JOHNSTONE'S JOURNAL is published monthly, and designed to provide topical information of interest not only to plan administrators, but to all employees who enjoy coverage under the benefit plan. Feel free to make copies, and use as a payroll stuffer.

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Prescription Drug Claims

Prescription drug cards

Coverage for prescription drugs is the most visible and most often used part of extended health care (EHC) plans, resulting in 60%-80% of claims costs. Most group plans offer comprehensive drug coverage that we don't have through provincial or federal government programs and can't purchase on our own. And submitting your claim for reimbursement is getting even easier now that most plans offer a **Pay Direct Drug Card**—you show your card at the pharmacy and only pay the cost not covered by your EHC plan. Your pharmacist submits your claim electronically and is reimbursed directly by the insurer. Other plans may include a **Deferred Drug Card**—you pay the full cost of the prescription and your pharmacist submits the claim electronically. You're reimbursed either by cheque or direct deposit to your bank account.

Drug card claiming complications

This convenient service usually works smoothly. Until it doesn't. Fortunately, once problems are identified, they're usually easy to fix.

"My pharmacist told me my drug card doesn't work"—out-of-date or incorrect information can be the issue. Claims processing systems rely on accurate name, birth date and relationship codes. Without correct identification, the insurer must decline payment of the claim.

"I'm paying more for my prescription"—This can be caused by changes in the benefit plan. Most plans that include drug cards also limit reimbursement to the lowest-cost generic (see *Journal* March 2012). In addition, insurers often limit the reimbursement of prescriptions to an amount based on a reasonable and customary pricing file (see *Journal* July 2015). These prices will vary by insurer.

"My spouse and dependent children's claims are no longer accepted at the pharmacy"—This may be caused by changes to an insurers records regarding spousal coverage. When both spouses have coverage through their employers' plans, claims may be submitted under both plans but must follow coordination of benefit rules (see *Journal* August 2014). If claims have been submitted in an incorrect order or the spouse's coverage isn't recorded properly, claims may be rejected at the pharmacy and must be submitted manually.

If you have benefits under two plans (COB)

Coordinating benefits between two plans hasn't changed (see *Coordination of Benefits: Who Pays When Both Spouses Have Coverage?* August 2014). However, how COB rules apply to prescription drugs is changing.

The change you may notice is that some insurers are applying reasonable and customary limits to prescription drugs, which hasn't been the case historically.

As with all other claims, when coordinating benefits for the second plan, insurers only pay the outstanding balance between what the primary benefit plan paid and the total amount submitted. However, they may now also limit reimbursement so that both plans only cover up to 100% of their maximum benefit (see *Understanding Your Health and Dental Benefits: Reasonable and Customary Limits*, July 2015).

For example: A member submits a prescription drug claim totalling $100. The primary plan pays $80. The member submits the $20 balance to the secondary plan. The reasonable and customary price is $90. The insurer only pays $10 (the difference between $90 and $80).

Most plan members will only be affected by this change when they have coverage under two plans, and when the cost of the drug is over the insurer's reasonable and customary limit. As benefit (drug) plan costs continue to increase, we will continue to see insurers implement cost containment features and controls as employers pressure them to keep costs down.