



An Independent Licensee of the Blue Cross and Blue Shield Association

November 2009

Dear Member:

The hot topic both locally and nationally is the cost of health care and health insurance. As your health plan, it is a concern that we deal with constantly. Our commitment to you is to provide quality health plans that are as affordable as possible. One way is to ensure that we coordinate benefits between two drug plans in a manner consistent with industry norm.

In the past, your secondary HMSA drug plan has been paying the copayment assessed by your primary drug plan. It was a simple way to coordinate benefits between two drug plans. Beginning January 1, 2010, we will coordinate benefits to limit the amount paid by your secondary drug plan so that the secondary plan will not pay more than it would have if it were your only plan. As a result, you may have out-of-pocket expenses that you did not previously have.

The enclosed insert provides a detailed explanation of coordination of benefits and an example to illustrate how you might be affected. For additional examples, you can visit [www.hmsa.com/kb00130](http://www.hmsa.com/kb00130).

We hope you will take the time to read the insert. The high cost of health care affects us all and we hope that we can count on you to support our efforts to keep coverage affordable.

If you have any questions about this letter, please call your local HMSA office on Monday through Friday from 8 a.m. to 4 p.m. The best times to call for a shorter wait are Thursday or Friday afternoon.

Oahu: Group and Individual Plans 948-6111  
Health Plan Hawaii (HMO) 948-6372

Toll-free: 1 (800) 776-4672

Sincerely,

A handwritten signature in black ink, appearing to read "John T. Berthiaume".

John T. Berthiaume, MD  
Vice President and Medical Director  
Care Management

09317DB

## Understanding “coordination of benefits”

Coordination-of-benefits rules are used by most group health plans to determine the order of payment of two or more health plans and to determine the amount of payment. In coordinating of benefits of two plans, one plan (primary plan) pays its benefits in full and the other plan (secondary plan) normally pays reduced benefits.

These rules help plans to avoid unnecessary delay in deciding which plan is primary and also avoid making costly duplicate payments.

Once HMSA determines the order of payment, we calculate whether there will be any portion for you to pay after your primary plan pays. Payment by your secondary HMSA plan will not exceed the amount that would have been paid if it were your only plan.

Beginning Jan. 1, 2010, you may have an out-of-pocket cost even after both of your drug plans pay. Whether your primary plan is HMSA or another carrier's plan, your secondary HMSA plan will pay the **lesser** of the amounts listed below:

- The eligible charge for the drug, minus the amount paid by the primary plan (member cost share amounts are not part of the eligible charge), or
- The amount the secondary plan would have paid if it were the only plan.

The example on the other side of this page illustrates one way a member would have an out-of-pocket cost even after benefits are coordinated between his two HMSA plans.

(over)

You may have a remaining out-of-pocket cost, depending on your HMSA plan benefits and the cost and type of your drug. This example illustrates one way a member would have an out-of-pocket cost even after benefits are coordinated between his two HMSA plans.

*Stan has two HMSA drug plans. His primary drug plan is provided through his employer and his secondary drug coverage is provided through his wife's employer. Stan's doctor prescribes generic drug XYZ for Stan's allergies. Stan's drug plans provide generic drug benefits – each with a \$5 copayment.*

***A little information about the cost of drugs and the maximum amount a pharmacy can collect:***  
*The actual cost of a 30-day supply of drug XYZ is \$6. However, because Stan is an HMSA member, participating pharmacies agree to collect only up to a certain amount from HMSA (benefit payment) and Stan (copayment). That amount is called the eligible charge and is slightly lower than the actual cost. For the XYZ drug, the eligible charge is \$4.50.*

**Box 1**

**Box 2**

<p><i>How HMSA would coordinate the claim prior to 2010:</i></p> <p style="padding-left: 40px;"><i>\$4.50 Eligible charge</i></p> <p><i>minus \$4.50 Stan's primary plan copay (A)</i></p> <p><i>equals \$0 Primary plan payment</i></p> <hr style="border-top: 1px dashed black;"/> <p><i>\$4.50 Stan's primary plan copay (A)</i></p> <p><i>minus \$4.50 Secondary plan payment</i></p> <p><i>equals \$0 Stan's out of pocket cost (after coordination of benefits)</i></p>	<p><i>How HMSA would coordinate the claim in 2010:</i></p> <p style="padding-left: 40px;"><i>\$4.50 Eligible charge</i></p> <p><i>minus \$4.50 Stan's primary plan copay (B)</i></p> <p><i>equals \$0 Primary plan payment</i></p> <hr style="border-top: 1px dashed black;"/> <p><i>\$4.50 Stan's primary plan copay (B)</i></p> <p><i>minus \$0 Secondary plan payment</i></p> <p><i>equals \$4.50 Stan's out of pocket cost (after coordination of benefits)</i></p>
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*Notice that the \$4.50 eligible charge is lower than the \$5 primary plan copayment. Since Stan is responsible for the copayment under his primary plan, but the only collectible amount is \$4.50, Stan's copayment is \$4.50 (A). Nothing is left of the eligible charge for HMSA to pay.*

