BENEFITS TOOLKIT

Mitigating Health Care Costs

Provided by Horst Insurance

HORST INSURANCE

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Introduction

It's no secret—health care costs in the United States have risen sharply over the past two decades. In fact, a study by the Journal of the American Medical Association found that U.S. health care spending increased by nearly $1 trillion from 1996 to 2015. In 2018, the average premium rose 3% for single coverage and 5% for family coverage, according to the Kaiser Family Foundation's Employer Health Benefits 2018 Annual Survey. The average premiums were $6,896 and $19,616, respectively, and employers shouldered the majority of those costs. As costs continue to climb at a steady rate each year, employers across the country are feeling the pressure.

Why are health care costs rising?

When considering the problem of rising health care costs, it's important to explore the reasons behind the cost increases. It's also important to note that each organization will likely experience different cost drivers, but the following are among the most common across the country:

Skyrocketing prescription costs—Prescription drug costs continue to represent an increasingly large portion of health care expenditures. The Centers for Medicare & Medicaid Services (CMS) projects that from 2012 to 2022, annual expenditures on prescription drugs will grow by 75% to $455 billion, and outpatient prescription drugs will account for about 9% of total health care spending.

Increase in chronic conditions—Chronic conditions not only deeply affect those who suffer from them, but can also lead to increased medical expenditures and lost productivity for employers. Approximately 133 million Americans live with one or more chronic diseases, which translates into an increased cost for employers. As a nation, 86% of our health care dollars go to treatment of chronic diseases.

Increased usage—Utilization of many health care services has risen over the last decade. A number of factors such as improvements in medical technology, the influence of managed care, elevated consumer awareness and demand, and a boost in the number of practicing physicians caused health services—like the number of surgical procedures and the number of prescription drugs dispensed—to rise significantly. Other services such as breast cancer screenings, immunizations for children, and diagnostic procedures like CT scans and MRIs have also experienced sharp utilization increases.

Aging population—According to the U.S. Census Bureau, the number of Americans ages 65 and older is expected to nearly double by 2025, and the elderly population (80 and older) will increase by 80%. As this population ages, there is a subsequent rise in the occurrence of chronic diseases such as asthma, heart disease and cancer, and the need for more resources to fight these diseases. This leads to the increased use of

prescription drugs and other medical services, and an overall increase in health care spending.

Low health literacy—More than 1 in 3 Americans have difficulty with common health tasks like reading a prescription drug label or making a wise health care decision, according the U.S. Department of Education's National Assessment of Adult Literacy. Low health literacy often results in higher utilization of basic and expensive health services like emergency care and inpatient visits, which add up quickly. It is estimated that low health literacy costs the United States $106 billion to $238 billion annually and accounts for 7% to 17% of all personal health care expenditures. The 2018 Broker Services Survey found that 41% of survey respondents believe helping employees become better consumers of health care was a top benefits challenge.

How can employers address rising costs?

Mitigating health care costs has been a top-of-mind concern for employers nationwide for a few years.

> According to Zywave's 2018 Broker Services Survey, **68% of employers** believe managing health care costs is their biggest employee benefits challenge.

Many want to continue to offer valuable health benefits to their current employees, and many want those benefits to help them attract and retain quality employees. However, they must also weigh the cost-effectiveness of those benefits at a time when hefty rate hikes are the norm.

Employers are struggling to contain accelerating health plan costs. After trying to absorb most of the costs because of hiring and retention issues, many firms are attacking the root causes of rising costs with sustained, systemic changes. With the growing epidemic of poor health and the uncertain overall impact of health care reform, many employers are looking at both short- and long-term strategies to manage costs, which include making plan design changes, focusing on employee well-being and education, and implementing additional benefits offerings.

As costs continue to climb, your organization needs to take action. This toolkit serves as an introductory guide to health care cost-mitigation strategies. The various strategies outlined within this toolkit are merely suggestions and are not intended to be exhaustive. Before implementing any of the changes discussed, please contact us at Horst Insurance so we can help determine if the chosen strategy is the best option for your organization.

Note: This toolkit explains many different cost-mitigation strategies, but some of the strategies discussed may not be applicable or right for your organization.

Making Plan Design Changes

When it comes to mitigating health care costs, one of the most prominent strategies is to make plan design changes. This section outlines various plan designs that may help your organization address and mitigate rising health care costs.

Self-insured Health Plans

A self-insured health plan is one in which the employer assumes the financial risk associated with providing health care benefits to its employees. Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk of paying claims—the employer pays for medical claims out-of-pocket as they are incurred.

According to the Kaiser Family Foundation (KFF) and the Health Research and Educational Trust's (HRET) Employer Health Benefits 2018 Annual Survey, **61% of covered workers** are in a self-insured health plan.

Of these covered workers, 13% are workers in small firms and 81% are in large firms. Generally speaking, as the number of workers in a firm increases, the percentage of covered workers in a self-insured plan increases. Experts believe this is because large firms can spread the risk of costly, large claims or unexpectedly high expenses over a larger pool of workers and dependents. These trends are on par with what the market has seen in the past few years.

With a self-insured health plan, employers operate their own health plan as opposed to purchasing a fully insured plan from an insurance carrier. One reason that employers choose to self-insure is that it allows them to save the profit margin that an insurance company adds to its premium for a fully insured plan. However, self-insuring can expose the company to much larger risk in the event that more claims than expected must be paid. With a self-insured health plan:

- There are two main costs to consider: fixed costs and variable costs.
- The fixed costs include administrative fees, any stop-loss premiums and any other set fees charged per employee. These costs are generally billed monthly by the third-party administrator (TPA) or the carrier handling plan administration, and are charged based on plan enrollment.
- The variable costs include payment of health care claims. These costs vary from month to month based on health care use by covered persons (that is, employees and dependents).
- To limit risk, some employers use stop-loss or excess-loss insurance which reimburses the employer for claims that exceed a predetermined level. This coverage can be purchased to cover catastrophic claims on one covered person (specific coverage) or to cover claims that significantly exceed the expected level for the group of covered persons (aggregate coverage).

Advantages of Self-insurance

The primary reasons employers cite for self-insuring are:

- Reduced insurance overhead costs—Carriers assess a risk charge for insured policies (approximately 2% annually), but self-insurance removes this charge.
- Employer control—Employers who want to revise covered benefits and the levels of coverage are free from state regulations that mandate coverage and the carrier negotiation typically required with changes in insured coverage. By self-funding, employers are able to design their own customized health benefit packages.
- Employers see improved cash flow since they do not have to prepay for coverage—Claims are paid as they become due. There is also a cash flow advantage in the year of adoption when "run-out" claims are being covered by the prior insurance policy. Employers pay for claims rather than premiums and earn interest income on any unclaimed reserves.
- Choice of claim administrator—An insured policy can be administered only by the insurance carrier. A self-insured plan can be administered by the company, an insurance company or independent TPA, which gives the employer greater choice and flexibility. When selecting a TPA, employers should consider whether the TPA efficiently handles claims; has contacts with stop-loss carriers; has a strong reputation, cost management skills and negotiating clout; has medical expertise on staff; and provides excellent customer service and claims administration.

Note: Talk to an attorney for self-insured health plan specifics related to your state. This guide is intended for informational use only and uses general statements.

