

# It's *Your* Benefit

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



## E-Health: Using Technology to Improve Health Care Quality and Safety

**Scenario 1: Patient A** goes to her doctor's office for follow-up care. The physician enters the exam room, file folder in hand. The folder is empty. The doctor apologizes, explaining that her medical records are at another location. Patient A has to provide an update on the nature of her appointment and the history of her medical issue.

**Scenario 2: Patient B** goes to her doctor's office for follow-up care. The physician enters the exam room, sits down at a computer, and at the push of a button views her complete medical history, including medical notes from previous appointments, test results, prescriptions, and treatment plan. The record also shows she sought treatment at an urgent care clinic two weeks earlier.

Patient B's physician, like a growing number of health care providers across the country, has instant access to her records via a secure electronic medical records system,

called an "e-health" system. You may notice this same type of technology in use the next time you go to the doctor. Nearly half of all U.S. hospitals and 20% to 25% of physicians nationwide are fully automated with electronic medical records technologies.

The sophistication of systems in use across the country varies, but the overarching goal is to use the technology to help improve health care quality, safety, and effectiveness while reducing health care costs. In Wisconsin, Governor Doyle recently created the E-Health Care Quality and Patient Safety Board, of which ETF Secretary Eric Stanchfield is a member. The Board is charged with developing a plan that would lead to the development of a secure electronic medical records network shared by hospitals, doctors, and clinics statewide.

**How does an e-health system improve the quality of the health care I receive?** For *E-Health*, continued on page 2

## Avoid Common Problems with Your Health Plan: In-Network Treatment

What would you do if you were on vacation and needed emergency care, or if your child was away at college and needed medical attention? What if your doctor wants you to see a specialist in another town? These are just a few situations that can lead to health insurance coverage problems. The first step to avoiding the problems like these is to understand your health plan's requirements for in-network treatment. Here are some basics you should know:

- **Know which providers are in your health plan's network.** Most health plans will only pay for medical services provided by a doc-

tor or other medical provider who is in the plan's network. Look in your most recent provider directory, which may also be available on your health plan's Web site, or call your health plan directly for a list of providers included in the plan's network. Except for an emergency, if you go to a provider who is not in the network, you may have to pay for the service unless you get a referral in writing from your plan before the appointment.



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your doctor, having immediate access to an organized, complete, and legible record of your health history can reduce errors, improve safety, and speed up diagnosis and treatment. Remember Patient B's urgent care visit? Because the notes were complete, up-to-date, and right there on the screen, her doctor was immediately able to use that information at the follow-up visit.

When your doctor has electronic access to your complete medical history, you are more likely to:

- get the right care at the right time;
- become more engaged in and knowledgeable about your specific health care issues;

- feel more satisfied with your health care and treatment; and
- notice improved communication between you and your doctor.

The implementation of a secure, confidential e-health system makes sense for all involved, patients as well as providers. Its use will result in higher quality service for you, increased efficiencies for your doctor and your health plan, and, ultimately, lower costs for all.

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- **Know your plan's referral requirements.** Referral requirements vary among health plans and are described in Section G of your *It's Your Choice* booklet. Most health plans will notify members in writing whether a referral request is approved or denied. If you receive services from a provider who is not in your health plan's network without an approved referral, you may have to pay for the services yourself. If your health plan has a provider in its network that can treat your condition, your health plan is not required to approve the referral request.

- **Know how to get urgent/emergency care.** A medical situation requiring emergency treatment is an exception to the "in-network" requirement. In the event of such a situation, you should always try to see a provider in your health plan's network. If that is not possible, and you have to see a provider outside of your plan's network, call your health plan the next business day to re-

port the incident. If follow-up care is needed, you must go to a provider in your health plan's network unless you obtain an approved referral from your health plan.

- **Know how to get care away from home (for example, on vacation or away at college).** Your health plan will cover out-of-network urgent or emergency care when you are away from home and outside your health plan's service area. You must still report the care to your health plan the next business day. If you need follow-up care before you return home, you must contact your health plan and request a referral. Your health plan is not required to approve referral requests for care that can be safely postponed until you return home or care that is preventive or routine in nature.

If you have questions about your health insurance benefits, network providers or referral requirements, contact your health plan.

## Have a Complaint About Your Plan? Know Your Rights

**D**id you know you have the right to question your health care provider, health plan, or disability program administrator about the care or service you receive? Did you know that you can file a complaint or grievance with your plan without fear of being denied care or services?

All plans that participate in the state's group insurance program, including the pharmacy benefit and disability program managers, are required to have a grievance process – that is, a process to help resolve issues with denied claims or difficulties obtaining prior authorizations/referrals, and other customer service problems.

