



## DECODING THE LANGUAGE OF HEALTH CARE

Healthcare affordability has been a topic of increased interest. In our everyday discussions, we use the language of healthcare finance with some, but not full, clarity. And at times we find ourselves frustrated especially when reading the insurance companies forms, elements of coverage, and doctors' bills. In this edition of *For A HealthierYou* we explain a few commonly used terms and the relationship between the types of health plans and how they determine your access to care and your financial responsibility. We will follow with two scenarios to actually see these concepts in use.

COMMONLY USED TERMS IN HEALTH CARE AND INSURANCE PLANS	
TERM	EXPLANATION
<b>Monthly Premium</b>	Your share of the health insurance cost. If you are purchasing your health insurance through an employer-sponsored program your monthly premium is usually set up as an automatic deduction from your payroll. And the total cost is shared between the employer and you (the employee).
<b>Co-payment</b>	Monies you pay the service provider, for example the doctor at each visit. Depending on your plan you may pay anywhere between \$10 - \$35 or more every time you are checked in by the front office staff. Do not confuse co-payments with co-insurance.
<b>Co-insurance</b>	A percentage (%) of payment that is paid by you for the service you receive. For example, in a 30/70 health plan, after the co-payment, you still pay 30% of the Doctor's visit bill and the insurance pays 70%.
<b>Annual Deductible</b>	Refers to monies you pay before your insurance benefits begin. In the above example, your plan had a \$1,000 deductible, you will be asked to make your co-payment and To pay the entire doctor's bill.
<b>Out-of-Pocket</b>	A summation of co-insurance and annual deductible. You pay these independent of your monthly premiums and co-payments. Even though monthly premiums and co-pay are truly monies out of your pocket, in health insurance language only the co-insurance and annual deductibles are considered out-of-pocket.
<b>Explanation of Benefit (EOB)</b>	A document from the insurance company that explains your financial responsibility. An EOB is not a bill. It helps you understand how much you have to pay for a particular service, like a lab or a doctor's visit, and how much your insurance will pay or had paid already.
<b>Network</b>	Insurance companies have worked with a network of doctors, labs, diagnostic imaging companies, and other health care to provide service at a reduced rate. It is advantageous to visit an in-network provider because it will reduce some of your out-of-pocket expenses.
<b>Preferred Provider Organization (PPO)</b>	A PPO is a network of providers who agree to provide care and treatment at a reduced rate.
<b>Consumer Driven Health Plans</b>	Consumer driven health plans imply that you, the consumer, is in control of your health care cost and structure. These plans are generally more expensive than traditional health plans.
<b>Fee-for-Service (FFS)</b>	The most traditional type of health plan. <ul style="list-style-type: none"> <li>You see a doctor or hospital (provider) of choice</li> <li>The plan pays a portion of the cost for <u>covered</u> medical services.</li> <li>You have to file claims paperwork.</li> <li>The plan defines what medical services are covered.</li> </ul>
<b>FFS with PPO</b>	<ul style="list-style-type: none"> <li>You see providers in the PPO network.</li> <li>The plan pays a portion of the cost for covered medical services but at a reduced network (PPO) rate.</li> <li>No claims paperwork is required.</li> <li>In an emergency and while out of your network area you may visit other providers. The plan defines what medical services are covered.</li> </ul>
<b>Health Maintenance Organization (HMO)</b>	This health plans type provides care through a network of physicians and hospitals in a particular geographic or service area. <ul style="list-style-type: none"> <li>No claims paperwork or providers' bills.</li> <li>Relatively low amounts out-of-pocket (co-insurance and deductible).</li> <li>Limited network of providers – some find this restrictive.</li> <li>Charges a copayment for primary physician and specialist visits.</li> <li>Most HMOs require you to choose a doctor as your primary care physician (PCP)</li> <li>Many HMOs require an authorization or a "referral" from your PCP before you can be evaluated or treated by other doctor or specialists. Some find this feature restrictive and limiting in nature.</li> </ul>
<b>HMO with Point of Service (POS)</b>	This health plan allows you to see providers who are not part of the HMO network. This implies that you will be paying more out of pocket. <ul style="list-style-type: none"> <li>Not limited to a network of providers.</li> <li>Pay higher deductibles and coinsurances, than a traditional HMO.</li> </ul>

