

It's *Your* Benefit

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



Developing and delivering quality benefits and services to members while safeguarding the integrity of the Trust Funds.

2013: Continue Focus on Making Wise Choices

As you will read in this edition of *It's Your Benefit*, the state continues to implement program design changes (e.g., wellness initiatives, prior authorizations for certain procedures, coinsurance, and higher copayments for specialty medications) that help slow the rate of premium increases for employees and employers. Negotiating these premium rates is one of ETF's primary responsibilities. For the fifth year in a row, our negotiations resulted in premium increases that are significantly below industry trends. Our goal remains to help contain costs without sacrificing quality.

To achieve this goal we need to work together. One important way you can help is to use information to make wise choices about when and where to spend health care dollars. Using information about cost and

quality can help improve quality and drive down costs overall. We continue to ramp up efforts to provide you with the information you need to make informed decisions. Start by checking out the total monthly premium of the various plans in the *It's Your Choice* materials. Then compare the plans' quality and service ratings in those same materials. High cost does not necessarily mean higher quality and service.

Also, make sure to ask your primary care physician for information about cost and quality. Your primary care physician is often in an excellent position to help you make wise choices. If tests or special procedures are being considered, ask what they're for, whether they are necessary, which providers offer the tests or procedures with the highest quality outcomes, and how much

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It's Your Choice October 8 - November 2

The *It's Your Choice* health insurance enrollment period is set for October 8-November 2, 2012. This is your annual opportunity to change from one health plan to another, switch from single to family coverage, or add/delete certain dependents. It is also the only open enrollment opportunity of the year for eligible state employees, retired state employees and active local government employees of participating employers (unless you experience a qualifying event). Changes become effective January 1, 2013.

All current members: Even if you are satisfied with your health plan, take the time to review any changes to your plan's premium, service area and health care providers. If

you want to remain with your current plan, you do not need to do anything if it is still offered in 2013.

Active employees (excluding UW System employees): If you want to switch plans or change your level of coverage for 2013, you must make the change during the enrollment period. You can make the change online through the myETF Benefits system (see page 7) or submit a paper application to your payroll representative by 4:30 p.m. November 2.

UW System employees: Do NOT use the myETF Benefits system to enroll in or make changes to coverage. Instead, go to

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Wisconsin
Department of
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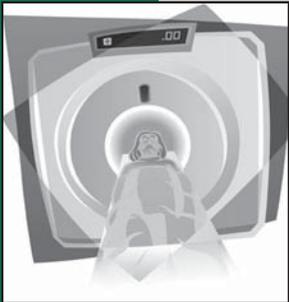
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September 2012

Notable Changes for 2013

This edition of *It's Your Benefit* provides an overview of some of the health insurance benefit changes in the State of Wisconsin Group Health Insurance Program for 2013. For complete details, please refer to the many resources on our website, including:

- The *It's Your Choice: 2013 Decision Guide* and *It's Your Choice: 2013 Reference Guide* (available in late September).
- Online materials, including a tutorial explaining 2013 changes to the group health insurance program. Find them under the Group Health Insurance menu at http://etf.wi.gov/members/health_ins.htm.
- Your employer's payroll and benefits office.



Two of the most notable changes for 2013 are as follows:

Prior Authorization Requirement for High-Tech Radiology and Low Back Surgery

The program is adding a prior authorization procedure for certain elective outpatient high technology radiologic tests. For tests provided on

or after January 1, 2013, a prior authorization must be obtained by the ordering provider. Such authorizations are required for the following procedures: CT and CTA scan, MRI and MRA scan, cardiac (nuclear) study, and PET scan.

Exceptions to this requirement include studies obtained at emergency or urgent care facilities. In addition, specialists are required to prior authorize office visits for low back conditions, unless there is a need for an emergency evaluation. Health plans will vary as to how they will implement these new requirements. Make sure that you take the time to understand your plan's procedures and ask your plan or doctor to verify that an authorization is in place before having such a procedure.

