

It's *Your* Benefit

Health insurance and other benefit programs for state and local employees



Major Health Insurance Program Changes Take Effect in 2004

The Department of Employee Trust Funds (DETF), as administrator of the State and Local Group Health Insurance Program, is working to implement significant program changes in 2004.

There is so much to tell that we are making special efforts to get the word out. Examples: This issue of *It's Your Benefit* is primarily dedicated to explaining the program changes; annuitants covered under the program have received a special letter from DETF explaining the changes; there is a "button" on our Internet site detailing all of the health insurance program changes; DETF staff will be present at many upcoming employee health fairs set for various sites in the state; and our Telephone Message Center contains specially recorded messages covering important changes to the health insurance program.

Why make program changes now?

The catalyst for change came from efforts by the Group Insurance Board (GIB) and Governor Doyle to improve service delivery and quality

of care while controlling escalating costs for the program's 200,000 members. Initiatives that required statutory changes were subsequently passed into law as part of the 2003-05 biennial budget.

Spiraling health care costs are a problem everywhere. According to an annual survey of public and private employers, the percentage of cost increases have consistently averaged in the high 'teens over the past five years. In our program, the preliminary bids from plans wanting to participate showed a 17% increase for 2004. As a result of the negotiation process, however, the plans ultimately reduced their premium bids and we were able to adjust that rate of growth to about 12%.

What can members expect and when?

As you might expect, no single approach is a "silver bullet" for rising health costs. The GIB discussed many different strategies and approaches but decided to avoid those that would simply

Changes continued on page 2

Standard Plans Incorporated Into One Preferred Provider Network

The Group Insurance Board (GIB) redesigned the Standard Plan to incorporate a preferred provider network and eliminated the Standard Plan II effective January 1, 2004. The use of this concept will enable the State to lessen cost increases by negotiating discounts with providers within an established provider network.

What is the new Standard Plan? This plan offers you the choice to see any provider, but there are differences in reimbursement depending on whether you visit an in-network or an out-of-network provider. If you receive services from an in-network provider, you will have lower out-of-pocket costs. If you choose an out-of-network provider, you will incur additional deductible costs

and coinsurance similar to those in the old Standard Plan II. This arrangement can be attractive to those members who would like the option of receiving care outside of the provider network or who wish to provide coverage for family members (e.g., college students who live outside of the area).

Note that the benefits for the new Standard Plan for 2004 are different from the Uniform Benefits schedule offered by the Health Maintenance Organizations. All eligible State employees and retirees have the option to enroll in this plan.

How do I know which providers are in-network providers? See the plan description page in Section G of the *It's Your Choice* booklet for more

Standard Plan continued on page 4

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Changes continued from page 1

shift costs around or affect one group of participants at the expense of others. For instance, the GIB considered implementing new office co-pays but believed this approach primarily shifted costs to members. Although some studies suggest that co-pays may reduce some utilization (e.g., the overall number of people going to the doctor or using other medical services would decrease), other studies suggest that members may defer important medical services and procedures, ultimately leading to more expensive care. This would do little to reduce overall costs or improve the overall management of health care.

Be aware that some changes do not apply to **all** participants and we are presenting what was known as of *It's Your Benefit* printing deadlines. **The following new features are effective January 1, 2004:**

- A single Pharmacy Benefit Manager (PBM) will provide pharmacy services to all participants;
- For State employees, the Standard Plan and Standard Plan II will be redesigned to include a preferred provider network, which will be known as the Standard Plan;
- Subject to the respective pay plan or collective bargaining agreements, a three-tier premium contribution structure for State employees will replace the existing program that began in 1984*;
- The State Maintenance Plan will be available in counties with no other qualified Tier 1 Health Maintenance Organization participating in the program, thus making a Tier 1 plan available to employees throughout the State; and
- Leapfrog quality and safety standards will be integrated into program requirements.

