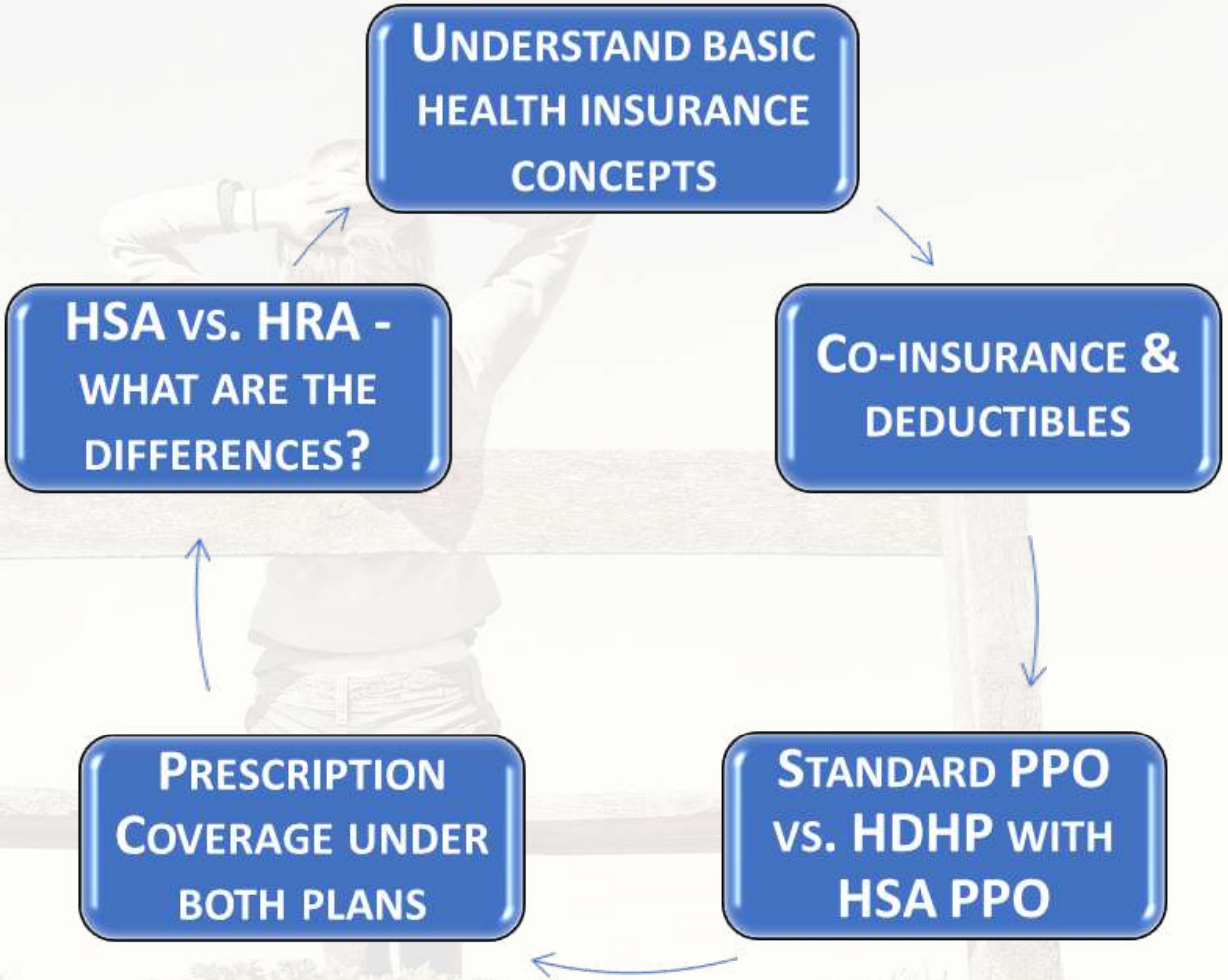
Benefits 101: Benefit Basics

Presented by Winton-Ireland, Strom & Green Insurance Agency

Open Enrollment Education



KNOW YOUR BENEFITS.