Hospice Care Benefit

The group health insurance program is adding in-patient stays of up to 30 days at an approved hospice facility or skilled nursing facility to the hospice care benefit. This means that in-patient charges are payable for up to a total maximum of 30 days of confinement in a health plan-approved or Medicare-certified hospice care facility.

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they charge. If medication is prescribed, see if there is a less expensive generic alternative available.

Finally, with enhancements to our wellness initiative, you can now be a more active participant in your own health care. By taking the health risk assessment offered by your health plan, you can help your primary care physician determine whether you may be at risk for certain diseases or chronic conditions. Often, those conditions are more successfully—and cost-effectively—treated (or avoided entirely) if discovered early. Also, by taking advantage of biometric screenings, which all health plans will be offering in 2013, you can understand your blood pressure, cholesterol levels, body mass index and glucose levels so

that you and your primary care physician can take better control of your health care.

Through negotiations, ETF was able to keep premium increases at 5% for most program participants in 2013. This relatively small increase was good news, given the tight budgets facing governmental employers and employees. But for more and more of us, any increase is too large.

If you have an idea for holding down costs, send an e-mail to Itsyourbenefit@etf.wi.gov. We cannot promise your suggestion will be implemented, but we are certainly interested in hearing what you have to say. Hopefully, working together, we can help drive costs down and quality up.

What are Effects of Federal Law Changes on the Group Health Insurance Program?

The state's group health insurance program continues to implement the applicable requirements of the Patient Protection & Affordable Care Act (PPACA). Several provisions of the law may affect or interest members. These provisions are as follows:

- The medical loss ratio (MLR) provision of PPACA
- Changes in preventive care that are required to be covered at 100% without deductible and/or coinsurance
- Notices of summaries of benefits and coverage (SBCs)
- A Uniform Glossary

The MLR is a measurement of the portion of the premium paid to the health plan that is used to pay for health care *claims* (versus administrative and overhead costs). In July 2012, PPACA began a new annual process that, in some instances, requires plans to notify members about the MLR and the potential for monetary rebates. Because they met or exceeded the MLR requirement for 2011, no health plans offered under the state's group health insurance program were required to issue rebates. In other words, the plans spent a sufficient amount of health premiums on health care services, as determined under federal law.

Preventive care that is required to be covered in full changes periodically and must be incorporated into a health plan, effective upon a group's renewal date. Based on the recommendation of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices and the Bright Futures Guidelines recommended by the Academy of Pediatrics, PPACA added eight new service areas for women, starting January 1, 2013, for our program. See www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html for more information on covered preventive care services.

An SBC is a federally-mandated document intended to help individuals across the nation compare health plans. Each health plan is currently required to issue an SBC for every network offered. An SBC details deductibles, coinsurance and out-of-pocket limits for various services in a prescribed format.

SBCs and the Uniform Glossary can be found on ETF's website or in your *It's Your Choice: 2013 Decision Guide*. You may also contact the Department of Employee Trust Funds to request a specific plan's SBC.



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the UW System fall enrollment website at <http://uwservice.wisc.edu/2013> for enrollment information. Contact your institution's payroll and benefits office if you have questions about the enrollment process.

Retirees: If you want to make a change, you can either make the change online through the myETF Benefits system, or submit a completed application to ETF, postmarked no later than November 2. Health plan changes will be listed in the *It's Your Choice* materials, which you will

receive prior to the beginning of the enrollment period. It is especially important that you take the time to ensure that your plan and/or plan service area will be offered in 2013 and review the premium rate information.

All state employees (including UW employees) will receive from their employers e-mail notification of the online availability of the *It's Your Choice* materials. The materials can also be found on the Department's website at http://etf.wi.gov/members/health_ins.htm.



State Employees

Enroll in the Employee Reimbursement Accounts (ERA) Program and Save Money

Participating in the Employee Reimbursement Accounts (ERA) Program is like getting a discount on certain expenses—not because they cost less, but because you are using pre-tax money to pay for them. You decide how much to set aside and that amount is deducted from each paycheck before your federal, state and FICA taxes are calculated.

