

SEBAC Tentative Agreement Question and Answer

The following was prepared from a series of questions posed by a Local member. These questions seem to express universal concerns that many of the members have posed in different forums.

The answers are provided by the Local's Staff Representative, Tricia Cardin, from AFSCME Council 4.

Q. We received one paper from the union saying the deductible is per family and one saying it is per person. Please help us clear this up. Is it \$350 per family or per person?

A. The \$100 penalty for not participating in the value based concept is per employee whether the employee insures dependents or not. The \$350 deductible is for the employee and another \$350 for each dependent covered and applies only to those items that co-pays don't (i.e. Hospital admissions, high cost diagnostics), but not prescriptions and office visits.

Q. What happens to our dental plan and who will it be with? Since they require 2 cleanings a year, will there be other changes?

A. The dental plan is exactly the same coverage and plan design. The only difference is for those that chose the value based option to avoid an additional \$100 in month for health insurance and the \$350 deductible per insured, you must get your teeth cleaned 2x per year as we all should anyway.

Q. Some employees pay extra for their medical insurance so they can have a choice...doctors...where they want to be treated etc. Will our monthly costs go down if the new plan passes? Who oversees it? Will the State be our new insurer?

A. This is the area that is most misunderstood. There is no change (other than a few minor copay changes for prescriptions and ER visits) to the existing health insurance design plans. The 3rd party administrators (Anthem and United) are the same, the provider lists are the same and what is covered is the same. If no referrals were required before, no referrals will be required after. The only change, again to avoid the \$100 additional cost for coverage/month and the \$350 deductible (s) is the option to choose the value

based plan. With that choice, the employee and his/her dependents, commit to regular check-ups as established by the doctor (once per year for those over 40), to participate in recommended screenings (a colonoscopy annually for those over 50 and mammograms as recommended by your doctor for example) and to fill prescriptions for high blood pressure, diabetes, asthma/COPD, heart disease and high cholesterol if prescribed by the doctor. It does not require weight loss or one to quit smoking. If an employee does not do the above (or a dependent) a reminder letter will be sent by the 3rd party Administrator (Anthem/United). If that is ignored, HR will be notified to start collecting the additional \$100 per month. There will also be an appeals process just as there is now when claims are denied. The goal is that insurance premiums will go down if more employees are addressing their medical needs sooner rather than waiting for the high cost crisis. That is why the \$100 is a penalty for those who don't participate with the philosophy that their lack of care drives up the cost of insurance and healthcare for all. The State is and will remain self insured. Because the State is self insured, it pays the claims for those who let their lack of care develop into a crisis or if the claims are higher than anticipated the insurance portion will kick in. Again this is not a change as to how you are insured now.

Q. What are patient center medical homes and how does that pertain to our care?

A. The cost containment committee which currently exists now will continue to find providers that will stay open beyond 5 and on weekends so patients can have regular office visits rather than E.R. visits to address medical concerns at times when typically the doctor is not open. I personally have an orthopedist that stays open until 8 certain days of the week and has Saturday hours as well.

Q. Can we still choose any doctor we want?

A. Yes, you can continue to pick your doctors. This is just to offer additional office time, not to get you to change providers.

Q. Who decides the disease management program...my doctor or the State?

A. Your doctor

Q. Sal Luciano is on the Sustinet Board of Directors. Is this not considered a conflict of interest?

A. Sal answered this question earlier. Here is his response:

I am a proud member of Sustinet. I have been fighting for Health Care systems and against the Health Care industry for years.

People should not have to lose their homes, their retirement savings and their children's college fund paying for health care.

And for more selfish people who don't care about that:

If 2017 comes around and state employees are one of the few workers left with decent health care, we will lose it too.

Having said that: The health care plan SEBAC has in the concession framework has nothing to do with Sustinet.

I am a member of the State Employees Health Care Cost Containment Committee. We have done a good job keeping costs low.

Two years ago, we had a zero % increase. Last year a 7% increase and this year a 5% increase.

