Navigating Health Care

For Employees

DENVER METRO CHAMBER OF COMMERCE

Health care is expensive and confusing. Many employers and employees alike consider it a burden and a hassle – myself included.

Whether we're choosing or using our health coverage, we want to make our decisions quickly and get back to our real work. So, we end up paying a lot of money without ever taking the time and trouble to really understand our coverage or how to maximize it.

There's an opportunity for consumers of health care to be more engaged and more empowered. While we are all frustrated, we can do more to ensure the system works better for us.

At the Denver Metro Chamber of Commerce, we're working to make changes. To reduce costs and improve quality in health care. To fight for more transparency and accountability. To create a more rational, functional, lower-cost system through legislative advocacy and partnerships with organizations like the Colorado Business Group on Health and the Center for Improving Value in Health Care. Change is necessary – and we have had some early success in Colorado. But it is also slow-going and can feel far removed from the day-to-day experiences of businesses and consumers.

Luckily for us, we also have an opportunity – and a responsibility – to support employers and employees to be more savvy and effective consumers of health care insurance and services.

This toolkit is a first step in our effort to engage and empower Chamber members and businesses across Colorado. Inside you'll find tools and resources that are a starting point for thinking about why we need health insurance, how we use our coverage and how to maximize its value.

This high-level resource is intended to be relevant to a broad cross-section of companies. It is designed to complement, not replace, other tools available from brokers or insurance companies. Recognizing that every company is different and that the health care landscape varies significantly from Denver to Durango, we're not endorsing any specific approach or recommending any products. Rather, we're offering key questions for you and your organization to consider, providing clear definitions to confusing terms and connecting you to other resources that we've found helpful for employees and employers of all sizes.

We put this together with the help and input of dozens of Chamber members – inside and outside the health sector – and health care stakeholders who aren't our members. We're grateful to them for sharing their time and expertise! We offer this with the hope of helping empower employers and employees to be part of the health care solutions we so desperately need.

Best,

Kelly Brough, President and CEO
Denver Metro Chamber of Commerce

Table of Contents

1

Why Health Insurance?

A values approach.

At its most basic, employer-sponsored health insurance is an agreement between you, your employer and your health insurance plan to provide you with access to health care for an agreed-upon price, so long as you follow the terms of the plan.

Health insurance can provide:

- **access *to*** and **care *from*** health providers who can address everything from routine preventive care to management of complex chronic conditions or emergency treatment for an unexpected medical crisis, not only for yourself but also for family members if they are covered by your plan;
- **predictability and financial protection** through regular monthly premiums paid by you, your employer or a combination and pre-determined fees for health care services as well as limits on your costs in case of catastrophic illness or injury; and
- **information** about how to stay healthy, how to manage and treat illness and how to navigate the health care system.

Health insurance comes in lots of different shapes and sizes, and your own health care needs and financial risk tolerance will change over time. It makes sense to think about which qualities in a plan are most important to you and which you might be willing to compromise on. This is true whether you have multiple insurance plan options or your employer only offers one. As you make choices about your health plan and your health care, it's important for those choices to reflect your needs and your values.

Do you care more about access to a large range of providers and many options for the type of care you receive? Or are you more concerned about ways to keep your health care costs as low as possible?

One option that may control health care costs is focusing solely on providers who offer high value for the cost. For example, a health insurance plan with a narrower network of providers – a smaller list of providers from whom you can choose for your care – will likely cost less than a plan with a very broad network and, when done right, can deliver better quality care. But, you might have to change the doctor you are used to seeing.

Another option that may control costs is requiring pre-approval for certain types or quantities of health care. For example, a health insurance plan may require you to see a primary care provider before getting a referral to a specialist.

Is it more important to keep prices predictable throughout the year or to keep your upfront costs low? Do you want to avoid high unexpected bills or are you willing to take more risk for the chance to spend less?

(See more about how the costs of health care are covered by health insurance in Section 2).

Understanding what you need and want to get from your health insurance plan will help you select the best plan and use your insurance wisely – to stay healthy, get the best care available when you need it and watch out for your bottom line.

Additional Resources

Kaiser Family Foundation: Health Insurance Explained

This five-minute, animated video (https://bit.ly/14hSaIp) provides a high-level overview of how health insurance – public and private coverage – works. While not specific to employer-sponsored insurance, it provides helpful definitions of key terms and suggestions for how to maximize the value of your coverage.

1

Continuum of Coverage

There are many different types of health plans. Generally, they vary based on flexibility - or amount of choice in how, when and from whom you get health care services - and cost. Often, consumers are asked to trade flexibility for cost savings. This chart shows four common types of health plans with typical features or elements of each.