Disadvantages of Self-insuring

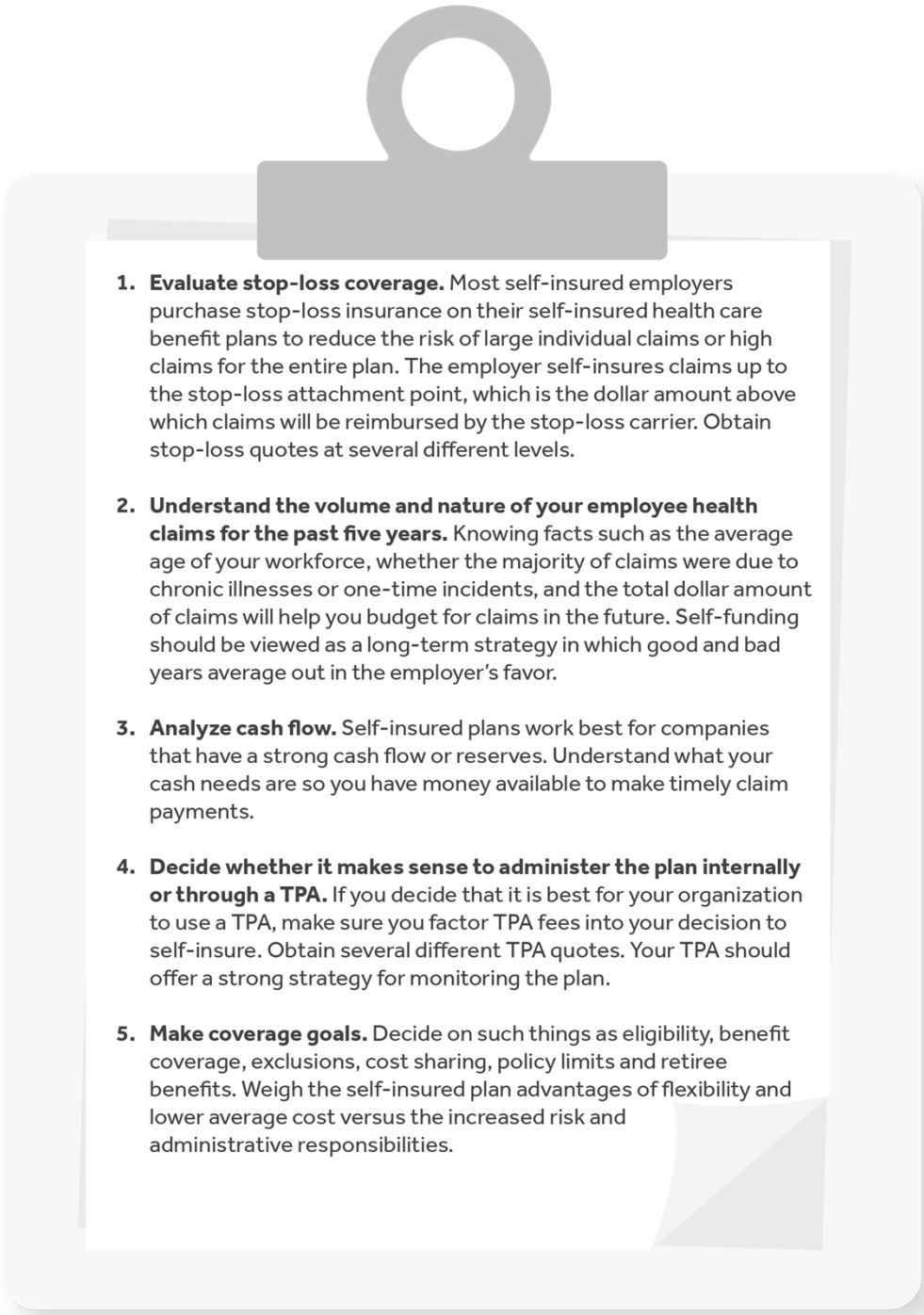
While self-insuring can have its advantages, it can be a lengthy process for employers, and it can sometimes be a long time before they see results. This section outlines other potential disadvantages to self-insuring.

- Greater risk—The main risks of self-insuring involve situations when claims are higher than anticipated. While stop-loss coverage will protect employers from paying excessive claims in a given year, the cost of that coverage will likely increase, and it may be more difficult to get rates from other stop-loss providers. Claims that are higher than expected in a self-insured plan may also make it more difficult for employers to go back to a fully insured plan in the future. And, an employer's assets may be exposed to liability as a result of any legal action taken against the plan. Legal matters in regards to self-insured plans can be complex.
- Higher administrative costs—For organizations that choose to run their self-insured plans internally, the administrative costs involved can be significant. However, using TPAs to operate

the plans will still likely involve lower administrative costs than those associated with fully insured plans.

Deciding If Self-insurance Is Right for You

When deciding if self-funding is right for your organization, make sure that you consider the following best practices to ensure that your self-funding strategy is appropriate and effective.



1. **Evaluate stop-loss coverage.** Most self-insured employers purchase stop-loss insurance on their self-insured health care benefit plans to reduce the risk of large individual claims or high claims for the entire plan. The employer self-insures claims up to the stop-loss attachment point, which is the dollar amount above which claims will be reimbursed by the stop-loss carrier. Obtain stop-loss quotes at several different levels.

2. **Understand the volume and nature of your employee health claims for the past five years.** Knowing facts such as the average age of your workforce, whether the majority of claims were due to chronic illnesses or one-time incidents, and the total dollar amount of claims will help you budget for claims in the future. Self-funding should be viewed as a long-term strategy in which good and bad years average out in the employer's favor.

3. **Analyze cash flow.** Self-insured plans work best for companies that have a strong cash flow or reserves. Understand what your cash needs are so you have money available to make timely claim payments.

4. **Decide whether it makes sense to administer the plan internally or through a TPA.** If you decide that it is best for your organization to use a TPA, make sure you factor TPA fees into your decision to self-insure. Obtain several different TPA quotes. Your TPA should offer a strong strategy for monitoring the plan.

5. **Make coverage goals.** Decide on such things as eligibility, benefit coverage, exclusions, cost sharing, policy limits and retiree benefits. Weigh the self-insured plan advantages of flexibility and lower average cost versus the increased risk and administrative responsibilities.

Because the employer assumes the financial risk of providing health care benefits, a company can either save or lose money depending on the level of claims incurred by its employees. The most important step you can take to assure that you make the best decision is to have an experienced professional assist you. Your Horst Insurance representative has experience with self-insurance programs, and can answer your questions and assist you with your decision to self-insure your company health plan.

Level Funded Health Plans

If you desire the freedom of a self-insured health plan but need a little more certainty for your budgeting concerns, level funding might be an option for you. Level funding is also an option for employers who were told that they aren't a large enough group to make self-insuring fully work. Weigh the advantages and disadvantages, and decide what's best for your company.

Level funding is an option that can assist employers in their health coverage budgeting efforts. With level funding, employers pay a set amount each month to a carrier.

> This amount typically includes the cost of administrative and other fees and the maximum amount of expected claims based on underwriting projections, as well as embedded stop-loss insurance.

The carrier facilitating the level funding will pay your employees' claims throughout the year. At the end of the year, if your payments exceeded claims, you will receive a refund from the excess you paid in monthly claim allotments. If the claims exceeded what you paid into the program, your stop-loss insurance will cover the overage amount in most cases.

Advantages of Level Funding

Level funding offers several advantages. Like other self-funded plans, you don't have to pay premiums that are based on community rates, which might be higher than your employee group's risk. Instead, you only pay the actual claims and an additional administrative fee. Another benefit of level funding is that if all the money you set aside each month to cover claims is not used, you will receive a refund at the end of the year from the surplus, instead of paying expensive premiums for a fully insured plan and essentially using or losing that money. If you are already self-funded, then you will enjoy a more budget-friendly method of monthly claims payment, with stop-loss insurance to protect you from unexpected high costs.

Generally, the monetary advantages of level funding are that you are better able to manage your budget and prepare for claims costs. You will benefit from a smoother cash flow and not worrying that a high claim near the beginning of the year will impact your business. Additionally, many level funding plans provide detailed reporting on utilization trends, giving you important information on where employees may be causing overspending (such as unnecessary use of emergency room (ER) visits instead of urgent care).

