Benefits Management Briefing

For Group, Benefit and Human Resource Administrators

Fall 2002

New Illinois HMO Network Choices, Change in 2003

The HMOs of Blue Cross and Blue Shield of Illinois announce two changes effective January 1, 2003.

More HMO network choices

Employers and consumers asked for choices in provider network size and cost – and the Blue Cross HMOs listened. We are pleased to offer you more network options upon your renewal, giving you and your employees even more choice and affordability.

The networks are:

• **HMO Illinois** – the largest provider network in the state.

• **BlueAdvantage HMO** – to include a broad provider network of more than 80 medical groups/IPAs at a lower cost.

Depending on your group's size, you can either select one network for all employees or offer both networks and let your employees choose the one that best suits their needs.

Both offer many provider choices, including the state's largest pharmacy network and a range of health care benefits. They also feature the same physician credentialing process and member services resources.

Also, HMO Illinois and BlueAdvantage HMO earned an Excellent accreditation from the National Committee for Quality Assurance – its highest accreditation level.

When you offer a network option more suited for your employees' needs, you can potentially increase your overall health care savings.

Woman's Principal Health Care Provider change

Female HMO members' primary care physicians (PCP) and Woman's Principal Health Care Providers (WPHCP) must now have a *referral arrangement* with each other. Physicians usually have referral arrangements when they are in the same medical group. This change should help increase the continuity of care by facilitating coordination of treatment by – and direct communication between – providers. Members can continue to see a WPHCP without a written referral.

Approximately six percent of members will be affected by this change. Members are being sent a letter explaining that they need to contact Member Services by November 15, 2002, to change to one medical group. A variety of other communications is being used to inform members and groups of this change. If you would like to receive a list of affected members in your group or have any other questions, contact your account executive.

HCSC's Financial Rating Remains Strong

HCSC earns another 'A' rating from A.M. Best

The A.M. Best Company reaffirmed Health Care Service Corporation's (HCSC) "A" (Excellent) rating this past June. HCSC is the parent company for Blue Cross and Blue Shield of Illinois.

S&P affirms HCSC's 'A' rating

Standard & Poor's also affirmed its single-"A" counterparty credit and financial strength ratings on HCSC. The outlook is stable.

These ratings confirm HCSC's financial strength and ability to meet its obligations to policyholders.

BCBSIL Redefines 2-150 Market Size to Serve You Better

Keeping up with the marketplace is a challenge – particularly in the health care field. Regulation, legislation, competition and market demands are constantly changing.

To better align our services with customers' needs, we are redefining the 2-150 group market into two new segments effective January 1, 2003.

- **BlueAdvantage Entrepreneur, CPO for groups with 2-50 lives**

This segment of 2-50 lives is defined by HIPAA and other federal regulations: group size based on total number of full- and part-time employees, nationwide, regardless of whether or where they are enrolled. These groups are protected by HIPAA small group provisions (federal legislation) and SEHIRA small group regulation (State of Illinois).

The BlueAdvantage Entrepreneur plans will still be offered to this Small Group segment much as they are now.

- **BluePrint, CPO for groups with 51-150 lives**

This new segment includes groups with more than 50 lives as defined by HIPAA, but no more than 150 enrolled with Blue Cross (51-150). All groups in this segment will have standard BluePrint benefit programs, premium prospective funding and be subject to many of the same business practices as the current Small Group segment is today.

Groups in this category will experience the most changes. Groups with 51-99 lives will find more options – all of the extensive BluePrint product portfolio, except HMO Illinois, will be available. Existing groups of 100-150 who have already purchased a BluePrint plan with HMO Illinois may maintain this coverage if they make no changes and will not be placed into this segment. Existing groups of 100-150 who have already purchased a BluePrint plan on a premium prospective basis with BlueAdvantage HMO will now be handled in a more automated, streamlined basis in this 51-150 segment.

All other 100-150 groups may keep their current plans, if no changes are made. Their account administration will remain the same.

As a reminder, those groups that are still enrolled in our Million Max plans can continue to keep their existing coverage.

You can expect to hear more about how these changes will impact your company from your broker or account executive as your renewal approaches. At your renewal, you can make a plan change as described in this article if desired.

BlueCare Dental Plans Are a Smart Choice

Along with health insurance plans, Blue Cross and Blue Shield of Illinois offers a portfolio of dental products to complete your employee benefit program. Our BlueCare Dental plans give you the flexibility to choose the dental coverage right for your employees.

You can select either the BlueCare Dental PPO plan or the Traditional plan for your employees and you can combine it with the Dental HMO.

- **BlueCare Dental Preferred Choice (PPO).** Dental PPO products are among the fastest growing benefit products in the market today. BlueCare Dental Preferred Choice has one of the largest PPO provider networks in Illinois (more than 1,800 providers) with access to a national PPO network (more than 34,000 providers in 38 states). The national dental PPO network provides access for multistate employer groups interested in providing a PPO dental program to their employees. Our average provider discount of 25 percent is the highest in the state.

When your employees select participating PPO dentists, their out-of-pocket expense is less – just like a medical PPO. Plus, there is no balance billing or claim forms to complete. If employees receive care from a nonparticipating dentist, their out-of-pocket expenses are higher and they may have to file a claim.