**What should I do if I am unhappy with my health insurance plan?** If you have a problem with your health plan, you need to know how

the grievance process works. The first step, however, is to attempt to resolve the issue by contacting your plan's customer service department. If you are not satisfied with the answers you receive, or if you disagree with the plan's decision, ask your plan how to begin the plan's more formal grievance process. Information about the grievance process can also be found in your plan's membership booklet and in the "Question and Answer" section of your *It's Your Choice* booklet.

If you exhaust your appeal rights with your plan and the plan continues to uphold its denial, you will be notified of further rights that may apply to your situation. In addition, if you have completed your health plan's griev-

# Understanding Your Medications

## Generic Savings Opportunities

Getting the best possible value from your pharmacy benefits means that securing high quality prescription drugs must be balanced with keeping costs low. One way to do this is by using generic drugs in place of name brand drugs. In many instances generic drugs are a safe and economical alternative to higher cost brand name drugs.

In 2007, the Food and Drug Administration (FDA) may approve generic versions of the most popular brand name drugs used in the treatment of esophageal reflux, convulsions, hyperlipidemia (high cholesterol), migraine headaches, and high blood pressure. Some of the more common brand name drugs that may “go generic” include:

Imitrex	Topamax
Norvasc	Wellbutrin XL
Plavix	Zyprexa
Protonix	Zyrtec

This is by no means a complete list. The list of generic drugs being considered for approval by the FDA is too long to be listed here. Be aware that when a brand name becomes available as a generic, within six months the brand is usually moved to Level 3 on the Navitus formulary (a formulary is a list of preferred prescription drugs deemed medically effective and cost effective). At that time, the pharmacy should automatically substitute the generic for the brand name.

If you wonder whether the brand name medications you are taking will become available as generic alternatives, please speak with your doctor, pharmacist, or call Navitus Customer Care toll free at 1-866-333-2757. You can also review the “State of WI and WI Public Employers” formulary at <http://www.navitus.com>.



## Medication Labels

A medication’s label provides important and useful information about your prescription. If you do not understand the label, ask your pharmacist to explain it. Many pharmacies can provide large-print labels for easier reading or labels in multiple languages. Medication labels commonly include the following information:

- your name
- pharmacy name, address, phone number
- name of the medication
- quantity
- how to take the medication
- prescription number
- refills remaining
- expiration date
- doctor’s name

If the label or dispensing directions are confusing to you, don’t hesitate to ask for clarification. Finally, always keep your medications in their original containers.

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ance process or contacted the disability program administrator, and remain dissatisfied with the outcome, you may contact an ombudsperson at the Department of Employee Trust Funds (ETF) for further assistance.

**Important note:** You must complete your plan’s grievance process in order for your complaint to be formally reviewed by ETF. The Department’s ombudsperson can only review issues that involve a plan participating in the state’s group insurance programs. If unsuccessful in resolving your complaint, the ombudsperson will provide a written explanation and advise you of subsequent avenues of appeal. The ETF Ombudsperson Assistance Line is (608) 261-7947; or dial toll free 1-877-533-5020, extension 17947. You may also send an e-mail to [Ombudsperson@etf.state.wi.us](mailto:Ombudsperson@etf.state.wi.us).

### **For additional information:**

The *It’s Your Choice* booklet is a useful resource for more information on this topic. Check out:

- **Section B** for details on your rights and responsibilities as a participant in the group health insurance program.
- **Section C** for common questions and answers about the insurance complaint process.
- **Section E**, the *Health Plan Report Card*, which provides the results of the annual member satisfaction survey and clinical evidence of health plan performance. Review how your plan compares to others in the number of grievances filed and resolved in favor of the member.



## ETF Gathers Member Comments About Health Care

The annual survey on member satisfaction (also known as CAHPS®) is almost finished and the Department of Employee Trust Funds (ETF) would like to thank survey participants for their important feedback.

This year the Department collected open-ended comments from participants about their health plans and the health care they receive. Here are some common themes to responses shared with ETF thus far:

### Participants have been satisfied with:

- the comprehensive level of benefit coverage;
- access to providers, customer service, and health plan information;
- preventive care and exercise/health behavior reimbursements and rebates;

- health information provided by health plans and health care providers; and
- online access to health information

### Participants have expressed concerns about:

- out-of-pocket expenses for premiums and copayments;
- wanting more covered benefits in such areas as dental, weight loss, and vision care;
- the prescription drug formulary; and
- the length of time it takes to see a specialist

ETF will provide a summary of the comments received to the Group Insurance Board and publish the information in the Report Card section of the 2008 *It's Your Choice* booklet. We will also share the survey results with the participating health plans.

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