Another advantage of level funding is having fewer governmental regulations than fully insured plans are subject to. Check with your legal counsel about regulatory benefits specific to your state and business.

Disadvantages of Level Funding

Although there are upsides to level funding, there are also some disadvantages. One is that when you choose to self-fund you are likely looking to cut costs—and with level funding, part of your monthly payment is to cover administrative fees. Depending on the plan and your other options, these fees have the potential to cut into the savings you hope to gain from running a self-funded plan. You'll need to weigh the cost effectiveness of administering your self-funded plan in-house, hiring a TPA or choosing a level funded option with the attached administrative fees.

Additionally, you still have to pay the claims. With level funding you're paying for the convenience of having equal payments throughout the year and the security of stop-loss coverage.

Another challenge of level funding to consider is the terms of the contract; make sure you understand how the contract will impact a business of your size—companies with smaller numbers of employees may benefit differently than those with larger numbers. Also, many level funding plans restrict their offerings to companies with a certain minimum or maximum number of employees, which may affect your ability to contract with your desired carrier.

Making Your Decision

Ultimately, level funding is an option that must be considered in light of your company's cash flow, risk tolerance, employee numbers and preferred budgeting methods. Please note that plan designs may vary from what's outlined above. Contact Horst Insurance for more information about plan design specifics and coverage options.

Cost Sharing

Many employers are choosing to pass more costs to employees or restructure their health plans to incentivize lower-cost options.

> Zywave's 2019 Survey Results: Employee Benefits Benchmark revealed that **30% of employers** plan to increase cost sharing to employees to manage rising costs.

When it comes to cost sharing, these are a few strategies employers are using:

- Increasing deductibles and out-of-pocket maximums
- Increasing employee cost sharing for out-of-network providers
- Increasing employee cost sharing for brand-name prescription drugs to incentivize use of generics

According to the KFF and HRET's Employer Health Benefits 2018 Annual Survey, most workers must pay a share of their health care costs, and 85% had a general annual deductible and 58% had a deductible of at least $1,000 for single coverage in 2018. Even without a deductible, the vast majority of workers cover some portion of the costs from their in-network physician visits. For instance, 66% have a copayment for primary doctor visits and 24% have coinsurance. Nearly all workers are covered by a plan with an out-of-pocket maximum (OOPM), but the costs vary considerably. Of workers with single coverage, 14% have an OOPM of less than $2,000, and 20% have an OOPM of $6,000 or more.

High Deductible Health Plans

Implementing a high deductible health plan (HDHP) is something many employers across the country have opted to do in recent years.

> According to Zywave's 2019 Survey Results: Employee Benefits Benchmark, from 2015 to 2019, there's been a **10% increase in the number of employers** who offer an HDHP with a health savings account (HSA) plan offering.

Standard plans and HDHPs are set up much in the same way. Under both plans, the member pays a premium for coverage. Both must cover preventive services free of charge. If a member receives non-preventive medical care, he or she pays a deductible—a specified amount of money that the insured must pay before an insurance company will pay a claim. The chief difference between the plans is that under an HDHP, premium payments are considerably lower and the deductible is considerably higher.

The second major factor setting HDHPs apart from standard plans is the addition of an HSA. With an HSA, the account holder or his or her employer (usually both) make contributions into a savings account. No taxes are deducted from money placed into the account, as the HSA contribution is withdrawn from a paycheck before taxes are assessed. While in the savings account, the money can earn interest. The employee is free to spend that money on qualified medical expenses.

One important thing to note about HDHPs, though, is that part of their success relies on how employees use the plan. If employees aren't wise health care consumers, health care costs will still be high, even with the cost-sharing benefits of the plan. If you opt to implement this type of plan, you'll need to be prepared to provide educational resources that help employees become smart health care consumers.

Contact us at Horst Insurance to learn more about the HDHP and consumerism resources we can provide to you. We're here to help you make the most informed plan design decision.

Reference-based Pricing

Another plan design measure that employers use to mitigate rising health care costs is to employ reference-based pricing (RBP). RBP works by setting spending limits on certain procedures or services—meaning an individual would only be covered up to the established limit for these services and would have to pay the cost difference out of pocket. Most plans base their prices on Medicare-allowable costs, which are marked up to establish a profit margin. However, limits should only be set on "shoppable" services. These are services that allow an individual to take time to make a decision based on price and quality, like for prescriptions, lab tests or joint replacements. In all of these examples, there are lower-cost options that are typically the same quality as the more expensive alternatives.

Employers typically work with a third-party vendor to establish the best limit for a procedure. The vendor will help conduct market research and negotiate the most appropriate deals with providers. Finding a reliable vendor that works well with your company is crucial for negotiating the best prices for your employees.

RBP is most effective when applied to procedures with fluctuating costs. For instance, colonoscopies may range from $400 to $6,000, depending on the physician. In this case, an employer using RBP might set the spending limit to the median price of the procedure, based on market findings. If an employee uses a health facility that charges above the spending limit for a specific procedure, he or she will need to cover the difference out of pocket.

Benefits of RBP

Employers who use RBP have the potential for three main benefits:

1. **Wider network of providers and facilities**—RBP doesn't limit employers and employees to a narrow network of providers, so there are more doctors and facilities to choose from.

2. **Lower overall health care expenses**—Employers pay a set amount for each service, so their health care costs may be lower when using RBP.

3. **Increased health literacy**—Given the nature of RBP, employees will be encouraged to take charge of their own health care decisions and shop around for the best priced option whenever possible. Doing so increases their health literacy and helps make them wiser health care consumers.

Health coverage usually extends to any in-network procedure, regardless of cost. With RBP, employers do not risk paying exorbitant prices for services that could be done more inexpensively. By setting a limit on certain procedures, employers are empowering employees to take charge of their health care decisions.

Having established limits on specific services means employees must consider cost, in addition to quality, when choosing where to have a procedure. This requires research on the employee's part, encouraging active participation in his or her health care. It is estimated that low health literacy costs the United States $106 billion to $238 billion annually. By promoting employee engagement in health care decision-making, you are helping to educate employees, while lowering overall health costs.

Disadvantages of RBP

There are a number of considerations to make when implementing RBP, given the complexity of the model. It is paramount you work with a vendor who is reliable and experienced in the RBP process. The vendor must be able to ensure a smooth transition into this model, otherwise you risk disrupting highly utilized providers. If you choose a vendor who is inexperienced, your RBP limits might be too low for the services your employees need, making the plans unaffordable. Moreover, not using a vendor (and its legal advocacy) could potentially leave you vulnerable to providers attempting to balance bill.

Considerations

RBP is an innovative strategy for lowering health care costs. As the market continues to evolve, employers are tasked with developing creative strategies for saving money. The RBP model is unique in its ability to reduce costs while simultaneously promoting employee health literacy.

To learn more about RBP, and to see if it is right for your organization, contact your Horst Insurance representative today.

Direct Primary Care

While it isn't a replacement for health insurance, direct primary care (DPC) is an innovative solution that can help reduce health care costs.

> With DPC, physicians, pediatricians and internists charge a monthly membership fee that covers most of what the average patient needs for primary care, including visits and drugs at lower prices, instead of accepting insurance for routine visits.

As a result, DPC can provide substantial savings to patients. Here is an example of a typical DPC plan:

- Cost of visit—Free with monthly membership
- Copay cost—No copays
- Length of visit—Typically 30-60 minutes (traditional doctor's office visits are less than 20 minutes)

Because they don't operate under the typical fee-for-service model, many DPC providers are able to spend more time with their patients. Research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive.

Popularity of DPC

DPC is emerging as a way to combat rising health care costs and maintain a high quality of care. Recently, the U.S. Senate Committee on Health, Education, Labor & Pensions (HELP) met to discuss how expanded access to primary care can help reduce overall health care costs.

