WE’RE LISTENING TO YOUR QUESTIONS

Since our announcement about the changes to the State Group Insurance Program, we have received a number of questions from our active and retired members.

While we still don’t have all the answers, we think it’s important to address as many questions as we can. That’s why this issue of ParTNers for Health is devoted to answering those that have been asked most frequently.

We will continue to keep you informed as decisions about carriers and costs are finalized. In the meantime, please submit any additional questions to benefits.info@tn.gov. If you do not have access to the Web, you can contact the Benefits Administration Service Center at 1-800-253-9981 to request a printed copy of the questions and answers that are posted on our website at www.tn.gov/finance/ins.

Attention Retirees!

The information described in this newsletter affects all retirees younger than age 65. Be sure to read the Q&A about retiree health care on page 7 and all future ParTNers for Health communications.

Q&A BENEFIT CHANGES

How is the State Group Insurance Program changing?

- We will offer two new PPO (preferred provider organization) health insurance options—the Partnership PPO and the Standard PPO.
- The current PPO, HMO and POS options will no longer be available.
- Both new health insurance options will have deductibles, co-pays and co-insurance.
- You will save money if you take an active role in your health.
- Premium levels (tiers) will expand from two to four:
  - employee
  - employee + spouse
  - employee + child(ren)
  - employee + spouse + child(ren)
- For the first time in many years, you will have to choose a health insurance option during the Annual Enrollment Transfer Period. This means all members will have to complete an enrollment form.
- The Annual Enrollment Transfer Period will be from September 15 through October 15, 2010.

What is NOT changing?

- All health care services covered under your current plan will be covered under both of the new health insurance options.
- You will continue to have a choice of plan options and carriers.
- No matter which option and carrier you choose, you will still have a large network of doctors and hospitals.
- You can continue to cover your spouse and eligible children.
What’s the difference between the Partnership PPO and the Standard PPO?
The Partnership PPO and Standard PPO will both pay for the same services that are covered under your current plan—regardless of whether you’re in the PPO, POS or HMO. In addition, both will include a deductible that you must meet before benefits are paid for certain services. Both also include an out-of-pocket maximum, which protects you financially if your medical expenses run very high.

Despite these similarities, there’s an important difference between the two health insurance options: under the Partnership PPO, you and the State will work together to bring down costs. You will commit to a Partnership Promise. The State will reward you with lower costs.

Why are you making changes to the Group Insurance Program?
We can no longer afford to provide the medical plan options that we currently offer. Medical expenses are greater than premium collections. Rather than cut covered services or eliminate coverage for dependents, our solution is to reduce plan costs with new health insurance options. These options are designed to help reduce the high rate and cost of chronic disease in our membership. This solution allows us to preserve the comprehensive, affordable and dependable benefits you’ve come to expect.

How and when will I find out more about the changes?
You will receive more information each month leading up to the Annual Enrollment Transfer Period, which will be September 15 through October 15. Please be sure to look for any mail with the PartNers for Health logo. We will also provide information via our website. A 24-hour call center will also open in August.

Why won’t members be able to choose the HMO or POS?
The State simply can no longer afford these options. Premiums for the HMO option have been kept very low for the last few years. If we were to continue an HMO option, we would have to increase member premiums by more than 40 percent and include a deductible. The same would be true for the POS option.

What is the difference between “benefits” and “covered services?”
“Benefits” refers to the entire health plan, including who the plan covers, what services are covered and how much the plan and members pay. “Covered services” refers to medical care, such as a doctor visit, that is paid for by the health plan.

If the State’s financial situation improves, could the HMO and POS be included as options in 2011?
No. We will not offer these options in 2011.

Who has been involved in planning the new health insurance options?
The Insurance Committees are responsible by law for any changes to benefits. The Benefits Administration team supports the work of the Committees on a day-to-day basis. Together, these groups have worked hard to develop new health insurance options that preserve comprehensive, affordable and dependable coverage for plan members.

Throughout the process, we consulted with TSEA, TEA, representatives from local government, the legislature and other stakeholders as appropriate. We continue to work with them as we finalize details.

Are other public and private employers making similar changes?
Yes. However, many employers are simply raising premiums or dropping dependent coverage entirely in order to control their costs. We are working to address the situation differently—and to preserve comprehensive, affordable, and dependable benefits for employees and their families.
CHOICE AND COVERAGE

Will all Plan members have the same health insurance choices?
Yes. We will offer the Partnership PPO and the Standard PPO options to all 275,000 members. This includes legislators, employees of the State, higher education agencies, local education agencies and local government agencies and eligible retirees.

Will everyone have a choice of insurance carriers?
Yes. Every Plan member will be able to choose between two insurance carriers. Both carriers will offer the Partnership PPO and Standard PPO options. Each carrier will also offer its own network of providers.