***Attention active State employees:** Monthly out-of-pocket premium contributions will be determined through collective bargaining and the compensation plans (for non-represented employees). Please keep checking with your payroll and benefits office or the DETF Web site, <http://etf.wi.gov>, for the most up-to-date information. **Attention local employees:** Employee premium contributions will be set through your usual procedures. Consult your payroll and benefits offices for further information.

How will the changes help hold down costs and improve services for members? The PBM will process and pay prescription drug claims and provide drug coverage through a single vendor to all participants in all of our plans. Because all drug coverage is funneled through one system, the PBM will provide checks and balances to alert members to dangerous drug interactions. In addition, the dollars saved through such cost reduction initiatives as discounts with drug manufacturers, rebate negotiations, and management of the list of preferred prescription drugs, will directly benefit the **health insurance program and its members**, in-

stead of the individual health plans. There is also great potential for even deeper discounts in the future, as more and more employee groups join the State's health insurance "pool."

*Rewarding cost-efficient health plans

DETF evaluated each health plan's cost of providing benefits to members and placed them in tiers, based on their ability to control costs while providing quality health care. Plans that proved to be most cost-effective were placed in Tier 1; moderately cost-effective plans in Tier 2; and the least cost-effective in Tier 3. Under this system, plans that received high marks for quality and patient safety measures were rewarded during the negotiation of their premium bids.

This approach creates incentives for the plans to become more efficient in providing services while at the same time reducing charges to the State. The current program does not necessarily give the most efficient plans a competitive advantage over other plans. In addition, the tiered approach will eliminate different State employee contribution rates based on county of residence. Under the current program's county-by-county method of premium calculations, State employees who selected the same plan sometimes pay significantly different out of pocket premiums, just because they live in different counties. The tiered approach will be more equitable: State employees will pay the same contribution for any plan within a tier.

Switch to preferred provider network

Premium rates for the Standard Plan have become unaffordable for most of our health insurance program members. At the same time costs have risen to the point that the plan does not appear to be a sustainable plan. The implementation of a preferred provider network for the Standard Plan will allow the State to control cost increases by negotiating discounts with providers within an established network. Participants in the new Standard Plan may still see any provider, but use of providers within the provider network will result in lower out-of-pocket costs for the member.

Medical errors cost millions

Preventable medical errors cost Americans one million injuries, 120,000 deaths, and \$69 billion dollars per year, according to a national report. DETF has required participating health plans to report on their hospitals' progress in incorporating key patient safety and health care quality standards recommended by the Leapfrog group (see page three). We have incorporated this information into our own evaluations of the health plans. Further, we encourage all health insurance program participants to use this information to choose health plans with hospitals and providers who have embraced these important standards. We've included this information in the *It's Your Choice* booklet, throughout the "plan description" pages in the back of the book.

Enroll in the ERA Program and Save Money!

Open Enrollment for Medical Expense and Dependent Care Reimbursement Accounts for the 2004 plan year is from October 6 through November 21, 2003. Simply log on to the ETF Internet site and click on the ERA Enrollment link, or call 1-800-847-8253 and follow the voice prompts.

When you participate in the Employee Reimbursement Accounts Program, the money that you pay for insurance premiums or deposit into your Medical Expense and/or Dependent Day Care Reimbursement Account comes straight out of your gross pay before taxes are calculated. You keep more money in your pocket because you pay less in taxes.

You must enroll in a Medical Expense and/or Dependent Care Reimbursement Account during the Open Enrollment period to participate in 2004. A Medical Expense Reimbursement Account allows you to contribute money on a tax-free basis to pay for your family's health plan co-pays, deductibles, and other qualifying expenses that you pay out-of-pocket such as dental, orthodontia, and vision care. A Dependent Care Expense Reimbursement Account allows you to contribute up to \$5,000 annually on a tax-free basis to pay for dependent day care expenses.

Before your enroll...