Those who partner with the right providers may find great success with this type of health care model. While DPC has grown steadily in the past few years, the market is still slow. Despite this, DPC providers and supporters are optimistic about its future.

Considerations

As health care costs continue to climb and the prevalence of expensive chronic conditions increases, the importance of choosing the right doctor and type of care is exemplified. DPC presents a way for employees to receive more personalized health care while containing their health care costs. Moreover, DPC can be an attractive option for employees with high deductible health plans and health savings accounts, as it would provide them with the option of receiving care without paying high out-of-pocket costs.

It may be worthwhile to further investigate this model and evaluate if it's right for your organization. For more information on DPC, please contact us today.

Reducing Drug Prices

As discussed before, the increased cost of prescription drugs is a contributor to the overall rising cost of health care. Ensuring your employees have the correct medications is important for their health and your bottom line. Employees who only use brand-name drugs might forego their prescriptions in order to save money. This leads to lost productivity, increased employee stress and a whole host of issues related to not taking prescription medication.

Alternatively, some employees might have a variety of brand-name drugs they take. While it is good that they are taking their medications and staying healthy, using only brand-name drugs means higher costs for employers, plan sponsors and the end users—the employees. With drug costs increasing at a faster rate than other health spending, now is the time for employers to review their drug cost-saving options.

Encourage Use of Generic Medications

Generic drugs can sometimes be misunderstood as subpar or not up to the same quality standards as brand-name prescription drugs. Consumers recognize a brand name and consider the unknown labels as inferior products. This is unfortunate because generic drugs are not only of the same high quality as brand-name prescriptions, but they can cost up to 85% less.

> Moreover, according to the U.S. Food and Drug Administration (FDA), **"Generic drugs are important options that allow greater access to health care for all Americans. They are copies of brand-name drugs and are the same as those brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use."**

If generic drugs are of the same high quality as brand-name drugs, *and* they cost less, why isn't everyone using them? The problem could be employee education. Teach your employees the value of buying generic so they can save money—for you and themselves.

According to the FDA, generic medications lead to a savings of $3 billion every week and more than $150 billion annually. Boosting the use of generic medications by incorporating the strategies of consumer driven health plans into your prescription coverage design can potentially save you and your employees significant money.

A good way to begin employee education is by integrating information about generic drugs into your benefits communications. Send employees informational articles or emails explaining the differences between generic and brand-name medications and encouraging them to request generics when filling a prescription. You may wish to reach out to employees through social media with additional information regarding generics.

Other Cost-saving Strategies

Beyond using generic drugs, there are a number of other ways to save your company money. Many carriers and third parties offer options like mail-order delivery or other unique cost-saving programs. This section will go over some of those programs. Please note that some programs are carrier-specific and might not be available to you. Speak with your Horst Insurance representative to discuss the available program options.

Half-tablet Programs

This program aims to reduce the number of tablets participants consume, while still receiving the same strength of medication. For instance, individuals might need 15 milligrams (mg) of a daily medication, so they receive a prescription for 30 tablets. With the half-tablet program, individuals would receive a prescription for 15 tablets, with 30 mg strength each. Instead of taking one daily, they would only take half of a tablet.

Participants in this program only pay half of their usual prescription copay because they are receiving half the number of tablets. Likewise, individuals who pay coinsurance would be paying a smaller percentage for fewer tablets. According to Anthem, this program would save participants an average of about $5 a month for generic drugs and $35 a month for brand-name drugs. This equates to around $60 to $420 annually for each participant, which means serious savings for employers.

Mail-order Prescriptions

Many carriers offer the option for mail-order prescriptions. This means participants can have their drugs mailed by simply calling a phone number or sending in a paper form. Prescriptions are then delivered to their homes instead of pharmacies, commonly at a lower rate.

Plan Design

According to Zywave's 2019 Survey Results: Employee Benefits Benchmark, the most popular technique employers use to combat high prescription costs is to use three tiers for cost sharing. These tiers typically separate prescription drugs by cost. Based on the tier level, there will be a pre-determined copay that the employee is responsible for paying. While not all prescription drug plans are the same, here is an overview of how drug tiers can work:

- Tier I: Low-cost prescription drugs, which most often end up being generic drugs, are included in the vast majority of Tier I plans. In some cases, cheaper brand-name drugs may fall in the Tier I level, too. Tier I drugs come with the lowest copay, if there is one assessed at all.

- Tier II: Brand-name drugs and more expensive generic drugs are often included in this tier. Employees can expect to pay a moderate copay if they are using medications within this tier.

- Tier III: More expensive and non-preferred brand-name drugs are typically included within this tier. For plans with only three drug tiers, this tier comes with the highest copay. In many cases, prescription drugs that fall within this tier will require pre-authorization from an insurance company before it can be filled at a pharmacy.

Some employers offer a four-tier plan design, with the fourth tier costing employees the most amount of money out-of-pocket. Typically, new brand-name drugs or specialty drugs are included within Tier IV.

Creating a tiered prescription drug plan isn't the right option for everyone. Talk to Horst Insurance to find out if it's the right option for you and, if so, to review the best tier design for your organization.

Saving on Specialty Drug Costs

Specialty drugs are very expensive and used to treat complex conditions, like cancer, hemophilia or multiple sclerosis. Individuals who need these medications must often be monitored by their physician, who assesses whether the medications are working. Additionally, these drugs usually require complicated applications, like an injection or infusion, adding to the price. Employers should look for ways to reduce specialty drug costs because experts predict their utilization and price will only increase.

The National Business Group on Health suggests doing the following to curb specialty drug spending:

- Develop a comprehensive utilization strategy for the company, based on necessity and eligibility.
- Use a step program, so employees must try generic drugs before moving to more costly alternatives.
- Place quantity limits on drugs so employees use the correct dosage.
- Consider excluding the most expensive drugs, if cheaper alternatives are available.
- Consider moving some specialty drugs to the pharmacy benefit instead of medical benefit, increasing cost control and oversight.
- Utilize a preferred network of pharmacies to help lower costs.

For more information on prescription drug plans and cost-mitigation strategies, contact Horst Insurance.

Using Telemedicine to Reduce Costs

As technology has developed, so has people's ability to overcome the traditional communication barriers of time and distance. The practice of telemedicine (also known as virtual visits, telehealth and e-health) is a step forward in the health care industry to use telecommunication to bridge the gap of time, distance and affordability to reach patients in need of medical attention.

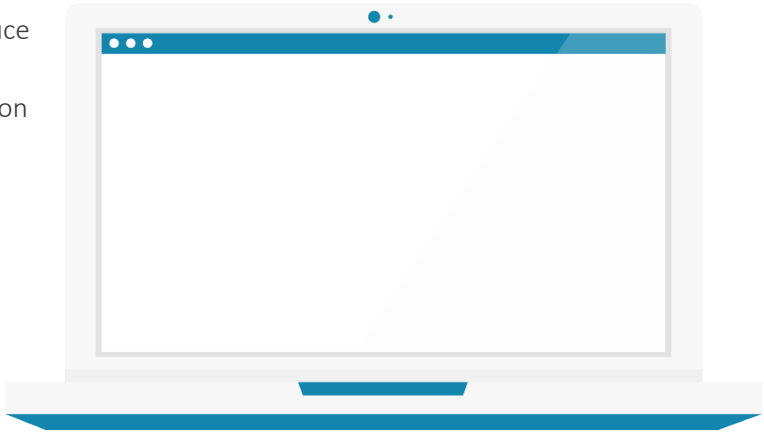
Telemedicine uses technology to facilitate communication, whether real-time or delayed, between a doctor and patient who are not in the same physical location for the purpose of medical evaluation, diagnosis and treatment. Usually a patient is able to communicate from his or her home with a doctor through a live video, audio or patient data transfer system. Doctors can see the patient and assess his or her symptoms, as well as obtain the patient's records and medical history from electronic medical records.