Typically less flexible and less expensive → **Typically more flexible and more expensive**

HMO	EPO	PPO	FFS
HMO plans are often the most restrictive type of plan but with lowest monthly premiums. Typically, HMO plans:	EPO plans are often less restrictive than HMO plans but with lower monthly premiums than PPOs. Typically, EPO plans:	PPO plans often have higher monthly premiums, but with more flexibility to choose providers. Typically, PPO plans:	Typically, fee-for-service, or FFS, plans will only pay a % of reasonable and customary charges, leaving clients responsible for the remainder. Typically, FFS plans:
Don't cover out-of-network care	Don't cover out-of-network care, except emergencies	Provide some coverage for out-of-network care	Don't limit care to a network
Require referrals from primary care providers, especially specialty care	Allow some visits to specialists without a referral	Don't require referrals for specialty care	Don't put restrictions on benefits
Limit care from specialty providers	Limit in-network providers, but provide more choice than HMOs	Offer broader provider networks	Don't negotiate lower rates with providers for cost of care
Have narrow limits on in-network providers			

Note that different health insurance policies vary in both costs and benefits, regardless of plan type. Ask your HR team, insurance broker or carrier to learn any plan's specifics.

Health insurance plans are complex. Breaking them down into different components can help.

2

What To Ask When Selecting a Health Plan

The basics for navigating a complex system.

After considering what qualities you value in a health insurance plan, the logical next step is to find a health plan that best aligns with those values. But health insurance plans are complex, even for experts. Breaking down a plan into different components can help make sense of what a plan will offer, what it will ask of you in return and how it compares to other choices you may have.

Who needs coverage?

First, consider who needs to be covered under your health insurance. Is it just you or you and dependents? What are the current health needs of each person that will be covered, and could those change over time? Do you anticipate having a baby, getting married or another qualifying event during the year? Could anyone in your household be eligible for Medicare, Medicaid or CHP+?

What is covered?

Under the Affordable Care Act, most employer plans are required to provide certain benefits, such as preventive services like vaccinations and some screening tests. However, there are still many differences in the level of services a plan may provide. One area of variation may be coverage of mental health and substance use treatment. If this is a need for you or your dependents, you may want to talk with your employer or representatives of the plan(s) to fully understand the coverage that would be

provided. In addition, your employer plan may include additional coverage such as dental care, prescription coverage, vision care and more.

Which providers can you see?

Depending on the network of providers included in a plan, you may be required to switch providers from one you know. But a trade-off could be lower premiums. For example, a health insurance plan with a narrower network of providers – a smaller list of providers from whom you can choose for your care – will likely cost less than a plan with a very broad network.

What are the costs?

All employer-sponsored plans include premiums, or regular (usually monthly) payments made by your employer, you the employee or a combination. Premiums are set for the term of the plan and don't change based on what care you receive.

In addition, there is probably some type of cost-sharing, where you pay part of the cost of the care you receive, and the plan covers some of the cost for you. Co-pays, deductibles and coinsurance are all types of cost-sharing. Health plans also have out-of-pocket maximums – the most that you would pay before your insurance covers the full cost of any additional care.

Lower premiums are a tradeoff for higher cost-sharing: if you don't plan to use much care, your total costs may be lower. But if you do expect to access more care, it may be cost-effective in the long run to accept a higher premium and less cost-sharing. Planning ahead may help you save money.

You may also want to consider how your health needs have changed, or will change, over time. Do you have a new spouse or baby that may be covered by your plan? Are you thinking about your personal wellness and looking for ways to lose weight or exercise more? Would you benefit from mental health coverage or substance use treatment? Have you developed a chronic illness or do you anticipate surgery?

Premiums, cost sharing and out-of-pocket maximums may all be different depending on if you have dependents on your plan. If you receive care outside of your plan's network, those costs may be higher – or not covered at all.

How is the plan structured?

Plans are structured differently both in how costs are shared and how care is accessed. Co-pays may be required at every provider visit, or you may pay nothing at all until you receive a bill. You may be in an HMO that requires you to get a referral to a specialist

from a pre-selected primary care provider, or you may be able to see any provider you want from the plan's network or even pay higher co-insurance to see an out-of-network provider. Your employer may offer a tax-free account for covering health expenses. Understanding the details of your own health plan's structure is important so that you know where to go for care and you are not surprised by unexpected costs that are your responsibility. You should also take into consideration your employer's open enrollment period when you need to make decisions about your health care needs for the following year and whether you may have a qualifying event like getting married, having a baby or losing health coverage that would allow you to change your health plan at a different time of year.

