

State of Maryland
Employees and Retirees

Health Benefit Plan Changes
for Plan Year 2012

(July 1, 2011 – June 30, 2012)

Open Enrollment Dates

- **April 26, 2011** **Open Enrollment Begins**
IVR is turned on at 8:00 a.m.

- **May 26, 2011** **Open Enrollment closes at midnight**

- **Forms are due to your ABC's by 4:30 pm**

- **No Correction Period this Year**

- Due to federal healthcare reform, Open Enrollment must run for 30 consecutive days.

Open Enrollment Materials

- Active/Satellite packets delivered to Agency Benefit Coordinator
- Retiree packets delivered to home address
- Individually sealed packets contain:
 - Active/Satellite Pre-printed Benefits Statement
 - 2011-2012 Benefit Guide
 - Personal Information Change Form*
 - Supplemental Notice Flyer
 - Rates now distributed and available on DBM HB website

Important Reference Information

➤ Benefit Guide:

- Phone numbers and websites for all the plans
- Eligibility details
- Plan comparison charts
- Important notices regarding **Healthcare reform**, HIPAA, COBRA, Medicare Part D, etc.

➤ Health Benefits website:

➤ **www.dbm.maryland.gov/benefits**

New for FY 2012

Cost Containment

- Prescription drug changes for actives and retirees
- No changes to medical or dental

Healthcare Reform

- Child eligibility
- Preventive care
- Lifetime maximums
- Open Enrollment period
- Appeals standards

Background

- Public Employees' and Retirees' Benefit Sustainability Commission
- OPEB liability
- Need to make sure program is around for current and future employees and retirees

How We Compare

- ✓ More than half of state plans nationally require a copayment of \$10-\$19 on generic drugs – our current plan is \$5 (\$0 if one of the five drug classes)
- ✓ Our current plan requires a \$25 copay for non-preferred drugs – 87% of state plans nationally apply copays of \$30 or more and 68% in excess of \$40
- ✓ Current plan design includes an annual cap on copays paid of \$700
- ✓ Our copays are per 45-day supply or 90-day supply rather than 30-day supply

Current Prescription Drug Plan Benefits

Type of Drug	Retail		Mail Order	
	1-45 days	46-90 days	1-45 days	46-90 days
GENERIC	\$5	\$10	\$5	\$10
PREFERRED BRAND	\$15	\$30	\$15	\$20
NON-PREFERRED BRAND	\$25	\$50	\$20	\$20

\$700 out-of-pocket copay max

NEW! Prescription Drug Plan Changes

Type of Drug	Retail		Mail Order	
	1-45 days	46-90 days	1-45 days	46-90 days
GENERIC	\$10	\$20	\$10	\$20
PREFERRED BRAND	\$25	\$50	\$25	\$50
NON-PREFERRED BRAND	\$40	\$80	\$40	\$80

\$1,000 per Individual/\$1,500 per Family Annual out-of-pocket copay max

NEW! Prescription Drug Plan Changes

Type of Drug	Retail		Mail Order	
	1-45 days	46-90 days	1-45 days	46-90 days
GENERIC	\$10	\$20	\$10	\$20
PREFERRED BRAND	\$25	\$50	\$25	\$50
NON-PREFERRED BRAND	\$40	\$80	\$40	\$80

\$1,500 per Individual/\$2,000 per Family Annual out-of-pocket copay max

Future Prescription Drug Plan Changes

- Retirees will transition to Medicare Part D prescription coverage in 2020 when the Part D “coverage gap” is phased-out
- Effective July 1, 2020, Medicare-eligible retirees will be required to enroll in Medicare Part D through Medicare and they will no longer be eligible to participate in the State prescription drug plan

Our Customer Service Unit is staffed with representatives available to assist you

8:30 a.m. – 4:30 p.m.

Monday-Friday

410-767-4775 or 1-800-30-STATE

EBDMail@dbm.state.md.us



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Questions?



