

Choosing a HEALTHCARE PLAN



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Navigating the health insurance system can be a stressful experience facing people with diabetes in the US throughout the year, as well as during the selection process. Whether through private insurance (through an employer or on our own), public insurance (offered in some states), Medicare, or Medicaid, we must research and request additional information from the plan to confirm what coverage is offered for diabetes needs.

Much like diabetes, selecting a healthcare plan is a complex decision-making process that involves numbers and calculated risks/benefits discussions. And like living with this disease, making healthcare choices without having the full information may have consequences. Ironically, as important as these decisions are many of us are not taught about healthcare plans and what the specialized terminology means to women with diabetes.



Types of Health Insurance Plans

PPO or Preferred Provider Organization

PPOs provide the most options when it comes to medical care, permitting you to use providers and services regardless of being on the insurance plan's list of preferred providers. You'll pay more to see a medical professional, hospital, or service that isn't part of their network, but you will not need to get a referral to do so. Referrals are the process by which primary care providers select the specialist or service needed within the network of an insurance plan.

POS or Point-of-Service Plan

Point-of-Service Plans are less flexible than PPOs, but still permit options for care from outside the plan's list of preferred providers with a referral. POS plans require you to choose a primary physician from a list provided, and they coordinate referrals to other providers within the network. You must have a referral from your primary physician for any care outside of the preferred list. Out-of-network referrals result in higher out-of-pocket costs.

EPO or Exclusive Provider Organization

While you will not need referrals to see providers, hospitals, and services on an EPO list, EPOs are restrictive health insurance plans, limiting coverage and payments to their specific list. The one exception would be in an emergency situation outside of the plan's coverage area. They may be a little less expensive than PPOs.

HMO or Health Maintenance Organization

Health Maintenance Organizations are the most limiting of all health insurance plan types. Coverage is limited to their list of providers, hospitals, and services. You choose a primary care physician to coordinate all services and referrals, which must be within the plan. If you go outside of the HMO list, you bear the entire cost of any service you receive, except in the case of an emergency.

HDHP or High Deductible Health Plan

HDHPs have a monthly premium that is often lower than other plans but is offset with high deductibles. These types of plans may cover some preventive care, but most often are categorized as "catastrophic" health insurance plans. HDHPs require you to pay most or all costs of health care yourself before a plan begins to pay its portion.





Common Terms to Know

Premium

A premium is the fixed payment made to the insurance company on a monthly or quarterly basis, in order to benefit from the healthcare plan you've selected. Currently, the cost of a premium is based on the type of plan, the number of family members covered, and their ages. Changes in federal healthcare laws may allow preexisting conditions like diabetes to increase the premium cost. If premiums are not paid by the due date, you will lose health insurance coverage.

Deductible

A deductible is an amount you, as the patient, pay yourself for a medical professional visit, pharmacy prescription, diagnostic test, or service before insurance will pay for services. Once you pay the full deductible, insurance covers a portion of the payments made for your health care services. The amount you pay for your deductible will vary but cannot currently exceed \$7,150 for an individual plan and \$14,100 for a family plan.

Copay/Coinsurance

Some health insurance plans require you to pay a copay for medical visits, medications, or procedures. Copays may be a fixed amount (i.e., \$20 for a primary care physician visit) or a percentage of the cost to obtain medical services (i.e., 20% of the primary care physician visit after you've met your deductible). With few plan exceptions, you always pay a portion of the cost of all healthcare-related services.

Health Savings Accounts (HSA) - only with HDHP

HDHPs allow individuals to maintain a Health Savings Account (HSA), which permits pre-tax dollars to be deposited into this type of bank account used for medical expenses. Money may be deposited by the individual with coverage, an employer, or a third-party, but may only be withdrawn without a tax penalty for medical reimbursements or payments. The maximum annual contribution into an HSA for 2022 is \$3,650 for an individual and \$7,300 for a family, and funds that are not used can be rolled over to the next year.

Flexible Spending Accounts (FSA)

Some employer-based health insurance plans will offer an FSA, which like an HSA, allows pre-tax dollars to be used for medical expenses during the calendar year. The amount an individual selects to place into the account must match closely to what will be spent on medical services (and some over-the-counter medications or supplies), as only \$550 per year is allowed to be rolled over annually.

Out-of-Pocket (OOP) Maximum

An out-of-pocket cost is the amount paid annually for healthcare costs (excluding your monthly premium) before your health insurance plan will pay 100% of covered benefits. Under the Affordable Care Act, in 2022 the out-of-pocket maximum limit is \$8,750 for an individual and \$17,400 for an annual plan. Plans have different out-of-pocket maximum limit amounts, with HDHPs tending toward higher or highest deductible due to lower premiums.



