OPERS HealthCare

For participants in the OPERS health care plan.

Connector Readiness 2016

Connector Readiness

OPERS is introducing a new, standing newsletter section called Connector Readiness. In each issue, articles pertaining to the OPERS Medicare Connector or general Medicare education will be placed within this section. The section will be designed using an exclusive dark red accent color, so important information can be easily identified.

We continue to receive questions around the specifics of the Connector implementation in 2016. Because we are currently in the process of negotiating a contract with a Connector vendor, we have relatively few details to share right now. However, in the coming months and into 2015, we will be providing information on the Connector vendor, Medicare plans, premium allowance amounts and the enrollment process. Please stay tuned and read the Connector Readiness section thoroughly to stay informed.


OPERS Health Care Plan Bulletin

OpersHC Connector

OPERS announces changes to health care plan for 2016

Table of contents

OPERS

Medicare 101 – Individual Medicare Plans – *What's the Difference?*

Medigap plans (also called Medicare supplement plans)

What is a Medigap plan? A Medigap plan is private health insurance that supplements or fills in the "gaps" where Medicare Parts A and B leave an individual uncovered. Medicare Parts A and B cover only some health care costs. Medicare generally pays 80 percent after deductibles (annual and/or hospital) leaving the member to pay 20 percent of the cost of medical care after deductibles. As a result, many Americans choose to purchase a Medigap policy.

What will a Medigap plan cost? These plans have a higher monthly premium (around $80-$280 a month) but often have little or no out-of-pocket costs for medical services.

Who should purchase a Medigap plan? An individual must be enrolled in both Medicare Parts A and B before applying for a Medigap plan. Medigap plans are most appropriate for people who travel or have medical issues requiring frequent visits to doctors/hospitals. Most times, Medigap plans do not have networks. Therefore, policy holders can utilize any provider who takes Medicare.

Because Medigap plans do not provide drug coverage, individuals who select a Medigap plan generally also select a Medicare Part D prescription drug plan. Premiums range between $20 and $90 per month.

Medicare Advantage plans

What is a Medicare Advantage plan? Medicare Advantage (MA) plans are private health insurance plans that replace traditional Medicare and must provide the same level of coverage that traditional Medicare does. MA plans often provide additional coverage as well.

What will a Medicare Advantage plan cost? Medicare Advantage plans have a lower monthly premium ($0 - $80 a month), but often feature higher out-of-pocket costs for medical coverage. While monthly costs will be low, MA plan participants will have deductibles and co-pays for physician visits, hospital stays and testing.

Who should purchase a Medicare Advantage plan? An individual must be enrolled in both Medicare Parts A and B before applying for a Medicare Advantage plan. MA plans are most appropriate for people who do not travel and have relatively few medical issues and do not frequently visit physicians or hospitals.

MA plans generally feature a network. Participants must utilize physicians and hospitals in their network for the best coverage.

A prescription drug plan is often included with a Medicare Advantage plan. In that case, they are called MAPD plans.

How does the current OPERS Humana Plan compare? Though the current OPERS Humana plan is technically a Medicare Advantage plan, it is designed much like a Medigap or Medicare Supplement plan. For example, the OPERS Humana plan has more comprehensive coverage than is typically found in an MA plan. Also, the plan does not require the use of a network of doctors that retirees must use to get the highest level of coverage. The cost share an OPERS Humana Plan participant currently pays for medical services ranges between 0 percent and 8 percent . The annual deductible is only $250 per year and there is no daily hospital deductible.

Medicare 101

(continued)

The Humana plan does feature office visit co-pays for emergency room or urgent care visits. Due to the relatively low levels of cost sharing, the OPERS Humana plan is considered somewhat richer, or more comprehensive, than the typical Medicare Advantage plan on the individual marketplace.

The current monthly cost for the OPERS Humana Medicare Plan is $383 a month, much higher than most plans on the individual market—which is why making the move to a Connector is so important. OPERS can provide our retirees with more affordable choices than ever before.

How will I choose the best Medicare plan for me?

