to continue to grow the list to give members greater access to coverage. For a current list of authorized providers, please visit **www.nycpba.org** ■

Medicare Part D and Creditable Coverage: What You Should Know



As Medicare's annual open enrollment period approaches later this year, Medicare-eligible Members and dependents can expect to see a flurry of marketing materials from insurance companies advertising their Medicare Part D prescription plans. Retired New York City employees are also eligible to participate in the City of New York Health Benefits Program transfer period later this year, and may transfer between Medicare plans offered through the City's Health Plan.

When deciding whether to join a Medicare Part D drug plan, it is important to understand the impact of having "creditable coverage" through the Retiree Health and Welfare Fund of the PBA (The Fund). Here are the key points you should know:

- Medicare Part D drug coverage is available as part of most **Medicare Advantage** plans, which also provide Part A (hospital) and Part B (medical) coverage through a private insurer.

- Medicare Part D drug coverage is also available through **stand-alone Prescription Drug Plans (PDPs)** for those who have opted for original Medicare. In most cases, you cannot simultaneously be enrolled in both a Medicare Advantage plan and a PDP.

- Although Medicare Part D drug coverage is optional, people who do not enroll in Part D coverage when they first become eligible are generally subject to a **late enrollment penalty** if they decide to enroll in Part D coverage at a later time.

- **The late enrollment penalty described above does not apply to periods during which you are covered by a prescription drug plan that is deemed "creditable coverage."** "Creditable coverage" is prescription drug coverage that is, on average for all plan participants, expected to pay at least as much as the standard Medicare Part D benefit.

- **The prescription drug coverage provided by the Retiree Health and Welfare Fund of the PBA has been deemed to be "creditable coverage,"** which means that you will not be subject to the Part D late enrollment penalty for periods during which you are covered by the Fund. The Fund will mail **Creditable Coverage Notices** to retired Members later this year.

- Although coverage provided through the Fund is creditable coverage, you may elect to enroll in a Part D plan. Possible reasons for joining a Part D plan may include:

  - You expect to have significant prescription drug utilization and enroll in a Part D plan that has lower copayments and is not subject to annual benefit maximums.

  - You wish to join a Medicare Advantage plan that covers prescription drugs for reasons not related to prescription drug coverage (i.e., lower out of pocket costs for Part A and part B).

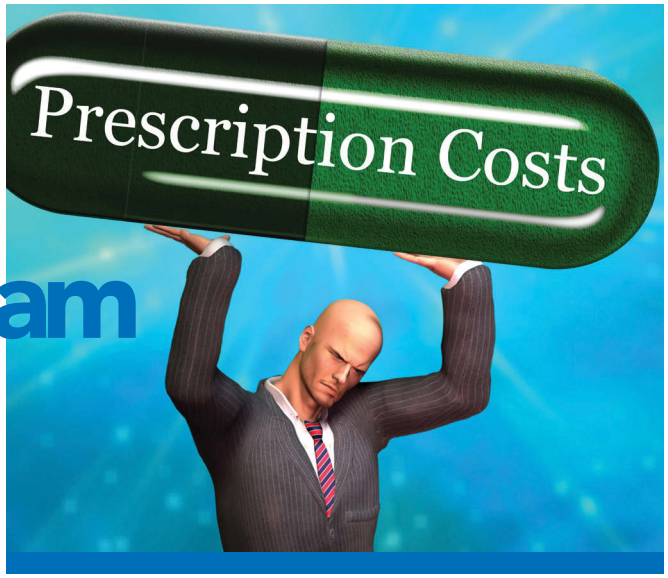
  - If you decide to join a Medicare Part D plan, **you will not lose your PBA coverage.** Your Part D plan will be your primary coverage and the Fund will be secondary.

New Summary Plan Descriptions Coming Soon

Keep an eye out for new Summary Plan Descriptions (SPDs) for the Health and Welfare and Retiree Health and Welfare Funds. The New SPDs are expected to be available this summer and will reflect the benefit plan changes described in this newsletter as well as other changes that have been made since the last SPD printing.