Benefits of Telemedicine

Fueled by technological advances and answering the demand for convenient care, telemedicine delivers many advantages. Although it is not the same as sitting in a doctor's office, a telemedicine visit with a doctor can prove beneficial by warding off further illness or disease, stabilizing a condition until a patient is able to reach a hospital or monitoring a patient at home. Telemedicine is not a complete replacement for face-to-face health care, but it can be a tremendously helpful supplement and even a temporary substitute for traditional medical care.

Cost Savings

Reduction in costs is another major benefit of telemedicine. Patients save money for routine and specialist care because they don't have to pay travel expenses for distant doctors and don't have to take time off work to travel and then sit in a waiting room. Doctors are also more efficient in the number of patients they can see in a day, which can help reduce overhead costs. In addition, remote monitoring can help lessen the much larger cost of long hospitalizations or in-home nursing, and it may reduce the cost of managing chronic conditions. Remote monitoring can also help prevent hospital readmission by properly supervising care following a patient's discharge from the hospital.



Remote Access and Specialist Availability

Communicating remotely with a doctor is a primary function of telemedicine. With this

technology, doctors can reach patients in remote, rural and underserved areas where there might not be an available doctor or hospital. Through telemedicine, patients can access doctors for routine visits, emergency care or diagnostics from a specialist. Another benefit of telemedicine is increased access to specialists.

Even when patients live in urban areas with numerous doctors and hospitals, specialists for rare health conditions may not practice in the area. Telemedicine enables patients in both rural and urban areas to connect with specialists who may be hundreds of miles away. This can translate into cost savings as telemedicine reaches those who would not normally seek care or preventive services, helping them remain healthy.

Convenient Care

For some patients, the comfort and convenience of consulting with a doctor from the safety of their own home is a tremendous advantage. The convenience can also improve care. For example, whereas patients might forget to bring medications with them to a traditional office visit, they have ready access to the information necessary for the doctor to diagnose and prescribe when they are at home. Telemedicine is particularly convenient for elderly and disabled patients, patients who may not speak English and patients who have agoraphobia. Also, because the patient is at home, it is often easier to take notes or even include a family member who can help retain important information from the doctor.

Telemedicine Considerations

Though telemedicine and telemental health services clearly have their advantages, there are also a handful of disadvantages and potential legal pitfalls.

Fewer In-person Consultations and Reduced Care Continuity

Having a well-established, trusting relationship with your doctor is crucial to your long-term health, and can also save you money in the long run. Moreover, research shows that patients who have a good relationship with their doctor receive better care and are happier with the care they receive. In cases where patients are using on-demand telemedicine services that connect them with a random health care provider, care continuity may suffer. Moreover, a patient's primary care provider may not have access to records from telehealth visits, and telehealth doctors may not have access to a patient's health history, which can create problems for both health care providers and the patient.

Telemedicine Requires Specific Equipment

Because telemedicine is done over the internet, patients must have access to the internet and possess the necessary technological skills in order for virtual visits to be effective. According to eVisit, a telehealth software company, patients need to have the following pieces of equipment to have a virtual visit:

- A computer or mobile device
- An integrated or external microphone
- An integrated or external camera
- Internet connection
    - Ideally, a patient's internet speeds should be at least 15 megabits per second (Mbps) download and 5 Mbps upload. Patients can check their internet connection at www.speedtest.net.

Potential Legal Issues

Telemedicine is currently subject to various federal and state laws and regulations. Additionally, employers that offer HDHPs that are compatible with HSAs should consider how a telemedicine benefit may impact participants' HSA eligibility. Whether telemedicine is disqualifying coverage for HSA purposes depends on how the telemedicine benefit is structured. With the Affordable Care Act, the federal government announced the move toward encouraging and including telehealth services in health care coverage at the federal level through Medicare, in selected circumstances.

However, there is not currently a uniform legal approach to telemedicine, which is a major challenge for employers. The federal government strictly limits the telemedicine services provided for and reimbursed by Medicare, but leaves such decisions for Medicaid programs up to the state. Due to the complexity of such laws and the differing state-by-state compliance obligations, it is highly recommended that your organization speak with an attorney or legal professional prior to plan implementation.

Utilizing Case Management Services

According to the International Foundation of Employee Benefit Plans, using a case management service that identifies barriers to getting the best care for employees is the most common technique employers are using to control rising health care costs, with 71% of respondents saying they employ the technique. With case management services, the goal is to promote individualized health and wellness, which results in increased patient outcomes and lower costs. Case management typically includes evaluating the employee's health and situation, coordinating care and establishing the best plan for the employee.

How does case management work?

When an employee obtains care, they're often met with many complex and confusing decisions to make. Considering one-third of American adults have low health literacy, making these decisions can be extremely difficult. That's where a case manager and case management services come into play. The case manager's goal is to advocate for an employee and serve as the main source of communication between them and the health care professionals.

Additionally, a case manager will be responsible for explaining the care options and decisions available to an employee so that they fully understand what's going on. When it comes time for treatment to end or for a patient to be discharged, the case manager coordinates this process and determines if follow-up care may be needed.

Different Types of Case Management Services

Depending on the insurer or plan, there can be different types of case management. Here are a few examples:

1. **Large case management—**This type of case management service is used for catastrophic illnesses and injuries. These case managers address the needs of patients, diagnoses, care environments and available alternatives.

2. **Disease case management—**This type of case management service focuses on managing costly chronic conditions that require treatments and medications that can drive the overall cost of health care for employers. These case managers will evaluate each employee's conditions and create a plan to help them more effectively manage their condition and their health care costs.

3. **Wellness case management—**One of the best ways to control health care costs is to focus on prevention as much as possible. That's where wellness case management services can help. Typically, these services involve delivering easy-to-understand health and wellness information to employees. Ultimately, the goal is to motivate and support those who wish to take charge of their wellness by providing them with weekly topics, instructions, worksheets and assignments that help build a foundation for better health and help avoid the clinical and financial impact of chronic disease.

Is it right for your organization?

In an age where health literacy is a concern and health care costs continue to climb, employers must act and find strategies that work for them in order to mitigate their health care costs. Implementing case management services at your organization may be the key to lowering overall health care costs, increasing health literacy and improving the health outcomes of your employees.

Case managers can work with your employees to coordinate care, develop transition plans, learn more about their condition and understand the billing process. Research shows that when patients are informed of their choices, they are more satisfied with their care and receive fewer unnecessary tests or treatments. This, in turn, saves the employer money in health care costs and lost productivity.

For more information on case management services, contact Horst Insurance.

Using Nurse Advice Lines

According to the Wellness Council of America, 70% of doctor's office visits and 66% of ER visits are unnecessary.

> A PwC study revealed that the most common reasons for these unnecessary—and expensive—visits were patient convenience, lack of appointment availability and need for after-hours care.

While obtaining health care services when employees need them is essential to their health, it comes at a cost. For example, the current national average cost for a primary care physician visit is around $155, and the cost for an ER visit is around $1,022. These figures, which were provided by Thomson Reuters allowable cost information, vary by region but demonstrate that unnecessary visits can add up quickly for both employees and employers. One way to prevent these unnecessary visits from occurring is to offer a nurse advice line.

What is a nurse advice line?

The vast majority of insurers offer this type of service, but be sure to check with them. In short, a nurse advice line is a way for employees to connect with a health care professional 24/7, 365 days a year. While this may sound like telemedicine, the important distinction is that the nurse on the line can't write prescriptions or give a diagnosis. Moreover, this line shouldn't be used in lieu of calling 911 in the event of an emergency. The nurse advice line can be thought of as a triage that will help employees determine the best next step to take. Additionally, a nurse advice line can give answers to common health questions.

How does it work?