- For child day care and/or adult day care expenses, you can contribute up to \$5,000 in pre-tax money to a dependent day care account.
- Use a medical expense account for out-of-pocket health care expenses such as co-insurance, prescription drug copays, and many other medical expenses not covered by insurance such as dental and vision care.
- The ERA Program is administered by WageWorks (a division of FBMC).

New in 2013

Under the Patient Protection and Affordable Care Act (PPACA), contributions to a medical flexible spending account will be limited to **\$2,500 per year**. Any 2012 funds that you use during the grace period are not included in the \$2,500 annual contribution limit.

WageWorks card

When you enroll in a medical expense reimbursement account, you will receive a health care card from WageWorks to pay for many of your medical expenses. Remember to keep documentation for all expenses. In some cases, for example when using the card to pay a co-insurance expense, you will also be required to provide documentation for that medical expense. WageWorks will notify you of any card transactions that require documentation.

How much money should I set aside in my medical expense reimbursement account?

Review what you paid last year in coinsurance,

prescription drug copayments and other qualifying expenses and, if those needs remain about the same, use that figure to decide how much to contribute to your account in 2013. Consult the It's Your Choice materials for a list of coinsurance and copayment amounts, deductibles, and out-of-pocket maximums for all services and health plans. The out-of-pocket maximum for plans subject to Uniform Benefits is \$500 for single coverage and \$1,000 for family coverage (\$500 per individual; up to \$1,000 cumulative for family coverage.)

Manage your account online

Managing your account(s) is quick and convenient on the WageWorks website. You can set up direct deposit reimbursements and have on-demand access to account activity statements. If you provide an e-mail address when registering, you will receive e-mails with account and claims status information as well. The site has the ability to upload claims and has a "Pay My Provider" feature, allowing you to send a payment electronically from your ERA account to a provider for eligible services rendered. You can use the mobile application to file a claim and submit receipts from your smart phone. Go to www.wageworks.com to find out more about managing your account and the options for claiming your reimbursements.

Enroll online

Open enrollment for medical expense and dependent day care reimbursement accounts for the 2013 plan year runs from October 8 through November 2, 2012. To enroll online, go to www.wageworks.com and click "Register with WageWorks now!". Or call WageWorks Customer Service at 1-855-428-0446.

Watch for an e-mail from your employer for more information regarding the ERA enrollment period. Information will also be available by late September on the Department of Employee Trust Funds website, <http://etf.wi.gov>.

Medicare News and Notes

Navitus MedicareRx (PDP) Provides Medicare Part D Coverage

Navitus MedicareRx (PDP), underwritten by Sterling Life Insurance Company, provides prescription drug coverage for Medicare-enrolled retirees and their dependents in both the State and Wisconsin Public Employers (WPE) group health insurance programs in 2013. Navitus MedicareRx is group coverage exclusively for state and WPE members.

This plan provides Medicare-required benefits and supplemental coverage that “wraps” around the Medicare benefits to ensure the pharmacy benefits you have when you become eligible for Medicare are essentially the same as the pharmacy benefits you had as an early-retiree or an active employee. Navitus MedicareRx coverage doesn't extend to U.S. territories or foreign countries. Contact Medicare at 1-800-MEDICARE (1-800-633-4227) or go to <http://www.medicare.gov> to find out more about your Medicare Part D coverage options if you live in a U.S. territory.

Understanding Medicare's Explanation of Benefits (EOB)

On occasion you may receive from Medicare an *Explanation of Benefits* (EOB), which provides information on the Medicare Part D benefits paid by Navitus MedicareRx. Medicare's EOB does not include the benefits that have been paid, or will be paid, by your “wrap” benefit under our program. This may seem confusing to you, but remember: Your “wrap” benefit most often provides your coverage when Medicare does not. It is not possible to have Medicare's EOB reflect your wrap benefits, so we have to rely on you to know and understand your benefit coverage.

Opting Out of Navitus MedicareRx Coverage

Although individuals covered under the State and WPE programs and who are Medicare enrolled are automatically enrolled in the Navitus MedicareRx plan, they may become enrolled in another Medicare Part D prescription drug plan.

