# **ARBenefits News Monthly**



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## 2017 Plan-Year Approaches



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State Employees with a current FSA remember:

There will be a blackout period from December 23-27 while your FSA account is transferred from WageWorks over to DataPath.

More information on page two.

Beginning on January 1, 2017, any plan elections members made during the Open Enrollment periods will go into effect.

Please keep in mind that deductibles will reset on January 1 as well.

Due to the plan deductibles staying the same for 2017, EBD will not be mailing out new ID cards to everyone, and your current cards will be good for the upcoming year. ID cards have been mailed out to anyone who made election changes during the Open Enrollment periods regarding their new choices.

Should you need a new set of cards, you can login to your account at www.ARBenefits.org and request a new set be mailed to you. You may wish to print out a set of temporary cards to use as well while you wait for your mailed set to arrive.

You can also contact EBD Member Services at 1-877-815-1017 x1, email AskEBD@dfa.arkansas.gov, or go to your agency/district Health Insurance Representative if you need new cards during the year.

A list of coverages for each plan can be found in the Plan Documents section at www.ARBenefits.org. Please keep in mind that the Plan does follow the coverage policies of your provider, Health Advantage or QualChoice.

#### **Bariatric Surgery**

Enrollment into the Bariatric Surgery Program will reopen on Tuesday, January 3, 2017.

For 2017, the Arkansas State Employee (ASE) and Public School Employee (PSE) groups will each have 125 spots available for the program.

Members must call EBD at 501-682-9656 or 1-877-815-1017 to enroll. Enrollments will not be accepted prior to January 3rd.

Bariatric Surgery Program information is available at www.ARBenefits.org or <u>click here</u>.

#### **EBD Hours for the Holidays**

The EBD Office will be closed on:

Friday, December 23, 2016

Monday, December 26, 2016

(In observance of Christmas Eve & Christmas Day)

Monday, January 2, 2017

(In observance of New Year's Day)

### **FSA/HSA Transition to DataPath**

The Employee Benefits Division (EBD) has notified WageWorks of the agency's decision to terminate its current contract with vendor. WageWorks served as the plan's vendor for Flexible Spending Accounts (FSA) and Health Savings Accounts (HSA).

The decision is effective 1/1/2017, and DataPath will take over as the plan's FSA and HSA vendor on that date.

Employees with an HSA, who have had an HSA with DataPath previously, will have that previous account reactivated by DataPath and do no need to fill out an enrollment form. Employees who have not had an HSA with DataPath will need to complete a DataPath enrollment form if they would like to contribute to an HSA. This includes any new hires as of 12/1/2016. A Transfer of Assets form is available for those who want to move their WageWorks balance over to DataPath.

State Employees with an FSA will not need to fill out another enrollment form for 2017 unless they are a new hire as of 12/1/2016. WageWorks will send the necessary files over to DataPath. However, for State Employees with an FSA, Friday, December 23 will be the last day that you can use your WageWorks FSA account before the switch to DataPath occurs. Between December 23-27, your current FSA debit card will not work. On December 28, your DataPath FSA card that you will be receiving prior to the first of the year will start working.

Forms and an FAQ are available at www.ARBenefits.org. Links for the documents are below.

DataPath FAQ	FSA Enrollment Form
HSA Enrollment Form	HSA Transfer of Assets

## **FSA Claim Substantiation (ASE Only)**

With the end of 2016 approaching, it is a good time to make sure that your FSA expenses for the year have been substantiated.

Your WageWorks and soon-to-be DataPath debit card makes using your Flexible Spending Account (FSA) convenient. However, there are some things to remember when using your card to make sure your purchases are substantiated.

What happens if you don't substantiate your claims? Your card could be shut down, you will have to pay for items and services out of pocket and file a paper claim for reimbursement. If you don't substantiate your claims by the run-out period of March 31, 2017, you could see a deduction on your paycheck to pay back claims that are unsubstantiated.

- Neep your itemized receipts for **EVERYTHING** you purchase with your FSA debit card Why? The charge may need to be substantiated to prove that the charge was for an eligible FSA approved expense.
- Make sure your documentation has everything to substantiate your claim.

