

Frequently Asked Questions

HMSA PPO 75/25 Medical Plan

Q.1 How are health insurance premiums determined?

A.1 Health insurance premiums are generally determined by three factors: benefit plan design, medical inflation and utilization. The benefit plan design determines the member's cost share for services such as physician visits and prescription drugs. Medical inflation relates to the rising cost of healthcare services. Similar to the rising cost of gasoline, a gallon of milk, and college tuition, healthcare also experiences increases for services such as physician visits, x-rays and emergency room visits. Utilization reflects how much the insurance was used. While health plans are there if you need them, the more you use your health insurance the more health insurance premiums increase in future years.

Q.2 Why are the HMSA PPO 75/25 medical and prescription drug plan premiums decreasing? Can they increase in the future?

A.2 Premiums have decreased because employees and their dependents enrolled in the HMSA PPO 75/25 medical and prescription drug plan have historically used their health benefits on a limited basis (i.e. their utilization is low). This resulted in more premiums being received than claims being reimbursed to physicians, hospitals, etc. which led to a decrease in premiums.

If the employees and their dependents enrolled in the HMSA PPO 75/25 medical and prescription drug plan begin using their benefits at higher rates the opposite could occur - premiums received are less than the claims being reimbursed - which would lead to an increase in premiums. This increase could occur in the next plan year beginning July 1, 2018.

Q.3 What services are subject to the in- and out-of-network deductible?

A.3 Services subject to the in- and out-of-network deductible include, but are not limited to:

- Maternity Physician Services
- Emergency Room (ER Care)
- Ambulance
- Inpatient Hospital Services
- Outpatient Services
- Mental Health Services (Inpatient and Outpatient Care)
- Other Services (Durable Medical Equipment, Home Health Care, Nursing Facility – Skilled Care, Physical & Occupational Therapy, etc.)

For complete plan information, please visit the EUTF website at eutf.hawaii.gov, click on the Health Plan Providers box, and select Hawaii Medical Service Association (HMSA), Active Employees, 2017 Guide to Benefits, 75/25 PPO plan.

Q.4 What services are not subject to the deductible?

A.4 Services not subject to the in- and out-of-network deductible include, but are not limited to:

- Primary Care Office Visit (In-Network only)
- Specialist Office Visit (In-Network only)
- Routine Physical Exams
- Screening Mammography
- Immunizations
- Well Baby Care Visits
- Second Opinion – Surgery (In-Network only)

For complete plan information, please visit the EUTF website at eutf.hawaii.gov, click on the Health Plan Providers box, and select Hawaii Medical Service Association (HMSA), Active Employees, 2017 Guide to Benefits, 75/25 PPO plan.

Q.5 How much is the deductible and how does it apply per person vs. a family?

A.5 The deductible is \$300 per person and \$900 per family. The \$300 deductible applies to each person on the plan up to the \$900 family maximum. The \$900 deductible per family does not really apply to a family of 3 (or a two-party plan) since each family member is subject to the \$300 per person deductible. However, for a family of 4 both the \$300 per person and \$900 per family deductibles apply. For example, if the first 3 members of the family meet their \$300 deductible which is \$900 for the family, the 4th member of the family would not be subject to the deductible as the \$900 family deductible has been met for the calendar year.

Q.6 How is the deductible measured?

A.6 The deductible is measured on a calendar year.

If you enroll in the plan with an effective date of 7/1/17, you will be responsible for meeting the \$300 per person/\$900 per family deductible for the six-month period 7/1/17 – 12/31/17 in order for the plan to begin making payments towards applicable services. On January 1, 2018, the deductible will reset for the calendar year 2018 (assuming you continue with the plan 7/1/18) and you will need to meet the \$300 per person/\$900 per family deductible for calendar year 2018 in order for the plan to begin making payments towards applicable services.

Example assuming you continue with the 75/25 plan 7/1/18:

- 7/1/17 – 12/31/17 – single deductible \$300, family deductible \$900
- 1/1/18 – 12/31/18 – single deductible \$300, family deductible \$900

Q.7 I'm enrolled in another HMSA plan. Will the payments I've made towards the out-of-network deductible carry over to my new HMSA plan?