Doing so is not recommended or required for your continued coverage under our program.

Because the group health insurance premiums in the State and WPE programs include all prescription drug coverage, if you are enrolled in a different Medicare Part D plan, your group health insurance premium does not change—there is no partial refund of premiums—and you may have to pay an additional premium to the other plan you enroll in. Navitus will coordinate coverage with Medicare and pay secondary claims after Medicare processes your prescription claims from the other Medicare Part D plan, minus the applicable copayments and coinsurance that are your responsibility.

If you are enrolled in another Medicare Part D plan before January 1, 2013, for coverage in 2013, and you intend to stay in that program, notify ETF immediately. If ETF automatically enrolls you in Navitus MedicareRx, you will be automatically disenrolled from your other plan by Medicare.

IRMAA adjustments

Some of our members may have noticed that the Social Security Administration (SSA) was requiring them to pay an additional amount for their monthly Medicare Part B (medical) and Medicare Part D (prescription drug) coverage. The additional amount is called the income-related monthly adjustment amount (IRMAA). IRMAA affects you if your income exceeds certain limits.

Additional information about IRMAA can be found in *SSA Publication No. 05-10536*, found at <http://www.socialsecurity.gov/pubs/10536.html>. To request a paper copy of this publication, call the SSA at 1-800-772-1213.



Take Charge: Complete a Health Risk Assessment and Biometric Screening

The group health insurance program continues to make disease management and wellness a central priority. We strongly encourage you to take full advantage of your health plan's disease management and wellness programs. Here are some of the specific tools that participating health plans are offering in 2013 to help you stay on the path toward optimal health and wellness.

Start 2013 off right by taking the **health risk assessment** (HRA) offered by your plan. An HRA is a questionnaire that helps you and your doctor assess your health risks to identify whether you may be at risk for certain diseases or chronic conditions. Health plans may offer HRAs on paper in your doctor's office, online or by telephone. Check with your plan or doctor to determine the most convenient way for you to take the HRA.

New for 2013: Coverage for biometric screening. Biometric screening is another important health and wellness tool that can identify

certain health characteristics that, if left unaddressed, could develop into serious conditions. All health plans will offer biometric tests, which measure blood pressure, body mass index, cholesterol and glucose levels.

Take advantage of your health plan's wellness offerings. Many plans provide substantial discounts or credits that can be applied to the purchase of fitness equipment or community supported agriculture shares, for example. Some health plans provide incentives such as gift cards and membership discounts for participation in disease management and wellness programs. For more information on disease management and wellness programs, see the Health Plan Features At-a-Glance section of the *It's Your Choice: 2013 Decision Guide* or contact your health plan.



Level 4 Copayment for Specialty, Other Medications

Effective January 1, 2013, formulary and non-formulary prescription drugs that are classified by Navitus as specialty medications will have a Level 4 copayment of \$50 when they are filled at a participating network pharmacy.

In general, specialty medications are drugs that require special storage and handling and, as a result, are more costly and usually not available from all participating pharmacies. This includes many injectable medications.

The \$50 copayment for formulary specialty drugs will count toward your Level 4 out-of-pocket limit (OOPL), which is \$1,000 per individual (\$2,000 per family). Formulary specialty drugs will be listed as Level 4 and marked with "ESP" on the formulary to make them easily identifiable. Copayments for non-formulary specialty drugs will not count toward the Level 4 OOPL. Non-formulary specialty drugs will simply be listed as Level 4. Please note that the Level 4 OOPL is separate from the OOPL for Level 1 and Level 2 drugs.

The current 2012 Navitus formulary shows specialty medications by marking them with "SP".

If you are taking a specialty medication we strongly encourage you to participate in Navitus SpecialtyRx, a specialty pharmacy program. If you have your prescriptions for specialty drugs filled at the preferred participating pharmacy for specialty medications, which is currently Diplomat Specialty Pharmacy, you will have a reduced copayment of \$15 for formulary specialty drugs (which also counts toward the Level 4 OOPL). Again, these specialty medications are marked on the formulary with "ESP". Participation also allows you to take advantage of the additional, personalized services available with Navitus SpecialtyRx.