If an employee calls the nurse advice line with a common health question, the answering professional will give an answer. If an employee calls with questions regarding an illness or injury, the answering professional will help them triage their condition. This will typically involve asking the employee questions about symptoms they may be experiencing and how long they've had the symptoms. Based on the information the employee provides, the nurse or health care professional can make recommendations on if the employee should head to the ER or an urgent care center, wait until they can see a primary care physician or treat their condition with over-the-counter medications (like ibuprofen or acetaminophen) or methods (like icing a sprained ankle).

Is it right for your organization?

When used properly, a nurse advice line can help match the proper care to employees, reducing the costs of unnecessary visits. They can also help employees obtain care sooner, resulting in healthier and happier employees. For more information on nurse advice lines or to find out if your health plan selections offer this cost-mitigation strategy, contact Horst Insurance today.

Offering Health Concierge Customer Service

In the health care system, the term "concierge" is associated with a few different concepts. In this instance, concierge is used to refer to health concierge customer service. This service operates similarly to a hotel concierge service. A hotel concierge can help coordinate reservations, make recommendations for activities or dining, and obtain tickets. Their job is to help you explore the city you're in and make the most of your stay. In a similar fashion, a health concierge helps employees navigate the ins and outs of the complex health care system and get the most out of their insurance and their health care services. In an age of rising health care costs, increased moves to consumer driven health care and low health literacy, utilizing a service that simplifies the health care process may be the key employers are looking for.

How does it work?

In its simplest form, a health concierge serves as a central point of contact for an employee's health care. Health concierge customer service coordinates all aspects of care and passes that information along to the employee in an easy-to-digest and actionable format. In many cases, these services are offered as a value-based reimbursement service. While concierge services differ in forms based on providers, they're typically offered as a subscription benefit for employees.

Generally, employees can access a variety of health care support services, including:

- Explanations of appropriate and available care
- Selection of in-network or plan-approved locations
- Help scheduling care
- Cost estimates
- Advocacy for claims and billing questions

To provide these services, health concierge companies employ different tactics. Some forms of health concierge services are algorithm-based, with service and care recommendations coming from the results of these algorithms. Other forms of health concierge services, which are more traditional, involve one-on-one work with an employee to develop personalized care plans and coordination. The most common form of health concierge services, though, combines the algorithm-based and one-on-one formats. The combination delivers a balance of live support and technology-driven solutions, allowing employees to speak to a health concierge in-person or navigate through a web interface to coordinate their care.

Is it right for your organization?

Health concierge services can centralize and simplify health care for employees, which may help enhance employee engagement, optimize benefits usage and lower overall costs. When properly and regularly used, these services can help employees stretch their health care dollar, which can result in cost savings for employers, too. In addition to everyday health care support, health concierge services can be of significant value to employees facing serious illnesses or injuries. The health concierge can take some of the stresses of coordinating and managing care off the employee's shoulder.

For more information about health concierge customer services, or to evaluate if it's the right fit for your organization, contact Horst Insurance.

Promoting Employee Well-being

Employers across the country have been keen to offer workplace wellness programs, with 82% of large firms offering one in 2018, according to the KFF. While these programs are a great start to improving the physical health of employees, they miss the mark on focusing on an employee's overall wellness. What's more, a PwC analysis revealed that employees view employee engagement as a sense of fulfillment with their job, contributing to their sense of wellness as a whole. When combined, these two realizations reveal that something's missing. That's where workplace well-being comes in.

At its most basic, well-being refers to feeling good and living both safely and healthily. It refers to wellness is all aspects of life, including, but not limited to, physical health, mental health, social health and financial health. The concept of well-being can have implications on an employee's overall quality of life, health and happiness. From an organizational standpoint, an employee's well-being is directly related to the quality of their work, as well as their engagement, performance and productivity.

According to a Gallup poll, organizations with **highly engaged employees outperform their competition in earnings per share by 147%.**

In a tightened labor market, where it's imperative to retain your top-performing employees as well as recruit the best and brightest candidates, taking strides to incorporate a holistic approach to wellness is a viable solution. Fortunately, doing so isn't as complicated or expensive as it may seem. The best practices listed throughout this toolkit will serve as examples for how you can incorporate initiatives that will address and support the four tenants of well-being: physical, mental, financial and social.

Physical Well-being

Creating a culture that supports employees' physical well-being goes beyond offering gym discounts and implementing weight-loss, smoking cessation or walking programs at your organization. It's all about giving employees the tools they need to manage costly chronic conditions and to make healthy choices while they're at the office. Focusing on managing chronic conditions may help you lower your organization's overall health care costs.

According to the Centers for Disease Control and Prevention (CDC), chronic diseases are health conditions that require ongoing management over an extended period of time, and these conditions account for 86% of the nation's health care costs.

Moreover, it's estimated that **133 million Americans live with at least one chronic condition.**

Some chronic conditions have very few symptoms while others severely limit a person's ability to perform normal, routine tasks. Chronic conditions not only deeply affect those who suffer from them, but can also lead to increased medical expenditures and lost productivity for employers. However, in spite of their devastating effects, many chronic conditions are preventable. While some factors such as age, genetics and environmental triggers may be unavoidable, controlling modifiable risk factors such as smoking, physical inactivity and eating an unhealthy diet can play an important part in preventing chronic conditions.

Treating chronic diseases involves physician visits, extended hospital stays, prescription drugs and expensive treatments. Chronic diseases are serious, costly and often, preventable. Once they are fully developed, these conditions may be managed, yet never cured. Despite this, there are safe, cost-effective interventions to avoid chronic diseases altogether. To avoid productivity loss, presenteeism, absenteeism, disability and early retirement for your employees, you should educate them on the value of chronic disease prevention.

Here are three costly chronic conditions plaguing employees across the country, accompanied with what you can do to help prevent them.

1. **Heart Disease—**According to the CDC, about 1 in every 4 deaths in the United States involve heart disease, a term that includes several different types of heart conditions. Heart disease contributes to absences from work, poor performance and death. Treatment and the indirect costs related to heart disease, such as missed days of work, add up to nearly $313 billion each year.
    - **What can you do?** Similar to preventing diabetes, leading a healthy lifestyle through eating healthy, exercising, and avoiding tobacco and alcohol is a great way to lower one's risk of developing heart disease. Consider offering heart-healthy options in vending machines or in your cafeteria and encourage employees to exercise regularly to prevent heart disease.

2. **Diabetes—**It's estimated that 90%-95% of individuals with diabetes have Type 2 diabetes. Type 2 diabetes is commonly referred to as adult-onset diabetes, which means that individuals with this form of diabetes aren't born with it, but develop it later in life. Treating this condition, which is the seventh leading cause of death in the United States, is costly for both employees and employers, but is necessary to avoid further complications.
    - **What can you do?** Research shows that eating a healthy diet, maintaining a healthy weight, exercising regularly, and avoiding tobacco and alcohol are all ways to lower one's risk of developing Type 2 diabetes. Consider implementing small changes around your workplace, like offering healthy vending machine options, prohibiting smoking on-site and establishing a workout club or gym discounts, to encourage employees to lead a healthy lifestyle and prevent Type 2 diabetes.

3. **Opioid Addiction—**In the face of the opioid epidemic, employers nationwide are having to address opioid use, abuse and addiction in their workplace. Estimates show that the opioid crisis costs the U.S. economy over $95 billion every year, with employers footing $18 billion of that bill themselves.
    - **What can you do?** Employers need to do everything possible to combat the impact opioids have in the workplace. There is no silver bullet for this crisis. However, exploring new initiatives can help you develop your own strategy to best suit the needs of your employees. These new initiatives can include expanding coverage options for alternative pain treatment (e.g., acupuncture or chiropractic care), educating employees extensively on the risks opioids present, encouraging employees to speak with a doctor, and establishing or promoting an employee assistance program (EAP).