*In Box 1, Stan ended up paying nothing out of pocket because his secondary drug plan kicked in and paid the \$4.50 copayment (A) carried over from his primary plan. Notice that the secondary plan paid more than the primary plan, although both plans are identical in generic drug benefits.*

*In Box 2, Stan's secondary plan will pay up to the amount it would have paid if it were Stan's only drug plan. Therefore, the secondary plan will pay nothing and Stan still owes a copayment of \$4.50.*

## ADDITIONAL EXAMPLES

### What if Stan's doctor prescribed ABC (a slightly more expensive generic drug)?

Let's say Stan has two HMSA drug plans and his doctor prescribes drug ABC, which is a generic drug slightly more expensive than the drug in the previous scenario.

Stan's generic drug benefit:

- Primary drug plan: \$5 copayment
- Secondary drug plan: \$2 copayment

In this scenario, the actual cost of a 30-day supply of drug ABC is \$8 and the eligible charge is \$6.39 (see **Figure 1A**).

#### **Prior to 2010, Stan visited the pharmacy to refill his prescription:**

Under his primary plan, Stan owes a \$5 copayment to the pharmacy, while HMSA paid the remaining \$1.39. After coordination of benefits, Stan ended up paying nothing out of pocket because his secondary HMSA drug plan kicked in and just paid the \$5 copayment carried over from his primary plan (see **Figure 2A**).

Consider for a moment how this drug would be paid if Stan's primary plan is canceled and his secondary plan is now his only drug coverage. Stan would pay the \$2 copayment and HMSA would pay the remaining \$4.39 to the pharmacy (see **Figure 3A**). In other words, \$4.39 is the maximum amount the plan will pay if it were Stan's only plan. This is an important point when benefits are coordinated starting in 2010.

#### **When Stan refills his prescription on or after Jan. 1, 2010:**

Stan's primary plan copayment was \$5. His secondary plan pays up to the amount it would have paid if it were Stan's only drug plan, which is \$4.39. After coordination of benefits, Stan's secondary plan pays \$4.39 and Stan ends up paying a \$0.61 copayment out of his pocket. (see **Figure 4A**).

Figure 1A

Generic drug ABC	
Actual cost	= \$8
Eligible charge	= \$6.39
The pharmacy has agreed to collect only up to the eligible charge from HMSA (benefit payment) and our member (copayment).	

Figure 2A

Prior to 2010	
Eligible charge	\$6.39
Member copayment	— \$5
Primary plan pays	\$1.39
-----	
Member copayment	\$5
Secondary plan pays	— \$5
Member out of pocket	\$0

Figure 3A

If the secondary plan had been Stan's only drug plan	
Eligible charge	\$6.39
Member copayment	— \$2
HMSA pays	\$4.39

Figure 4A

From 2010	
Eligible charge	\$6.39
Member copayment	— \$5
Primary plan pays	\$1.39
-----	
Member copayment	\$5
Secondary plan pays	— \$4.39
Member out of pocket	\$0.61

**What if Stan’s doctor prescribed DDD (a brand-name drug)?**

Brand-name drugs generally have a higher actual cost, a higher eligible charge, and a higher copayment, than generic drugs.

Let’s say Stan has the same two HMSA drug plans in Scenario A, and his doctor prescribes drug DDD (a brand-name drug) for Stan’s high blood pressure. The two HMSA drug plans provide Brand Name Drug benefits – each with a \$20 copayment.

In this scenario, the actual cost of a 30-day supply of drug DDD is \$100 and the eligible charge is \$90 (see **Figure 1B**).