We were the ones that discovered the employee that used the emergency room 150 times last year. We are the ones who know that the United/Anthem identified over 6,000 diabetics that are not taking insulin and are at risk for organ failure, limb amputation and blindness.

We are self funded so health care costs get born by employees and the State.

The pension that has been called 'unsustainable' has a \$19 billion liability but not growing.

Our health care has a \$26 billion dollar liability and growing.

If we don't do something soon, you don't need to be a scientist to know what the state's proposal on retiree health care will be at the end of the SEBAC deal in 2017.

Q. Are Tier 1 employees subject to the same changes in the retirement health care fund?

A. I think you are asking about the 3% payment – if you are, yes if they are not retired by 7/1/13 they will begin to contribute for 10 years or until retirement which ever is sooner beginning at ½% on 7/1/13. If you are asking something else, let me know.

Q. What does "comparable provisions for managers" mean? Are they not required to follow the same guidelines...are they offered a different plan?

A. I am not sure what provision you are voting from, but if your question is regarding longevity, if the managers don't give back a portion of their longevity, the provision that you give is nullified. If you are asking something else, please let me know.

Q. What does "enhanced surveillance" related to key health indicators mean?

A. I am not sure what provision you are quoting from but I think it may be referring to early screenings and checkups so medical issues can be addressed prior to them becoming a crisis.

Q. What about Privacy rights?

A. There is no difference from the way the insurance works now, if you have a diagnosis of asthma for example, the insurance company (third party administrator) sends you information regarding addressing asthma. Overall medical statistic (for example how many employees in general with no identifying information go to the ER) is and will continue to be shared with the Cost Containment Committee). The medical information is not shared beyond that.

Q. What are the details to the health plan?

A. The health insurance plan designs are unchanged. The only new option is to participate in the checkups, screenings and fill prescriptions are prescribed by the doctor for the 5 chronic conditions listed above.

Q. All papers we receive are vague?

A. So far, the documents that have been posted on the websites are summaries and frameworks. The actual agreement is currently being prepared. That agreement contains the actual contract language. The agreement itself is complicated and contains charts and formulas which is why it is taking longer than the conceptual summary. The agreement will be distributed before the vote and in all likelihood will be passed out at informational sessions. It will also be posted on the Council 4 and Local 749 websites.

Q. If people are to vote on this we should have all the information needed to make a good decision.

A. Agreed

Q. How does the voluntary tobacco and obesity program work? If I am referred and don't want to go does that mean I pay more for my insurance? Who decides if you are referred?

A. You would only be referred if you requested to be referred. It is entirely voluntary.

Q. How is this new health care plan saving money?

A. It will save money because medical issues will be addressed early with the regular checkups before the crisis. The medical issues will also be addressed with by dealing with the 5 chronic conditions listed above.

Q. Some people go for dental checkups, physical, pap smears etc? Who is setting up these guidelines?

A. The employee's medical doctors.

Q. Why was the SEBAC agreement re-negotiated? SEBAC IX state unless specifically provided otherwise, the parties hereby agree that the State Employees Retirement system shall not be changed through June 30, 2017...

A. The no-layoff provision from SEBAC 2009 is set to expire 7/1/11. Because of the real threat of significant layoffs, and the fact that most of the Collective Bargaining Agreements are set to expire next year, we begin negotiations for the Judicial contract this August. 2017 is also just around the corner. If left unchanged, the risk is that the things this agreement preserves, retirement and retiree medical, would be in serious jeopardy. The trade off to the changes in this agreement are the 4 years of no layoffs, wages in the outer years of the 5 year agreement that we would not get in arbitration, no changes to the contract itself (we risk to lose longevity altogether, hazardous duty stipends, vacation time, sick time, the pay out of sick time upon retirement, etc.) and extending out the SEBAC agreement until 2022.

Q. Was it put to a vote to reopen SEBAC?

A. The agreement that is being presented is tentative and subject to the vote of the members.