

# Messenger



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## Message from the Fund's Executive Director, Richard Burker

**W**arm wishes to you from the Fund's staff and Trustees. I have chosen to use my allotted space (plus a bit more) exclusively to address the issues that you have raised with the Prescription Drug Program's new dual tier co-payment structure, as well as related matters.

For those of you who are not fully familiar with the change that became effective January 1, 2002, the flat \$5 co-payment, which most plan participants were previously required to pay for both retail and mail order generic and brand name drug purchases, was increased for other than retail purchases of generic drugs. (For most participants, the co-payment for retail brand name drugs was increased to \$15, for mail order generic drugs to \$10 and for mail order brand name drugs to \$30; retail generic remains at \$5.)

The goals which the Fund seeks to accomplish, are aimed at achieving an essential moderation in the relentlessly, upward spiraling cost of the Program, driven primarily by the extraordinary cost of a number of brand name drugs. While the patents for many brand name drugs have expired allowing for the manufacture of generic equivalents of those drugs at competitively lower prices, there are many new and older brand name drugs protected by patent and therefore sold at whatever price the market will bear. Thus, the Fund's goals are to encourage the greater usage of generic drugs and to otherwise shift to participants a more equitable portion of the cost of brand name drugs (which on average, cost about five times that of generic drugs). The Fund also seeks to shift to participants a more equitable portion of their mail order multi-month fills.

To those who protest their increased out-of-pocket expense, the Fund certainly would have preferred not to have been forced to act, but reiterate that it looked long and hard at the issue and deemed a change to be unavoidable after steadfastly maintaining its single tier co-payment structure for over 11 years. The Fund considered other alternatives that would have further reduced its expense, but found them unacceptably burdensome on participants. Among such alternatives was the flat 20% of price based co-payment which is common to many plans, but given the remarkably high cost of many frequently prescribed drugs, that approach was determined to create too much financial exposure to participants, and was rejected accordingly.

Those participants who protest the lack of fairness in being forced to pay a brand co-payment when no generic equivalent exists are ignoring the Fund's absolute need to reduce its costs. It's regrettable, but the present reality is that pharmaceutical manufacturers, with earnings reflecting a huge return on investment, are protected from competition for 20 years. However, please note that in many instances, although there is no generic equivalent to your prescribed brand name drug, there may be therapeutic alternative drugs that can be purchased with a generic co-payment. We urge you to discuss this with your doctor in each such case.

The Fund has received a number of participant inquiries regarding their assessment of a brand name co-payment despite the pharmacist's expressed belief that the co-payment should be at the generic level. We have investigated each instance in which the participant has provided us with the necessary detail and have discovered two design issues in the Blue Cross pharmacy claims adjudication system (DRAMS) contributing to the confusion. The bottom line is that the Fund will reimburse participants for the co-payment differential when the drug is determined by the Fund to be, in fact, a generic. I have attempted to explain this matter in the sidebar article, *Generic vs. Brand Co-payment Determination*, on page 2.

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Other than a procedural issue affecting certain retirees (please see *Retiree Drug Prescriptions* on Page 5), our final concern is with the Merck-Medco member services group. For active participants and pre-65 retirees, Merck-Medco's responsibility for mail service orders is no different than that of your local pharmacist for retail orders. Merck-Medco cannot answer any of your pre-fill questions regarding your eligibility or determination of whether your prescribed drug is generic or brand for co-payment purposes. To do so, it would have to access DRAMS, but cannot do so without filling your prescription. It can only respond to questions regarding your prescription after it has been submitted or filled. Merck-Medco's member service staff has been instructed on several occasions to refer you to the Fund's Member Services department, but occasionally they will attempt to respond to your questions and have done so incorrectly. We are working with Blue Cross and Merck-Medco to address this matter and to otherwise refine our relationship.

In conclusion, I assure you that the Fund is seeking to address all issues conscientiously, with respect and sensitivity for your concerns.

## Generic vs. Brand Co-payment Determination

As noted above, the Fund has received a number of inquiries as a result of the assessment of brand name co-pays for drugs which the participant's pharmacist believes should be assessed at a generic co-payment level. This issue does not concern non-Michigan retail orders or any Affinity Rx Program orders.