**Prior to 2010, Stan visited the pharmacy to refill his prescription:** Under his primary plan, Stan owes a \$20 copayment to the pharmacy, while HMSA paid the pharmacy the remaining \$70. However, Stan ended up paying nothing out of pocket because his secondary HMSA drug plan kicked in and paid the \$20 copayment carried over from his primary plan (see **Figure 2B**).

Consider for a moment how this drug would be paid if Stan’s primary plan is canceled and his secondary plan is now his only drug coverage. Stan would pay the \$20 copayment and HMSA would pay the remaining \$70 to the pharmacy (see **Figure 3B**). In other words, \$20 is the maximum amount the plan will pay if it were Stan’s only plan. This is an important point when benefits are coordinated starting in 2010.

**When Stan refills his prescription on or after Jan. 1, 2010:** His secondary plan will still pay \$20, and Stan ends up paying nothing out of his pocket. His secondary plan pays up to the amount it would have paid if it were Stan’s only drug plan, which is \$70. However, because Stan’s \$20 primary plan copayment is the only amount left over, his secondary plan picks up the \$20 (see **Figure 4B**).

Figure 1B

<u>Brand name drug DDD</u>	
Actual cost	= \$100
Eligible charge	= \$90

Figure 2B

Prior to 2010

Eligible charge	\$90	
Member copayment	– \$20	}
Primary plan pays	\$70	
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Member copayment	\$20	←
Secondary plan pays	– \$20	
Member out of pocket	\$0	

Figure 3B

If HMSA had been Stan’s only drug plan:	
Eligible charge	\$90
Member copayment	– \$20
HMSA pays	\$70

Figure 4B

From 2010

Eligible charge	\$90	
Member copayment	– \$20	}
Primary plan pays	\$70	
<hr style="border-top: 1px dashed black;"/>		
Member copayment	\$20	←
Secondary plan pays	– \$20	
Member out of pocket	\$0	

## What if HMSA was not Stan's primary plan?

### Stan and his prescription for XYZ (a generic drug)

**Primary drug coverage:** another drug plan (not HMSA)

**Secondary drug coverage:** HMSA

Stan has two drug plans. His primary drug plan is another drug plan (not HMSA) provided through his employer. His secondary drug coverage is an HMSA plan provided through his wife's employer.

Stan's doctor prescribes generic drug XYZ for Stan's allergies. Under Stan's primary drug plan, the generic drug copayment is \$4. Under his secondary HMSA drug plan, the generic drug copayment is \$5.

Remember that for the XYZ drug, the eligible charge is \$8.

**Prior to 2010, Stan visited the pharmacy to refill his prescription:** Stan paid the \$4 primary plan copayment to the pharmacy. He then submitted his receipt for the \$4 primary plan copayment to HMSA (his secondary drug plan) for reimbursement.

HMSA, as Stan's secondary drug plan, reimbursed \$4 to Stan for his primary plan copayment. In effect, Stan ended up paying nothing for his drug refill (**see Figure 1C**).

HMSA as the secondary plan reimburses the member for their entire primary plan copayment, as long as it does not exceed the eligible charge. If the generic drug copayment under the primary plan were \$7, HMSA would reimburse Stan \$7. If the primary plan copayment were \$10, HMSA would reimburse Stan \$8.

Consider for a moment how this drug would be paid if Stan's primary plan is canceled and his secondary plan is now his only drug coverage. Stan would pay the \$5 copayment and HMSA would pay the remaining \$3 to the pharmacy (**see Figure 2C**). In other words, \$3 is the maximum amount the plan will pay if it were Stan's only plan. This is an important point when benefits are coordinated starting in 2010.

**When Stan refills his prescription on or after Jan. 1, 2010:** His secondary HMSA plan will pay up to the amount it would have paid if it were Stan's only drug plan. In other words, HMSA will pay \$3. Because Stan had a \$4 copayment from the primary plan, he will have a remaining copayment of \$1 (**see Figure 3C**).

Figure 1C Prior to 2010

Primary plan* copayment	\$4
Secondary (HMSA) plan pays	— \$4
Member out of pocket	\$0
*Primary plan is another drug plan (not HMSA)	

Figure 2C

If HMSA had been Stan's only drug plan:	
Eligible charge	\$8
Member copayment	— \$5
HMSA pays	\$3

Figure 3C From 2010

Primary plan* copayment	\$4
Secondary (HMSA) plan pays	— \$3
Member out of pocket	\$1
*Primary plan is another drug plan (not HMSA)	