

Changes Coming to State Group Health Insurance And Union-Related Deductions

July 19, 2011

A number of changes to the Wisconsin Retirement System, the state health insurance program and union-related deductions are taking effect due to the implementation of Wisconsin Act 10 (2011 Budget Repair Bill) and Wisconsin Act 32 (Biennial Budget for 2011-2013). In addition to this summary of changes to the State of Wisconsin Group Health Insurance program, please see the Impact of Act 10 on UW System Employee Benefits [Frequently Asked Questions](#).

Changes to Health Insurance Program

Employee Premium Contributions

Effective with the biweekly payroll ending August 13 (pay date of August 25) and monthly payroll ending August 31 (pay date of September 1):

- Health insurance premiums will increase as specified in WI Act 10 as amended by WI Act 32 (see below for new premium contributions).
- Employees working less than 50% of full-time will continue to pay the less-than-half-time rates.
- LTEs must have at least two concurrent appointments to be eligible for the full employer premium contributions.

New Employee Health Insurance Monthly Premium Contributions for WRS-Participants	Single	Family
Tier 1 (all plans, except the Standard Plan)	\$84	\$208
Tier 2 (Standard Plan – required to work outside WI)	\$122	\$307
Tier 3 (Standard Plan – work in WI)	\$226	\$567
Less-than-half –time rates	50% of premium	

New Employee Health Insurance Monthly Premium Contributions for Graduate Assistants, Post Docs and Short-Term Academic	Single	Family
Tier 1 (all plans, except the Standard Plan)	\$42	\$104
Tier 2 (Standard Plan – required to work outside WI)	\$61	\$153.50
Tier 3 (Standard Plan – work in WI)	\$113	\$283.50

Special Opportunity to Cancel or Change Level of Coverage

Treasury regulations governing IRS Code Section 125 restricts mid-year changes to health insurance coverage for employees who pay their premium contribution on a pre-tax basis. However, a significant cost

change is a circumstance that allows for mid-year changes. Due to the increase in the employee's premium cost, you may cancel your coverage entirely or change from family to single coverage provided a [Health Application/Change Form](#) is submitted to your payroll and benefits office within 30 days of the date of the first paycheck from which the increased premium is deducted.

Coverage changes will be effective on the later of the end of the month on or following your employer's receipt of the [application](#) to cancel coverage or the end of the month after the date of the premium increase.

For more specific details, please see the [Detailed FAQ on Impact of Act 10 and Act 32](#), questions 8 – 14.

Uniform Benefits

Section 9115 of WI Act 10 requires that the Group Insurance Board (GIB) design health care coverage plans for the 2012 calendar year that, after adjusting for inflation, reduces the average premium cost of tier 1 plans by at least 5% from the cost of the plan during the 2011 calendar year.

The GIB considered various options of achieving the cost reduction, such as the implementation of office visit and inpatient copayments, deductibles, coinsurance, adjusting the prescription drug benefit and eliminating the optional dental benefits offered by most plans.

After due deliberation, the GIB approved the following changes to Uniform Benefits, effective January 1, 2012, resulting from WI Act 10 implementation:

- Apply coinsurance to medical services. Benefits will be payable at 90% up to an annual out-of-pocket maximum of \$500 for an individual/\$1,000 for a family.
 - Coinsurance is based on a set percentage of the cost. For example, if the discounted medical charges are \$200, the member will be responsible for \$20, which is 10% of the charge.
 - Once a member has paid \$500 in coinsurance for an individual, or \$1000 for family coverage, in a calendar year, the 10% coinsurance will not be applied for the remainder of the year. The \$1000 out-of-pocket maximum for families is cumulative, so once any combination of family members has paid \$1000 in coinsurance, the coinsurance ends for the rest of that calendar year. It is not required that two family members each incur \$500 in coinsurance in order to satisfy the \$1000 coinsurance requirement.
 - Preventive care, such as physicals and well-baby care, is not subject to coinsurance. Examples of preventive care will be provided by the Department of Employee Trust Funds this fall.
 - Coinsurance will be applied to the discounted fee negotiated by the plan and the provider (as opposed the actual amount charged).
 - Members will be billed for the coinsurance. Payment will not be due at the time of service.
- Increase the emergency room copayment from \$60 per occurrence to \$75 (waived if admitted). This does not get applied to the out-of-pocket maximum.

- If eligible to participate in the Employee Reimbursement Account (ERA) program, out-of-pocket costs for coinsurance and copays are eligible for reimbursement under the ERA Medical Expense Reimbursement Account.