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	<ul style="list-style-type: none"> <li>• Must file claim paperwork for reimbursement, like in a FFS plan.</li> <li>• A “referral” may not be required to see another doctor.</li> </ul>
<b>High Deductible Health Plan (HDHP)</b>	<p>A HDHP is a type of Consumer Driven Health Plan. As the name implies it has a high annual deductible and a maximum limit on other annual out of pocket expenses. The minimum and maximum limits are established by the IRS on annual basis.</p> <ul style="list-style-type: none"> <li>• Most HDHP plans support preventive care services such as an annual physical or a well check visit for your child. The coverage includes associated labs and diagnostics without a deductible.</li> <li>• Use a PPO but allow you to go outside of the network. You pay more for this freedom of choice. .</li> <li>• HDHP plans offer HSA and HRS.</li> </ul>
<b>Health Savings Account (HSA)</b>	<ul style="list-style-type: none"> <li>• A type of tax-exempt trust or custodial account, a special savings account.</li> <li>• You deposit cash funds to pay for current or future medical expenses.</li> <li>• The type of HDHP determined the amount you or any other person can contribute to the HAS.</li> <li>• Employers may also contribute to an HSA.</li> <li>• HSA funds and any interest earned are tax-free.</li> <li>• An HSA is “portable”. It means that if you change employers or retire the HAS stays with you because it is yours.</li> <li>• HSAs are subject to a number of rules and limitations established by the Department of Treasury. Visit <a href="http://www.ustreas.gov/offices/public-affairs/hsa/">www.ustreas.gov/offices/public-affairs/hsa/</a> for more information.</li> </ul>
<b>Health Reimbursement Arrangement (HRA)</b>	<ul style="list-style-type: none"> <li>• ONLY funded by an employer.</li> <li>• An HRA may be offered with other health plans not just HDHP.</li> <li>• Employers have flexibility over its structure because it is considered an employer-established benefit.</li> <li>• HRAs are available to those who are ineligible for an HSA.</li> <li>• There is no limit on the amount of money your employer can contribute.</li> <li>• Unused funds can be rolled over to the next year.</li> <li>• Funds are used to pay you for qualified medical expenses you have incurred since enrollment in the HRA.</li> <li>• Not “transferable or portable” unlike an HSA.</li> <li>• Interest is not earned on an HRA.</li> </ul>

Remember - 1) Co-payments and monthly premiums do not apply to what health insurance companies define as out-of-pocket. You pay these amounts in addition to co-insurance and annual deductible. 2) Co-insurance does not apply until you meet the annual deductible.

## HEALTH PLAN TYPES AT A GLANCE

	Monthly premiums	Co-payments	Co-insurance	Annual Deductible	HSA	HRA	Limiting features (Disadvantages)	Features (Advantages)
<b>FFS</b>	x	x	x	x		x	<ul style="list-style-type: none"> <li>• Must file claims paperwork</li> <li>• Pay more than FFS/PPO</li> <li>• Limited coverage of preventive services</li> </ul>	<ul style="list-style-type: none"> <li>• No provider network restrictions</li> <li>• As with all plans, FFS plan do not pay for the all medical care and services, only those that are covered.</li> <li>• As with most all plans, FFS plans pay a certain percentage of the providers charge not their full charge.</li> </ul>
<b>FFS/PPO</b>	x	x	x	x		x	<ul style="list-style-type: none"> <li>• Provider network,</li> <li>• Manage EOBs and provider bills,</li> </ul>	<ul style="list-style-type: none"> <li>• No Claims paperwork,</li> <li>• More preventive services covered,</li> <li>• Pay less than traditional FFS,</li> <li>• Some FFS/PPO may not have an annual deductible (check your plan)</li> </ul>

