

your health

N E T W O R K

A NEWSLETTER FOR ALL STATE GROUP INSURANCE PROGRAM PARTICIPANTS

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Temporary COBRA Subsidy

The American Recovery and Reinvestment Act of 2009 (also known as the stimulus bill), signed into law by President Obama on February 17, 2009, included provisions to address job loss due to the recession and the maintenance of health insurance.

To help displaced workers maintain their health coverage while they are between jobs, the stimulus bill provides for a temporary 65 percent reduction in the premiums payable by involuntary terminated workers and their families for healthcare continuation coverage under COBRA. The subsidy became effective for coverage beginning March 1, 2009.

To be eligible for the subsidy, an employee's loss of health coverage must be due to involuntary loss of employment (other than by reason of gross misconduct or simply quitting) which occurred from September 1, 2008, through December 31, 2009. Covered dependents will also receive the subsidy if they lose health insurance coverage due to the employee's involuntary termination.

Even though someone may have lost their job due to involuntary termination between September 1, 2008, and

February 28, 2009, and are eligible for the subsidy (that is a reduced COBRA premium starting on March 1, 2009) they *are not* eligible for a refund of any full premiums paid for COBRA during this time frame. The COBRA subsidy/reduced premium begins for eligible persons in March.

The maximum period of subsidized COBRA coverage is nine months, followed by unsubsidized coverage for up to nine more months, for a total of 18 months of coverage from the date of the qualifying event as under current law. The subsidy ends when the participant becomes *eligible* (as opposed to actually covered) for employer-sponsored health coverage, or Medicare, or when the normal 18-month COBRA period expires — whichever is earliest.

Participants must notify Benefits Administration when they become *eligible* under another employer-sponsored health plan or Medicare. Failure to do so will result in a penalty tax equal to 110 percent of the premium subsidy.

For more information about the COBRA subsidy provision, please visit the www.ustreas.gov/recovery/ and www.dol.gov/recovery/ web sites.

Tobacco Use Surcharge and Quitter's Refund

On March 31, the State, Local Education and Local Government Insurance Committees approved a Tobacco Use Surcharge and Quitter's Refund program for the 2010 plan year. The goal of this policy is intended to encourage plan members who use tobacco to take a positive step toward better health by giving up all tobacco products.

The program will be funded through a \$50 per-month surcharge for plan members enrolled in health coverage who use tobacco. The surcharge will not exceed \$50 per month even if both the employee and spouse are tobacco users. The surcharge does not apply to dependent children who use tobacco products.

During the annual enrollment transfer period in the fall, all plan members will be provided with a form which must be returned attesting to whether or not they have used tobacco products since July 1, 2009. The surcharge will apply to all active employees, retirees and covered spouses and will be collected through post-tax payroll deduction. If you do not use tobacco products, it is extremely important that you return your form timely so you are not assessed the surcharge.

Employees and covered spouses who currently use tobacco and wish to avoid the surcharge entirely have access to a variety of free and low-cost quit supports. Members who choose to quit by July 1, 2009, will not be subject to the surcharge in 2010.

Plan members already have access to the Tennessee Department of Health Tobacco Quitline at 1.800.QUITNOW (1.800.784.8669) seven days a week. This free hotline provides cessation counseling and resource information which can help kick the habit.

Effective May 1, several additional resources were made available to plan members who wish to quit using tobacco. These include:

- \$5 copay with a prescription for nicotine replacement patches, gum and lozenges (\$10 copay for 90-day supply)
- \$5 copay for prescriptions to help members quit, such as Chantix® and bupropion (\$10 copay for 90-day supply)

These copays and benefits are available for all members, regardless of their insurance carrier.



Members must get a prescription from their doctor for all quit aids, including those which are available over the counter. This prescription, coupled with the insurance card, will ensure members pay only the \$5 (30 day) or \$10 (90 day) copay. The choice of the right quit aids varies by patient, which is why the state sponsored plans are requiring a prescription. The plans will cover any clinically appropriate tobacco cessation treatment, including combination therapy. This benefit is limited to two courses of treatment, each for a maximum of 12 weeks during a calendar year, for each type of treatment.