Effective July 1, 2014

New Step Therapy Program



In recent years, the introduction of generic drugs has presented both health plans and their enrollees with cost savings opportunities. Many chronic health conditions can now be treated with a variety of medications that act in similar ways. Although these drugs are similar in how they work, there can be great variation in how much they cost, particularly when comparing brand drugs to generic alternatives. For example, acid reflux can be treated with a brand proton pump inhibitor (PPI) that can cost more than $700.00 for a 90-day supply, or with a generic PPI that can cost under $30.00 for a 90-day supply —just a fraction of the cost of the brand medication.

Effective July 1, 2014, the Health and Welfare Fund of the PBA will introduce a Step Therapy program under which generic alternatives must be tried before brand drugs can be covered in certain drug classes. The affected drug classes are those in which, despite the availability of lower cost generic drugs, there tends to be higher brand utilization. There are many reasons why brands may be prescribed rather than more cost-effective generic alternatives, including:

- *Marketing/advertising efforts on the part of brand pharmaceutical manufacturers.*
- *Doctors not being aware of newly available generic alternatives.*
- *Misconceptions about the effectiveness of generic medications.*

Please see the table below for a list of drug classes subject to Step Therapy, as well as the "look-back" period during which a generic alternative must be tried. ■

Drug Classes Subject to Step Therapy

Drug Class	Condition Treated	Look-Back Period (Days)
PPI	Acid Reflux	180
HMG	High Cholesterol	365
ACE/ARB	High Blood Pressure	365
Nasal Steroids	Allergy	180
Hypnotics	Insomnia	180
Bisphosphonates	Osteoporosis	365
Urinary Antispasmodics	Urinary Incontinence	180
Cox-2 Inhibitors/ NSAIDs	Pain	180
Triptans	Headache	180
SABA*	Asthma	365
SSRI	Depression	365
Fibrates	High Cholesterol	365
Prostaglandin Analogs	Glaucoma	365
Alpha-Reductase Inhibitors	Enlarged Prostate	365
SNRI	Depression	365
Anti-Dementia Agents	Alzheimer's	365
Antipsychotics*	Antipsychotics	365
Acne	Acne	180

*If no suitable generic drug exists in these classes, Caremark may require the use of an alternative preferred brand.

Step Therapy Q&A

Question	Answer
I have been taking a brand medication in one of the listed drug classes for five years. Can I keep taking the same drug or will I have to switch to a generic alternative?	If you have not filled a prescription for a generic during the look-back period (180 days or 365 days depending on the drug class), you will have to try a generic alternative in that drug class. After you have tried a generic alternative, if your doctor determines that it is medically necessary for you to switch back to the brand, he or she can contact Caremark for authorization to switch back to the brand.
My doctor switched my prescription from a generic to a brand 2 months ago. Do I have to go back to the generic?	No. As long as you have filled a prescription for a generic during the look-back period (180 days or 365 days depending on the drug class), you can continue to be covered for the brand drug without interruption.
Why do I have to try a generic drug if the brand has been working for me?	There have been many generic drug launches within the past few years. If you have been taking a brand medication for a number of years, it is possible that no generic alternatives were available at the time the prescription was originally written. Trying a generic alternative can cut unnecessary costs for both the Funds and for you. After you have tried a generic alternative, if your doctor determines that it is medically necessary for you to switch back to the brand, he or she can contact Caremark for authorization to switch back to the brand.
I am currently taking a brand drug in one of the listed classes and have never tried a generic. Will my next re-fill automatically be switched or do I have to obtain a new prescription?	Pharmacies are generally not permitted to switch your prescription to a generic unless is it is chemically the same. Therefore, you will have to obtain a new prescription from your doctor. If you are currently taking a medication that will require a new prescription, you and your doctor will be contacted by Caremark in advance.
Does step therapy apply to all prescriptions?	No. Step therapy applies only to the specific drug classes listed on the opposite page. These are primarily maintenance medications which are typically taken over a long period of time. Step therapy does not apply to medications used to treat acute conditions such as antibiotics, seasonal flu remedies, and pain relievers.
I am currently not taking any medication at all. If my doctor prescribes a medication for me in the future, how will he or she know whether I have to try a generic drug?	If your doctor writes a prescription for a brand medication that is subject to Step Therapy, the pharmacy generally will not be permitted to automatically switch your prescription to a generic, and you will need to obtain a new prescription. There are a number of ways that you and your doctor can prevent a delay or denial of your prescription at the pharmacy: • If your doctor participates in electronic prescribing, he or she will be notified when entering your prescription online. • You can ask your doctor if he or she can prescribe an appropriate generic alternative. Generic drugs are not subject to Step Therapy. • You can contact Caremark by calling the telephone number on the back of your PBA/Caremark prescription card to inquire as to whether a drug is subject to Step Therapy.

