Let’s Ask 4?¡s

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4 Questions for Every Consumer and Provider About Health Insurance . . .

1. What are my choices for health insurance?
2. How do I get it?
3. How do I use it?
4. How much will it cost me?
Health Insurance: How Do I Use It?
How to Use My Insurance
There is no fine print anymore!

The more you know about your plan, the better you can use it!

Understand what is in your Summary of Benefits and Coverage and what is on the front and back of your insurance card...
Using Insurance Can Be Confusing . . .

Think about using health insurance like navigating through public transport!!!
The Insurance Card
Your ticket to ride . . .

Sample Front

ID: A1234 5678Z
NAME: Jane A. Doe
Health Plan (0000) 987654
GRP: 1010-89898-TZX

PCP: Dr. John Smith
PCP Telephone: (404)123-4567

DirectPPO

Hospital Admissions Require Prior Approval

Sample Back

www.yourInsuranceCompanyName.com

In Network Deductible/coinsurance: $600/10%
OON Deductible/coinsurance: $1500/20%

Your insurance company may list general information regarding your health plan. It can direct you to other resources to answer your questions.

MEMBER SERVICES:
1-800-XXX-XXXX

PROVIDERS CALL:
1-800-XXX-XXXX

Your ticket to ride . . .
Your insurance card is your ticket to health care
Your insurance plan sets the fare rules

Your plan type determines . . .

Where you can get health care
Which providers you can see
How much it will cost you

FFS
Preferred Provider Organization
Fee-For-Service Plan

HRA
Health Reimbursement Account

HSA
Health Savings Account

HMO
Health Maintenance Organization

PPO
Point of Service Plan

POS
Preferred Provider Organization

FSA
Flexible Spending Accounts
What Kind of Ticket Do I Have?

HMO
Health Maintenance Organization (i.e. Managed Care)
- Uses a NETWORK of providers
- Must see in-network providers
- You must have a PCP
- PCP refers you to specialty services

PPO
Preferred Provider Organization
- Uses a NETWORK of providers
- Can see any provider you want, but costs you more if out-of-network
- Must file your own claims if you go out-of-network

POS
Point of Service Plan
- Uses a NETWORK of providers
- Combines a PPO with an HMO
- You will have a PCP but PCP not needed for referrals
- Costs more to see providers out-of-network

Provider Network
Providers & hospitals agree with an insurance company to see all members of a plan at discounted rates

Out of Network
I can see any doctor “in-network” but will have to pay extra if I go out of network
**Consumer Directed Health Plans** are medical savings accounts with tax benefits you can use to pay your medical costs.

**HSA**
- Health Savings Account
- Medical bank account that must be combined with a high deductible insurance plan
- Money in HSA rolls over each year

**HRA/FSA**
- Health Reimbursement Account or Flexible Spending Account
- Tied to employer-sponsored insurance plans
- May have a “use it or lose it” provision
- Has different tax advantages depending on your plan

If an unexpected serious medical event happens, I’m covered. In the meantime, I’ll use my HSA to pay for medical costs.
Moving Through the Health Care System

- Primary Care Provider
- Specialty Services
- Health Care Settings
- Preventive Care and Disease Management
- Coverage Benefits

- Preventive Care and Disease Management
Stop #1

General Boarding Rules for your PCP

1. Everybody needs one
2. Main place for care, especially prevention & screening
3. Most plans cover one free PCP annual visit
4. Ask your PCP if they take your insurance plan
5. Ask your insurance company to help you find a PCP if you don’t have one

Not all providers accept Medicaid, most accept Medicare

Veterans will be assigned a VA PCP close to where they live

Your PCP is main point of contact and also makes your referrals

Your PCP is important but isn’t required for referrals
Stop #2

My doctor says it’s time for a colonoscopy. I should contact my insurance company or doctor’s office and ask them the following...

Examples of specialty services include laboratory testing, imaging, surgeries and procedures.

MY CHECK LIST

- Do I need a referral from my PCP?
- Will I have to pay out of pocket?
- Is the specialty provider or service in-network and covered by my insurance plan?
- Do I need prior approval from my insurance?
Different health care settings provide different types of care at different costs.

Rules for Health Care Settings

1. Your insurance plan may not cover your care at every health care setting.
2. Know the best place to get the care you need.
3. Check your insurance plan for all the details.
Where Else Can I Get Care?