Documentation must include the following to substantiate your claim: (1) Patient's name, (2) Provider's name, (3) Date of Service (not date of payment), (4) Type of service received or goods purchased, and (5) Amount of the service or goods purchased.

**DON'T** Don't assume that the charge is approved because the debit card worked *Why?* 

Some charges may not be eligible FSA expenditures. For example, you may have used your debit card at the dentist, but part of the payment was for teeth whitening. Teeth whitening is NOT an approved FSA expenditure. That is why substantiation documentation is needed, to make sure ALL charges are for FSA eligible expenses. IRS regulations for cafeteria plans **REQUIRE** substantiation of charges.

DataPath will administer the runout period for 2016, where all claims from the 2016 plan-year must be substantiated by the end of March 2017.

ARBenefits complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Language assistance services, free of charge, are available to you. Call 1-877-815-1017x1.

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-815-1017x1

## **Coverage Change for Pap Smear**

At the December 15, 2016 meeting, the Arkansas State and Public School Life and Health Insurance Board decided to make a change to how the plan covers preventative cervical cancer screenings using pap smears.

Effective 1/1/2017, the plan will align with the guidelines of the US Preventative Services Task Force (USPSTF), and will cover preventative screenings for cervical cancer using pap smear once every three years for women aged 21-65. Women aged 30-65 can have a pap test and co-testing for HPV every five years. The change also mirrors the Health Advantage coverage policy.

The change in coverage does not affect the ability for a woman to have more the one pap smear in that time period if deemed necessary by her doctor. The tests would be considered diagnostic and would go towards the member's deductible and coinsurance.

The plan will also continue to cover an annual OBGYN visit for women.

The USPSTF recommended the guidelines after their studies showed that there was no additional benefit to annual screenings, and there were potential harms.

The benefit of screening is that it can prevent cervical cancer, or can find the cancer early when treatment is most effective.

Cervical cancer screenings also come with possible harms. The tests can cause bleeding, pain or infection. Abnormal results may make women feel anxious or upset. Screening may also lead to additional tests or procedures that aren't needed, or that may cause harms for some women, including problems with future pregnancies.

#### Source:

#### **US Preventative Services Task Force**

www.uspreventiveservicestaskforce.org

## The Importance of Cervical Cancer Screening

While the coverage of preventative cervical cancer screenings is changing to once every three years, it is still important to be screened for cervical cancer.

Cervical cancer is most common in women aged 35-55 and almost always caused by the human papillomavirus (HPV). There are many different types of HPV, and some types of HPV can lead to cervical cancer. HPV is passed from one person to another during sex.

Most women who develop cervical cancer have not been screened at all, have not been screened recently, or did not have proper follow-up after receiving abnormal test results.

According to the Centers for Disease Control and Prevention (CDC), in 2012, 8 million women had not been screened within the past five years. Seven out of 10 of women that were not screened and had regular doctor and health insurance.

Arkansas has the highest rate of cervical cancer in the country. According to a 2013 study, Arkansas had a cervical cancer incidence rate of 10.6 per 100,000 women. Unfortunately, the high incidence rate, also means that Arkansas has one of the highest rates of death due to cervical cancer in the country.

The Arkansas Center for Health Improvement (ACHI) conducted a study regarding female members on the ARBenefits plan age 21-65 who did not have claims data reporting abnormal Pap smear test results. This study was done with a 3 year snapshot from 10/1/2012-

9/30/2015. Members also had to be continuous enrolled in the plan during final two years of measurement period.

According to the results, 60.2 percent of the PSE group that was analyzed had at least one pap smear in the three-year period. On the ASE side, 57.7 percent of the analyzed group had a pap smear within the timeline. Combining the groups show that while 59.3 percent of the population had at least one pap smear within the three years, 40 percent of the study's population had not been screened during the timeline of the study.

According to the American Cancer Society, If detected early, cervical cancer is one of the most successfully treatable cancers.

#### **Sources:**

**United States Preventative Services Task Force** 

www.uspreventiveservicestaskforce.org

**Arkansas Center for Health Improvement** 

www.achi.net

**American Cancer Society** 

www.cancer.org