By targeting these high-cost health issues, you may be able to mitigate some of their related health care costs and, in turn, help your employees become healthier. Remember to take a multichannel approach when educating employees. This includes sending out emails, delivering printed articles, hanging up infographics or posters, or sharing brief videos with employees. A multichannel communication plan will help ensure as many employees as possible receive your message.

Mental Well-being

According to the World Health Organization, there's not a specific definition of mental well-being. However, various studies agree that achieving a state of mental well-being includes being able to:

- Realize one's full potential.
- Work productively.
- Cope with the normal stresses of life.
- Contribute meaningfully to one's community.

Mental well-being includes mental health, but goes far beyond treating mental illness. One main roadblock that employees face when it comes to their mental well-being is chronic stress, which can lead to lack of sleep, which, in turn, can exacerbate workplace stress.

Nearly 80% of Americans consider their jobs stressful. And, according to the American Institute of Stress, 1 in 4 employees view their jobs as the top stressor in their life.

While it may not be possible to eliminate job stress altogether for your employees, you can help them learn how to manage it effectively. Common job stressors include a heavy workload, intense pressure to perform at high levels, job insecurity, long work hours, excessive travel, office politics and conflicts with co-workers. Moreover, work-related stress is more strongly associated with illness and health complications than financial or familial stress.

Lowering stress can lower the risk of medical conditions and can help employees feel better on a day-to-day basis. You can implement various activities to help reduce employee stress, which can improve health and morale—and productivity. As an employer, you can take several steps to help employees reduce their work-related stress and achieve mental well-being:

- Make sure that workloads are appropriate.
- Have managers meet regularly with employees to facilitate communication.
- Address negative and illegal actions in the workplace immediately—do not tolerate bullying, discrimination or any other similar behaviors.
- Recognize and celebrate employees' successes. This contributes to morale and decreases stress levels.

Aside from addressing job-related issues, you can implement a variety of activities and initiatives to help reduce stress. Some suggestions include the following:

- Provide a designated space where employees can sit quietly and use meditation to alleviate their stress.
- Offer exercise classes—exercise is a great way to relieve and even prevent stress. Offer a variety of class times (e.g., before and after work, or during lunch) as well as various types of classes—such as yoga and kickboxing.
- Provide employees with the education and tools to manage time and tasks, to cope with daily stressors and to prevent stress from damaging their health. You can present a stress management class or provide educational materials.
- Establish and promote an EAP. If an employee is significantly stressed, it's possible that they may seek unhealthy ways to cope with their stress. Offering an EAP can help employees get the help they need.

By giving your employees the tools and resources they need to reduce their workplace stress, you can help them be well on their way toward achieving a state of mental well-being. Openly communicate your organization's commitment to cultivating the mental well-being of your employees. Too often, employees don't seek out mental health services because they feel ashamed. By communicating your commitment to mental well-being, you will incorporate into your organization's culture and everyday way of life. Doing so will help encourage employees to seek the services they need.

Social Well-being

The concept of social well-being is one that's commonly forgotten about, mainly because not many are familiar with it. Of course, there's the social interaction component to social well-being, which involves encouraging employees to form professional relationships and volunteer in the community. However, there's also the societal component, which involves incorporating initiatives into your organization that reflect societal issues like environmentally friendly offices.

One way to promote social well-being is by encouraging volunteerism. Having a well-established employee volunteer program (EVP) can help attract and keep talented, socially conscious and ambitious employees. Volunteering can be fun and rewarding, as well as good for team building. What's more, giving back to one's community has been proven to boost one's mood. There is no right answer as to which companies should or should not have volunteer programs, because each company is different. How you choose to volunteer and the programs you offer will be unique to you and your brand.

The common belief among these companies is that employees who volunteer with their colleagues feel a strong connection to the workplace and also a sense of belonging, promoting an employee's social well-being.

When employees are exposed to activities that help them boost their social well-being, it helps them feel like you really care about them as individuals, which boosts their engagement and sense of belonging. As has been discussed throughout this toolkit, happy and engaged employees are more productive and more likely to remain at your organization.

Financial Well-being

Behind work-related stress, financial stress is the next biggest stressor for employees. Employee financial instability affects workplace performance. Imagine trying to focus on work when you don't know how you'll make your monthly car payment, or how productive you'd be if you had a pile of bills waiting at home. These situations illustrate the impact financial wellness can have on job performance and overall well-being.

Think about employee financial education another way: offering financial wellness tools can enable employees to get the most out of their benefits, most notably their employer-sponsored retirement plans. Why bother offering such plans if employees aren't maximizing their value? With this in mind, consider pairing your conventional retirement plans with other financial wellness programs.

Employee financial education varies by employer, but over 80% of employers offer some sort of financial wellness program, according to a study from Prudential. The study notes that common programs include retirement and saving calculators, and access to financial advisors. These programs can help employees understand basic financial concepts and avoid risky decisions, like payday loans.

You don't need to spend thousands of dollars to implement an effective employee financial education campaign. Even small, informative offerings can be enough to get employees thinking about their savings goals. The following are just some of the ways you can start encouraging financial wellness:

- Hold a class on budgeting basics.
- Distribute surveys about financial concepts to gauge employee understanding.
- Offer access to financial planners through your employee assistance program.
- Provide access to debt calculator tools.
- Hold a meeting to explain retirement benefits before open enrollment.

Source: IRS

Focusing on Health Literacy and Benefits Education

The Institute of Medicine defines health literacy as the "degree to which individuals have the capacity to obtain, process and understand the basic health information and services needed to make appropriate health decisions."

According to the U.S. Department of Education's National Assessment of Adult Literacy, more than 1 in 3 Americans, or over 77 million people, are considered to have inadequate health literacy, which means that they have difficulty with common health tasks like reading a prescription drug label or making a wise health care decision.

Low health literacy often results in higher utilization of basic and expensive health services like emergency care and inpatient visits, which add up quickly. It is estimated that low health literacy costs the United States $106 billion to $238 billion annually and accounts for 7% to 17% of all personal health care expenditures.

Becoming health care literate, though, is harder than it might seem. According to the National Network of Libraries of Medicine, in order to be considered health care literate, a consumer must be able to do the following tasks:

- Access health care services.
- Analyze relative risks and benefits.
- Calculate dosages.
- Communicate with health care providers.
- Evaluate information for credibility and quality.
- Interpret test results.
- Locate health information.

This is where you can help your employees. Beyond providing employees with required plan documents and open enrollment assistance, you should provide year-round employee education and communications. To achieve buy-in, communication regarding health insurance and benefits should resemble a marketing campaign more than a typical HR information campaign. Use a variety of communication methods, such as handouts, emails, videos, face-to-face meetings and presentations.

Repeat key messages to ensure sufficient exposure and understanding. Doing so will help them become wiser health care consumers, which, in turn, will help lower overall health care costs.

At the very minimum, your education and communication strategy should focus on teaching employees about the basics of health insurance. This can include explaining the different types of health plans, the difference between in-network and out-of-network care, how to use health spending accounts and how claims become bills. You plan should also communicate cost-savings strategies, such as opting for generic medication, choosing urgent care over the ER and shopping around before obtaining treatment whenever possible. By educating employees on the basics of health insurance and health benefits, you're empowering them to make more informed health care decisions.

In addition to providing basic benefits education, a robust plan will include information on preventive care and wellness, and be focused on increasing employee engagement. Beyond understanding the cost of health care, many employees are not engaged in taking charge of their health. One example is the growing prevalence of obesity in the United States. According to the CDC, more than one-third of adults in the United States are obese.

Employee behavior and lifestyle are significant factors in health status—often trumping genetics, the environment or access to care—and can have a huge impact on the cost of health care. Employers, who pay the majority of their employees' health care costs, have an enormous stake in engaging their employees in their own health care.

