



# STATE HEALTH BENEFIT PLAN UPDATER

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

January 1, 2001

*This UPDATER constitutes official notification to State Health Benefit Plan (SHBP) members of Plan changes and, as such, supersedes any previously published information that conflicts with the material included in this UPDATER. It will be used—in conjunction with the SHBP Booklet dated November 1, 1995, the HMO Member Handbook dated March 1998, plus any UPDATER published after November 1, 1995—to administer the Plan until new booklets are published. If you are disabled and need this information in an alternative format, write the State Health Benefit Plan at P.O. Box 38342, Atlanta, GA 30334 or for TDD Relay Service only, call (800) 255-0056 (text telephone) or (800) 255-0135 (voice).*

**T**he Department of Community Health continues to work toward improving the benefits and service to members of the State Health Benefit Plan. This UPDATER provides you with important information concerning an update on the PPO network, a new Voice Response Unit providing enhanced access to claims status, a change in the Plan's Pharmacy Benefit Manager (effective January 1, 2001), and a change to the Plan's pharmacy benefit (effective July 1, 2001).

*The following section applies to PPO and PPO Choice Option members:*

## **1. UPDATE ON HOSPITAL-BASED PHYSICIANS**

Under direction from the Department of Community Health (DCH), the Plan's network manager (Georgia 1st/MRN) has been actively recruiting hospital-based physicians (emergency room physicians, anesthesiologists, radiologists, and pathologists) to join the network of participating providers for our Standard PPO and PPO Choice Options. The recruiting efforts have resulted in the addition of over 1,500 hospital-based physicians. As of this writing, 112 hospitals (of 170 in the network) have full participation and recruiting efforts continue at the remaining facilities.

DCH is aware that even though your hospital may be in the PPO network, some hospital-based physicians at the facility may not have participated in the PPO. Business relationships between a hospital and its physicians vary; for example, an individual hospital-based physician or a group of hospital-based physicians may contract with a hospital to provide services and may bill patients separately from the hospital bill or include their charges in the hospital bill.

We are pleased to announce that any hospital-based physician that has joined the PPO network since July 1 will be considered a network provider retroactive to July 1, 2000. As a result, if you or a covered dependent received hospital-based physician services from a non-participating physician that later joined the network (on or

before December 31, 2000), your claim will be reprocessed at the in-network level of benefit coverage and a new Explanation of Benefits (EOB) form will be sent to you.

The EOB will indicate the dollar amount the provider should adjust from your balance due, if any. If you already have paid your provider any part of the amount adjusted off, you may obtain a refund of that amount from your provider.

To assist members with selecting in-network providers, including hospital-based physicians, we are pleased to provide important new information on the PPO network's Web site at [www.healthygeorgia.com](http://www.healthygeorgia.com). The Web site will include the network status for each group of physicians at the hospital. The Web site also includes a special search feature so that you can view individual hospital-based physicians by specialty group and by hospital.

Please note, however, that even when a hospital does have full participation from its hospital-based physicians, it is possible that a member could receive services from a non-participating, visiting hospital-based physician.

*The following sections apply to PPO, PPO Choice, and High Option members:*

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## **2. ENHANCED SERVICES TO MEMBERS**

The Plan is pleased to announce that the BlueCross BlueShield Member Services Unit now offers a voice response unit (VRU). The new service is available 24-hours a day,

7-days a week to provide you with up-to-date claim information, and is available as an option when you call Member Services. Callers can use their telephone keypad to enter their social security number and the date of service for which a claim has been filed. If you do not know the date of service, an option allows you to review recent claims.

The VRU retrieves claim information and gives you a computer-generated voice response. Use of the VRU can decrease the time you might wait on the phone to get claim status information from a Customer Service Representative. The VRU telephone number is the same as the regular member services numbers given on page 3.

To make it more convenient for members to reach a Customer Service Representative, the Plan's Member Services Unit has extended weekday hours to 8:00 p.m. and is now open on Saturdays from 8:00 a.m. to 12:00 p.m.

## **3. NEW PHARMACY BENEFIT MANAGER**

Effective January 1, 2001, the SHBP will change from PAID Prescriptions to Express Scripts to manage the pharmacy benefits offered to Standard PPO, PPO Choice, and High Option Plan members. The pharmacy benefit applies to prescription drugs purchased from a licensed pharmacy.

