Healthcare Navigation, LLC

Health Insurance Basics

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Introduction

Healthcare coverage is a vital financial protection, but many people remain fairly uninformed about common terms, how health insurance works, and the coverage they have.

Understanding your coverage can help you get the most value from it and minimize your risk of receiving medical bills you didn't expect.

Not understanding your healthcare coverage can be very, very costly.

Thanks for joining us. Let's get started.

Terms and Definitions

In order to understand health Insurance, you must understand basic healthcare terms and definitions.

Benefits

- Benefits are the services your health insurance covers.

- This sounds deceptively simple. All coverage includes a hospital benefit but if you go to a hospital not in your network or don’t obtain prior authorization, you might not get the full value from that benefit.

- The Affordable Care Act (ACA), also known as Obamacare, mandated ten essential benefits.

Federally Mandated Essential Health Benefits

- Ambulatory Services
- Emergency Services
- Hospitalization
- Pregnancy, Maternity, and newborn care
- Mental health and substance use disorder services
- Prescription medications
- Rehabilitative services
- Lab work
- Preventive and Wellness Services
- Pediatrics services, including oral and vision care

Exclusions

An exclusion is the opposite of a benefit. An exclusion is what your plan will not cover. A major ACA change was not allowing pre-existing condition exclusions. Eliminating pre-existing conditions exclusions means the ten essential benefits must be covered for anyone on an ACA-compliant plan regardless of their health.

Some common exclusions include:

- Acupuncture
- Massage
- Procedures considered “experimental”
- Medications being used for off-brand purposes

Common Product Types

•**HMO**: Health Maintenance Organization: a limited network often requiring referral to a specialist. No out-of-network benefits.

•**EPO:** Exclusive Provider Organization: a limited network which may not require referral to a specialist. No out-of-network benefits.

•**PPO**: Preferred Provider Organization: typically includes out-of-network coverage with no referral requirement.

•**POS**: Point of Service Plan: typically includes out-of-network coverage with no referral requirement.

•**HDHP:** High Deductible Health Plan. Tax-free savings account.

Rules

HMOs and EPOs typically include more rules such as the following:

•**PCP:** A plan may require you to have a primary care physician on record.

•**Referral:** A plan may require your PCP to issue a referral to see a specialist.

•**Prior authorization or precertification**: The rules associated with advance approval of a procedure, hospitalization or prescription drug.

In-Network Benefits

The doctors, hospitals and other providers that contract with your Plan.

Using network providers is always advisable if maximizing financial protection (minimizing surprise bills) is important to you. In-network providers are responsible for obtaining prior-authorization for tests and hospitalizations.

Some Plans have regional networks, others have national networks.

In-network providers submit claims to the insurer on your behalf. To determine who is in your network, create an on-line account with your insurer and search **by product.** You can also call your insurer and request a list of in-network providers by specialization. Verify the information from the insurer when making your appointment.

Out-of-Network Benefits

A benefit which allows for partial payment of services if the provider is not in-network/does not have a contract with your Plan.

You assume more financial risk when you use out-of-network providers because the insurer pays according to its fee schedule and charges may be high compared to that fee schedule.

You are responsible for paying the excess out-of-network providers charge that is disallowed by the insurer.

It is often your responsibility to submit claims for reimbursement for out-of-network benefits because the provider is not obligated to do so.

Deductibles, Coinsurance and Copayments

The amounts you pay for covered services that your insurance company does not. Also called “cost-share.”

Deductible: an annual amount you pay before the insurer pays.

Coinsurance: an amount expressed as a percentage that you and your insurer share after meeting the deductible.

Copayment: a fixed payment you owe for a given service. Depending on plan, can be before or after deductible (or both)! Generally co-pays only apply for in-network services.

In-Network Vs. Out-of-Network Example*

In-Network Surgeon	Out-Of-Network Surgeon
Billed Charges: $10,000	Billed Charges: $10,000
Contracted/Negotiated Amount: $3,000	Allowed Amount: $3,000
20% Coinsurance: $600	50% Coinsurance: $1,500
Plan Pays: $2,400	Plan Pays: $1,500
You Owe: $600	You Owe: $8,500

*this example assumes in-network and out-of-network deductibles have been met

Out-of-Pocket Maximum

Is the threshold at which your plan pays 100% of in-network claims for the remainder of the benefit period. The amount includes deductibles, coinsurance and copayments but not your premiums or contribution toward premiums. There can be both an in-network and out-of-network OOP maximum. It is very difficult to reach an out-of-network OOP maximum.

Claims, EOB's, and Bills

Claims

A claim is submitted to an insurer for payment after covered services are provided.