The first cause for the generic vs. brand confusion is attributable to the use by Blue Cross, of a nationally accepted drug data file (First DataBank) that determines brand and generic co-payment levels. The problem with that file is that it attributes a brand level co-payment to a small number of generic drugs whose price (i.e., its manufacturer's average wholesale price) is very close to that of their brand name equivalent. The Fund has determined to rectify this situation by reimbursing affected participants, as described below.

The second cause of this confusion, we believe, is occurring because the Blue Cross pharmacy claims administration system (DRAMS) has been reflecting Blue Cross' payment to the pharmacy for the filled prescriptions in question at a highly discounted rate while instructing the pharmacist to collect a brand level co-payment. Many pharmacists are aware that such discounted rate typically indicates that the co-payment should be charged at the generic level and are communicating that to the participant. These highly discounted drugs should be treated as generic for co-payment purposes (even though as described above, the First DataBank file has determined them to require a brand co-payment), but DRAMS fails to do so for Fund participants. DRAMS has now been corrected and all affected participants will be reimbursed as soon as possible for the co-payment differential automatically.

However, Blue Cross will not modify the First DataBank file. Therefore, for those generics classified as brand by the First DataBank file and which are not on Blue Cross' list of highly discounted drugs, participants will continue to be charged by their pharmacists for brand level co-payments. The accompanying chart reflects those drugs (with their National Drug Code, or NDC, number) known to the Fund and Blue Cross at this time. To address this, the Fund will process your claims for reimbursement for the co-payment differential, or automatically reimburse the differential, in most cases, between 60 and 90 days following purchase.

Generics Equivalent Drugs Classified as Brand Name Drug by First DataBank	
Generic Name	NDC #
Colchicine / Probenecid	00591532501
Indomethacin SR 75mg	00185072060
Indomethacin SR 75mg	60951073870
Isosorbide Dinitrate 40mg	54569045400
Isosorbide Dinitrate 40mg	54569045401
Isosorbide Dinitrate 40mg	58016058430
Isosorbide Dinitrate 40mg	58016058420
Isosorbide Dinitrate 40mg	58016058415
Isosorbide Dinitrate 40mg	58016058412
Clotrimazole/Betamethasone Cream	58016561201
Clotrimazole/Betamethasone Cream	52959063315
Clotrimazole/Betamethasone Cream	51672404806
Clotrimazole/Betamethasone Cream	51672404801
Clotrimazole/Betamethasone Cream	00168025846
Clotrimazole/Betamethasone Cream	00168025815
Vitacon Forte	52152007804
Vitacon Forte	52152007802

## Recognition of Other Fund Participation

One of the requirements a retiree must satisfy to establish eligibility in the Fund's Retiree Plan is the Fund's minimum active participation requirement, which may include participation in the Central States, Southeast and Southwest Areas Health and Welfare Plan.

This rule was inaccurately stated in the most recent Summary Plan Description under the Retiree Plan Eligibility Rules section entitled, "Recognition of Other Fund Participation-Reciprocity". The rule is hereby restated as follows:

*If contributions were made to the Fund on your behalf for at least 26 weeks immediately preceding your retirement, the Fund will recognize contributions made on your behalf to the Central States, Southeast and Southwest Areas Health and Welfare Plan in determining whether you meet the contribution requirements for Retiree Plan coverage.*

## Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law October 21, 1998. This law amended the Employee Retirement Income Security Act of 1974 ) and provides important protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Under the Women's Health Act, group plans offering mastectomy coverage must also provide for reconstructive surgery in a manner determined in consultation between the attending physician and the patient. Coverage must include:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The Fund has provided this coverage, subject to Plan rules, for many years. Please refer to your Summary Plan Description for further details.



## Address Changes

In order to keep all participants up to date on benefit and rule modifications, including new programs with limited enrollment windows, the Fund must have your current address on file. For those who are retired, this is especially important, since we are unable to contact your company or local for current address information when necessary.

Any time you change your address, please send written notification to the Fund office at your earliest convenience, at the address listed on the back page of this newsletter.