Which insurance carriers will I be able to choose from?
We don’t know yet. Our current contracts expire in December 2010, and we are in the process of a competitive bid for these services. We will let you know as soon as the contracts are signed this summer.

Will my current doctor(s) be in both PPO networks?
We will work closely with all carriers to make sure large networks are offered to our members. We won’t know which doctors are in the networks until the new insurance carriers are selected in June. During the Annual Enrollment Transfer Period (September 15 through October 15), Plan members will have a choice between two insurance carriers and will be able to see in advance which doctors are in each network.

Q&A COSTS IN 2011

When will the State tell me what the health insurance options will cost in 2011?
We expect to have this information some time in June. We need cost data for 2009 and the first few months of 2010 to set premiums, deductibles, co-pays and co-insurance for 2011.

Can’t we just increase member premiums and keep the current options?
No. By law, the State pays 80 percent of the premiums for State and higher education employees. The State also pays roughly 45 percent of the premiums for instructional staff of local education agencies and their families. If we were to increase member premiums, we would also increase costs to the State—making the State’s budget situation even worse.

Will the new benefit options include a tobacco surcharge?
No. There will not be a surcharge for tobacco use. However, the Partnership PPO will require you to try to stop using tobacco. It will also offer incentives and resources to help you quit.
I have heart disease and diabetes. Will this affect how much I pay?
No. In fact, if you enroll in the Partnership PPO, you'll pay less in premiums and co-insurance than someone who enrolls in the Standard PPO. You’ll also take part in health coaching and disease management resources to help manage your conditions.

I recently had a $70,000 hospital bill. If I were to have another bill like that in 2011, would I have to pay co-insurance on the whole amount?
No. The new plan design has what's known as an “out-of-pocket maximum.” If you reach this limit, the Plan will pay 100 percent of covered expenses that require co-insurance for the rest of the year. We put the out-of-pocket maximum in place to protect members who have very high medical bills. We will know out-of-pocket maximums in June along with premiums, deductibles, co-pays and co-insurance.

I live out of State. Will the networks cover areas outside Tennessee?
Yes. If you live in a border state, providers in the area will be included in the network. Members will also have access to the carriers' national networks of providers.

I live and work in Knoxville but go to a specialist in Nashville. Will I have to change doctors?
No, not necessarily. The insurance carriers serving your area will have doctors throughout the State. You’ll be able to check whether your doctor is in the selected insurance carriers’ networks later this year.

Q&A

What does it mean when the Partnership Promise talks about “taking an active role in my health?”
If you choose the Partnership PPO, your Partnership Promise will commit you to taking these steps toward healthier living:
1. Know your health history.
2. Know your health risks.
3. Take steps to get and stay healthy.

In return for committing to the Partnership Promise, you can expect lower monthly premiums, annual deductibles, co-pays, co-insurance and a lower out-of-pocket maximum for covered health care services.

If I commit to the Partnership Promise, what will I have to do?
You'll start by completing a health questionnaire. The questionnaire will ask about your age, what you eat, how much you exercise and whether you use tobacco or alcohol. An independent wellness vendor will conduct this survey. The questionnaire will be available online and on paper for those without Internet access.

Next, you’ll take part in a health screening. This screening measures your height, weight, blood pressure, cholesterol levels and blood sugar levels. You can do the screening at one of the free workplace health screening sites that will be set up around the State. You may also visit your doctor to have the same type of screening.

Finally, depending on the results of your questionnaire and screening, you may take part in professional support services to help lower your health risks. For example, the State’s independent wellness vendor may recommend that you work with one of their health coaches.
Do I have to make the Partnership Promise?
No. Members who don’t want to commit to the Partnership Promise can choose the Standard PPO, which covers exactly the same services but does not offer the incentives and discounts.

If I choose the Partnership PPO, when do I have to complete my health screening?
The information about your height, weight, blood pressure, cholesterol level and blood sugar level can be provided based on any tests or screenings conducted on or after July 1, 2010. This information will be reported to the new health and wellness vendor in 2011. We’ll provide more details on this process in a future issue of Partners for Health.

Who will see my answers to the health questionnaire and the results of my health screening?
The State is currently in the process of contracting with a health and wellness vendor. The vendor will help you with the health questionnaire and schedule health screening events. The vendor will collect your data—but, by law, it will never release any identifiable information about you to either the State or your employer without your permission.

I want to enroll in the Partnership PPO, but my spouse does not. Can we enroll in separate options?
The answer depends on your family situation:

If you and your spouse both work for the State or a participating agency, you may enroll separately and each of you may choose whichever health insurance option you want. You may also enroll in the same option as an employee plus spouse.

If only you work for the State or a participating agency and you cover your spouse, you will both be required to enroll in the same option.