What's Covered or Coverage

Preventative Care

Through the Affordable Care Act, every healthcare insurance plan must provide the following services at no charge if they are done within the insurance's network, including:

- Screenings for depression, diabetes, blood pressure issues, cholesterol, colon cancer (over 50), sexually transmitted diseases
- Contraception
- Mammograms (every 1 to 2 years if you are over 40 years of age)
- Well-woman visits
- Vaccines and flu shots

It is crucial to take advantage of the preventive care services and make well-woman visits annually.

In-Network, Out of Network

Insurance plans negotiate discounted pricing contracts with medical providers, hospitals, pharmacies, and services to include them in the plan's network. If a provider or service is "in-network," you'll be offered a discounted rate or copay.

However, if a provider or service is "out of network," you will either pay a higher rate (often with little or no discount) or your insurance plan will not cover the charge at all. In that case, you are responsible for all charges.

Specialist

Specialists are medical professionals who focus on a certain part of the body or mind (and have additional training in that area). Women with diabetes often incorporate specialists such as endocrinologists, cardiologists, and podiatrists into their healthcare teams. Most insurance plans require a higher copay or lower the percentage amount due for specialist coverage.

Prescriptions & Formularies

While prescriptions are covered under your insurance plan, you may find that the cost of obtaining these medications can vary widely. Some plans require payment for prescriptions as part of the deductible, so until you've met the deductible you pay entirely out-of-pocket. Others use a tiered cost system, so you may pay \$20 for one medication and \$60 for another.

Formularies are lists of prescriptions that your insurance covers based on agreements with insurance companies and pharmacy benefit managers. If a particular medication or device is not on the list, you will pay out-of-pocket or at the highest tiered rate. Formularies may change annually or more often.

Most recently, certain diabetes supplies such as insulin pump supplies and continuous glucose monitors have been covered under this benefit rather than durable medical equipment (see below).

Durable Medical Equipment (DME)

DME is a prescribed device or item that provides a “therapeutic” benefit and can be reused. Wheelchairs, oxygen, and hospital beds are common examples of DME. For women with diabetes, DME coverage can include insulin pumps and pump supplies, blood glucose monitors, orthotics, and continuous glucose monitors.

Insurance Coverage for Your Needs

When beginning to choose a health insurance plan, have the following items written down and readily available:

- Complete list of your current prescriptions and dosages
- Complete list of your current healthcare team, including specialists
- Your preferred hospital
- Where you get mammograms, diagnostic tests, x-rays
- Current pharmacy

Research

For any plan that you are considering, look at the following details:

List of Healthcare Providers and Services

Each insurance company has its own network and is available for your review before you select a plan. With your list close by, find out if the following are in the plan’s network:

- Your primary care physician and specialists
- Your preferred hospital
- The radiology center where you receive your mammogram and your diagnostic testing facility
- Your preferred pharmacy

Formulary

Insurance companies must provide an updated list of medications that they cover during the open enrollment period. Using your list of prescriptions, check to see if:

- Is the medication covered, and if so, under what tier is it listed?
- If any of your medications aren’t covered, what is the plan’s policy on exemptions? (It should be stated in the formulary guide.)

Determine The Annual Costs of Your Care

An HDHP may, or may not, be financially beneficial for you. It’s crucial to explore what you will pay out-of-pocket on an annual basis before selecting this type of plan.

Some individuals find a low or no deductible plan suits them because they see many specialists or require significant durable medical equipment expenses. Others realize after a detailed and personalized review that they may save money over the year with a high deductible plan.

For each plan you are considering, gather the following:

- Monthly premium
- Deductible (if any) that must be met before insurance covers costs
- Costs of primary care visits (either the fixed copay or the percentage you would pay for the visit)
- Costs of specialist visits (either the fixed copay or the percentage you would pay for the visit)
- Monthly cost of medications under the plan's formulary
- Emergency room and surgery costs (if needed)
- Durable medical equipment costs

An Example

Amy is a 45-year-old woman living with Type 2 diabetes. She is a non-smoker living in Virginia and is comparing two options for health insurance in her area.

Amy sees her primary care physician once per year and two specialists, a cardiologist and a gynecologist, annually. She sees an advanced registered nurse practitioner (ARNP) who is a diabetes care and education specialist (DCES) four times per year. She takes basal insulin and oral diabetes medications and uses a continuous glucose monitor (CGM) and a blood glucose monitor to manage her diabetes.

Note that this example is hypothetical and generalized.

