Demystifying The Mystical World Of Health Insurance

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Erika Gross
Director of Finance, Administration and Risk Management: SHS

Raina Vyas
Public Health Outreach Coordinator: SHS
Overview

- Health Insurance 101
- Affordable Care Act and impact on health insurance
- Penn’s Health Care Requirements and PSIP Summary
Insurance

- Insurance is purchased to guard against excessive medical expenses
- Insurance works by smoothing risk over an entire population
  - Each person has some risk of incurring medical costs
  - By pooling individuals, health insurance carriers can provide preventative services in order to mitigate the risk of an expensive claim
- The population’s risk level is determined by historical trends, demographics and a trend factor
Insurance Companies

- Collect premium and pay claims and invest in health care quality improvement - medical loss ratio
  - What’s left over – administrative costs, salaries, overhead, profit

- Large carriers are able to negotiate contractual savings with providers and hospitals – these savings can reduce claim costs by 10%-75%

- Insurance carriers share costs with their insureds through deductibles, co-pays, co-insurance and out of pocket provisions.
  - Premiums generally trend lower when the insured shares more of the costs
Defining Networks and Providers

- **PREFERRED PROVIDER**
  - Provider that has contracted to furnish services for a negotiated charge
  - Care received from a preferred provider is “in-network”
  - An insured individual who receives care from a preferred provider can be charged only the negotiated rate – “allowable expense”

- **NON-PREFERRED PROVIDER**
  - Provider that has not contracted to furnish services for a negotiated charge
  - Care received from a non-preferred provider is “out-of-network”
  - An insured individual who receives care from a non-preferred provider can be charged the difference between the actual charge and the benefit paid by the insurance carrier
  - Reasonable and customary – the rate determined to be appropriate based on the prevailing charges in the geographic area
Definition of Charges

• **Deductible** – amount of care expenses that must be paid by YOU before an insurer will pay any expenses. Different deductibles apply for in-network and out-of-network care.

• **Co-pay** - fixed dollar amounts (for example, $15) you pay for covered health care by an in-network (preferred) provider, usually when you receive the service.

• **Co-Insurance** - is the percentage of covered medical expenses paid by the insurance carrier. Co-Insurance is calculated based on allowable and reasonable charges. Your share of the costs of a covered service, will vary depending on if the care is in-network or out of networks.

  • *For example*: if the plan’s allowed amount for an overnight hospital stay is $1,000 and the plan covers 70% then your co-insurance payment of 30% would be $300.

  • *Keep in mind*: you may pay more than $300 for the service if you have not yet met your deductible.
MAXIMUMS

- Out of Pocket Maximum – intended to limit expenses and co-insurance
  - Includes annual deductible amount
  - Does not include co-pays

- Aggregate Maximum - benefit paid for covered medical expenses
  - May pertain to all medical expenses or to all expenses per condition
  - Annual or lifetime
    - Lifetime aggregates accumulate from one year to the next
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Patient Protection and Affordable Care Act (ACA)

- Health care reform legislation signed in March 23, 2010
  - Goal was to provide increased access to health care by increasing access to health insurance
  - Individual mandate – all Americans will be forced to maintain health insurance or pay a penalty

- Various provisions of the legislation are currently under review by the Supreme Court
  - Ruling by June 30, 2012
  - Humana, Aetna and United Healthcare Group all have agreed to uphold components of legislation regardless of outcome
Key Components of ACA

- More options for affordable coverage
  - State insurance exchanges – 2014

- Better access to care
  - No cost sharing on “preventative care”
  - Eliminating annual/lifetime limits on essential care

- Stronger Medicare

- Stronger consumer rights and protections
  - Mechanism for appeals
  - Regulation on rate increases
  - Rebates to insured when medical loss ratio below 80%
Consumer Driven Healthcare

- High Deductible Health Plans
  - Increasing in popularity as a way to control premium costs
  - Usually include a Healthcare Savings Account (HSA) for pre-tax savings

- Preliminary studies show that health care spending drops by 14% primarily on inpatient, outpatient, prescriptions and preventative care
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University Health Insurance Requirement

- **Full-time, dissertation, or exchange students:**
  - If at the University for a semester or more must carry adequate health insurance
  - This is a condition for student enrollment

- **Part-time students:**
  - Not required to purchase insurance or show proof of alternative coverage
  - Eligible to enroll in the Penn Student Insurance Plan (PSIP)
What if I have my own insurance?

Students can use their own insurance plans **BUT**........

- The insurance plan must meet requirements listed online at [http://www.vpul.upenn.edu/shs/insurance.php](http://www.vpul.upenn.edu/shs/insurance.php)

- Students must submit a request online to waive the Penn Student Insurance Plan (PSIP)
  - Documentation mailed, e-mailed or faxed will **NOT** be processed.
  - Follow the links on the SHS website [http://www.vpul.upenn.edu/shs/insurance.php](http://www.vpul.upenn.edu/shs/insurance.php) and have PennKey to access the waiver document.

- You must waive the PSIP plan each academic year that you choose to use your own insurance
Penn Student Insurance Plan

- $2,000,000 maximum per policy year

- Annual deductible of $300 In-network/$1500 Out-of-network

- Annual maximum out-of-pocket expense of $1,500 in-network/$4,000 out-of-network

- Co-pays (in-network)
  - Emergency Room: $100 (deductible waived)
  - Office visits: $30 (after deductible satisfied)
  - Mental health visits: $30 (deductible waived)
  - Lab/x-ray: $35 (after deductible satisfied)

- Prescription coverage
  - 30-day supply of medication: $20 generic/$40 brand
  - 90-day supply of medication (mail-order): $40 generic/$80 brand
How do I use PSIP?

PSIP offers three options for care......

1. SHS *(least expensive)*
2. In-Network *(moderately expensive)*
3. Out-of-Network *(most expensive)*

**Price does not indicate level of care or service**
Three Care Options with your PSIP Insurance

1. At SHS
2. In-Network
3. Out-Of-Network

Outside SHS
Three Care Options with your PSIP Insurance

1. At SHS
   - No Deductible
   - No Co-pay

2. In-Network
   - $300 deductible per policy year
   - Co-pay or co-insurance

3. Out-of-network
   - $1500 deductible per policy year
   - 70% coverage on "reasonable" amount, you pay 30% co-insurance

You pay the difference between the total price of service and how much is deemed "reasonable"
## Impact of ACA on PSIP

<table>
<thead>
<tr>
<th>Coverage Improvements</th>
<th>Cost Implications</th>
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<tbody>
<tr>
<td>Preventative Care is covered at 100% (no cost sharing)</td>
<td>1% to annual student rate - $27</td>
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<tr>
<td>Preventative care includes screenings, counseling,</td>
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<td>immunizations and vaccinations</td>
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<tr>
<td>Contraceptives – covered 100%</td>
<td>2.1% to annual student rate - $56</td>
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<tr>
<td>No visit maximums (even for out-of-network)</td>
<td>1.15% to annual student rate - $31</td>
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Questions????
Thank You!