If I enroll in the Partnership PPO for 2011, will I be able to switch to the Standard PPO in 2012?
Yes. You will be able to switch during the Annual Enrollment Transfer Period to be held in the fall of 2011.

I know I’m overweight. If I enroll in the Partnership PPO, will I be required to lose a certain number of pounds?
No. There will be no “target weights” for members. The requirement for the Partnership PPO is to show that you are taking steps to meet your health goals.

If I have a pre-existing condition, can I sign up for the Partnership PPO?
Yes, absolutely!

If I join the Partnership PPO and get sick, will you kick me out?
No. You can stay in the Partnership PPO as long as you keep your Partnership Promise. We know that people can get sick even when they do everything right—and we want you to be able to rely on your benefits if this happens to you.

The only way someone can be kicked out of the Partnership PPO is by not fulfilling the Partnership Promise.

If I join the Partnership PPO and decide to work on my high blood pressure, can I stay in even if my blood pressure doesn’t go down?
Yes. You can stay in the Partnership PPO as long as you keep your Partnership Promise. This means that you will need to make a good faith effort to work on one or more of your risk factors. You must take steps to improve or maintain your health.
Would the Plans consider offering wellness incentives or discounts to members who use facilities like the YMCA?

All State employees are already eligible for the fitness center discount program. Participating fitness centers have agreed to discounted initiation and membership fees. A complete list of fitness centers along with information on how to access the discounts is available at www.tn.gov/finance/ins/sewp_fit.html. We are evaluating similar options for all Plan members.

What about pharmacy ID cards?

You will receive a new pharmacy benefits ID card as part of a welcome packet in early June. The welcome packet will come from CVS Caremark, and the ID card will have the Caremark logo on it. Remember, this does not mean you have to use a CVS pharmacy. More than 1,600 pharmacies across the State are part of the 30-day network—including large retail chains and local, independent pharmacies.

I’m going away for the summer. What should I do about my prescription drugs?

If you’re taking medication, make sure you get a three-month supply before you leave. Your new ID card will arrive in the mail at your home and be waiting for you when you get back. Or, it will be forwarded to you if you have provided the post office with another address.

When will I receive the pharmacy ID cards for my family?

Welcome packets, including ID cards, will be mailed to all members and families in early June for use starting July 1, 2010. The packets will arrive in two envelopes, both addressed to the member. One envelope will have the member’s ID card and information about how to use your benefits. The second envelope will have the cards for the family. The envelopes may arrive on different days. If one envelope arrives by itself, wait a day or two to see if you receive the other one. If you don’t, contact Caremark at 1-877-522-TNRX (8679).

Will my local pharmacy participate in the new network?

Many local pharmacies and most big chain drugstores and grocery stores (Walgreens, Wal-Mart, Target, Kroger, etc.) will participate in the new pharmacy network. Also, any pharmacy that does not currently participate can contact CVS Caremark about joining.

When will I know which pharmacies are in the network?

The pharmacy network for 30-day supplies of medication has been finalized. It is available on our website at www.tn.gov/finance/ins. The 90-day network will be available later this spring.
Do I have to choose a new health insurance option for 2011?
Yes. If you are currently enrolled in a State health insurance option, you will need to choose either the Partnership PPO or the Standard PPO during the Annual Enrollment Transfer Period in the fall. Your plan choice will be effective January 1, 2011.

When will I choose my new health insurance option?
The Annual Enrollment Transfer Period for 2011 will be September 15 to October 15.

What happens if I don’t choose a health insurance option?
Members who don’t complete an enrollment form during the Annual Enrollment Transfer Period will be automatically enrolled in the Standard PPO and will not be able to switch options until the next Annual Enrollment Transfer Period.

More Questions?
If you’d like to ask another question, you may e-mail benefits.info@tn.gov or contact the Benefits Administration Service Center at 1-800-253-9981. We’ll include more questions and answers in our next issue of ParTNers for Health.

Reminder: New Pharmacy Benefits Manager Is Just Weeks Away
We will have a new pharmacy benefits manager for all Plans on July 1, 2010. The pharmacy network will include both independent pharmacies and national chains such as Wal-Mart, Walgreens, Target, Kroger and CVS. You will receive a new member packet from CVS Caremark in early June that will include your ID card, a prescription drug list (formulary) and a list of the network pharmacies nearest to your home.

What’s Next?
We’ll keep the information coming. Our next issue of ParTNers for Health will give you an update on our new carriers and wellness vendor. We’ll answer your latest questions and provide you with some background on how health plans work. Meanwhile, new questions and answers are posted regularly on our website at www.tn.gov/finance/ins.
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The information in this newsletter is current as of May 2010. Final plan information will be provided in future communications.