- **BlueCare Dental Traditional.** This standard indemnity product gives your employees the freedom to choose any dentist and receive the full level of benefits without a referral or network requirement.
- **BlueCare Dental HMO.** This dental HMO program particularly encourages preventive and diagnostic care. Your employees select a primary care dentist to oversee all of their general and specialty dental care. Members know their copayments in advance and they never have to file a claim for a scheduled treatment.

For more information regarding the Blue Cross dental products, please contact your account executive or broker.

Web Site Enhancements Make Navigation Easier

Several enhancements have been made to the BCBSIL Web site. Check it out at *www.bcbsil.com*.

Employer portal

Groups using BCBSIL's Web site will find a new look on the "For Employer Groups" portal. The portal was redesigned to make it easier and quicker for you to obtain the information and resources you need. You can download forms, find product information and access this newsletter.

Automatic routing for members

BCBSIL members who select "For Current Members" will find a new authentication process that prompts them to enter their group number from their ID cards. Members are then quickly routed to their appropriate product information.

- National Account members are routed to the content and applications specific to their employer's product configuration.
- Local account members are routed to the appropriate product home page – HMO, PPO or Blue*Choice*/ Point of Service.
- Members of accounts with a custom Web site will be routed to the appropriate site.

Home delivery prescription program now online

Information about home delivery now appears within the Prescription Drugs section of our member portal. Members can get instructions on how to use the home delivery benefit, including the oral contraceptive benefit, and learn about the advantages of using generic drugs.

Other information and forms are available for downloading in the member portal, including the:

- Home Delivery Prescription Drug Program benefit brochure
- Registration and Prescription Order form for Walgreens Healthcare Plus
- Physician's fax form for Walgreens Healthcare Plus

Now that this program is accessible online, it's easier than ever for members to enjoy the convenience of prescription home delivery. Members can access this information from the "For Current Members" page by entering their group ID number.

ERISA Clarification

The following clarifies the effective dates in the ERISA article featured in the summer 2002 issue of *Benefits Management Briefing*, as well as urgent care under HMO.

The Department of Labor ERISA law takes effect:

- On the group's plan year date for groups whose plan year falls on or after July 1 to December 31, 2002.
- On January 1, 2003, for groups whose plan year falls on January 1 or after.

In either case, our claim processes have been changed to meet the ERISA guidelines as of July 1, 2002.

For HMO groups only: HMO urgent care that occurs on weekends *will be handled by the medical groups within their 24-hour urgent care coverage*. (Urgent care is handled differently for non-HMO business – see the summer issue of *Benefits Management Briefing* for details.)

Address Corrections

If you need to change your *Benefits Management Briefing* mailing address or have any other changes, such as adding or deleting names, please contact your broker or Blue Cross and Blue Shield of Illinois account executive and ask him or her to make the correction.

HCSC Responds to California Privacy Law

A new California privacy law (CA SB168) that restricts the use of Social Security numbers as identifiers for communication purposes will take effect between January 1, 2003, and July 1, 2005. Health Care Service Corporation (HCSC), which operates as BCBSIL, has established a corporatewide task force to explore the implications and respond to the impact of this legislation. Look for more information in future issues of *Benefits Management Briefing*.

Pharmacy Corner

Savings Opportunities with Generic and OTC Products

In July, four widely prescribed antihypertensive medications became available as generics: Zestril, Prinivil and their combination forms with a diuretic, Zestoretic and Prinzide. The generic versions of these products initially were priced at about 50 percent of their brand counterparts. As more generic manufacturers produce them, the price is expected to decline further.

Three-tier formularies encourage generic utilization

To take advantage of the savings opportunities that become available when drug patents expire, plan benefit decision makers may want to consider including incentives that encourage employees to use generic products. Significant copayment differentials may encourage generic utilization. A three-tier formulary benefit design is structured as follows:

Tier 1: generics

Tier 2: formulary brands (no generics available)

Tier 3: nonformulary brands (may have generics available)

This benefit design allows for a higher copay to be charged for brand drugs that have a generic available, while allowing a lower copay for brand drugs without a generic.

Some employers may be able to build additional incentives into the benefit structure to use generic products by including a generic buy-up or member-pay-the-difference provision. A member who elects to have his prescription filled with a nonformulary brand name drug when a generic is available is then charged the nonformulary copay, plus the cost difference between the brand and generic product.

Because generic products must have the same active ingredients as their brand counterparts and must meet strict Food and Drug Administration (FDA) requirements for bioequivalency, nearly all brand name drugs can be substituted with a generic without consent from the prescribing physician.

Over-the-counter medicines offer cost savings

Later this year, the popular non-sedating antihistamine product, Claritin, is expected to become available as an over-the-counter (OTC) item (no prescription needed). As the OTC version is anticipated to have the same strength and indications as the current prescription version, many current Claritin users will switch to the OTC product.

Consequently, benefit costs for this very expensive class of medications will decrease. Pending the outcome of a petition to the FDA to require other antihistamines, such as Allegra and Zyrtec, to be available as OTC products, costs in this drug category may be reduced even more dramatically.

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