What is Health Insurance?

- Health insurance is a financial arrangement that helps to protect you from high healthcare costs
- Health insurance works by spreading the cost of care among a group of people so insurance paid by one person helps pay for the care of others
  - Pooling of risk
- In addition to spreading financial risk, health insurance has another important function: improving access to health care services

UNDERSTAND BASIC HEALTH INSURANCE CONCEPTS

KNOW YOUR BENEFITS.

Types of Health Insurance

- Group health insurance
  - Employer-based plans
  - Discounted coverage for a large pool of mostly healthy people
  - Costs of premiums can be split by the employer and employee
- Individual health insurance
  - Covers an individual person or family
  - Paid for entirely by the purchaser
    - State “exchanges” may provide advance premium tax credits
  - Premiums typically vary by the age of the purchaser(s)
  - Generally have fewer benefits and much smaller provider networks than group insurance
- Government-sponsored health insurance
  - Health insurance obtained through a government agency or program
  - Usually requires a “qualification”
    - Medicare: elderly or serious health condition
    - Medicaid: low-income, children
    - TriCare/VA: active service member, retired military, Peace Corps volunteer
  - Costs are split between the government and the insured

KNOW YOUR BENEFITS.

UNDERSTAND BASIC HEALTH INSURANCE CONCEPTS

Benefits Insurance Terminology

The world of health insurance has many terms that can be confusing.

Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you can make sense of the terminology.

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UNDERSTAND BASIC HEALTH INSURANCE CONCEPTS

Key Players…

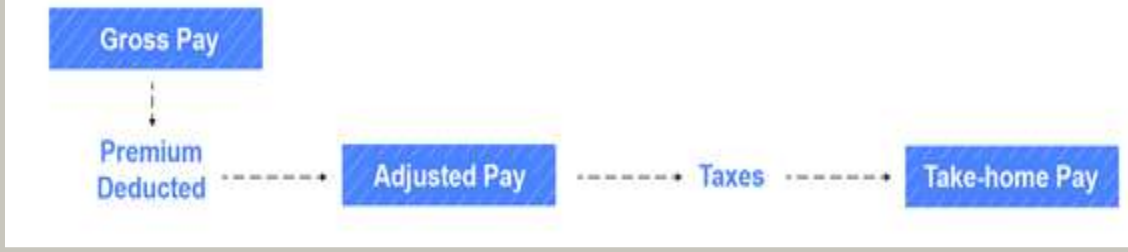
- ***Provider***
  - The clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy that provides medical services.
- ***Third Party Administrator (TPA)***
  - The service provider that processes day-to-day transactions for the plan
- ***Policyholder (City of Turlock)***
  - The individual or entity that has entered into a contractual relationship with the insurance company
- ***Insured (aka eligible employee)***
  - The person with the health insurance coverage

Premiums & Rates

- Amount of money charged to have coverage
  - Carrier/insurer sets the rates
  - Employer or plan sponsor sets the contribution
- Employers determine how much of the premium employees must pay (usually paid pre-tax)
  - City of Turlock plan requires no premium participation by the employee at this time

Premium Example

Mary has group insurance & pays pre-tax premiums. Every pay period, her share of the health insurance premium is deducted from her paycheck before taxes are calculated to cover the cost of her health insurance contribution.



Copayment

- A copayment, or co-pay, is a fixed amount you pay for a covered healthcare service, typically a flat dollar amount due at the time of service.
- The amount can vary by the type of covered health care service.

Copayment Example

Sally takes her son to the pediatrician for a bad cough. She has a $20 copay at the doctor's office.