In fall 2015, OPERS retirees enrolled in Medicare Parts A and B will have the opportunity to select a health care plan that best meets their individual needs and budget via the OPERS Medicare Connector. Retirees will receive personalized help with choosing a plan. The Connector will provide guidance so that each retiree makes the choice that is right for them.

For more information on individual Medicare plans available where you live, please visit www.medicare.gov or www.insurance.ohio.gov.

Heath Care Preservation Plan – Featured Question

Why did OPERS decide to stop reimbursing retirees for Medicare Part B premiums? OPERS has provided reimbursement of Medicare Part B premiums to qualified recipients for more than a decade. Less than 1 percent of the retirement plans across the nation provide this level of compensation for retirees. In 2012, OPERS reimbursed retirees more than $112 million for those premiums.

Reimbursing for Medicare Part B premiums became a strain on the health care fund. As part of the Health Care Preservation Plan adopted by OPERS in 2012, the reimbursement will be incrementally eliminated. Reductions to the amount of reimbursement a retiree receives per month will begin in 2015 ($63.62), continue in 2016 ($31.81) and reach a $0 reimbursement in 2017.

As we look to the implementation of the Connector and beyond, OPERS has a new allowance model that may help to compensate for this lost reimbursement. We will soon be able to communicate more about the OPERS Medicare Connector and how retirees may be able to use some of their monthly allowance to offset the cost of their Medicare Part B premium.

Connector Readiness – *Can I be denied coverage on the OPERS Medicare Connector?*

When the OPERS Humana plan is closed at the end of 2015, can I be denied coverage on the Connector? As an OPERS retiree or qualified dependent enrolled in both Medicare Parts A and B, you cannot be denied the opportunity to enroll in an individual Medicare plan through the Connector as long as you do so during the required open enrollment period. For OPERS retirees moving to the Connector, this open enrollment period will occur in the fall of 2015.

Individual Medicare plans must offer coverage to individuals whose Medicare group plans have been terminated provided they enroll during the required timeframe. This rule is commonly referred to as guaranteed issue. You are guaranteed that the insurance company will issue you a plan. Guaranteed issue also applies when people first turn age 65 and become eligible for Medicare or when they first retire if they are older than 65.

If you fail to enroll during the open enrollment period, you could be subject to medical underwriting. Medical underwriting requires you to answer questions about your health status. Insurance companies can deny your coverage or charge you a higher premium based on the findings of medical underwriting.

What if I select a Medicare plan but want to change to a different one in the future? Once you are enrolled in an individual Medicare plan, rules for guaranteed issue and medical underwriting vary depending on the type of plan. All Medicare Advantage (MA) and Part D prescription drug plans are always guaranteed issue. You cannot be denied insurance based on a medical condition. You will never need to go through medical underwriting when moving to a MA plan or a Part D drug plan, no matter how many times you switch plans.

If, after your initial enrollment period, you wish to switch from an individual MA plan to a Medigap plan, you can be required to undergo medical underwriting and you can be denied coverage. Also, if you want to switch from one Medigap plan to another (after the initial enrollment period), you may be required to undergo medical underwriting.

In order to avoid any potential problems with guaranteed issue and medical underwriting, it is very important that you choose the Medicare plan that is right for you during the initial Connector open enrollment period. Please pay close attention to open enrollment time frames and deadlines when they are announced in 2015.

The chart below helps illustrate when you may be subject to medical underwriting if you choose to switch plans after your initial enrollment.

From	To	Medical Underwriting?*
Medicare Advantage	Medicare Advantage	No
Medicare Supplement (Medigap)	Medicare Supplement (Medigap)	Yes**
Medicare Advantage	Medicare Supplement (Medigap)	Yes
Medicare Supplement (Medigap)	Medicare Advantage	No
Medicare D Prescription Plan	Medicare D Prescription Plan	No

* This chart includes general information only.
** If lower level coverage with same carrier is selected, then medical underwriting will not be required.

With this issue of the newsletter, OPERS is introducing a standing column called *It's Your Health*. Topics will focus on the importance of being an active partner in your health care.