Additional Resources

Patient Advocate Foundation – Chatter That Matters: Choosing a Health Plan

This one-minute video (https://bit.ly/2JQ9WKH) explains open enrollment and provides some basic tips on what to look for when shopping for plans.

Medicare Interactive

A two-minute video (https://bit.ly/2Ma7T5P), *Medicare or Medicaid – Which Program Covers Who?* explains the difference between these two public coverage programs. With more and more people in the workforce eligible for public coverage, it is important for employers and employees to understand what public benefits are available.

One of the most confusing aspects of health insurance is understanding how to evaluate the quality of care. It's not like buying a car.

3

How To Maximize The Value Of Your Health Insurance

In health care, higher cost does not equal better quality.

How do you know if you are getting the best health care possible at a reasonable price? One of the most confusing aspects of navigating health insurance is understanding how to evaluate the quality of your care. It's not like buying a car, where you can look up average costs of future maintenance, or like buying coffee, where the sweeter or larger the drink, the higher the price of the cup. Typically, in health care, more treatment – whether testing, procedures or office visits – is not necessarily better and, often, the highest quality care is not the highest price.

The Institute of Medicine (IOM) defines health care quality as: "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." It identifies several factors that comprise quality of care, including effectiveness, efficiency, equity, patient-centeredness, safety and timeliness.

To make things even more confusing, it's often hard to know what health care really costs. Sometimes, it's only after the fact that the true price – what your health plan pays plus what you pay – becomes clear.

But there are steps you can take to keep your price down and get the highest quality care available.

Where to go

Be thoughtful about where to go when you need health care. Often, your own primary care provider is a good place to start. Even if you suspect that

you need treatment from a specialist or to visit a more urgent setting, most physicians' offices and medical clinics can refer you to the best place to be treated and have after-hours answering services that can also provide this information. Many physicians are even accessible by email.

Urgent care and walk-in clinics can be a cost-effective option when your regular provider's office is closed. Emergency rooms will likely cost you more out of pocket and you may be there longer as well. Free-standing emergency rooms still charge ER prices, even if they are not physically connected to a hospital. Out-of-network providers, even if you are at an in-network facility, can charge you the full cost of any care they provide. If you are in a hospital-type setting, you may want to confirm with all of your providers that they are in your network.

Know Where To Go

PHYSICIAN

Many medical conditions, even if they are acute, are best treated at a physician's office. Many physician's offices have after-hours call lines to help you determine where to be seen. Physician's offices can typically best treat:

- Coughs, colds and sore throats
- Diarrhea
- Earaches
- Fevers that respond to medication
- Minor cuts and burns
- Pink eye
- Sinus infections
- UTIs

URGENT CARE

Urgent care clinics are a great option when your primary care physician isn't available. Urgent care clinics can typically treat:

- Minor illness and injury
- Flu symptoms
- Rashes, cuts or scrapes
- Sinus infections
- Sprains
- Stitches

EMERGENCY

Any condition where you feel that delaying your care could have a significant impact on your health should be treated at the emergency room. Go to the ER or call 911 if you experience:

- Any chest pain or concern about a heart condition, including:
  - Tightness in the chest
  - Sudden sharp chest pain
  - Shortness of breath
  - Rapid heartbeat
- Stroke symptoms
- Sudden or severe pain
- Uncontrolled bleeding
- Blue or purple lips, skin or fingernails
- Bones that appear broken
- Coughing or vomiting blood
- Loss of consciousness
- Seizures
- Trouble breathing

3

Be cautious about putting weight into internet reviews of health care providers and facilities. There is no "Yelp" for health care that takes into account all of the aspects of health care quality, some of which can be hard to discern even for experienced professionals.

You may also want to talk with your employer and your health insurance plan representative about ways to access health care advice through telemedicine and other kinds of technology.

Prescription medications

Prescription medications are also a major component of health care costs. Be sure to ask both your provider and your pharmacist if a medication is covered by your insurance and if there are more affordable options when given a prescription. Often, this can be a generic and sometimes it may be different than the medication you are familiar with. Don't be shy about advocating for yourself – you should be given the best medication for you at the best price. You may also want to ask your pharmacist if paying for medication out-of-pocket would be less expensive than your co-pay. However, if you do choose the out-of-pocket option, you should be aware that what you pay will not count toward your deductible if you have one.