Non-formulary specialty drugs are not eligible for the reduced copayment, and the copayments do not count toward the Level 4 OOPL.

To enroll in the Navitus SpecialtyRx program, or for more information, call Navitus SpecialtyRx Customer Care at 1-877-651-4943 or see Diplomat Specialty Pharmacy's website, <http://diplomatpharmacy.com>.

How to Find and Use myETF Benefits System

All employees* and annuitants covered under the group insurance program should submit It's Your Choice Open Enrollment changes via the myETFBenefits system. Find it on our website (see link in grey box below). Making changes via this dedicated and secure system is a quick and easy process:

- If you have not previously registered for online access to myETF Benefits, select the *Register Now* button. Follow the on-screen instructions to set up a **Wisconsin User ID** and password. Note: You will also be asked for your ETF Member ID, which can be found on your Navitus card, on your annual *Statement of Benefits* or on any recent annuity statement from ETF.
- If you already have a Wisconsin User ID and password, then click on the Login button.

- You will also find instructions and links if you forgot your Wisconsin User ID, need to change your password, etc.

Note: If you do not have access to a computer, you may submit your enrollment change on a paper application, the *Health Insurance Application/Change Form (ET-2301)*, found in your *It's Your Choice: 2013 Decision Guide*. Employees should submit the form to their benefits/payroll/personnel office. Annuitants and continuants should send the form to ETF. All changes must be entered online, submitted, faxed or postmarked no later than November 2, 2012.

**UW System employees: Do not use MyETF Benefits site. Instead, go to <http://uwservice.wisc.edu/2013>. Contact your payroll/benefits office for more information.*



Need Help Using MyETF Benefits?

- Read the instructions on the myETF Benefits log on page, located at on ETF's website at <https://myetf.wi.gov/etf/internet/member/onm.html>.
- View the instructional webcast (also on the log on page).
- Call ETF at 1-877-533-5020 or (608) 266-3285 between 7:00 a.m. and 5:00 p.m. (CST), Monday through Friday.

Everyone Benefits from Electronic Health Records

Many of the health plans and provider groups that serve members covered under the state's group health insurance program have implemented electronic health records systems. These systems provide patient access to medical records, improve health care providers' ability to coordinate care, create administrative efficiencies and, perhaps most important, can facilitate better communications between patients and their health care providers.

If your health plan offers such a system (e.g., MyChart, CareEverywhere), some of the things you could do with it would include:

- make and view appointments online;
- view test results and compare historical results;
- communicate with your providers;
- review medications and immunization records; and
- access billing information and other helpful online medical resources.

Contact your health plan or ask your health care provider if this type of service is available. Take a few minutes to sign up today—and start benefiting now.

Reminders and Announcements

Benefit/Health Fairs Scheduled Throughout State

The Department of Employee Trust Funds (ETF) has scheduled health/benefit fairs throughout the state during the It's Your Choice open enrollment period. The fairs are a great opportunity to ask questions on the full range of ETF-administered benefit programs, including health insurance benefits for participating employees and retirees.

To review ETF's interactive map showing benefit/health fairs in Wisconsin, see the Benefit Presentations page on our website at http://etf.wi.gov/members/presentation_map.html or call ETF at 1-877-533-5020 or (608)266-3285. State employees and retirees can also see the schedule in their *It's Your Choice: Decision Guide*.

Select a Primary Care Physician

The Department of Employee Trust Funds strongly recommends, and plans may require, that you select a primary care physician (PCP) for yourself and your covered dependents if you submit a health insurance application. Your PCP coordinates your care with specialists and is one of your most important health care partners.

It's Your Benefit is published by the Wisconsin Department of Employee Trust Funds for members in Wisconsin Retirement System insurance programs. To view this newsletter online, go to <http://etf.wi.gov/publications.htm>.

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ET-7116

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