A series of free quit support seminars are also being conducted at locations across the state. These voluntary sessions provide tips for successfully giving up tobacco and a chance for members to learn more about safely quitting and how to get the most from the state's quit support program.

Those who successfully kick the habit after July 1, 2009, can qualify for a Quitter's Refund. Members who pay at least six months of the surcharge will be eligible to receive a \$300 refund for remaining tobacco-free for six months and an additional \$300 for remaining tobacco-free for an additional six months (one year total). If both you and your spouse use tobacco products, you both must quit to qualify for the refund.

At least ten other states have implemented a tobacco surcharge for their respective employee insurance programs. However, no other state has included an incentive in the form of the Quitter's Refund, nor have they offered coverage of quit supports as generous as Tennessee's.

This initiative is the first of several steps to encourage positive habits among plan members as they relate to tobacco use, wellness habits and overall health. The Insurance Committees will be considering other programs for plan years 2011 and beyond.

It is vital that all participants return the form provided during annual transfer by the deadline. Failure to do so, whether or not you or your spouse use tobacco products, will result in the assessment of the surcharge.

Detailed information about the tobacco surcharge, including a list of frequently asked questions, online seminar registration and links to other resources on the internet is available on the Benefits Administration web site at www.tn.gov/finance/ins/.

notable

If you are at a doctor's office or pharmacy and are declined services, please contact our customer service center at 1.800.253.9981, press "5" for urgent and a representative will assist you. The service center is open Monday through Friday from 7:00 a.m. until 5:00 p.m. (CST).

Beginning this year, actively employed State Plan members will see changes in coverage for basic term life, basic special accident and optional special accident effective the first day of October based upon age or salary as of September 1.

Any time you have a question regarding your coverage, please remember that you can submit your questions via email to benefits.administration@tn.gov.

Please be advised that for services to be covered under your health insurance, they must be medically necessary. Having a physical for the purpose of playing a sports event or attending camp is not a covered expense.

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color or national origin. If you have a complaint regarding discrimination, please call 1.866.576.0029 or 615.741.4517.

When adding or canceling coverage for a dependent, please remember to do so in a timely manner. To add coverage for a newly acquired dependent, an application must be completed and returned within 60 days of the date a dependent is acquired. When you request cancellation, a dependent's coverage will terminate according to plan provisions.

Brand Name Proton Pump Inhibitors

At the instruction of the Insurance Committees, effective May 1, 2009, coverage was excluded for brand name proton pump inhibitors (PPIs) — a group of medications typically used to treat stomach acid problems. This includes Aciphex®, Nexium®, Prevacid®, Prilosec®, Protonix® and Zegerid®. Generic PPIs such as omeprazole and pantoprazole, will continue to be covered.

Coverage for the brand name drug will only be provided through a prior authorization process in which the member's doctor contacts the health

insurance carrier to provide clinical reasons to support the need to cover the brand name drug. If prior authorization is provided, then the member will be allowed to receive the brand name medication at whatever copayment is applicable based on his or her selected healthcare option (this can vary from carrier to carrier).

Participants who were identified as having a prescription filled for one of these drugs within the last six months were mailed detailed information regarding this change in benefits from the healthcare vendors.

Changes in Pharmacy Benefit Providers

Under the current structure of the state sponsored healthcare options, pharmacy benefits are managed by the individual insurance companies. Each insurance company has a pharmacy benefits committee that establishes their drug formulary. While Benefits Administration can request certain modifications to the formulary, it is typically accepted to use the insurance companies clinically appropriate recommendations. As a result, there can be differences in covered drugs and the associated copayment tiers depending on which healthcare option you are enrolled in.

Benefits Administration plans to conduct a competitive procurement process to secure the services of a single pharmacy benefit manager (PBM). This is commonly referred to as a pharmacy benefit "carve out." PBMs provide value and savings because they are able to negotiate directly with drug companies for discounts on prescription drugs. While our current healthcare vendors do

negotiate for these discounts, pooling our covered population together into one group of approximately 300,000 participants allows for greater buying power and increased discounts. A savings not only for the plans, but for all covered participants.