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<b>HMO</b>	x	x				x	<ul style="list-style-type: none"> <li>• Provider network,</li> <li>• Must choose a PCP,</li> <li>• Requires PCP referral to see specialist,</li> </ul>	<ul style="list-style-type: none"> <li>• Reduced cost structure,</li> <li>• Little to no paperwork like provider bills,</li> <li>• Wide coverage of preventive care services,</li> <li>• Resembles a restricted FFS/PPO</li> </ul>
<b>HMO/POS</b>	x	x	x	x		x	<ul style="list-style-type: none"> <li>• Must file claims paperwork,</li> <li>• Service coverage may be limited,</li> </ul>	<ul style="list-style-type: none"> <li>• Pay more than a traditional HMO,</li> <li>• Not limited to a network of providers,</li> <li>• Claims paperwork,</li> <li>• Resembles a restricted FFS plan</li> </ul>
<b>CDHP</b>	x	x	x	x	x	x	<ul style="list-style-type: none"> <li>• Uses a PPO,</li> <li>• Higher deductible and out of pocket ,</li> <li>• Self-management of paperwork,</li> <li>• Management of HRA and HSA</li> </ul>	<ul style="list-style-type: none"> <li>• Resemble a FFS/PPO,</li> <li>• More freedom in management of care,</li> <li>• Availability of HRAs and HSA,</li> <li>• Preventive services generally covered</li> </ul>

## CASE STUDIES

To completely understand these terms in use we have developed two scenarios. To answer the questions for each case use the fictitious health insurance plan structure listed in this table.

Fictitious Health Insurance X Benefit Package		
Benefit	In-Network	Out-of-Network
Annual Deductible	\$1,000 two per family members	\$4,000 two per family members
Co-insurance	30/70 after deductible	50/50 after deductible
Lifetime Maximum	Unlimited	Unlimited
Office visit	\$20	50 after deductible
Specialist visit	70 after deductible	50 after deductible
ER visit	\$150 co-pay 70 after deductible	\$300 co-pay 50 after deductible
Prescription	\$15/ \$35/ \$50	NA
Mail order prescription	\$5/ \$15/ \$35	NA

### CASE STUDY #1

Your employer- sponsored health insurance went into effect 90 days after your date of hire on Oct 1, 2010. It is now January 3, 2011 and you are scheduled to see your family doctor who happens to be In-Network. This is the first time you are using your health insurance in 2011. You have not been feeling well lately, very tired, a bad cough, and headaches that come and go. Your children have had bad colds and everyone in the office has been sick. When registering at the front desk the receptionist asks for the co-pay for this visit. The doctor orders two lab tests, a chest x-ray, examines you, completes a throat culture, and sends you home with two prescriptions and a slip to return for a follow up in one week.

1. How much is the co-payment for the visit?
2. How much is your out of pocket for the lab, chest x-ray, and the throat culture?
3. How much is the cost of your two prescriptions? One is available in generic but the other is brand name only.
4. What is your total out of pocket for this visit?

### CASE STUDY #2

Before you can make the doctor's follow up visit you feel bad enough to go to the local emergency room (ER). The physician examines you, recommends that you continue with your current medications, and to see your physician as instructed for follow up.

1. How much do you pay for the ER visit?
2. Did you have any other option for assessment and advice besides the ER?



### CASE STUDY ANSWERS

#### CASE STUDY #1

1. How much is the co-payment for the visit? Your co-payment for a doctor's visit is \$20 as long as he/she isn't considered a specialist.
2. How much is your out of pocket for the lab, chest x-ray, and the throat culture? The answer to this question is unknown because the table is not a complete explanation of your benefit package. You have to review the insurance company's description of benefits or call their customer service line for an explanation.
3. How much is the cost of your two prescriptions? One is available in generic but the other is brand name only. Since these medications are for an acute illness, you would not use the mail order provision of your plan. Rather, you will be filling the prescriptions at your In-Network local pharmacy. For the generic, you will pay \$15. For the brand name, depending on the tier the medication belongs to, you will be paying either \$35 or \$50.

Some insurance companies have all medications divided into tiers based on their cost. They also use a formulary (list of medications) that is covered under their plans.

Generic medications are lower in cost than brand names. They are required to have the same active ingredient, strength, dosage form, and route of administration as the brand name (or reference) product. Generic drugs do not need to contain the same inactive ingredients as the brand product; but, they are tested, and are confirmed, to perform the same as their respective brand name or referenced product. Always ask your doctor if a generic is available to help control cost.

Brand name drugs are divided by the health plan's formulary into different tiers depending on their cost. Generally, those that are new to the pharmaceutical market are higher in cost.

4. What is your total out of pocket for this visit?
  - a. Use this EOB statement to answer the question:
    - Provider Billable: \$150
    - Plan discounts/adjustments: \$50
    - Plan pays: 0
    - You pay: \$150
    - Applied to deductible: \$150

The provider is In-Network; therefore, the provider's \$150 bill for the visit is according to the fee structure. Otherwise, the bill would have been \$200; hence, the \$50 plan discount/adjustment.