Carefully review your expected expenses for 2004. The ERA Enrollment booklet contains information about qualified expenses for the reimbursement accounts. Plan conservatively when contributing to a reimbursement account. Your annual election amount cannot be changed during the plan year unless you

OTC Medications Allowable Expense

The Internal Revenue Service (IRS) recently ruled that employees who participate in medical expense reimbursement accounts such as the Wisconsin ERA program may be reimbursed for over-the-counter medicine or drugs purchased without a prescription. This ruling is effective October 1, 2003 for the categories of medicines or drugs mentioned in the ruling: allergy medicines, cold medicines, pain relievers, and antacids. Excluded expenses include products used to maintain general health such as vitamins and herbal supplements, as well as toiletries and cosmetics.

Requests for reimbursement must be accompanied by a receipt showing the name of the drug, the date it was purchased and the cost. For more information about qualified expenses, contact Fringe Benefits Management Company at 1-800-342-8017.

experience a qualified change-in-status event. Read the It's Your Choice booklet for changes in your health plan coverage. **Review the drug formulary** found at www.Navitushealth.com to determine the co-pay amount for the prescriptions you use. Remember, the out-of-pocket maximums apply only to Level 1 and Level 2 prescription drugs and insulin. Drugs listed under Level 3 are not subject to the out-of-pocket maximums.

Mid-year changes in drug coverage (i.e. switching to a lower *ERA continued on page 4*

Leapfrog Update: Wisconsin Hospitals Making Progress

To date, 77.6% of urban Wisconsin hospitals (38 out of 49) have publicly reported their progress on three proven standards to reduce medical errors and save lives. This information is now available to consumers via the Internet at www.qualitycounts.org.

The three standards include:

• Computerized Physician Order Entry

Serious medication errors can be reduced by up to 88% when prescriptions are entered into computers and then linked to error prevention software.

• Intensive Care Unit (ICU) Staffing

Staffing ICUs with trained specialist physicians (intensivists) increases one out of every ten patients' chance to live if they require care that must be managed for at least eight hours per day.

• Evidence Based Hospital Referral

Patients undergoing certain high-risk procedures increase their chances of survival if they are treated by hospitals that perform these procedures more often and follow proven processes of caring for patients.

These three standards were selected by The Leapfrog

Group, a group of more than 140 Fortune 500 corporations, business coalitions and other large public or private sector health care purchasers. The standards were created to help save lives and reduce preventable medical mistakes by giving consumers information to make more informed hospital choices, and by encouraging employers to use their purchasing power to select high quality providers for their employees' plans.

Wisconsin is among 22 regions for The Leapfrog Group patient safety survey. Leading the effort to adopt Leapfrog safety standards is Wisconsin Healthcare Purchasers for Quality (WHPQ), a newly formed network of healthcare purchasers and business allies, committed to creating and promoting comparative information on healthcare costs, quality and patient safety. The Department of Employee Trust Funds is a founding member of WHPQ and has been at the forefront of efforts to build awareness of health care safety and quality among its 235,000 Wisconsin group health insurance members and all participating health plans and hospitals.

Sick Leave Program for State Employees Gains Flexibility

The recently signed budget (2003 Wisconsin Act 33) contained a provision that affects the Accumulated Sick Leave Conversion Credit (ASLCC) program and active state employees. Now, any employee with at least 20 years of Wisconsin Retirement System (WRS) creditable service who is not eligible for an immediate annuity but who terminates employment without taking a separation benefit can retain their accumulated sick leave credits.

Those sick leave credits will be available for use or escrow at retirement unless used during a period of reemployment. Previously, an employee had to be eligible for an immediate annuity from the WRS in order to retain sick leave credits. In addition, the ASLCC value calculated at retirement will change from the current rate in effect at the time of retirement to the highest rate of pay earned while employed in a position that earns State sick leave credits.

Standard Plan continued from page 1



information on how to access or receive a provider directory from Blue Cross/Blue Shield United of Wisconsin, the Standard Plan administrator.

What are the new features of this plan? On January 1, 2004, under the new Standard Plan, when you receive services from network providers, you must meet an up-front deductible.