## Filling Prescriptions through the Mail Order Program

If you are a participant covered by a Plan that provides prescription drug coverage and want to utilize the Fund's Mail Service Prescription Drug Program, please refer to your prescription drug information kit and follow these steps:

1. Fill out the entire *Health, Allergy and Medication Questionnaire* for your whole family.
2. Fill out the entire *Ordering Medications from the Mail Service Pharmacy* form which includes a Member Information section, a Patient Information section, and an Order Information section. The Member ID # is your social security number and the group plan (BCBSMLG) is pre-printed on the form.
3. The Order Information section asks you to determine your co-payment amount. You may leave this amount blank if you are paying by credit card. If you are paying by check and do not know your co-payment(s), it is recommended that you state the generic co-payment for each such prescription. However, because there is presently allowed by Merck-Medco a maximum shortage of \$100, a participant filling multiple prescriptions may choose to submit brand co-payments in order to ensure that all prescriptions are filled. Merck-Medco will either bill you for your shortages or credit you for overpayments, as is appropriate.
4. Mail in your payment and original prescription in the postage paid envelope provided, to Merck-Medco Rx Services which is listed on the back of the *Ordering Medication from the Mail Services* form.

## Anti-Fraud Hotlines

In order to provide you with your plan benefits at the lowest possible cost, the Fund must pursue an aggressive strategy in the prevention of fraud. While only a small number of providers engage in fraudulent activities, the impact can be significant both to the Fund and to you as well (for example, undetected fraud may not only lead to higher self-pay contribution rates or benefit reductions, but to higher out of pocket expenses for deductible and co-insurance payments and out-of-network balance due bills and a consequent reduction of your remaining annual and lifetime maximum benefit allowances). We seek your help in taking an active role in and reporting incidents of attempted fraud.

Each time you receive services from your medical, dental, or optical provider, you will receive an Explanation of Benefits statement. Please review the statement carefully and look for evidence of mistake or fraud such as:

- Services listed that you believe were not performed
- More expensive services than those actually performed
- The patient name listed is not the actual patient who received the services
- Non-covered services that were billed as covered services
- Service dates that do not match your appointment dates
- Charges listed that do not match your records

If you spot any of the above discrepancies or if you are otherwise aware of a mistake or possible fraud, please call the applicable anti-fraud hotline listed below:

**1-800-637-6907 for Medical and Optical Claims**  
**1-800-524-0147 for Dental Claims**

## Fund Expands Ohio Provider Network

PPOM recently acquired the Flora Health Network, one of the largest PPOs in the state of Ohio, adding more than 18,000 physicians to the current list of network providers available to Fund participants.

The Fund will be mailing an Ohio/Indiana directory to participants residing in or near Ohio, as soon as printing of the directories is completed. In the meantime, please make use of the Fund's website at [www.mctwf.org](http://www.mctwf.org) to link to PPOM, or phone the Fund's Member Services department to determine if a provider is participating in the Fund's physician network.

## Fund Receipt of Documents Rule

The Fund's Trustees have determined, consistent with the requirements of ERISA, that it is appropriate and in the interest of the Fund's participants to adopt rules for deciding benefit claims and questions concerning receipt of documents sent by mail. To this end, the Trustees have adopted a rule which rejects the common law "mailbox rule" under which a presumption is given subject to rebuttal, that an item properly mailed was received by the addressee. The Fund's rule is as follows:

*No document, including financial instruments such as checks or money orders, shall be presumed to have been received by the Fund unless actually received, regardless of the circumstances of mailing*

## Extended Retiree Spouse Contribution Rates

The Fund has adopted new monthly self-contribution rates for Extended Retiree Spouses. These rates are effective April 1, 2002 through March 31, 2003 and are as follows:

Plan SOA or TIF	\$485.16
Plan I&S	\$433.37

Extended Retiree Spouse coverage was implemented in 1990 to accommodate pre-Medicare eligible spouses who lose entitlement to coverage under the Retiree Medical Program upon the later of five years of Program coverage or the Retiree's 65th birthday (or if earlier than the 65th birthday, upon the Retiree's death).

Entitlement to Extended Retiree Spouse coverage may continue until the earlier of the spouse's re-marriage or attainment of age 65 (or if earlier than age 65, upon commencement of Medicare eligibility).



