Understanding the New World of Health Insurance
Healthcare Consumer Seminar
Fall 2014
Today’s Agenda

1. Introductions

2. Healthcare Today – How did we get here?

3. The Components – Everyday definitions to help you navigate your benefit options

4. Considerations when selecting a plan

5. Examples

6. Q&A
Today’s Presenters

• **Laura Handy-Oldham** is Director of Patient Access at Phoenix Children’s Hospital where she has worked for the past 4 years. She is responsible for the Hospital’s family financial services, pre-registration, benefits, eligibility, authorizations, registration and admitting functions. Ms. Handy-Oldham has more than 20 years of national experience in health care administration, primarily focused on patient revenue cycle operations. She received a Bachelor of Arts in Management from Hood College in Frederick, Maryland, and a Masters of Health Services Administration from the University of Washington in Seattle, Washington.

• **Clara Divis** is Manager of Patient Access at Phoenix Children’s Hospital and is responsible for Family Financial Services, Admitting, Emergency Department and Radiology Registration. Ms. Divis has more than 10 years of experience in the hospital patient access arena. She received her Bachelor of Arts degree in Biological Sciences at San Jose State University and a Master of Business Administration – Health Care Management from the University of Phoenix.
Today Presenters

• **Karen Sanchez** is the Manager of Pre-Access Services at Phoenix Children’s Hospital and has been with PCH for 4 years. Ms. Sanchez has 8 years of experience in healthcare working in geriatric and pediatric environments including the Emergency Department, Registration, Rehab, Infusion and Radiology. She has a bachelors degree in Business Administration.

• **Elizabeth Marquez** is the Lead Family Financial Services Counselor. Ms. Marquez has more than 20 years of experience in healthcare including 5 years with the Department of Economic Security (DES) within the State of Arizona and 8 years at PCH in a Financial Counselor role. She is certified in Family and Human Services Administration.
Today Presenters

- **Maria Gonzalez** is a Family Financial Services Counselor. Ms. Gonzalez has been with PCH in the role of Financial Counselor for 10 years. Previous to that she worked for the State of Arizona AHCCCS program. In addition, she is certified in Medical Billing and Coding.

- **Michael Timmons** is a Family Financial Services Counselor. Mr. Timmons has 20 years of experience with 16 in healthcare in the business office, financial counseling, clinical operations and patient advocacy. He has a Bachelor’s degree in Accounting from SUNY.
Healthcare Today – How Did We Get Here?

% OF INCOME ON SPENT ON HEALTH CARE

INCREASE IN WAGES VS. HEALTH CARE SPENDING

Sources – Office of Social Security Administration and Health Insurance Cost Statistics
The Choluteca Bridge in Honduras
Are we building bridges or preparing for a moving river?
Types of Plans and Coverage

Health insurance is a program or plan that pays for all or part of your medical costs with two primary payer sources.

• **Government Plans** – government programs that pay for medical costs, usually without a monthly premium and little or no out of pocket amount due from the patient.

• **Commercial Plans** – private companies that require you to pay a monthly premium in return for them to pay some of your medical costs.
Government Plans

- **Arizona Health Care Cost Containment System (AHCCCS)** – Arizona’s state Medicaid program. Must be an Arizona resident with a household income less than 147% of the Federal Poverty Level (FPL) for children under 1 year of age, 141% of FPL for children between the ages of 1-5, and 133% for all others to qualify.

- **DES Programs** –
  - **Family Assistance Administration (FAA)** determines Medicaid eligibility for children, families and non-disabled adults under the age of 65.
  - **Comprehensive Medical and Dental Program (CMDP)** is AHCCCS contracted health plan to provide medical services to foster children.
  - **Division of Child Support Enforcement (DCSE)** enforces child and medical support orders.
  - **Disability Determination Services Administration (DDSA)** makes medical determinations of blindness and disability for AHCCCS.
  - **Division of Developmental Disabilities (DDD)** covers persons with developmental disabilities. DDD is ALTCS’ program contractor for all developmentally disabled individuals in AZ.
Government Plans (Cont.)

- **Supplemental Security Income (SSI)** – A Federal income supplement program administered by the Social Security Administration designed to help aged, blind, and disabled low or no income children and adults. SSI beneficiaries can also get medical assistance.

- **Supplemental Security Income Medical Assistance Only (SSI MAO)** – Beneficiaries receive medical coverage through AHCCCS.

- **Arizona Long Term Care Services (ALTCS)** – helps pay long term care and acute care expenses for the elderly, physically disabled, blind and developmentally disabled. Eligibility is based on diagnosis, resources and income for the patient only.