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Healthcare Reform 2011-2012

Overview

- On March 23, 2010, President Obama signed the **Patient Protection and Affordable Care Act (PPACA) into law**
- Comprehensive healthcare reforms that roll out over the next four years and beyond, with most changes taking place by 2014

Required Plan Changes

January 1, 2011

- Over-the-counter medications no longer eligible for FSA reimbursement without a prescription

July 1, 2011

- PPACA changes for the State of Maryland Program take effect
 - ❑ **Law states the first day of the plan year following September 23, 2010**

Quick List

- ✓ Eliminate pre-ex limit for children under age 19
- Coverage for children until age 26
- Eliminate cost-sharing for preventive care
- Eliminate lifetime coverage maximums
- ✓ Eliminate annual coverage maximums on essential benefits
- Primary Care Provider designation
- Appeals Standards

Young Adult Coverage

- Coverage to end of month in which child reaches age 26
- Eliminates most eligibility criteria
 - ✗ Financial dependency
 - ✗ Residency
 - ✗ Student status
 - ✗ Employment
 - ✗ Marital status
- Child defined as biological, adopted, step

Young Adult Coverage

- **NOTE:** PPACA provision does not apply to **grandchildren and legal wards**

- **Grandchildren and legal wards who are 25 years of age now** subject to post-tax deductions and imputed income
 - ❑ See Imputed Income and Post-Tax Deductions rate tables on DBM Health Benefits website

Elimination of Cost-Sharing for Preventive Care

- Limited to **in network** only
- No copays
- Covered services greatly expanded
 - ❑ Based on recommendations made by the **U.S. Preventive Services Task Force (USPSTF)**
 - ❑ An independent, non-governmental panel of experts in prevention and primary care that is convened by Agency for Healthcare Research and Quality (AHRQ)
 - ❑ Lists A and B on:
www.uspreventiveservicestaskforce.org/recommendations.htm

Examples of Well-Child Care

- Well-child visits
 - ❑ Ages newborn to age 30 months - 12 visits
 - ❑ Ages 3-21, one physical exam per plan year
 - Currently only through age 19
- Physical exam and measurements
- Vision and hearing screenings, oral health risk assessments
- Screenings for hemoglobin level, lead, tuberculosis
- Counseling and guidance for child's health development including obesity, depression

Examples of Adult Preventive Care

➤ Adult physicals

- Age 22+
- One per plan year
- Screening/counseling for blood pressure, high cholesterol, diabetes, depression, tobacco/alcohol use, obesity
- Counseling to support breast-feeding and help nursing mothers
- Osteoporosis screening for women age 60 +
- Prostate cancer screening for men age 40 +



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**FLU SHOTS
NOW
COVERED**

How Will This Work?

- Special rules apply if preventive care is provided as part of an office visit:
 - ❑ Billing of office visit copay driven by **primary** reason for visit
 - If primary reason for visit to doctor is for an illness, copay applies
 - If primary reason for visit to doctor is preventive care, no copay applies

How Will This Work?

- EXAMPLE: Patient goes to the doctor's office for a sick visit and while there, the doctor gives the patient their annual flu shot
 - ❑ Doctor will bill for a "sick" visit – **copay applies**. Doctor also bills plan for the flu shot however, patient is not charged for this service.

- EXAMPLE: Patient goes to the doctor's office for annual physical, while there the doctor gives the patient their annual flu shot
 - ❑ Doctor will bill for a preventive care visit – **no copay applies**.

Elimination of Lifetime Maximum

- Applies only to PPO and POS
 - ❑ PPO/POS currently have \$2M lifetime maximum
 - ❑ EPO plans currently have unlimited lifetime maximum
- Individuals changed to EPO because they reached the lifetime max under PPO or POS may again enroll in PPO or POS

Primary Care Provider Designation

- Applies to CareFirst POS only
 - ❑ Only plan that requires participants to select a PCP
- Participants may now select **ANY in network physician**
- No longer limited to internist and general practitioners

30 Day Enrollment Period

- To allow
 - ❑ Previously ineligible children to be re-enrolled
 - ❑ Participants who had to change plans due to reaching lifetime maximums to change back
- **Remember – No Correction Period!**

Claims Appeals Standards

➤ Health Plans

- Shorter response time
- Coverage determinations
- Claims appeals

➤ Employers

- External appeals process
- Will be through MIA
- Guidelines to follow



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