Cost of visit:	**$125**
Sally pays:	**$20**
Health plan pays:	**$105**

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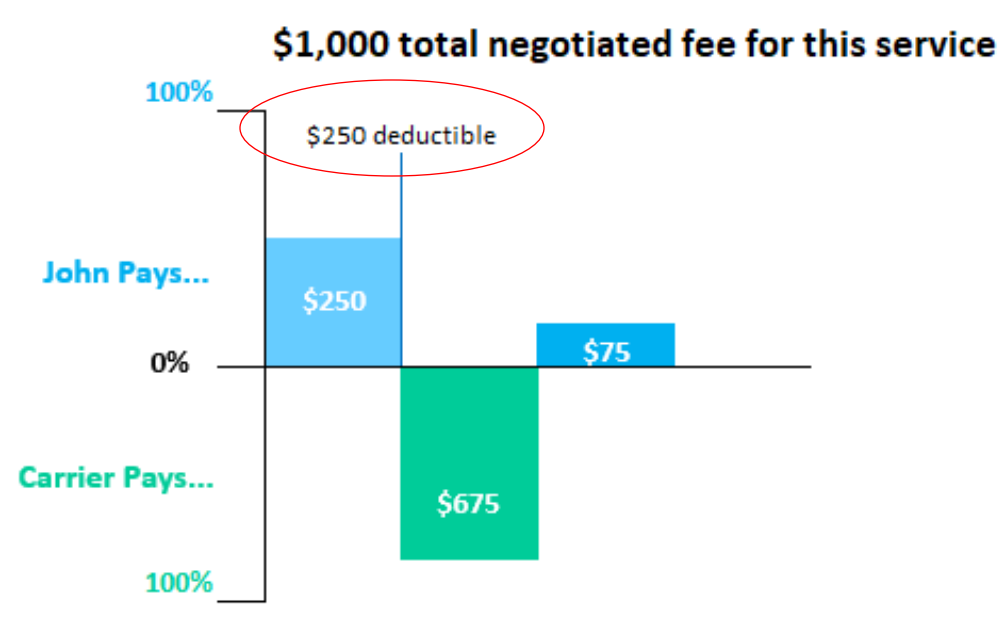
CO-INSURANCE & DEDUCTIBLES

Deductible

- The amount you owe for health care services each plan year before the insurance company or Plan begins to pay anything.

Deductible Example

John has a health plan with a $250 annual deductible.
John falls off his roof & has to have a multiple surgeries and services, the first is $1,000 negotiated fee in the network. Because John hasn't paid anything toward his deductible yet this year, John is responsible for the deductible first, then the plan pays after this is met.



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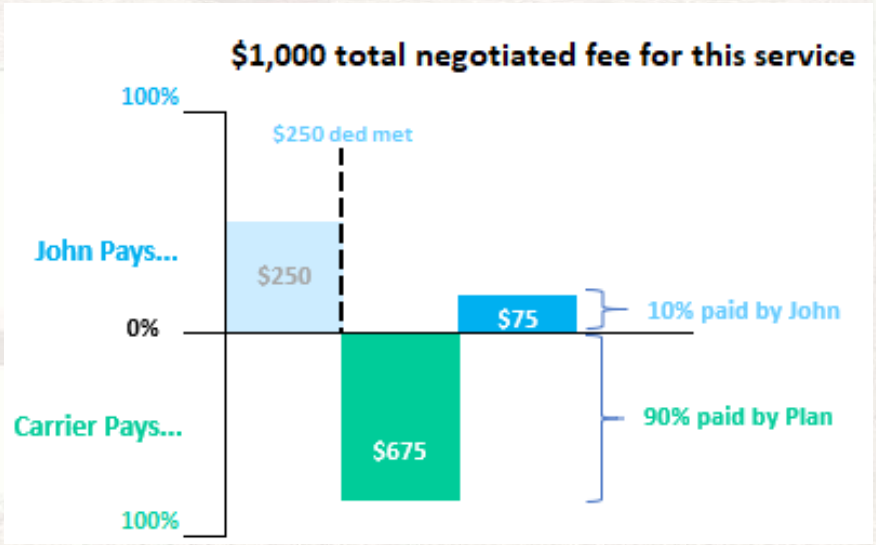
CO-INSURANCE & DEDUCTIBLES

Coinsurance

- Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service while in network.