Additional Resources

Colorado Drug Card
www.coloradodrugcard.com

This is a free, statewide discount prescription assistance program. There are no requirements needed to use the program and there are no income, age, pre-existing condition, deductible or waiting period restrictions. The program is designed to help patients who do not have prescription drug coverage or who have coverage but are subject to large out-of-pocket expenses. The cards are accepted at more than 68,000 pharmacies across the country. Average savings with the card are 30 percent, but could be as high as 80 percent on medications. The Chamber is a partner organization of the Colorado Drug Card. www.coloradodrugcard.com

GoodRx

This free online tool compares prices of thousands of prescription drugs at pharmacies across the U.S., including the lowest cost at a pharmacy in your area. Note that you should always confirm that a pharmacy accepts your insurance plan and that the GoodRx prescription is covered.
www.goodrx.com

Consumers can compare prices and patient experiences and save thousands of dollars.

4

What Resources Are Available To You?

Where to go for information and assistance.

There are a number of different resources for information on how to navigate employer-sponsored health insurance. Below are a few options for additional information, depending on your needs.

1. Your employer and your health insurance plan

These are the two best places to start – they will have information specific to you and your plan or they will be able to direct you to more information.

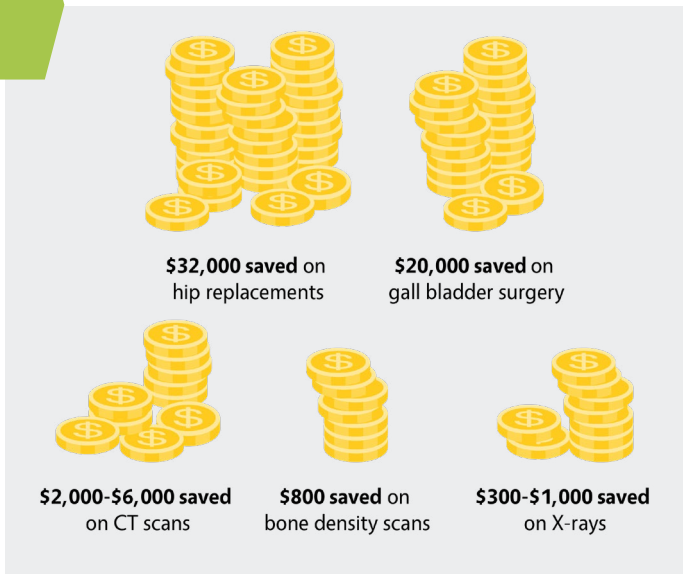
Human Resources Contact Information

Health Plan Contact Information

2. The Center for Improving Value in Health (CIVHC)

This objective, not-for-profit organization administers Colorado's comprehensive source of health care cost information, the All Payer Claims Database. CIVHC (CIVHC.org) empowers individuals and organizations to better health, better care and lower costs. CIVHC's Shop for Care tool allows consumers to compare prices and patient experiences at Colorado health care facilities for nearly 40 imaging and high cost procedures. Using Shop for Care, consumers could save thousands of dollars on imaging services and procedures.

Shop for Care could help identify thousands of dollars in savings on imaging services and procedures.



3. Patient Advocate Foundation

The article, What do I do if I can't get answers from my insurance company? provides brief tips for effectively communicating with your insurance company and steps you can take if you're not getting the answers you need. Read more: https://bit.ly/2Osdzei

4. Colorado Consumer Health Initiative

CCHI provides a consumer assistance program that can help you navigate your health coverage and health care and help resolve problems with insurance claims and billing.

CCHI Consumer Assistance: https://bit.ly/2ZbGWW0
help@cohealthinitiative.org
303-839-1261

5. State Division of Insurance at the Department of Regulatory Agencies

The agency that regulates health insurance in Colorado provides a website where you can ask a question or file a complaint against a health insurance company and access other resources about health insurance in Colorado. Read more: https://bit.ly/2cFwVa6.

5

Navigating Health Care – Words to Know

CHIP: Children's Health Insurance Program

Enacted in 1997, CHIP is a federal program that provides health coverage for low-to-moderate income children and pregnant women who earn too much to qualify for Medicaid. States design and help fund their own CHIP programs within broad federal guidelines, so CHIP programs vary from state to state. Colorado's CHIP program is called Children's Health Plan Plus, or CHP+, and there are more than 80,000 women and children enrolled. It is possible that low-to-moderate income working Coloradans have dependents who are eligible for or enrolled in CHP+.

COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 ensures that employees can continue to pay for and access their employer-sponsored health coverage for 18 to 36 months after they leave a job or reduce their hours. It is important to know that COBRA is a law protecting employee rights, not a type of health plan.