A.7 If you are enrolled in another HMSA plan (with EUTF or another non-EUTF plan) any payments made under the other plan during the same calendar year will be credited towards your new EUTF HMSA plan deductible and maximum out-of-pocket limit.

Q.8 What coinsurance amounts apply and do not apply to the deductible?

A.8 Coinsurance amounts paid by the patient for services subject to the deductible (services under A.3) apply to the deductible. Coinsurance amounts paid by the patient for services that are NOT subject to the deductible (services under A.4) do NOT apply to the deductible.

Q.9 What happens if I experience a catastrophic illness or injury under the HMSA PPO 75/25 plan?

A.9 All EUTF medical plan options contain a maximum out-of-pocket limit (MOOP) for your financial protection in the event of catastrophic illness or injury. The MOOP is the maximum deductible, copayment and coinsurance (i.e. out-of-pocket costs) amounts you are required to pay in a calendar year. Once you meet the plan's MOOP you are no longer responsible for deductible, copayment or coinsurance amounts for the remainder of the calendar year (see some exceptions below).

Amounts that do not apply toward meeting the MOOP include:

- The difference between the actual charge and the eligible charge that you pay when you receive services from an out-of-network provider
- Payments for non-covered services
- Any amounts you owe in addition to your share of covered services

Q.10 How does the MOOP under the HMSA PPO 75/25 plan compare to the other HMSA PPO plans?

A.10

- HMSA PPO 75/25 plan MOOP is \$5,000 per person/\$10,000 per family
- HMSA PPO 80/20 plan MOOP is \$2,500 per person/\$5,000 per family
- HMSA PPO 90/10 plan MOOP is \$2,000 per person/\$4,000 per family

Q.11 Does the HMSA PPO 75/25 plan have a higher or lower coinsurance requirement than the other EUTF HMSA PPO plans?

A.11 The HMSA PPO 75/25 plan has a higher member coinsurance than the other EUTF HMSA PPO plans. This means that you are contributing towards the claim payments at a higher percentage than the other plan participants. As a result, you experience a lower premium.

Q.12 Does the CVS prescription drug plan that is bundled with the HMSA PPO 75/25 plan differ from the other EUTF HMSA PPO and HMO plans?

A.12 The copayments for generic, preferred brand and other brand prescription drugs and the 20% coinsurance (limited to \$250 per prescription) for specialty prescription drugs under the CVS prescription drug plan bundled with the HMSA PPO 75/25 plan (75/25 prescription drug plan) are the same as the CVS prescription drug plan bundled with the other EUTF HMSA PPO and HMO plans. The 75/25 prescription drug actually has a lower MOOP (\$1,850 single/\$3,700 family) and annual specialty maximum of \$1,850 per person, which is a better benefit than the CVS prescription drug plan bundled with the other EUTF HMSA PPO and HMO plans MOOP (\$4,350 single/\$8,700 family) and specialty annual maximum of \$2,000 per person. Specialty coinsurance payments accumulate towards the MOOP.

Q13. Why is the monthly employer contribution lower for the HMSA 75/25 plan compared to the other medical/prescription drug plans?

A13. The premium for the CVS prescription drug plan that is bundled with the HMSA PPO 75/25 plan (75/25 prescription drug plan) is lower than the current employer contribution for prescription drug coverage. The lower rates for the 75/25 HMSA plan results as the actual premium for the 75/25 drug plan is less than 60% of the 2016-2017 actual drug plan premiums.

1. The 2016-2017 prescription drug premiums are \$114.46 single, \$278.10 two party and \$354.36 family
2. 60% of the rates in #1, which equal the employer contribution for 2016-2017, are \$68.68 single, \$166.86 two party and \$212.62
3. The 2017-2018 prescription drug premiums for those employees in the HMSA 75/25 plan are \$53.96 single, \$131.10 two party and \$167.06
4. The difference between #2 and #3 equals the difference in the employer contribution on the rate sheets.