Effective July 1, 2014

CVS/pharmacy®

Bigger Savings and More Options for PBA Members at CVS/pharmacy locations

PBA Members will soon enjoy more savings and greater flexibility at thousands of CVS/pharmacy locations nationwide. Currently, prescriptions filled at retail pharmacies are limited to a 30-day supply. Starting July 1, 2014, you may fill prescriptions for maintenance medications (medications normally taken for an extended period of time) for up to a 90-day supply at CVS/pharmacy locations. 90-day prescriptions filled at CVS/pharmacy locations can help lower Retirees' out-of-pocket costs since these prescriptions receive mail pricing which is generally lower than standard retail pharmacy pricing.

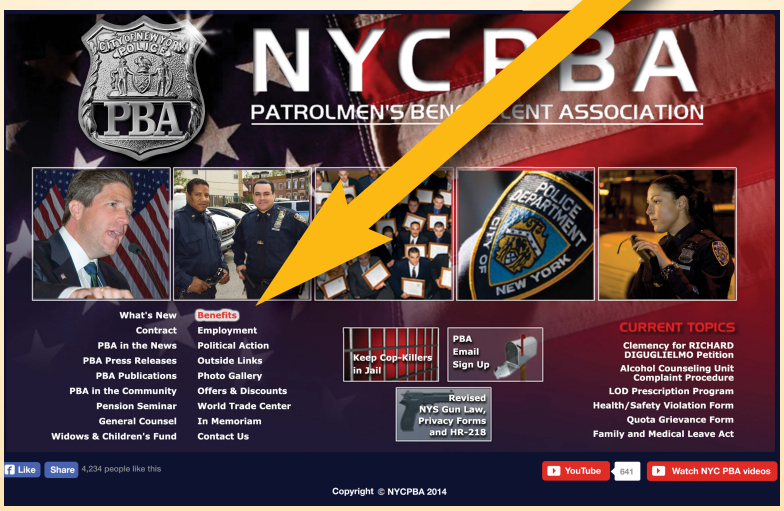
Additionally, check your mail for your new CVS Caremark ExtraCare® Health Card (you will receive 2 key tags). Your ExtraCare Health Card will provide a 20% discount on CVS brand health-related items. If you currently have a CVS ExtraCare Card, your new ExtraCare Health Card will replace that card. It gives you all of the same benefits of the regular ExtraCare Card, plus the additional 20% savings. Please note that the ExtraCare Health Card does not replace your PBA/Caremark Prescription Drug Plan ID Card. ■

Save Money by Using Participating Dental Providers

A trip to the dentist should be as painless as possible…for both you and your wallet. When you visit a dentist who is a participating provider in the PBA Dental Plan, most dental services are covered at no out-of-pocket cost to you. Using a participating provider also eliminates the need to complete and mail in claim forms; the provider sends the claims information directly to the PBA Funds Office.

Participating dental providers agree to accept the PBA Fund's "Fee Schedule" amount as payment-in-full for most dental services covered by the Dental Plan in exchange for the potential for increased business for their practices. If you use a non-participating dental provider, that provider can charge you his or her full price. You can submit a claim form to the PBA Funds Office for reimbursement at the Fee Schedule allowance, but that amount is usually much lower than most providers' full price. This can leave you with significant out-of-pocket costs.

To find a participating dental provider in your area, visit www.nycpba.org and click on "Benefits."



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Benefits Bulletin

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