Express Scripts will provide these Plan members with many services as the new pharmacy benefit manager (PBM), including contracting with drug manufacturers for the best prices available, managing the Plan's network of retail pharmacies, and processing prescription drug claims.

The current prescription drug benefit will continue through the remainder of the Plan year (through June 30, 2001). A new benefit program will begin July 1, 2001 (see page 5 for details).

With Express Scripts as the Plan's new PBM, you will continue to enjoy many of the advantages offered through the current pharmacy benefit manager — plus you will have access to some new and useful services. Just as with the PAID Prescriptions pharmacy network, members will continue to have access to thousands of pharmacies across Georgia and across the country.

Also, if your pharmacy is not already in the Express Scripts network, the store may join at any time without any extended waiting period. As before, most claims will be filed electronically by your network pharmacy and you will not be required to complete any paperwork.

*The following points will provide you with more details on how the new PBM will affect Standard PPO, PPO Choice, and High Option Plan members:*

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**EFFECTIVE JANUARY 1, 2001:**

1. The PAID retail pharmacy network will be replaced by the Express Scripts network. Currently, the Express Scripts network has 2,000 independent and chain pharmacies in Georgia and 53,000 pharmacies nationwide. Using a network pharmacy can save you money, so **ask your pharmacist if his or her store is in the Express Scripts network.**

Any licensed pharmacy can join the Express Scripts network — if your pharmacy is not

part of the network, ask your pharmacist to call Express Scripts at 1-877-650-9340.

Since the vast majority of pharmacies in Georgia participate in the Express Scripts network, the Plan is not printing a directory; however, you may call Express Scripts toll-free at 1-877-650-9342 to see if your pharmacy is in the network or, if you have Internet access, you can look up network pharmacies by visiting the DCH Web site at [www.communityhealth.state.ga.us](http://www.communityhealth.state.ga.us) (and then selecting "Public Employees" or "State Health Benefit Plan").

2. Express Scripts network pharmacies will file your claims for you at the point of sale. If you use a pharmacy not participating in the Express Scripts network or if you have other coverage in addition to the SHBP, you must submit a paper claim form.

New claim forms with the Express Scripts name will be available on or around January 1, 2001, and may be obtained by calling either Express Scripts at 1-877-650-9342 or member services at 1-800-483-6983 (in Atlanta, 404-233-4479). However, PAID claim forms will continue to be accepted through March 31, 2001. Pharmacies in the network agree not to bill you for amounts over the Plan's allowed amount.

**Reminder:** You are subject to balance billing for charges in excess of the network rate if you use an out-of-network pharmacy.

3. If you purchase a brand-name drug when an equivalent generic drug is available and your physician has not specified the

brand-name drug, your reimbursement will be based on the network reimbursement for the generic drug.

4. In the PAID network, members had to complete a paper claim form when they purchased a prescription for a compound drug (a drug with two or more active ingredients). Starting January 1, 2001, your Express Scripts network pharmacist will be able to submit compound drug claims electronically, eliminating the need for you to complete a paper claim form. Your reimbursement will be based on the allowed amount for the most expensive ingredient.
5. Some durable medical equipment (DME) suppliers also hold a pharmacy license and provide pharmaceutical items. Claims for pharmaceutical items that are purchased through DME suppliers must be submitted as pharmacy claims, which can only be done by DME suppliers that hold a pharmacy license.

Common examples of pharmaceutical items that are sometimes purchased through DME providers include inhalation supplies and diabetic supplies (including insulin). Use of an Express Scripts network pharmacy to purchase these supplies will generally save you money since you (and the Plan) will receive network discounts that are not available through your DME supplier (unless that supplier is in the network).

**Note:** If you are a retiree with primary coverage through Medicare and Medicare allows medical coverage for a pharmaceutical-type item, the Plan will continue to cover the item as a medical expense.