OPERS encourages Medical Mutual participants to use patient-centered medical homes

If you seek care from a patient-centered medical home (PCMH) recognized by the National Committee for Quality Assurance (NCQA), you will pay a lower copay - just $10 - for an office visit. NCQA-recognized medical homes follow national standards, and have changed their practices with the goals of improving the health of their patients and enhancing the patient experience through better care coordination and communication with the patient, their family, and all members of the patient's care team. The medical home is not a building or, for that matter, a final destination. Instead, it is a model for providing primary health care that facilitates partnerships between patients and their personal health care providers.

Currently, there are more than 300 NCQA-recognized medical homes in Ohio. To find out if your primary care doctor is a PCMH:

1. Visit MedMutual.com to use the Provider Search tool.
2. Confirm the state in which you are looking for a doctor and the network in which you participate.
3. Select "NCQA-Patient-Centered Medical Home" under the Awards and Recognitions section.

If you have any questions, contact Medical Mutual directly at 1-877-520-6728.

Help your doctor help you

Your health depends on good communication between you and your doctor. Despite being very busy, your doctor needs and wants you to share your questions and concerns. By doing so, you actually make it easier for your doctor to help you.

Ask questions

Asking questions is key to good communication with your doctor. If you don't ask questions, your doctor may think you do not need or want more information. Asking questions helps your doctor know what is important to you.

Before your appointment, take time to prepare a list of questions you want to ask. Making a list before your visit will help you remember everything you need to address during the appointment. And, your doctor's responses will help you receive quality care and make better decisions about your health.

Understand the answers and next steps

Asking questions is important, but so is making sure you hear—and understand—the answers you get. If you don't understand or are confused, ask your doctor to explain the answer again. Take notes. Or, bring someone to your appointment to help you understand and remember what you heard.

If you get home and realize you are unsure about what your doctor said - including instructions you were given - call your doctor's office. A staff member can check with your doctor and call you back.

For help in preparing questions you may want to ask your doctor before, during or after an appointment, check out: www.ahrq.gov and click on "Questions are the Answer".

Commonly Prescribed Brand-Name Drugs Will Soon Have Generic Equivalents

A number of commonly prescribed, brand-name medications will lose their patent protection in 2014. This will allow drug manufacturers to offer lower cost, generic versions of these medications. The use of generics saves health care dollars for both OPERS and you. Express Scripts will automatically substitute a generic version of a medication when one becomes available, unless your provider has indicated "dispense as written." You do not need to obtain a new prescription. The information about generic availability is subject to change. Common medications scheduled for generic release this year include:

Common medications scheduled for generic release in 2014

Actonel (Osteoporosis) June 2014	Lumigan (Glaucoma) Aug. 2014
Copaxone (Multiple Sclerosis) May 2014	Lunesta (Sleep Disorders) May 2014
Detrol LA (Urinary Incontinence), March 2014	Micardis/Micardis HCT (Blood Pressure, Heart Disease) Jan.2014
Evista (Osteoporosis), March 2014	Nasonex (Nasal Allergies) 2014*
Exforge/Exforge HCT (Blood Pressure, Heart Disease) 2014*	Nexium (Ulcers) May 2014
Flector (Pain, Inflammation) April 2014	Renagel (Chronic Kidney Disease) March 2014
Lovaza (High Cholesterol) 2014*	Restasis (Dry Eyes) May 2014

*Exact date yet to be determined

Launched in 2011 by the U.S. Department of Health and Human Services, Million Hearts is a national initiative to prevent 1 million heart attacks and strokes in the U.S. by 2017.

Key Facts:

- Heart disease is the leading cause of death.
- Stroke is the fourth leading cause of death.
- Cardiovascular disease is responsible for 1 of every 3 deaths.
- Everyday 2,200 people die from cardiovascular disease.
- Cardiovascular risk factors such as blood pressure, cholesterol, smoking and obesity are controllable.

What can you do?

Talk to your doctor about how you can prevent or manage heart disease, and then visit http://millionhearts.hhs.gov/ to take advantage of various resources to learn more about cardiovascular disease, assess your risk, and engage with the initiative.

