CONSENT DECREE UPDATE

EMPLOYER NEWSLETTER 4 SEPTEMBER 2018

Encouraging Your Employees to Stay In-Network

Why Is It Important for My Employees to Stay In-Network?

When your employees receive care from out-of-network providers, it impacts their out-of-pocket cost and your costs as well. This is especially important as the Consent Decrees will come to an end June 30, 2019. Any employee enrolled in Highmark insurance who continues to use UPMC providers or facilities will incur large expenses in the form of higher deductibles, coinsurance, out-of-pocket maximums, and potentially balance billing. These higher expenses could impact your renewal rates for the January 1, 2020 plan year.

This Open Enrollment period is *very important!* Please make sure your employees understand that they need to choose the Network that best meets their needs and those of their family.

- Highmark Insurance: In-network care can be received from any Highmark (including Allegheny Health Network) facility or physician, plus *limited access to some UPMC facilities under the Consent Decrees only until June 30,2019*
- UPMC Health Plan Insurance: In-network care can be received from any UPMC facility or physician

An updated In-Network Hospital Listing for both Highmark and UPMC Health Plan will be provided with the Employee Open Enrollment Packets in October. Until then, the current listing is available on the Consent Decrees section of the MBS website at: http://municipalbenefitsservices.com/consent-decree-newsletters/ along with all of the past Employee and Employer newsletters.

How to Help Employees Avoid Out-of-Network Costs

- ✓ Encourage your employees to select the Network that best suits them and their family during Open Enrollment
- ✓ Direct them to contact HealthAdvocate if they have questions regarding:
  - Choosing the right plan
  - Knowing if their doctor or facility is in-network
  - Finding an in-network physician
  - Transferring their medical records to their new physician, if needed
  - Their insurance coverage and how it works
  - In-network vs. out-of-network costs
  - Billing issues
- ✓ Suggest they call their Highmark or UPMC Health Plan Member Services with questions or concerns
- ✓ Continue to distribute Municipal Benefits Services' Consent Decree Newsletters
- ✓ Repeatedly inform your employees of the costly expenses that they will incur if they go out-of-network
  - For Emergency Situations ONLY, your employees or covered family members can go to ANY emergency room. Once the patient is stabilized, he or she will be transferred to a hospital that is in-network for their insurance plan.

To emphasize the often drastic difference in cost – *depending on the service* – when using out-of-network providers, we have included the two examples, which we will include in the Employee Newsletter, for your reference below.

As always if you have questions, please contact your Client Managers:

Tammy Cappo	Tammy.Cappo@mbgbenefits.com	(412) 394-6307
Kristen Chekan	Kristen.Chekan@mbgbenefits.com	(412) 246-2528

What Will Out-of-Network Costs Look Like?

*These are average charges for two health care service scenarios. The **examples are only** intended to show the impact between in-network versus out-of-network. Costs could vary greatly depending on service location, area, and provider.*

Example 1: Outpatient Surgery	
Coverage Tier	Individual
Claim	First claim of the year
Plan Option	MBS PPO 10 Plan
In-Network Deductible; Coinsurance	$0; 0% (plan pays 100%)
Out-of-Network Deductible; Coinsurance	$250 (individual) / $500 (family); 80% after deductible

Outpatient Charges	$15,000	
Plan Allowance	$5,550	
	In-Network	Out-of-Network
Plan Pays	$5,550	$4,240
	Plan Pays 100% *No deductible and no coinsurance* *(Paid to the Provider)*	*$5,550 - $250 = $5,300 X 80% = $4,240* *80% coinsurance after the deductible* *(Paid to the member who must pay the Provider)*
Member Pays	$0	$1,310
	No deductible *No coinsurance*	*$5,550 - $250 = $5,300 X 20% = $1,060* *$250 deductible + $1,060 coinsurance = $1,310*
Balance Billing	Not Applicable	Potentially $9,450 *$15,000 - $5,550 = $9,450*
Member Total Cost	$0	$1,310 up to $10,760 *depending on the provider's balance billing policy*

Example 2: Professional Visit	
Coverage Tier	Individual
Claim	First claim of the year
Plan Option	MBS PPO 10 Plan
In-Network Deductible; Coinsurance; Copay	$0; 0% (plan pays 100%); $10 Copay
Out-of-Network Deductible; Coinsurance	$250 (individual) / $500 (family); 80% after deductible

Professional Charges	$150	
Plan Allowance	$73	
	In-Network	Out-of-Network
Plan Pays	$63	$0
	$73 - $10 member copay = $63 *100% after the copay* *(Paid to the Provider)*	*$73 - $73 member deductible = $0* *$250 deductible has not been met* *(Nothing is Paid to the Provider)*
Member Pays	$10	$73
	$10 copay *(Member must Pay the Provider)*	*$250 deductible; $0 has been met* *$73 must be paid by member first* *(Member must Pay the Provider)*
Balance Billing	Not Applicable	Potentially $77 *$150 - $73 = $77*
Member Total Cost	$10	$73 up to $150 *depending on the provider's balance billing policy*