#### **POINTS TO KNOW ABOUT THE TRANSITION TO EXPRESS SCRIPTS:**

- **Most pharmacy claims at network pharmacies require no filing on the part of the SHBP member – the pharmacist submits a claim for you at the point of sale.** Your pharmacist in the PAID network will submit electronic claims for you through December 31, 2000. Your pharmacist in the Express Scripts network will submit electronic claims for you on or after January 1, 2001.
- Each Plan member will receive a new State Health Benefit Plan ID card that includes the Express Scripts logo and address. (Members with family coverage will receive two ID cards.) Be sure to show the card to your pharmacist so that he or she will know how to submit your claim. Both active and retired members should receive their card(s) in December. Personnel/payroll offices will distribute ID cards to active members and retirees will receive their ID cards through the mail.
- If you file a paper claim for a drug purchased on or before December 31, 2000, the claim must be received by PAID Prescriptions at P.O. Box 1012, Parsippany, New Jersey 07054-5412, no later than March 31, 2001. Claims received by PAID after March 31, 2001 will not be paid if the drug was purchased in the year 2000.

Paper claims for drugs purchased on or after January 1, 2001 are subject to the normal 12-month timely filing requirement and should be filed with Express Scripts at ESI-SHBP Paper Claims, P.O. Box 390863, Bloomington, Minnesota 55439.

- If you have filed a letter of medical necessity (LOMN) for a prescription drug that requires prior authorization, PAID will transfer that information to Express Scripts so that your authorization file can be continued. As your LOMN approaches its expiration date (generally one year after initial filing), Express Scripts will send you a renewal reminder.

Starting on January 1, 2001, you should mail LOMNs to Express Scripts at the address shown on your new SHBP ID card.

#### **4. SUMMARY OF NEW PRESCRIPTION DRUG BENEFITS EFFECTIVE JULY 1, 2001**

Many SHBP members have expressed concerns about having to pay in full at the point of purchase for expensive prescription medications and then having to wait for reimbursement. That is why we are informing you now about an important change to the pharmacy benefit on **July 1, 2001**.

The Health Plan understands your concern about paying up front for prescriptions that continue to cost more every year. In fact, drug expenditures for the SHBP have increased over 20 percent each year in the last two years. The escalating cost of drugs has had much to do with the necessity to increase premiums in the last two years.

Over the next five years, drug spending in the U.S. is expected to increase from 15 to 18 percent per year. With these considerations in mind, DCH has redesigned the Plan's pharmacy benefit program to keep your future premiums affordable while it continues to offer you a choice in selecting any covered drug.

*The following sections describe the new pharmacy benefit effective July 1, 2001:*

#### **A THREE-TIER COPAYMENT STRUCTURE**

DCH is pleased to announce a copayment program (commonly known as a "card program") for the SHBP pharmacy benefit. With the new copayment program, members will not have to pay for prescriptions at the point of sale and then wait for reimbursement from the Plan after satisfying a deductible.

Instead, members will pay one of three copayment amounts for up to a 30-day supply of prescription drugs. During June 2001, members will receive a second new SHBP ID card (or cards) showing the new copayments. To make using the new program easier, members will not need a separate prescription drug card.

A three-tier copayment structure offers a number of advantages. For example, members have access to all covered drugs, resulting in increased satisfaction and choice. The new structure also encourages members to use generics and preferred brand-name drugs, helping to control Plan costs and hold down premiums for members. Copayments also are more fair to members since they minimize the subsidy to members who choose to use more expensive drugs. Finally, a copayment program balances member choice with cost-controls.

Express Scripts services 2.65 million lives for its State and Local Government clients and millions more for private sector clients. Of these covered lives, approximately 50% are covered under health plans that have a multi-tiered prescription drug co-payment program. Although prescription drug co-payments will be a significant change for

SHBP members, several other state government plans have had a prescription drug co-payment program in place for many years.

**DESCRIPTION OF COPAYMENTS:**

Type of Drug	Copayment Amount Per Prescription (for up to a 30-day supply)
Generic	\$10 or cost of drug if lower
Preferred Brand	\$20 or cost of drug if lower
Non-Preferred Brand	\$35 to a maximum of \$75 depending on drug cost

Members will receive a printed preferred drug list during the spring 2001 Open Enrollment period. Participating Plan physicians will be sent information on the new drug program to help you maximize your prescription drug benefits. The list also will be available on a Web site (to be announced during the spring 2001 Open Enrollment).

**Note:** This is a general description of the prescription benefits effective July 1, 2001. Complete details will be made available to members prior to the upcoming Open Enrollment period.



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