1. **Get started.** Heart360® is an online tool which helps track and manage your heart health. www.heart360.org
2. **Calculate my risk.** Discover your 10-year risk of heart attack or dying from coronary heart diseases and what you can do about it. http://50.56.33.51/hart01/main_en_US.html
3. **Get my assessment.** With My Life Check, you can learn the state of your heart and what you can do to live a better life. http://50.56.33.51/mlc01/main_en_US.html

Sources:
American Heart Association, American Stroke Association
www.heart360.org
Million Hearts, http://millionhearts.hhs.gov

New in 2014 - HumanaVitality®

Effective Jan. 1, 2014, Humana began offering HumanaVitality®, a new wellness program exclusively for Humana participants. All OPERS Humana participants should have received an informational packet from Humana detailing this new program.

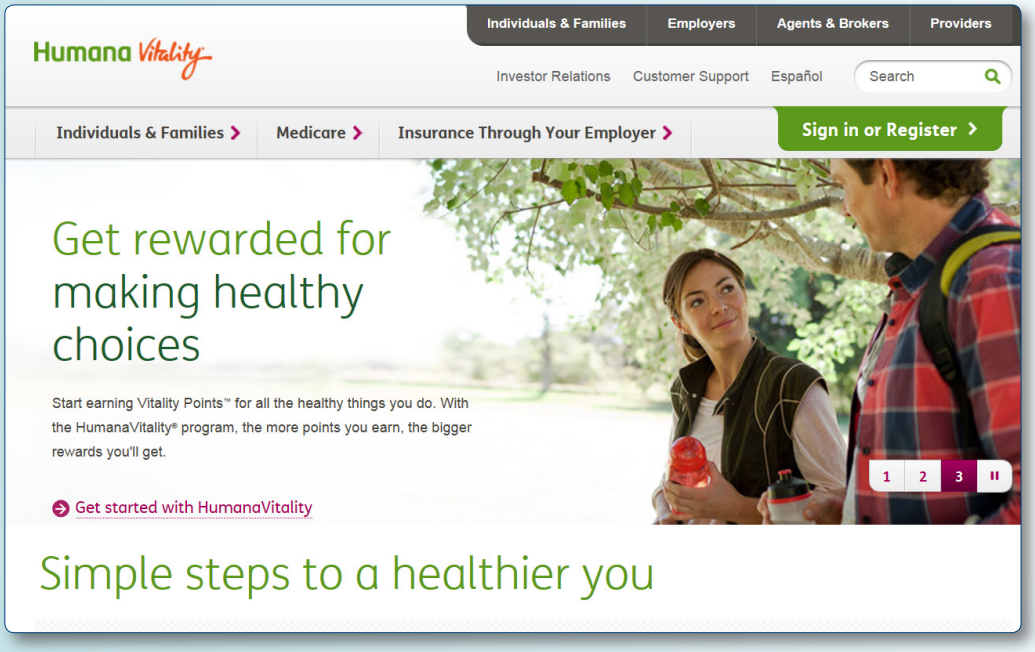
HumanaVitality is a fun, interactive online and telephonic program based on a comprehensive lifestyle approach to wellness. This program is free of charge to all Humana participants, and it provides tips and activities to help improve your health. The program focuses on the following:

- Physical activity
- Education
- Preventive screenings
- Tobacco cessation
- Nutrition

Participants will earn incentives from Humana for completing Medicare-approved prevention activities, such as doctor check-ups, screenings and vaccinations, and they can be spent on items like gift cards and fitness gear in the online HumanaVitality Mall.

In addition, Humana Vitality participants are eligible for 10 percent savings on "Great For You" labeled foods at Walmart.

You have to register for Humana Vitality to take advantage of these program features. Please use your current Humana login at Humana.com to register. Or if you don't currently have an online Humana account, you can register at HumanaVitality.com. Any further questions regarding the program should be directed to Humana at 1-877-890-4777.



OpersHealthCare

Ohio Public Employees Retirement System

277 East Town Street
Columbus, Ohio
43215-4642

1.800.222.7377

Web
opers.org

Blog
perspective.opers.org

Facebook
facebook.com/ohiopers

Twitter
twitter.com/ohiopers