Co-insurance

The amount the employee is required to pay toward covered health care services once the deductible is met. Typically, co-insurance is set as a percentage of the cost of the service, not a fixed amount. Not all plans are structured to include co-insurance.

Co-pay

A fixed dollar amount that the employee is required to pay for certain health care services. Co-

pays are typically a modest amount (e.g., $20 for a doctor's office visit or $10 to fill a prescription) paid at the time of routine medical service and are often printed on the insurance card, so a client can easily reference them before seeking care.

Deductible

The amount that the employee must pay each year for certain covered health care services before an insurance plan will begin to pay. For example, if the deductible is $2,000, the plan won't pay anything until an employee has paid $2,000 for covered health care services. Often, preventive health care services – such as annual physical exams – are not subject to deductibles, so are paid for by the health plan immediately.

EPO: Exclusive Provider Organizations

A type of health insurance plan. Typically, EPO plans:

- have limited networks;
- do not cover care provided by out-of-network providers, except in some cases of emergency; and
- allow visits to specialists without a referral.

Most EPO plans are thought to be more flexible than HMO plans.

HMO: Health Maintenance Organization

A type of health insurance plan. Typically, HMO plans:

- have limited networks;
- do not cover care provided by out-of-network providers, except in some cases of emergency; and
- have other benefit restrictions in place, such as requiring a referral for specialty care or limiting the number of eligible visits for services such as physical therapy.

In return for a more limited choice of provider and tighter caps on benefits than with a PPO plan, HMO plans are often less expensive, meaning they have lower premiums and low or no out-of-pocket expenses such as deductibles or co-insurance.

HSA: Health Savings Account

A tax-exempt savings account that can be used to pay for certain medical expenses. Employers may make HSAs available to their employees. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan (HDHP). Note that there are many different types of tax-exempt accounts that can be used for health and dependent care costs, including Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA). Each type of account comes with different rules for allowable contribution amounts, portability and acceptable expenses.

Indemnity or Fee-For-Service (FFS) Health Plan

A type of health insurance plan. Typically, Indemnity or Fee-for-Service plans:

- have no networks;

- put no restrictions on benefits; and
- will only pay a set percentage of reasonable and customary charges (the average price charged for services from a specific type of provider within a set geography) and the client is responsible for any/all charges above that amount.

While clients get maximum choice and flexibility, they do not get the benefit of negotiated rates as provided for in HMO and PPO network plans and they are responsible for paying all fees above the percentage of reasonable and customary charges paid by the insurer.

Medicaid

Enacted in 1965 under the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term-care coverage to certain low-income Americans, including children, pregnant women, adults and people with disabilities. States design and help fund their own Medicaid programs within broad federal guidelines, so Medicaid programs vary from state to state. Colorado's Medicaid program is called Health First Colorado and there are more than 1.2 million Coloradans enrolled, most of whom work.

Medicare

Enacted in 1965 under the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to people age 65 and older, and younger people with permanent disabilities, end-stage renal disease and Lou Gehrig's disease. Unlike Medicaid and CHIP, Medicare is a fully-federal program, consistent from state to state and people are eligible for it regardless of income. It is common for Medicare beneficiaries to also have private insurance.

Network

The health care professionals, facilities and suppliers – e.g. doctors, hospitals and companies – that an insurance company has contracted with to provide health care services to its clients. The health insurer has negotiated discounted rates for services with providers in their network, so clients will pay less – often substantially less – when they access care through in-network providers.

Some insurance plans offer "narrow" networks, which limit the client's choice of provider in return for lower premiums and out-of-pocket costs. And some plans have "tiered" networks, meaning the client pays differentiated rates depending on the provider. Some plans will cover a limited portion of costs for services provided by out-of-network providers and some plans will not cover any part of the cost of services provided by out-of-network providers. An insurer will tell clients which providers are in their network.

Out-of-pocket maximum

The most an employee will pay during a policy period – typically a year – before health insurance begins to pay 100 percent of covered services. The health insurance premium does not count toward the out-of-pocket maximum, nor do any health care services that are not covered by the plan. Health plans vary as to whether health care expenses, such as deductibles, co-pays and co-insurance, count toward your out-of-pocket maximum.

PPO: Preferred Provider Organization

A type of health insurance plan. Typically, PPO plans:

- have networks, but the networks are usually broader than the network offered in an HMO or EPO plan;
- will provide some coverage for care provided by out-of-network providers; and
- do not require referrals for specialty care or put other benefit restrictions in place.

While clients may get more choice and flexibility than with an HMO plan, PPO plans are typically more expensive, meaning they are likely to have higher premiums and more out-of-pocket expenses, including higher deductibles and co-insurance.

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