



# It's *Your* Benefit

Health insurance and other benefit programs for state and local employees and retirees

## Board Moves Forward to Study Program Changes

The Group Insurance Board (GIB) has taken steps to try to reduce the rate of cost increases and improve quality of care for members insured under the state's group health insurance program. The Board approved, in concept, a GIB study group's recommendation that the Department explore and develop significant health insurance program design changes, including:

- Changing the current premium contribution structure to a tiered approach;
- Using a single pharmacy benefit manager to handle prescription drug benefits;
- Converting the Standard Plans to one preferred provider network, with the option to go outside the network at additional cost;
- Creating a dental plan that is separate and distinct from any health plan, and
- Integrating select quality and safety standards

into program requirements.

The report capped off the study group's year-long, comprehensive review of health insurance program benefits and services. It sets a strategic direction – a platform on which the Department will explore changes. It's important for members to understand that these are *strategic initiatives only* – they are intended to be a broad declaration of a policy direction. Department officials caution there are many more questions to ask and details to work out. In addition, some of the changes will require legislative action and collective bargaining changes before implementation. Input from those arenas will likely shape the final product.

You can read the full text of the study group's report on our Internet site, [etf.wi.gov](http://etf.wi.gov). Go to "About Us," then "2002 Board Meeting Schedule & Agendas." Click on the "GIB Agenda" (November 19 meeting).

## ETF Endorses Effort to Improve Hospital Quality and Safety

The Department of Employee Trust Funds (ETF), administrator of the state's group health insurance program, has endorsed a growing effort within the health care industry that takes aim at improving the quality and safety of health care. The program is called "Leapfrog," and it raises consumer awareness of preventable medical mistakes that may occur in hospitals. Leapfrog achieves this by recommending specific practices and procedures for reducing preventable mistakes, and then asks health insurance programs and purchasers (like the state's health insurance program) to directly publicize compliance — or non-compliance — of these standards to members.

Research has shown that many medical mistakes in hospitals can cause harm and even death, and that many such mistakes are preventable. Requiring hospitals to adopt Leapfrog standards, and then spotlighting compliance or noncompliance, will ultimately spur these institutions to improve

quality and safety, thereby saving lives.

**The three key standards or practices the state will ask hospitals to adopt include:**

- **Using Computerized Prescription Order Entry (CPOE) systems for prescriptions.** CPOE systems eliminate problems like poor handwriting and have been shown to reduce serious medication errors by 86%.
- **Staffing intensive care units with specialists trained in critical care ("intensivists").** Scientific studies show that intensive care unit patients who are cared for by intensivists have better chances of survival.
- **Providing members with information about a hospital's experience with select high-risk conditions and procedures.** Research shows that sur-



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## Health Plans Mailing Over Age Dependent Letters

**I**f you have dependents on your health insurance policy age 19 or older, please read this carefully. Your Group Health Plan will be mailing you a letter with a form to see if these dependents are still eligible under your policy. **It is important that you promptly complete and return the form to your plan.** If you switched health plans during Dual-Choice, you may receive the materials from your previous plan and from your new plan. Complete and return the form to your new plan only.

To remain eligible on your policy, your dependent(s) over 19 years of age must be **all** of the following:

- dependent on you (or the other parent) for at least 50% of their support and maintenance;
- a full-time student; and
- not married.

There is an exception if your dependent is incapable of self-support because of a physical or mental disability that can be expected to be of long-continued or indefinite duration (which generally means the disability will last for one year or more). If you believe your dependent may be disabled according to our definition, contact your plan. Your plan will review medical information and decide if your dependent would qualify as a disabled dependent under our health insurance program.

To be a full-time student, your dependent must be enrolled in courses at an institution, such as a high school, college, or technical college. This does not include enrollment at correspondence schools, night schools, and on-the-job training. The institution will state the number of credits or courses that your dependent must be taking to be a full-time

student. This information is just a brief summary of the definition of "Dependent" as described in your *It's Your Choice* book for 2003. For the complete definition, please go to pages D-7 and D-8 of your book. If you have questions about the information, contact your plan or your employer's payroll/personnel office.

If your dependent does not meet these requirements, notify your employer's payroll/personnel office **no later than March 1, 2003** and **do one of the following so that your dependent gets offered COBRA\* continuation:**

- If your coverage will **remain as family** because you have other eligible dependents, file an Information Change form (ET-2329) with your employer, OR
- If your coverage will be changed from family to single, file a Health Insurance Application (ET-2301) with your employer.

If you do not receive a dependent letter and form from your plan and have a dependent that is 19 or older, contact your plan. For questions about your eligibility on the plan, contact your payroll/personnel office. Please remember to always report any changes to your insurance coverage to your payroll/personnel office. Failure to do so may result in loss of benefits.

\* COBRA is a federal law that requires employers to provide notification for continuing health insurance in the event that the employee or a covered dependent lose eligibility for coverage. For specific COBRA continuation of coverage provisions pertaining to the state's group health insurance program, see section B in *It's Your Choice*.

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vival rates are higher at hospitals that frequently perform high-risk treatments and procedures.

#### **What can you do with the information reported by hospitals?**

• **Use it to choose.** Find out which hospitals are included in your plan and if they have adopted the standards. If you are choosing a doctor, find out which hospital he/she would admit you to and check compliance before making your final decision. Try to select a hospital with proven outcomes or extensive experience with specific procedures or diagnoses.