EMERGENCY ROOM
- Best place for true medical emergency. Consider alternatives for routine or non-urgent care
- You can always receive ER care regardless of your insurance plan
- If medical condition can be treated elsewhere, it will cost you more to be seen in ER

PUBLIC HEALTH DPT
- Provides immunizations & infectious disease screening and treatment (ex. TB, HIV)
- Primary care centers for underserved areas

PUBLIC HEALTH DPT
COMMUNITY HEALTH CENTERS

URGENT CARE CENTERS
- Provides extended-hour access for acute illness and injury care
- Alternative if you can’t get appointment with your PCP
- Check to see if your insurance covers UCC’s
- UCC’s are not equivalent to ER’s

RETAIL CLINICS
- Staffed mostly by nurse practitioners, physician assistants
- Provide simple acute and preventive care using medical protocols
- Have extended hours
Coverage Benefits

My additional Benefits

- Mental Health Benefits
- Vision Services
- Dental Services
- Long Term care / Hospice benefits
- Prescription drug coverage
- Non-physician services (ex. Physical therapy / occupational therapy)
- Medical Equipment (ex. diabetic shoes wheelchairs, walkers, home oxygen)
- Non-allopathic services (ex. Chiropractic)

Find out what additional benefits are covered by your insurance plan beyond the basics!!

I wonder if Medicare covers my oxygen & the physical therapy my doctor recommended for me . . .
I have lots of medicines I’m supposed to take. Some are more expensive than others & some have names that aren’t the same as what my doctor said. What do I need to know?

Ask your doctor to prescribe medicines that will help you & cost you the least amount of money.

Rules for prescription drugs . . .

1. Know what a drug formulary is
2. Understand how the drug tiers of your insurance plan affect how much you pay
3. Know that generics will always be cheaper than brand name
4. Call your pharmacy to ask how much a drug will cost you
5. You may have a separate insurance card for prescription drugs. Keep it with you.
A **drug formulary** is the list of prescription drugs your insurance plan wants you to use.

**Drug formularies** change regularly.
- Formularies differ by insurance.
- Formularies differ in how many classes and types of medicines are provided.
- Insurance companies often use an outside pharmacy benefits manager to provide prescription drugs.

**Drug tiers** are a way to group drugs on your formulary by cost to you.
- Each tier has a different out-of-pocket cost.

<table>
<thead>
<tr>
<th>TIERED, PREFFERRED FORMULARIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classification</td>
</tr>
<tr>
<td>TIER 1</td>
</tr>
<tr>
<td>TIER 2</td>
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<tr>
<td>TIER 3</td>
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</tbody>
</table>

**Special Considerations**
- You may need **prior-authorization**, require **step-therapy**, or have **quantity limits** on your prescriptions.
- Prior authorization is usually required for non-formulary drugs, costly or over-utilized drugs, and drugs with safety concerns.
- Step therapy – drug is covered only if first-line therapy fails.
- Quantity limit drugs – eligible for limited quantity unless pre-approved by insurance plan.
Most insurance plans now offer many Preventive Care services without cost-sharing or deductibles.

1. Ask your provider which screening, vaccination, & counseling preventive services are right for you & your kids.
2. You will not pay cost-sharing or deductibles if you see an in-network provider.

Find out what Wellness Programs and Chronic Disease Management services you can use to help you get and stay healthy.

1. Your insurance plan may provide programs and coordinate services to help you manage long-standing medical issues.
2. Examples include weight loss programs, smoking cessation classes, or diabetes or high blood pressure management.
3. You may be rewarded for signing up for wellness programs.
All insurance plans are now required to give you a **Summary of Benefits and Coverage** that explains your benefits in plain language.

The SBC must include:
- A glossary of health coverage and medical terms
- Your cost-sharing requirements
- Examples illustrating common benefits
- Be no more than 4 pages long
- Link to where the actual coverage policy can be found

Also read the **Enrollment Packet** that you receive when you sign up!
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your cost if you use an In Network Provider</th>
<th>Your cost if you use an Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home health care</td>
<td>20% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 30 visits. Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 24 visits combined for PT/OT and chiropractic care up to an Aetna maximum payment of $25 per visit for chiropractic care. Speech therapy is covered only under home health and skilled nursing.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to 30 days. Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% co-insurance</td>
<td>50% co-insurance</td>
<td>Coverage is limited to $2,000 annual maximum.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% co-insurance</td>
<td>50% co-insurance</td>
<td>Precertification required for out-of-network care. Benefits will be reduced by $400 per occurrence if precertification is not obtained.</td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>$25 copay per visit, deductible waived</td>
<td>Not covered</td>
<td>Coverage is limited to one exam per 12 months.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>No charge, deductible waived</td>
<td>Not covered</td>
<td>Coverage is limited to $100 reimbursement maximum per 24 months.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
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Resources

www.consumerreports.org/SBCinfo
Let’s Ask 4 Project Team

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