The plan does not pay anything for this visit because you have not met your \$1000 annual deductible. In this case, you are responsible for the entire \$150. This money is applied to your annual deductible. Keep in mind that the co-payments (\$20 in this case) are never applied to the annual deductible.

Had you met your annual deductible your share of this visit would have been 30% of \$150 or \$45. The insurance would have paid the remainder or \$105. So, the total cost for the visit would be \$20 co-pay and \$45 co-insurance. The \$20 is paid at the time of the visit and the \$45 when the doctor bills you after the insurance has issued their EOB.

It is important to understand the concept of annual deductible. Based on this fictitious plan, two members must meet the \$1,000 annual deductible. Therefore, in a family of four if the mother and one child pay \$1000 each for healthcare services, the 30/70 co-insurance benefit applies to all four. However, each of the four members of the family will accrue deductibles until two members meet \$1,000 each.

#### CASE STUDY #2

1. How much do you pay for the ER visit? An ER visit is listed to have a \$150 or \$300 co-pay depending on the ER being In- or Out-of Network. You visited an Out-of-Network ER.

For this visit you will pay a \$300 co-pay. Remember, co-pays do not apply to any out-of-pocket calculations. Even if, you had met your annual deductible you would have had to still pay the ER co-pay.

Furthermore, the total ER bill was \$400. You are responsible to pay the remaining \$100 because you have not met your annual deductible.

With this \$100 and the \$150 you paid for the doctor's visit, in case #1, you have now paid down your annual deductible by \$250 out of \$1,000.

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2. Did you have any other option for assessment and advice besides the ER? The case didn't state whether the ER visit was on the weekend or after hours when the medical offices are normally closed. Generally speaking, a phone consult with the family doctor is always a sound first step. You can always augment this consult by visiting health related web portals such as the *Mayo Clinic EmbodyHealth*, [www.nasahealthieryou.com](http://www.nasahealthieryou.com). A visit to a reputable and recognized In-Network walk in clinic is also a good option. Provided you are not experiencing a life threatening condition. Emergency rooms are setup to rapidly care for emergency and life threatening situations. Generally, they are very busy and patients have reported a long wait times. Additionally, because of the caliber of resources they offer cost of ER care is always high.

To wrap up the two case studies lets calculate the true out-of-pocket cost for the two visits:

- o Co-pays are always covered by the individual : \$20 doctor + \$300 ER
- o Co-insurance has not been initiated because the annual deductible has not been met; therefore, \$150 doctors visit + \$100 ER visit
- o Medication co-pay: \$15 generic + \$35 brand
- o Your share of the lab, x-ray, and throat culture is unknown
- o TOTAL - \$620 plus the unknown cost of labs, x-ray, throat culture

Thus far, you have met \$250 of your \$1000 (2 per family) annual deductible before your 30/70 co-insurance benefit can begin for the family. Keep in mind that two members of your family each must meet \$1,000 out of pocket to satisfy annual deductible.

## CONCLUSION

We have merely touched upon some commonly used terminology in healthcare insurance and finance. There is so much more to learn. Some questions that come to mind are: What is the coverage for mental health and substance abuse counseling? Is there a difference between coverage for hospital admission vs. outpatient surgery? What are the other common facts and myths about generic and brand name drugs? What is the difference and advantages in using a local pharmacy vs. mail order?

If you are part of an employer-sponsored plan consider contacting your company's benefits officer for answers to your questions and information specific to your coverage. Also, consider contacting your carrier's customer service line.

NASA Federal employees please contact the NASA Shared Services Center (NSSC) 1.877.677.6123. for more information and clarification about your coverage and health plan.

NASA Contractor employees please contact your respective Human Resources representative.

## RESOURCES

For more information see Notice 2004-23, 2004-15 I.R.B. 725 available at [www.irs.gov/irb/2004-15\\_IRB/ar10.html](http://www.irs.gov/irb/2004-15_IRB/ar10.html)

[www.opm.gov/insure/health/planinfo/types.asp#ffs](http://www.opm.gov/insure/health/planinfo/types.asp#ffs)

[www.ustreas.gov/offices/public-affairs/hsa/](http://www.ustreas.gov/offices/public-affairs/hsa/)

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