The in-network deductible will be \$100 single/ \$200 family for the policy year. But you will no longer have to pay the 20% co-insurance. All benefits will be paid at 100% of charges after the deductible is met.

If you use out-of-network providers, you will have an initial \$500 single/\$1,000 family deductible and 80/20 co-insurance costs with a maximum co-insurance of \$2,000 single/\$4,000 family. Please keep in mind that these deductibles accumulate separately, so the in-network deductible does not apply to the out-of-network deductible, and vice versa.

A few other benefits have been adjusted to keep the overall benefit level comparable and to fit in with the preferred provider network concept. The lifetime maximum benefit will increase to \$2,000,000 to more

closely match Uniform Benefits. Prescription drug coverage will be administered by the Pharmacy Benefit Manager so the drug co-payments will align with those of Uniform Benefits, except the annual prescription out-of-pocket maximum for drug co-payment is \$1,000 single/\$2,000 family. The Standard Plans did not have an out-of-pocket drug maximum before. These out-of-pocket maximums are separate from your medical out-of-pocket costs.

Are there any changes to the State Maintenance Plan (SMP)? Yes. SMP, in addition to being offered in counties where no qualified plan is available, will also be offered in counties where no qualified Tier 1 plan is available. In addition to the added service areas:

- SMP in 2004 will have a \$100 single/ \$200 family deductible. Coinsurance will not be applied to hospital, professional and major medical services. Major medical previously was subject to a \$25 single deductible/\$50 family, and 80%/20% co-insurance with no out-of-pocket maximum.
- SMP will add a specialty care and hospital network. In 2004 Primary Care Physicians (PCPs) will refer you into the SMP specialty care and hospital network for services.

To be eligible for SMP, you must live in an SMP county. SMP counties are noted on the map in the *It's Your Choice* book and on our Web site.

ERA continued from page 4

or higher co-pay drug) are not events that allow election changes. If you are unsure of your drug needs for the upcoming year, consider contributing the lower co-pay amount for your monthly prescriptions.

Save money on your health insurance premiums...

You also save tax dollars on your payroll-deducted insurance premiums through Automatic Premium Conversion. Your share of premiums for state group

health insurance, as well as state group life, EPIC and Spectera insurance premiums are deducted from your paycheck on a tax-free basis automatically. You do not need to enroll to participate. However, if you waived participation in the past, but now wish to participate, complete an ERA Automatic Premium Conversion Waiver/Revocation of Waiver form (ET-2340) and return it to your payroll office during the open enrollment period.



STATE OF WISCONSIN PHARMACY BENEFIT MANAGER (PBM) PROGRAM INFORMATION

The Department of Employee Trust Funds (DETF) has contracted with a Pharmacy Benefit Manager (PBM) to provide pharmacy benefit services to all State of Wisconsin group health insurance participants. Beginning January 1, 2004, **all participants** will receive their pharmacy benefits from the PBM, Navitus Health Solutions (Navitus). Other than having a separate identification (ID) card, many participants will not notice a change. Your pharmacy benefit remains subject to the terms and conditions of Uniform Benefits.

NEW PHARMACY BENEFIT LEVELS

As part of the new prescription drug benefit administered by Navitus, a three-level copayment structure for pharmacy benefits will be implemented as of January 1, 2004, and is as follows:

Level 1*	Copayment per formulary prescription drugs	\$5.00
Level 2**	Copayment per formulary prescription drugs	\$15.00
Level 3	Copayment per non-formulary prescription drugs:	\$35.00

*Level 1 consists of preferred generic and certain low cost brand name drugs.

**Level 2 consists of preferred brand name and certain higher cost generic drugs.

OUT OF POCKET MAXIMUM *(applies to Level 1 and Level 2 prescription drugs and Insulin)*

There will be an annual out-of-pocket maximum of \$300 per individual or \$600 per family for all participants EXCEPT State participants enrolled in the Standard Plan. These participants will have a \$1,000 per individual or \$2,000 per family out-of-pocket maximum. There is no out-of-pocket maximum for Wisconsin Public Employer participants enrolled in the Standard Plan or State Maintenance Plan (SMP).