- **Indian Health Services (IHS)** – provides all medical services under AHCCCS for eligible Native Americans.
Commercial Plans

Health Maintenance Organization (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Preferred Provider Organization (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan’s network. You can use doctors, hospitals, and providers outside of the network for an additional cost.
Commercial Plans (Continued)

Exclusive Provider Organization (EPO) Plan - A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan’s network (except in an emergency).

Point of Service (POS) Plans - A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan’s network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

Consumer Directed Health Plan (CDHP) – A type of plan with high deductibles and out of pocket amounts where the insured is encouraged to shop for the best price for their healthcare dollar. Health Savings accounts typically accompany these health plans so the individual can put away money pre-tax to pay their out of pocket amounts.
Credits & Subsidies for Insurance Purchased from the Marketplace

**Premium Credits** – Available to families (US citizens and legal immigrants) with incomes between 100-400% of FPL who purchase the second lowest cost silver plan in the area. Adjusted annually. 2014 Limited to –

- Up to 133% FPL – 2% of income
- 133-150% FPL – 3-4% of income
- 150-200% FPL – 4-6.3% of income
- 200-250% FPL – 6.3-8.05% of income
- 250-300% FPL – 8.05-9.5% of income
- 300-400% FPL – 9.5% of income

**Cost Sharing Subsidies** – Reduce the amount of cost sharing amounts (coinsurance) and annual cost sharing limits (annual out of pocket maximums)

- 100-150% FPL – 94%
- 150-200% FPL – 87%
- 200-250% FPL – 73%
- 250-400% FPL – 70%
Commercial Plans Quiz
Key Components of Coverage

**Deductible** – The amount you owe for health care services before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay for services until you’ve paid $1,000 – meeting your deductible amount. The deductible may not apply to all services.

**Coinsurance** – Your share of the costs of covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s *allowed amount* for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. Your health insurance or plan pays the remainder of the allowed amount - $80. (If you haven’t met any of your deductible and it’s $1000 as in the above example, you will owe the entire $100 and your remaining deductible amount would be $900.)
Key Components of Coverage

**Copay** – A fixed amount (for example, $25) you pay for a covered health care service, usually due when you get the service. The amount can vary by the type of covered health care service, i.e., Urgent Care vs. Office Visit vs. Emergency Room Visit.

**Out of Pocket Maximum/Limit** – The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100% for covered health services. This limit includes deductibles, coinsurance, copays, or similar charges. This limit does not count premiums, balance billing for non-network providers and other out of network cost sharing or spending for “non-essential” health services. The maximum out of pocket cost limit for any individual Marketplace plan for 2014 was no more than $6,350 for an individual plan and $12,700 for a family plan.
Pay Attention To...

In Network/Out of Network (Provider Networks) – Provider networks are the group of providers that an insurance plan has contracted with for a specific plan or group of plans. If the provider is “In Network,” you will have full benefits according to your policy when receiving health care services from that provider. If the provider is “Out of Network,” you will either receive a lower benefit and pay higher out of pocket costs or you will have no benefit, meaning all charges are your responsibility.

Excluded Services – These are services that are specifically not covered by your insurance plan. This will vary by plan but a common exclusion is cosmetic services.

Covered Benefits – Those services that are specifically included in your insurance plan.
Pay Attention To...

**Essential Services** – Under the Affordable Care Act, all health plans must cover 10 essential services defined as Ambulatory Patient Services, Emergency Services, Hospitalization, Maternity and Newborn Care, Mental Health & Substance Use Disorder Services, Prescription Drugs, Rehabilitative and Habilitative Services & Devices, Laboratory Services, Preventive & Wellness Services & Chronic Disease Management, Preventive Services, including Oral & Vision Care (Pediatric can be stand alone).

**Allowed Amount** – The contractually agreed to amount that your insurance plan will pay your provider for health care services rendered. For example, you may have an x-ray and the charge billed to the insurance company is $250. The provider has a contract with the insurance plan, however, to perform that service for $200. The insurance company will pay $200 (minus any deductible and coinsurance owed by you) to the provider. The provider will accept that as payment in full.
Pay Attention To...

**Balance Billing** – When you seek health care services from an out of network provider, your out of network benefits will typically be less than your in network benefits. If you plan will cover part of the cost of the care, the provider may bill you for the remainder of the charges. This is known as balance billing.