Coinsurance Example

Continuing the prior example, John's $250 deductible is now met. After the deductible is met for the plan year, John is responsible for his co-insurance for this charge. The plan will cover 90% of the remaining cost, a total of $675. John will still be responsible for 10%, or $75, of the remaining cost. The total John must pay for this service in *co-insurance* is $75, in addition to the deductible of $250.



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CO-INSURANCE & DEDUCTIBLES

Out-of-pocket maximum (OOPM)

- OOPM = most you pay for your healthcare during one plan year, excluding any monthly contributions.
  - This protects you from very high medical expenses.
- After you reach the annual OOPM, your health plan begins to pay 100% of the allowed amount for covered healthcare services for the remainder of the plan year
  - July 1st thru June 30th accumulation.
- OOPM accumulates differently in vs. out-of-network.
  - OOPM accumulators are separate in- vs. out-of-network
  - OOPM out-of-network does not include charges that are above the usual, customary, and reasonable charges, as there are no provider contractual write-offs.

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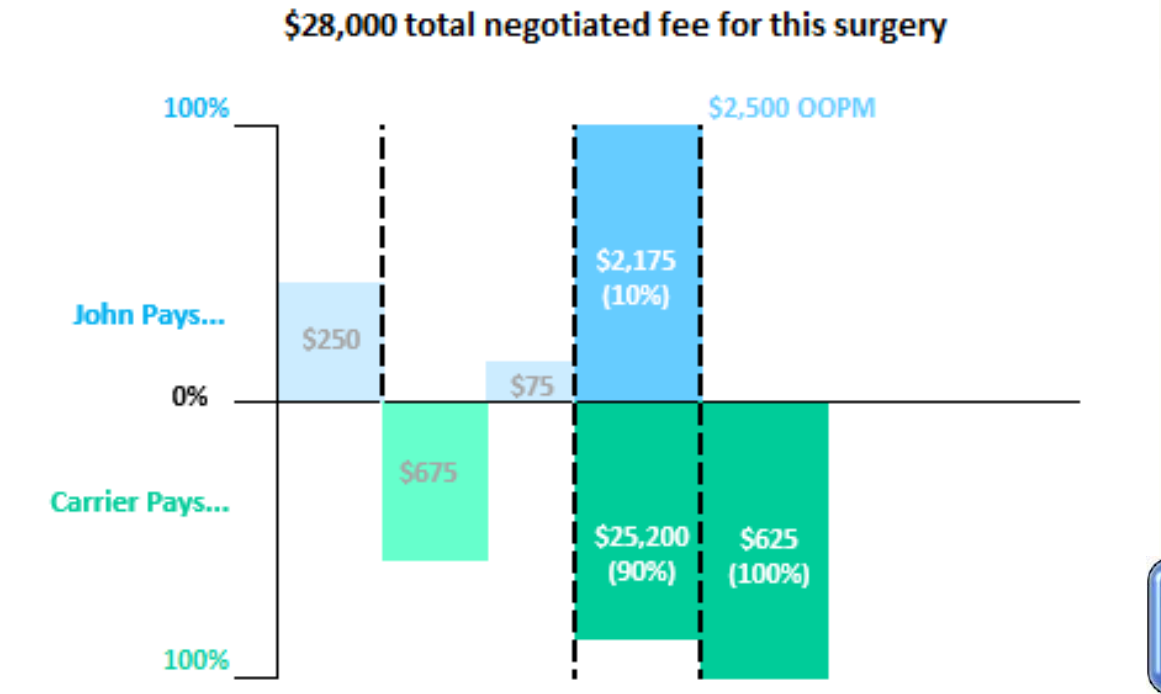
CO-INSURANCE & DEDUCTIBLES

Out-of-pocket maximum example

John's next service occurs in the same plan year as his first two and costs a total of $28,000. John has already met his deductible, so he only needs to pay the coinsurance on this surgery, up to the plan's $2,500 OOPM (per person). Because John has already spent $325 towards his OOPM on the previous healthcare services this year, he only needs to spend $2,175 before he hits his OOPM for the plan year. Once he hits the OOPM, his plan covers the remaining costs at 100%. Therefore, John's coinsurance total for this service is $2,175—the 10% coinsurance cost, up to the $2,500 maximum—and his plan will pay the remaining $25,825 (on the chart, this is shown as $25,200 before the OOPM, plus $625 after John hits his OOPM).