Costs	High Deductible Health Plan (HDHP)/EPO	Health Maintenance Organization (HMO)
Annual Premium	\$3,420 (\$285/month)	\$5,880 (\$490/month)
Deductible	\$5,750	\$1,300
Maximum Out-of-Pocket	\$8,750	\$4,800
<u>After Deductible Met</u>		
Cost of Primary Visit	\$75 (50% Coinsurance)	\$ 20 copay
Cost of Specialist Visit	\$150 (50% Coinsurance)	\$ 50 copay
Monthly Medication Cost	\$400 (50% Coinsurance)	\$100 tiered copay
Emergency Room Visit	\$500 (50% Coinsurance)	\$400 (40% Coinsurance)
DME Monthly Cost	\$300 (50% Coinsurance)	\$120 (20% Coinsurance)



Which type of insurance will Amy choose?

It depends on how flexible Amy is, how much monthly she budgets for her medical expenses and how much risk she is willing to assume.

High Deductible Health Plan/EPO

As EPOs are the most restrictive type of plan, Amy discovers that while her cardiologist is within the network, none of the remaining medical team she has would be covered. She would need to select new providers for her diabetes, gynecological, and primary care.

She would meet her \$5,750 deductible quickly, as her monthly medication and DME costs alone would be \$1400/month (She pays 100% until her deductible is met). Based on the number of visits to her medical team and the cost of those visits, she will meet her maximum out-of-pocket deductible by mid-year. After that, the insurance company would cover medical costs at 100%.

$$\begin{aligned}\text{Amy's total cost} &= \text{Annual Premium} + \text{Maximum Out-Of-Pocket} \\ \$12,170 &= \$3,420 + \$8,750\end{aligned}$$

Health Maintenance Organization

HMOs also may be restrictive, but all of Amy's medical team are part of the HMO's network. Her medications and DME payments cost \$700 per month, so she will meet the \$1,300 deductible by the end of February. In March she would pay \$220 per month for her medications and DME payments.

Amy's medical professional visits would cost \$320 annually under this plan. She would unlikely meet her out-of-pocket maximum of \$4,800. The \$1,300 deductible, \$320 for medical appointments, and \$2,200 for medications and DME after the deductible was met would be \$3,820.

$$\begin{aligned}\text{Amy's total cost} &= \text{Annual Premium} + \text{Annual Overall Costs} \\ \$9,700 &= \$5,880 + \$3,820\end{aligned}$$

Amy would be better served financially (and perhaps emotionally) by choosing the HMO. While the premium for the HMO is higher, the monthly costs after a relatively low deductible is met are reasonable to Amy.

This is not always the case, which is why you must carefully examine all the aspects of the true costs of your plan. If Amy had any additional expenditures (perhaps a single ER visit), she could meet her out-of-pocket maximum and the HMO plan would be worse from a financial standpoint.

Your Basic Worksheet

Costs	Your Information	Proposed Plan
Annual Premium		\$ _____
Deductible		\$ _____
Maximum Out-of-Pocket		\$ _____
<u>After Deductible Met</u>		
Cost of Primary Visit	(# of visits x proposed copay or coinsurance)	\$ _____
Cost of Specialist Visit	(# of visits for each specialist x proposed copay or coinsurance)	\$ _____
Monthly Medication Cost	(# of medications under the proposed plan)	\$ _____
Emergency Room Visit	(estimated cost/copay of ER visit under the proposed plan)	\$ _____
DME Monthly Cost	(monthly cost under the proposed plan)	\$ _____

For your estimated annual cost for the proposed plan, use the following equation:

Determine if you will meet your out-of-pocket maximum for this plan. To do so, combine the cost of all the items under the "After Deductible Met" section and subtract the deductible. If the cost is greater than the out-of-pocket maximum, you'll use the out-of-pocket maximum in your total estimated cost. If not, use the sum of all the items listed in that category.

$$\text{Total Estimated Cost} = \text{Annual Premium} + \text{Deductible} + \\ \text{(either Out-Of-Pocket Maximum or sum of all items under After Deductible Met section)}$$



The Annual Cost of Your Healthcare Plan Isn't All Financial

The example given above is just one way to examine what you need from a healthcare plan. Financial cost is one of the largest decision factors, but established provider relationships and treatment effectiveness are also important.

Some women do not mind changing doctors, while others have developed a helpful relationship with their medical team and would not want to stop seeing them. Changing from one type of generic medication to another may not matter to some, but many women with diabetes will fight to maintain their successful treatment plan once they find an insulin that helps them manage diabetes.

By researching the details of each healthcare plan and determining what your annual costs (financial and others) would be, you can make a more informed choice.