Standard Plan

Act 10 does not apply to the Standard Plan; however, the GIB also chose to modify the Standard Health Plan for the 2012 calendar year. The GIB's intent was to enact a similar benefit cut and modernize the Standard Plan to facilitate the long-term sustainability of the program. The GIB approved the following changes to the Standard Plan, effective January 1, 2012:

- In network:
 - Deductible will increase from \$100 for an individual/\$200 for a family to \$200 for an individual/\$400 for a family.
 - Apply coinsurance to medical services. Benefits will be payable at 90% up to an annual out-of-pocket maximum of \$800 for an individual/\$1,600 for a family.
 - Coinsurance is based on a set percentage of the cost. For example, if the discounted medical charges are \$200, the member will be responsible for \$20, which is 10% of the charge.
 - Once a member has paid \$800 in coinsurance for an individual, or \$1,600 for a family, in a calendar year, the 10% coinsurance will not be applied for the remainder of the year. The \$1,600 out-of-pocket maximum for families is cumulative, so once any combination of family members has paid \$1,600 in coinsurance, the coinsurance ends for the rest of that calendar year. It is not required that two family members each incur \$800 in coinsurance in order to satisfy the \$1,600 coinsurance requirement.
 - This does not apply to preventive care, such as physicals and well-baby care.
 - Coinsurance will be applied to the discounted fee negotiated by the plan and the provider (as opposed to the actual amount charged).
 - Members will be billed for the coinsurance. It will not be due at the time of service.
- Out of network:
 - Deductible will remain \$500 per individual and \$1,000 per family.
 - The annual out-of-pocket maximum will remain \$2,000 per individual and \$4,000 per family.
 - Coinsurance will change from 80/20 to 70/30. Coinsurance is based on a set percentage of the cost. For example, if the discounted medical charges are \$200, the member will be responsible for \$60 for coinsurance, which is 30% of the charge. Currently with the 20% coinsurance, the member is responsible for \$40 of a \$200 charge.
- Emergency Room Copayment
 - Add an emergency room copayment of \$75 per occurrence (waived if admitted). This does not get applied to the out-of-pocket maximum. It applies to emergency room services received in network or out of network.
- If eligible to participate in the Employee Reimbursement Account (ERA) program, out-of-pocket costs for coinsurance and copays are eligible for reimbursement under the ERA Medical Expense Reimbursement Account.

Prescription Drug Benefits

There will be no changes to the prescription drug program for 2012. The annual out-of-pocket maximum of \$410 for an individual or \$820 for a family will remain and is separate from the out-of-pocket maximum for medical services.

Employee Eligibility

Most employees hired on or after July 1, 2011 will need to work 2/3 of full-time to be eligible for health insurance. Any service with a WRS-employer prior to July 1, 2011 will be sufficient for the employee to be eligible under the old eligibility rules, which required that the employee work 1/3 of full-time. This applies even if the prior position was not eligible for participation in the WRS.

- WRS-eligible classified employees will need to work 2/3 of full-time to be eligible to enroll. This is equivalent to working 1200 hours per year, which is 58% of full-time.
- Faculty, academic staff and limited employees who work 9 months per year, will need to work at least 880 hours in a year, which is 56% of full-time.
- Faculty, academic staff and limited employees who work 12 months per year, will need to work at least 880 hours in a year, which is 42% of full-time.
- Eligibility for graduate assistants, post-docs and limited employees is not changing.

Adult Dependent Child Eligibility

Beginning January 1, 2012, adult children will be eligible to be covered under a parent's health plan only until the end of the month in which they turn age 26. In 2011, unmarried children remain eligible until the end of the month in which they turn age 27. The change to age 26 as the limiting age is consistent with federal law.

Termination of Coverage

For termination of employment that occurs on or after January 1, 2012, the employer contribution towards health insurance coverage will end on the last day of the month in which the employee terminates.

COBRA Continuation

For terminations of employment that occurs on or after January 1, 2012, former employees will be permitted to continue their health insurance coverage for 18 months instead of the current 36-months. Family members who lose eligibility for coverage will still be allowed to continue coverage for 36 months. COBRA periods will be administered in accordance with federal law, which only requires 18 months of COBRA continuation for former employees.

This does not affect employees who are retiring with an immediate or lump sum annuity or have escrowed sick leave credits as they may still maintain coverage for life.

Union-Related Deductions

Effective with the biweekly payroll ending July 16 (pay date of July 28) and monthly payroll ending July 31 (pay date of August 1):

- Deductions for union-sponsored dental plans will cease. The unions are responsible for informing their members of their options to maintain the union-sponsored dental plans going forward.
- Employees will need to pay premium directly to the union (post-tax).
- If an employee chooses to cancel coverage under a union-sponsored dental plan, it does not constitute a qualifying event for enrolling in Dental Wisconsin or Anthem DentalBlue.
 - There will be an open enrollment for Dental Wisconsin this fall for coverage effective on January 1, 2012. If the person has other dental coverage in force immediately prior to the effective date of the Dental Wisconsin coverage, the waiting periods will be waived. Proof of other coverage, such as an ID card, must accompany the application.
 - It is not yet known if an open enrollment period will be offered this fall for employees eligible to enroll in Anthem DentalBlue.

Questions?

Much more information will be provided as we get closer to the fall *It's Your Choice* enrollment period. If you have questions that need response prior to that time, please contact your payroll/benefits office. In addition, ETF has posted an FAQ on their website (<http://etf.wi.gov/>).