**Patient Liability** – This is the amount that you owe for health care services rendered. It may include your copay, deductible, coinsurance, total charges, or balance billing.
Pay Attention to - Final Thoughts

• Did you purchase a plan on the Marketplace last year?
  • You must log in and select a new plan if you want to change plans. Otherwise you will be re-enrolled in the same plan.

• Were you receiving government subsidies based on your income and plan selection?
  • Pay careful attention to new additions to the Marketplace. Subsidies were based on selecting the second lowest Silver plan available. New plans may have entered that are lower cost and therefore make your current plan ineligible for your subsidies.
Key Components Quiz
Considerations When Selecting a Plan

You have a lot to consider when evaluating health insurance plans. It’s better to start with an **understanding of your healthcare needs.**

You’ll be ready to make a more informed decision about your coverage by answering questions about:

- ✓ Your **Budget**
- ✓ Your **Health**
- ✓ Your **Lifestyle**
- ✓ Your **Physician and Provider Relationships**
Considerations When Selecting a Plan

**Your Budget**

- What do you currently pay for insurance each month?

- Do you maintain a savings account to pay for unplanned medical expenses?

- How much did you spend on healthcare last year, including prescriptions?

- Are you eligible to receive financial assistance to lower the cost of health insurance premiums and out-of-pocket medical expenses?
Considerations When Selecting a Plan

Your Family’s Health

• What are the care needs of you and your family members?

• What is the medical history of your family?

• How many times did your family see doctors or specialist last year?

• Do you currently take any prescription medications?
Considerations When Selecting a Plan

Your Life

• Who in your household needs health insurance (you, spouse, kids)?

• Are you between jobs?

• Do you need Long-Term or Short-Term coverage?

• Do you need coverage outside of the state or outside of the country?
Considerations When Selecting a Plan

Your Physician and Provider Relationships

• Is anyone in your family undergoing a current course of treatment that will continue into the next benefit year?

• Do you have an established relationship with your pediatrician and/or other physicians?

• Do you have established relationships with hospitals or are there hospitals that you want to have access to in case of emergency?
## Plan Comparisons

<table>
<thead>
<tr>
<th></th>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
<th>Plan D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium</strong></td>
<td>$341.53</td>
<td>$387.43</td>
<td>$550.58</td>
<td>$609.42</td>
</tr>
<tr>
<td><strong>Plan Type</strong></td>
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<td>HMO</td>
<td>PPO</td>
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<td><strong>Office Visit, Primary</strong></td>
<td>$0 Copay</td>
<td>$40 Copay</td>
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<td>$100 Copay</td>
<td>$100 Copay</td>
<td>$50 Copay</td>
<td>$50 Copay</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>Individual - $5,000</td>
<td>Individual - $5,000</td>
<td>Individual - $2,200</td>
<td>Individual - $1,500</td>
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<tr>
<td><strong>Coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>20%</td>
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<td><strong>Emergency Room</strong></td>
<td>$500 Copay</td>
<td>$800 Copay</td>
<td>$500 Copay</td>
<td>$500 Copay</td>
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<tr>
<td><strong>Hospitalization</strong></td>
<td>$1,000 Copay</td>
<td>$1,400 Copay</td>
<td>$500 Copay</td>
<td>$20% Coinsurance</td>
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<td><strong>Out of Pocket Limit</strong></td>
<td>$6,350</td>
<td>$6,350</td>
<td>$5,500</td>
<td>$5,500</td>
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</tbody>
</table>
Health Care Scenario

Patient has the following services –

• 2 visits to the Primary Care Physician – Charges $750, Allowed Amount $500
• 1 visit with a Specialist – Charges $1,500, Allowed Amount $1,000
• 1 trip to the Emergency Department – Charges $7,500, Allowed Amount $5,000
• 1 Inpatient Hospitalization – Charges $25,000, Allowed Amount $10,000
## Plan Comparisons