• **Use it to ask questions.** Call your health plan representative and your doctor to find out what hospitals in your plan are doing to reduce preventable mistakes. If the hospital you would

be using doesn't meet the standards, call and ask what it is doing to make progress in this area. If you have more than one hospital to choose from, ask your doctor and consult other sources of information to determine which one has the best care and results for your condition. Let your doctor and hospital know that improving safety and quality are important and you will use this information to make choices.

Want to learn more about hospital safety in Wisconsin, the performance of health care providers in South Central Wisconsin, Leapfrog ratings for hospitals in three state cities, and much more about Leapfrog? Go to [www.qualitycounts.org](http://www.qualitycounts.org), a web site courtesy of the Alliance, a not for profit, employer-owned health care purchasing cooperative.

## New Tools Aid Plan Selection, Quality Assessment

The Department of Employee Trust Funds (ETF) added a new section to the *Health Plan Report Card* made available to state and local employees during the Dual Choice enrollment period. It's called Health Plan Employer Data and Information Set (HEDIS®) data, and you can use it to help guide your future health plan selection and even compare the quality of local health care to national averages.

### What exactly is HEDIS?

HEDIS is a set of standardized performance measures. These measures are designed to help compare the performance of managed health care plans. The performance measures are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS, developed and maintained by the National Committee for Quality Assurance (NCQA), is the most widely used set of performance measures in the managed care industry. When used in conjunction with other means to evaluate a plan (such as member satisfaction data, number of providers in the plan, and employee share of insurance costs), HEDIS data will give you the ability to both evaluate the quality of different plans and make your decisions based on a host of features rather than simply on cost.

### Kudos for The Diabetes Project

The Diabetes Project represents a unique partnership among diverse public and private organizations working together to improve diabetes treatment and care in Wisconsin. Members include the majority of Wisconsin health maintenance organizations (HMOs), the state's Diabetes Control Program, the Wisconsin Quality Improvement Organization (MetaStar), Medicaid, and the University of Wisconsin. HMO participants in the project represent over 98% of the 1.5 million individuals currently enrolled in HMOs in Wisconsin.

Here's the big news: **HMOs involved in the Project collectively performed at a level that exceeded both the national and regional averages reported by NCQA for HEDIS 2001 in each of the 6 comprehensive diabetes care measures.** For more information on the Project, go to the Department of Health and Family Service web site at [www.dhfs.state.wi.us/health/diabetes](http://www.dhfs.state.wi.us/health/diabetes).

### Examples of HEDIS measures include:

- Childhood Immunization Status
- Breast Cancer Screening
- Controlling High Blood Pressure
- Cholesterol Management after Acute Cardiovascular Events
- Comprehensive Diabetes Care
- Follow-Up after Hospitalization for Mental Illness
- Adult's Access to Preventive/Ambulatory Health Services
- Prenatal and Postpartum Care

Within each category, there may be several different measures. For example, for the Comprehensive Diabetes Care measure there are six different scores, including the percentage of individuals with diabetes who had a cholesterol screening, an eye exam, and have been monitored for kidney disease.

**How did my health plan perform?** Some of the HEDIS results described above can be found in the report card section of the *It's Your Choice* book, and on our web site, [etf.wi.gov](http://etf.wi.gov). **Good news:** Wisconsin Health Maintenance Organizations (HMOs) have outperformed national averages on nearly every score measuring the effectiveness of care provided to members. In fact, NCQA rated three Wisconsin HMOs that participate in the state program among the top 15 performers nationally in effectiveness of care. They are: Group Health Cooperative-South Central, Physicians Plus, and Touchpoint.

Here are other examples of Wisconsin group health insurance program successes:

Among our members who are eligible to receive:

- a **breast cancer screening**, an average of 83% received it, while only 75.4% of the eligible population received the screening nationwide.

- **comprehensive diabetes care-eye exams**, an average of 72.8% received these exams; the national average is 52%.

- **comprehensive diabetes care-kidney screenings**, an average of 60.9% received the screening; the national average is 46.3%.

**Here's an idea:** Create your own interactive report card for evaluating HMOs participating in the NCQA accreditation process by visiting that organization's web site, [www.ncqa.org](http://www.ncqa.org). Click on the Health Plan Report Card link. You'll also find out how the organization rates health plans, and learn about finding quality health plans in your area.



## Look For Your New Identification Card

Did you change health plans this year or add or delete dependents from your health insurance policy? If so, you should have received a new identification (ID) card from your new health plan by now. The Department requires health plans to issue ID cards to newly enrolled members and to existing members with a change in coverage by January 2.

Health plans are also required to issue a new ID card if the previous year's card included information such as coverage effective dates, co-payment amounts and out of pocket maximums that are no longer applicable. Replacement ID cards for continuing subscribers should be received by January 15. If you believe you should have received a new ID card and have not received one, contact your health plan. The health

plan is the only entity that can issue an ID card to you. Replace your old ID card immediately and show your new one to all providers each time you receive services. This will ensure that providers submit your health insurance claims to the correct health plan and will help avoid other billing inaccuracies.

Remember: The health plans have different and independent drug formularies. Check with your pharmacist, health care provider, or your new health plan regarding coverage of any medications you are currently taking to verify that they are covered.

**New in 2003:** If you would like a subscriber number different than your Social Security number, you may request an alternate subscriber number directly from your health plan.

Do you want to see a doctor outside of your health plan's network? Did your doctor send in a referral – and if so, financially speaking, do you think this action gets you “out of the woods?” Perhaps not. The Department of Employee Trust Funds has seen several recent instances where a member obtained a referral from a provider, but did not **confirm** with the plan whether it was approved. **Under the contract, an out-of-plan verbal referral does not guarantee the plan will pay for it until the health plan approves it in writing.**



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