Due to the time frames involved to conduct a procurement, it is not known at this time when the pharmacy benefit carve-out will be in place. Further information will be provided to all members in advance of putting this benefit in place.



Medicare Part D Pharmacy Plan and Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the state-sponsored healthcare options (PPO, POS and HMO) and prescription drug coverage available for people eligible for Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. This notice applies to you and your covered family members who are eligible for Medicare. **If you are actively employed, you do not need to enroll in Medicare prescription drug coverage.**

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare advantage plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The insurance committees have determined that the prescription drug coverage offered under the state-sponsored healthcare options is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered creditable coverage.

Because your existing state-sponsored coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving state-sponsored coverage may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your state-sponsored coverage, which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the state-sponsored healthcare options and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.



If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact our office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the state-sponsored options changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.Medicare.gov
- Call your state health insurance assistance program (see your copy of the *Medicare & You* handbook for their telephone number) for personalized help
- Call 1.800.Medicare (1.800.633.4227). TTY users should call 1.877.486.2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration online at www.socialsecurity.gov, or you call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.



If my doctor recommends a certain treatment or surgery and the insurance company denies my claim or request for prior authorization, is there an appeals process in place if this is medically necessary according to my doctor?

If you experience a problem relating to the plan policies or the services provided, there are established procedures to help you resolve your complaint. These procedures do not apply to any complaint or grievance alleging possible professional liability, commonly known as malpractice, or for any complaint or grievance concerning benefits provided by any other plan.

If you are in disagreement with a decision or the way a claim has been paid or processed, you or your authorized representative should first call member services to discuss the issue. If the issue cannot be resolved through member services, you may file a formal request for review or member grievance with the insurance company. All requests must be filed within the specified time frame. When a determination is made, you will be notified in writing. If your request is denied you will be advised of any further appeal options.

Benefits Administration has an appeal process that is available to you **after** you have exhausted the grievance process with the claims administrator. To file an appeal at the state level, send a letter and supporting documentation to the appeals coordinator in Benefits Administration. The deadline for filing an appeal is two years after claim rejection.

Dependent Eligibility Verification

Benefits Administration is preparing to begin the dependent eligibility verification process which has been referenced in the past few issues of *Your Health Network*.

Within the next few months, all participants with family coverage will be asked to provide documentation verifying the eligibility of all covered dependents. Policy holders will be provided with a list of their covered dependents, a worksheet to assist in determining the eligibility status of their dependents and a list of appropriate documentation which may be provided to establish eligibility by dependent category. In addition, going forward we will begin requiring documentation regarding the eligibility for all new dependents being enrolled once the verification process begins.

As a reminder before the review begins, the following individuals are eligible for dependent coverage on your policy:

- Legally married spouse
- Natural child
- Legally adopted child
- Stepchild for whom you or your spouse has legal or joint custody or shared parenting
- Any child living in your home for 12 months per year for whom you are the legal guardian
- Any child living in your home for 12 months per year who you claim as a dependent on your federal income tax return
- Any child named as an alternate recipient under a qualified medical child support order

Dependent children are eligible for coverage until the end of the month in which they reach age 19. Dependent

children age 19 to 24 may only continue coverage if unmarried and either a full-time student or claimed on your federal income tax return. Exceptions apply for a dependent child over the age of 24 who is incapacitated (mentally or physically disabled and incapable of earning a living).

Once your dependent no longer meets eligibility guidelines, it is your responsibility to notify your agency benefits coordinator to terminate coverage. If you would like to verify the dependents currently insured under your policy, your benefits coordinator can provide you with this information as well.

The following individuals are **not** eligible for coverage as your dependent:

- Ex-spouse (even if court ordered)
- Parents of an employee or spouse
- Children in the armed forces on a full-time basis
- Children over age 24 (unless they meet qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

Once a dependent no longer meets eligibility guidelines, it is your responsibility to notify your agency benefits coordinator to terminate coverage.

To ensure no interruption in coverage for your eligible dependents, it is vital that you return the requested documentation by the designated deadline. Failure to do so will result in the termination of your dependent's coverage.

Please refer to your *Insurance Handbook* for further information on dependent eligibility. You may obtain a copy from your agency benefits coordinator or from the Benefits Administration web site.

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