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CO-INSURANCE & DEDUCTIBLES

Balance Billing

- Also called “Surprise Medical Billing”
- Balance billing happens when someone uses a non-PPO provider for a covered service
  - No provider contract in place to protect the consumer from this practice.
  - Gives providers incentives to billing exorbitant fees.
  - Remember the Plan will pay out of network no more than in-network providers.
  - Each patient is responsible to check their provider’s network status.

Two very different scenarios if this happens.

1. Voluntary: if you voluntarily use an out of network, it is the patient responsibility to work with this provider.
2. Involuntary: if you are using an in-network provider for a service (example: surgery), and the facility uses an out-of-network provider for an ancillary service (example: anesthesiology), you have no control over who the provider is, ***we can help***.
   1. UMR should process through the Plan as in-network. Check your explanation of benefits (EOB) for details on how it’s processed.
   2. The provider may bill you – or not. If they do, contact HR or Winton-Ireland for assistance.

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Preventive Care

- "Preventive care" refers to measures taken to prevent chronic illnesses
  - Aims to keep people healthy and catch illnesses in their earliest, most treatable stages
  - Medical tests, immunizations, screening tests, preventive medications and any other services that would prevent disease
- ACA requirement: non-grandfathered health insurance policies must provide coverage for certain preventive services and not charge any copayments, deductibles, or coinsurance to patients receiving preventive care.
  - Prior to 7/1/2020, only scheduled services were covered due to grandfathered health plan status
- Both traditional PPO and HDHP with HSA include preventive care with no cost share

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CO-INSURANCE & DEDUCTIBLES

Preventive Care Example

Mary schedules an appointment with her in-network health care provider for an annual physical and bi-annual mammogram. Because Mary is eligible for these preventive services under the ACA's preventive care coverage guidelines, the total cost of the visit is covered by her health insurance.

Cost of Physical	**$200**
Cost of Mammogram	**$200**
Mary Pays	**$0**
Health Plan Pays	**$400**

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CO-INSURANCE & DEDUCTIBLES

General Plan Setup
Traditional PPO vs. HDHP with HSA

Traditional PPO

- UHC Select Plus PPO (same as current) with Sutter excluded
- Traditional PPO modeled after prior COT plan
- Lower deductible and out of pocket maximum than the HDHP
- Can be paired with a flexible spending account (but not HSA-compatible)

HDHP with HSA option

- UHC Select Plus PPO (same as current) with Sutter excluded
- Follows IRS rules for plan setup (minimums and maximums defined by IRS, not COT)
- No first dollar coverage other than preventive care benefits (deductible applies to all other services)
- Aggregate deductible rules apply

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STANDARD PPO VS. HDHP WITH HSA PPO

Health Savings Account (HSA) Eligibility

- Anyone can enroll in the high deductible health plan (HDHP). This is the underlying health plan.
- The HSA is a bank account, a “mechanism” to pay a bill.
- HSA setup follows IRS rules.
- In order to set up an account, you must:
  - Enroll in a qualified high deductible health plan (HDHP) through the City of Turlock.
  - Have no other health insurance coverage.
    - This includes any other group coverage that is not a HDHP-HSA plan, an individual plan, Medicare (including part A), Tricare, or any plan providing “first dollar coverage” (with copays/services not applied to a deductible).
  - You cannot be claimed as a dependent on someone else’s tax return.
  - The underlying medical plan must meet minimum/maximum deductible and out of pocket limits set by the IRS. IRS increases these policy limits periodically due to inflation & therefore these changes will happen automatically per IRS rules (tax year).
  - 2020-21 minimum deductibles: $1,400 single enrollee or $2,800 aggregate family
    - Family is defined as having 2 or more members on the same contract.