EOB's

An explanation of benefits statement (EOB) is sent by the insurer to the medical provider and the patient/subscriber indicating how a claim was processed and the patient's versus the insurer's responsibility.

Bills

Only a provider issues a medical bill. An in-network provider submits a claim to the insurer before billing the patient. An out-of-network provider may ask the patient for payment at time of service. The patient may have to submit the claim to the insurer for out-of-network services.

Appeals or Grievance Process

The way an individual formally pursues a disagreement or dispute related to their coverage. You should determine the deadlines associated with initiating written disputes, confirm where the correspondence should be forwarded, know the number of dispute stages and track anything mailed, faxed or scanned.

The burden is on the consumer and/or patient in filing an appeal or grievance so it is your responsibility to understand your rights. Some insurers require mediation to resolve disputes.

Fully Insured vs. Self Insured Plan

Whether you are on a fully insured or self-insured plan is not apparent from an identification card.

Many insurers offer both fully insured products and self-insured plan services called “administrative services only.”

An important difference between a fully-Insured and self-Insured Plan is the appeals and grievance process.

Fully Insured Plan

An insurance product for which the insurance company is at risk for claims expense for those who are covered. All individual coverage and most small group coverage is fully insured and regulated by a State Insurance Department.

Fully insured plan coverage often includes an appeal to the State Insurance Department as the final stage in a dispute. Other insurers require a mediation process to resolve disputes.

Self-Insured Plan

An insurance product for which the employer pays the cost of claims to a specified level. These plans are typically offered by large employers who are paying an insurance company to process claims on the employer's behalf.

If you have this type of plan your appeals process is not likely to include an appeal to the State Insurance Department because self-insured plans are regulated under federal rather than state rules.

The Benefits staff in Human Resources can often be helpful in understanding your rights in a dispute. How to pursue a dispute should also be available on the on-line account you create on your insurer's web site to access benefit, claim and other information.

Avoiding a Dispute

Sometimes disputes are unavoidable. Ways to avoid common disputes include:

- **Use in-network medical services**
- **Confirm prior authorization has been obtained for any required procedure or hospitalization**
- **Confirm your plan will cover an outpatient procedure at a hospital (if referred) rather than a freestanding facility**
- **If you receive emergency services, notify your insurer as soon as possible**
- **If you don’t believe your situation is an emergency, consider going to urgent care**

Group Coverage Through an Employer

- **Subsidized by employer**
- **Options selected by employer**
- **More likely to have more generous benefits and broad network**
- **Can lull those who have it into believing most coverage is similar**
- **Loss of coverage triggers either federal or state COBRA (temporary extension of group coverage at individual's expense) depending on size of employer**

Individual Insurance

- **Can be subsidized through the ACA or paid for by an individual.**

- **Obamacare has transformed markets and products in many states to HMO products with narrow networks.**

Products with broad networks some would choose to buy are often not available because subsidized population is higher priority (for now) for insurer.

- **Those eligible for a premium subsidy must obtain coverage through healthcare.gov or through their state exchange.**

- **Those not eligible for a premium subsidy may purchase coverage directly through an insurer where that's an option.**

Ways to Lose Your Coverage

Employer – Based Coverage

- Reduction of hours
- Leaving a Job or Retiring
- COBRA ending
- Divorce from Employee Employer closing

Individual Coverage

- Moving out of Service Area
- Turning 65
- Income Change (Exchange Plans)
- Insurer discontinues product or
- stops selling product
- Failure to pay your premium

Both Job Based and Individual Coverage

- Turning 26 and aging off
- Death of Policyholder

Navigating Loss of Coverage

Anyone losing “minimum essential coverage” has a 60 day window to elect coverage in the individual market. This is referred to as a Special Enrollment due to a Qualifying Event.

When losing group coverage, a choice between COBRA and options in the individual market should be evaluated. Know how long you are entitled to the COBRA which varies by whether it is state or federal and whether you are the worker or a dependent losing coverage.

Look at more than just the difference in premiums. It is important to evaluate the network and out of pocket cost differences!

Dealing with Loss of Coverage, continued

- When buying individual coverage due to a Qualifying Event, one must have proof of loss of coverage (ie, COBRA offer letter; COBRA exhaustion letter).

- Coverage can be purchased through a state-based or federal exchange, the insurer's web site or a broker. If eligible for a premium subsidy, coverage must be purchased through an exchange. Find your state's info on healthcare.gov.

- You can change coverage in the individual market every year during open enrollment which begins November 1st for coverage beginning January 1st. Always verify the open enrollment deadline because it can vary from year to year and state to state.

- Important: Losing your individual coverage due to non-payment of premium does not entitle you to a special enrollment!!

THANK YOU