## Retiree Drug Prescriptions

**If you are a retiree or spouse covered under the Fund's Retiree Medical Program or Affinity Rx Program and you wish to fill a prescription, PLEASE READ...**

Merck-Medco provides mail order services to all retirees, as well as providing non-Michigan retail pharmacy services to Retiree Medical Program participants and all retail pharmacy services to Affinity Rx Program participants. Merck-Medco also provides discounted pharmacy benefits to Central States Teamster pension recipients through the TEAMRET program. Under TEAMRET, the retiree is responsible for the full cost of the prescription at a discounted rate. Under the Fund's Retiree Medical and Affinity Rx Programs, participants are responsible for co-payment amounts only.

Unfortunately some retail and mail order prescriptions are being filled under TEAMRET rather than under the Fund's Retiree Medical or Affinity Rx Programs, and the participant is being charged the full discounted amount.

If you are filling a prescription at a non-Michigan pharmacy and you are charged the discounted price of the drug instead of a co-payment, your pharmacy probably has processed the claim through the TEAMRET plan. If you provide the pharmacist with the Fund's group code, BCBSMLG, your charge will be corrected.

If you are using the mail order prescription benefit, please be sure to use the form you received in the Information Kit provided to you in December ( and thereafter, your Merck-Medco refill slip) . Your group code, BCBSMLG, is pre-printed on them. TEAMRET has similar forms, but the group code is, of course, different. If you receive a mail order prescription and are charged at the discounted rate rather than a co-payment, please contact the Fund's Member Services Department so that we may have this corrected for you.

### End Stage Renal Disease

As a general rule, if you or your spouse are participating in the Fund's Retiree Medical Program and during your participation either of you become eligible for Medicare coverage, Fund coverage ceases immediately for that individual.

However, if you or your spouse's Medicare eligibility is due to End Stage Renal Disease (ESRD), Federal law requires that the Fund coverage remain primary to Medicare for 30 months, starting with the first month you became eligible to receive Medicare. Upon expiration of the 30-month period, Fund coverage will cease for that individual. This Plan rule was inadvertently omitted from your most recent Summary Plan Description.

### Medicare Eligibility

The Retiree Medical Program is designed to provide health care benefits until a retiree participant or spouse becomes eligible for Medicare. It is your responsibility to notify the Fund when you or your spouse become Medicare eligible. The Fund must receive a copy of the individual's Medicare card or a letter from the Social Security Administration stating the effective date of Medicare Part A coverage. The Fund will pursue recovery of any Fund benefits paid following commencement of Medicare eligibility.

### Affinity Rx Prescription Drug Program Open Enrollment

The Fund's Affinity Rx Prescription Drug Program, implemented effective April, 1999, provides Medicare eligible retirees and their spouses with up to \$1,000 in annual prescription drug benefits per year, subject to co-payments. Once participants have reached their \$1,000 annual maximum, this Program provides participants with the ability to purchase prescription drugs at substantially discounted rates.

When this Program was introduced, an announcement was sent to those retirees whom the Fund believed to be eligible to enroll. However, many retirees had relocated without informing the Fund of their new addresses and thus only learned of the Program after the enrollment window had closed. Others, having ignored the Program due to their enrollment in Medicare HMOs or due to their coverage under Medigap insurance policies, now find themselves abandoned by the HMOs and insurance carriers and unable to enroll in the Program. Accordingly, the Fund has chosen to permit enrollment through June 30th, 2002. Program information, including an application form, will be sent shortly to those who may qualify. Please act quickly. The enrollment period will not be extended and this opportunity may not occur again.



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**Contribution Control/COBRA & Retiree Departments**

**Fund Tip**  
**From the Fund's COBRA Department**

Your right to continue health care coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) depends on timely self-payments. Payment is due on the last day of the month prior to the month you are paying for. Coverage will lapse if you fail to make self-payments within 52 days of the first day of the month for which a premium is due.

Further, during your coverage period, you are required to notify the Plan Administrator within 60 days of the date your family status changes. Family status changes may include but are not limited to marriage, divorce, death, overage dependents etc.

Included as part of your COBRA package is a Certificate of Group Health Plan Coverage that provides evidence of your coverage with the Fund. If you become covered under another health plan, the certificate should be given to your Plan Administrator. It may decrease or eliminate any pre-existing condition limitation period under your new plan.



Back row: Kathleen, Delores, Gail, Walter, Vicky  
Front row: Loretta, Nona, Shirley, Mary