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<thead>
<tr>
<th></th>
<th>Plan A</th>
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<td><strong>Premium</strong></td>
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<tr>
<td><strong>Annual Deductible</strong></td>
<td>Individual - $5,000</td>
<td>Individual - $5,000</td>
<td>Individual - $2,200</td>
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<td><strong>Office Visit, Primary</strong></td>
<td>$0 Copay</td>
<td>$80 Copay * 2 = $160</td>
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<td>$1,500</td>
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<td><strong>Office Visit, Specialist</strong></td>
<td>$100 Copay (Allowable - $500)</td>
<td>$100 Copay (Allowable - $500)</td>
<td>$50 Copay (Allowable - $500)</td>
<td>$50 Copay</td>
<td>$1,500</td>
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<td><strong>Emergency Room</strong></td>
<td>$500 Copay (Allowable - $5,000)</td>
<td>$800 Copay (Allowable - $5,000)</td>
<td>$500 Copay (Allowable - $5,000)</td>
<td>$500 Copay</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>Hospitalization</strong></td>
<td>$1,000 Copay</td>
<td>$1,400 Copay</td>
<td>$500 Copay</td>
<td>20% Coinsurance ($950 ded + $1,810 coins)</td>
<td>$25,000</td>
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<tr>
<td><strong>Total Cost of Care</strong></td>
<td>$6,500</td>
<td>$7,060</td>
<td>$3,200</td>
<td>$3,310</td>
<td>$35,500</td>
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<td><strong>Out of Pocket Limit</strong></td>
<td>$6,350</td>
<td>$6,350</td>
<td>$5,500</td>
<td>$5,500</td>
<td>N/A</td>
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<tr>
<td><strong>Total Premium Cost</strong></td>
<td>$4,098.36</td>
<td>$4,649.16</td>
<td>$6,606.96</td>
<td>$7,313.04</td>
<td>$0</td>
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<tr>
<td><strong>Total Out of Pocket</strong></td>
<td>$10,448.36</td>
<td>$10,999.16</td>
<td>$9,806.96</td>
<td>$10,623.04</td>
<td>$35,500</td>
</tr>
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</table>

*Phoenix Children's Hospital*  
*100% For Children*
What if our Patient receives services from a Narrow Network (out of network) provider?

Patient has the following services –

• 2 visits to an in network Primary Care Physician – Charges $750, Allowed Amount $500
• 1 visit with an out of network Specialist – Charges $1,500, Allowed Amount $1,000
• 1 trip to an in network Emergency Department – Charges $7,500, Allowed Amount $5,000
• 1 stay at an out of network Hospital – Charges $25,000, Allowed Amount $10,000
# Plan Comparisons

<table>
<thead>
<tr>
<th></th>
<th>Plan A - HMO</th>
<th>Plan B - HMO</th>
<th>Plan C - HMO</th>
<th>Plan D - PPO</th>
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<td><strong>Office Visit, Specialist</strong></td>
<td>$100 Copay</td>
<td>$100 Copay</td>
<td>$50 Copay</td>
<td>$50 Copay</td>
<td>$1,500</td>
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<td></td>
<td>Charges - $1,500</td>
<td>Charges - $1,500</td>
<td>Charges - $1,500</td>
<td>$20% OON Coinsurance - $300</td>
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</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$500 Copay</td>
<td>$800 Copay</td>
<td>$500 Copay, Allowable - $5,000</td>
<td>$500 Copay Allowable - $5,000</td>
<td>$7,500</td>
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<tr>
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<td>Allowable - $5,000</td>
<td>$5,000</td>
<td>Amt due - $2,200 + $500</td>
<td>Amt due - $1,500 + $500</td>
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<td>$500 Copay</td>
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<td>$25,000</td>
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<tr>
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<td>Charges - $25,000</td>
<td>Charges - $25,000</td>
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<tr>
<td><strong>Total Cost of Care</strong></td>
<td>$31,500</td>
<td>$31,660</td>
<td>$29,200</td>
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<td>$35,500</td>
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<td><strong>Out of Pocket Limit</strong></td>
<td>$6,350 – n/a</td>
<td>$6,350 – n/a</td>
<td>$5,500 – n/a</td>
<td>$5,500 – n/a</td>
<td>N/A</td>
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<td>$0</td>
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<tr>
<td><strong>Total Out of Pocket</strong></td>
<td>$35,598.36 (was $10,098.36)</td>
<td>$36,309.16 (was $10,999.16)</td>
<td>$35,806.96 (was $9,306.96)</td>
<td>$14,613.04 (was $10,623.04)</td>
<td>$35,500</td>
</tr>
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*Phoenix Children's Hospital*

100% For Children
Family Financial Services

- Family Financial Services is a service of Phoenix Children’s Hospital that coordinates with parents and the Hospital care team to ensure that families have a full understanding of what services are covered under their health care plan, in addition to providing guidance on options for obtaining coverage.

- Members of the Family Financial Services team are certified applications counselors for the health care Marketplace. They are able to aid families in the complicated process of researching health care coverage on the Marketplace and can demystify coverage, whether it comes from the Marketplace, an employer, or the government.
THANK YOU