Once the out-of-pocket maximum is reached the PBM will pay 100% of the formulary (Level 1 or Level 2) prescription drug costs. Please note that Level 3 copayments WILL NOT apply to the annual out-of-pocket maximum.

IDENTIFICATION CARDS

Subscribers will receive two identification cards for 2004, one from their health plan and one from Navitus. When filling prescriptions, members will need to present their Navitus ID card to the pharmacist. ID cards will be mailed out in December 2003.

PBM CONTACT INFORMATION

After October 1, 2003, Navitus can answer questions regarding your pharmacy benefits, the formulary, and ID cards. Contact Navitus customer service at: Navitus Health Solutions, 5 Innovation Court, Appleton, WI 54912.

Phone Toll-free: 1-866-333-2757

www.navitushealth.com

Will I have to use a different ID card when I go to the pharmacy? Yes. You will have two identification cards for 2004, one from your health plan and one from Navitus. Your member identification number will be different on each card, so it is important that you show the correct card when getting services. When filling prescriptions, you **must** present your Navitus ID card to the pharmacist. Navitus will mail ID cards to subscribers in December 2003.

Will there be prescription drugs that require a prior authorization from the PBM? Yes. Navitus will identify some prescription drugs that will require prior authorizations. More information on prior authorizations and the Navitus drug formulary should be available on their Web site after October 1, 2003. You may also contact Navitus customer service toll-free at 1-866-333-2757 with questions about the formulary.

Can participants continue to purchase prescriptions from their current pharmacy? In most cases, they will be able to continue using their current pharmacy. Navitus contracts with most national pharmacy chains and due to affiliations with other pharmacies in the state, members may have more choices than in the past. Navitus will post a list of network pharmacies on its Web site, or you can contact them for a printed version of the list.

Look for more questions and answers on the DETF Web site at <http://etf.wi.gov>

It's Your Benefit September 2003

How Will Uniform Benefits Change in 2004?

Each year, the Department of Employee Trust Funds and the Group Insurance Board (GIB) review the Uniform Benefits package, looking for ways to clarify, improve, or modify aspects of the package to better meet the health care needs of members, while remaining “cost neutral.” This means that any cost increases caused by changes or improvements to the package must be “offset” or reduced by changes or modifications elsewhere in the package. The net effect is overall benefit levels, taken as a whole, stay the same from year to year.



Note: *Uniform Benefits do not apply to the new Standard Plan, the State Maintenance Plan (SMP) or Medicare Plus \$100,000.*

Because of the major health insurance program changes for 2004, there are minimal changes to the Uniform Benefits package. Essentially, the only change is that the GIB approved adding coverage for non-surgical removal of wisdom teeth.

Other items of interest:

- Pharmacy benefits for all State of Wisconsin group health insurance participants will be administered by a Pharmacy Benefit Manager (PBM), Navitus Health Solutions. There will be a three-level copayment structure for pharmacy benefits. For

details, see page five.

- For 2004, some plans are changing their dental benefits. Please refer to the plan description pages in section G of the *It's Your Choice* booklet, distributed in October.
- Group Health Cooperative of South Central Wisconsin will offer Uniform Benefits for participating local government participants.

To review the entire package (*Certificate of Coverage*), review your *It's Your Choice* booklet or visit our Internet site, <http://etf.wi.gov> and go to “Benefit Programs,” then “Insurance Plans.”

Where To Get More Information

For the very latest information on health insurance program changes, check the following:

- DETF's Internet site at <http://etf.wi.gov>.
- *It's Your Choice* book (available in late September)
- DETF's Telephone Message Center at 1-800-991-5540 or (608) 264-6633.
- Attend a health fair in your area during the Dual-Choice period, which begins October 6. Representatives from the area plans will be available to provide you with information about their plans. The schedule is posted on our Web site and can be found in *It's Your Choice*.

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