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STANDARD PPO VS. HDHP WITH HSA PPO

Prescription Drugs
Traditional PPO vs. HDHP with HSA

Traditional PPO

- Same copays as prior COT plan
  - $10 copay generic
  - $25 copay preferred brand
  - $40 copay non-preferred brand
  - Specialty copays apply & will be $25/$40, depending on tier
- Adding preventive care benefits per ACA guidelines
  - Women's health initiative (i.e. birth control)

HDHP with HSA option

- Prescription drugs are covered after plan year deductible applied (no first dollar copays per IRS):
  - $10 copay generic
  - $25 copay preferred brand
  - $40 copay non-preferred brand
  - Specialty copays apply
- Adding preventive care benefits per ACA guidelines
  - Women's health initiative (i.e. birth control)

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PRESCRIPTION COVERAGE UNDER BOTH PLANS

Drug example = Lyrica
Traditional PPO vs. HDHP with HSA

Traditional PPO

- Lyrica is a brand drug
  - Preferred brand drug
  - Flat $25 copay due at the time of service
  - Balance is paid by the Plan.
- Normal pharmacy network applies.

HDHP with HSA option

- Lyrica retail cost is approximately $375 (varies by pharmacy)
- Optum Rx negotiated cost is approximately $92
  - If you have not met your plan year deductible, you pay $92 and this is applied to your deductible
  - If you have met your deductible, you pay $25
- Normal pharmacy network applies

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PRESCRIPTION COVERAGE UNDER BOTH PLANS

FSA vs. HSA: which one can I have?

Health Savings Account: HSA
Flexible Spending Account: FSA

- Both are part of the IRS code and reimburse the same expenses
  - §213(d) expenses are eligible to reimburse under either an FSA or HSA account
- Both are tax-advantaged accounts
  - Both are Federal tax-free accounts
  - California state law still taxes HSA contributions as income
- IRS limits how much money you can set aside in either account
  - Annual limits change periodically for inflation
- Cannot have both accounts per IRS rules
  - If you are enrolled on the Traditional PPO Plan, you can enroll and have an FSA account.
  - If you are enrolled on the HDHP PPO Plan, you can enroll and have an HSA account.
- Dependent daycare FSA can be used for either plan, as this is a separate type of FSA account.

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HSA vs. FSA - WHAT ARE THE DIFFERENCES?

Basic Concepts
FSA vs. HSA

Flexible Spending Account

- Enroll in Traditional PPO.
- Can also have an FSA if you waive COT coverage and have your spouse's employer PPO plan (non-HSA).
- Reimburse any 213(d) expense.
- "Use it or lose it" rule still applies to FSA elections, including dependent daycare.
- Can also enroll in separate dependent daycare FSA account.

Health Savings Account

- Enroll in HDHP PPO.
- Can have other coverage only if other coverage is also a HDHP through spouse's employer.
- Reimburse any 213(d) expense.
- You own your own bank account. Any unused amounts roll over indefinitely.
- Must provide a DL# or passport # (per Patriot Act banking rules).
- Can also enroll in separate dependent daycare account.

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HSA VS. FSA - WHAT ARE THE DIFFERENCES?

Maximum deposits (tax year) FSA vs. HSA

Flexible Spending Account

- $2,750 maximum for FSA contributions regardless of family size.
- $5,000 dependent daycare.
  - Separate accounts, separate limits applicable.
- Note that FSA's are funded by the employee only.

Health Savings Account

- $3,550 single
- $7,100 family
- $1,000 catch-up contribution
  - For any enrollee 55+
- This limit is the maximum limit for any contributions, including both employer & employee contributions.

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HSA vs. FSA - WHAT ARE THE DIFFERENCES?

Questions?

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