When employees are informed, they're better equipped to make the right decision for their health and their wallet. It's never too late to implement benefits education at your organization. In fact, aside from mitigating health care costs, helping employees become wiser health care consumers is the most prominent challenge that employers face, according to the 2019 Survey Results: Employee Benefits Benchmark.

Contact us at Horst Insurance to discuss your organization's employee education needs. Whether you require basic benefits educational materials, wellness resources or comprehensive guides, we can help you empower your employees to take charge of their health care.

Utilizing Transparency Tools

A price transparency tool typically contains pricing information from various health care facilities or providers for consumers. These tools can help employees make a more informed decision about what health care service they want to seek from which provider. These tools are currently offered by all major health plans, a variety of vendors, and by some states that collect this information from local payers or providers and share it with the public. Most tools contain information about hospitals and physicians, a wide range of services, quality information and the consumer's share of costs. Additionally, in early 2019, CMS passed transparent pricing rules that required health care organizations to post standard procedure pricing information online in a machine-readable format.

Price transparency tools are critical to empowering employees to become wiser health care consumers. These transparency tools look different from every vendor, but they should provide pricing information for health care services and prescription drug costs at the very least. In using these tools, employers can help employees better understand their health care options.

Price and quality transparency tools are widespread, but it's up to the employee to use the tools in order to reap the potential cost-saving rewards. Choosing the right transparency tool for your organization can help improve employee engagement and usage. Here are five things to consider when you're evaluating price transparency tools:

1. **Scope:** Tools possess an adequate breadth of information.
2. **Quality:** Tools leverage quality measures relevant to employers and consumers, displaying them in understandable ways.
3. **Price Accuracy:** Tools display accurate price data broken down in useful ways for consumers.
4. **Usability:** Tools are designed to facilitate ease of use for consumers by providing a search function and customer support.
5. **Engagement:** Tool provider employs communication, education and other engagement strategies to drive usage.

For more information on price transparency tools, contact Horst Insurance.

Eliminating Billing Fraud

Health care fraud is a costly problem that costs billions of dollars each year. While there are many different types of health care and medical fraud, billing fraud is one type that directly affects employers and employees. Knowing the signs of billing fraud and how you can address it is an important strategy to help keep health care costs down.

What is billing fraud?

When an employee goes to the doctor or has a procedure done, the health care provider enters a specific current procedural terminology (CPT) code on the claims they submit to insurance companies to get paid. The different codes determine how much a provider will be paid, as they detail the type of service or treatment provided. There are thousands of different codes, and while mistakes happen, an incorrect CPT code can result in a billing error.

Billing fraud happens when health care providers file claims, knowing they are not correct. This can happen several ways.

Upcoding: The doctor or other health care provider provides a service, but lists a billing code for a more complicated or lengthy procedure that pays more. By using codes for more serious procedures with higher rates of payment, providers can significantly increase how much they are paid.

Unbundling: Some codes are meant to include a group of procedures commonly done together, such as cleaning a wound, stitching it and applying a dressing. Using three separate codes when there is one code for the procedure is called unbundling.

Double billing: This happens when the same bill is submitted multiple times when the procedure was performed only once.

How can you address billing fraud?

Because they're the first to see their medical bills, employees are the first line of defense in eliminating billing fraud. Proper education and communications regarding how to read a medical bill is essential. Additionally, you should direct employees to report instance of billing errors or billing fraud to your insurer. If your group health plan is self-insured, direct employees to report these instances to a specific contact. This allows potential trends of billing fraud to be detected, which can help address the issue on a larger scale.

Implementing Network Steerage

One common health care cost driver is employees using out-of-network providers or facilities. Sometimes seeing an out-of-network specialist is unavoidable, but because your plan doesn't have pre-negotiated pricing agreements and discounts in place with providers outside of its network, costs can escalate quickly. And, even if a provider is considered to be an in-network physician, they may operate out of an out-of-network facility, which can result in additional charges. The intricacies of in-network vs. out-of-network can be difficult for even the wisest of health care consumers. One way to simplify the process and contain these costs is to implement a network steerage program at your organization.

What is steerage?

Network steerage is a strategy employers can use to ensure employees visit in-network doctors and facilities. These networks are carefully negotiated and planned to give patients access to convenient care. Often, these selected providers and facilities are vetted to ensure they can provide quality care, which can improve overall health outcomes. In creating these networks and steering employees to obtain care from the selected providers and facilities, employers encourage cost savings through negotiated pricing and better care.

How does it work?

Employers and plan sponsors evaluate local providers and facilities to determine which are able to provide the best quality of care at reasonable costs. This typically involves sorting through a large amount of data. Once you've determined the facilities and providers you want to steer your employees to use, you'll need to educate employees and explain the benefits of using the selected care professionals.

Is it right for your organization?

This cost-savings strategy enables employers to steer their employees to the appropriate type of care for their illness or injury based on quality outcomes and lower costs. With network steerage, employers and employees can benefit as the strategy helps prevent employees from seeing doctors that overcharge and underperform.

In order to see success with a network steerage program, you'll need to invest resources into finding the best facilities and providers in your area, and commit to extensive employee education and communication. You may have the best steerage program, but if your employees aren't aware it exists or don't understand how to use it, it won't be successful. For more information on network steerage or to discuss if it's a good option for your organization, contact Horst Insurance.

Conclusion

Mitigating health care costs has been a top-of-mind concern for employers nationwide for a few years. Many want to continue to offer valuable health benefits to their current employees, and many want those benefits to help them attract and retain quality employees. As costs continue to climb, your organization needs to take action.

The various strategies outlined within this toolkit are merely suggestions and are not intended to be exhaustive. Please contact us at Horst Insurance so we can help determine if the chosen strategy is the best option for your organization.

Appendix

The resources included in this section are for employee education and communications. Speak with Horst Insurance if you have any questions about these resources. Note that some sections may require customization.

Printing Help

There are many printable resources in this appendix. Please follow the instructions below if you need help printing individual pages.

1. Choose the "Print" option from the "File" menu.
2. Under the "Settings" option, click on the arrow next to "Print All Pages" to access the drop-down menu. Select "Custom Print" and enter the page number range you would like to print, or enter the page number range you would like to print in the "Pages" box.
3. Click "Print." For more information, please visit the Microsoft Word printing support page.

KNOW YOUR BENEFITS.

From

How to Research Health Care Prices

It's not a secret that health care can cost quite a bit. In 2010, the United States spent $3.1 trillion on health care, an average of $9,695 per person. The Milliman Medical Index suggests that the average family of four covered by an employer-sponsored health plan will spend over $25,826 on health care in 2016.

Who Sets Prices

So who do you suppose sets the price of individual medical procedures? While the government and insurance companies have a hand in determining costs, they are only two of many variables. The prices your insurance company pays for medical procedures are largely based on a set of values listed in a directory of billing codes published by the Relative Value Update Committee (RUC) of the American Medical Association (AMA).

The committee is tasked with determining a value for all medical procedures. The value is totaled by adding up several variables associated with the procedure, such as the time it takes to perform the procedure and the cost of supplies.

The RUC then advises the Center for Medicare and Medicaid Services (CMS) on the values for procedures. While the CMS is not obligated to go by the values set by the RUC they do so roughly 95% of the time. Accepted recommendations are then applied to a CMS formula incorporating other information that determines a dollar amount for the procedure that will be paid to health care providers.

Finding Out Prices

Researching health care costs is not easy. Aside from the sheer number of variables that go into determining the price for your particular situation, health values, like those submitted to CMS by the RUC, are not made public. Likewise, hospitals and other providers generally don't publicize how much they're paid for services, and they can charge different amounts depending on who is paying. Insurers, which often contract to receive lower prices for their customers, also generally do not disclose numbers.

Researching health care costs is not easy. Aside from the sheer number of variables that go into determining the price for your particular situation, health costs are generally not made public.

One way to help control health care costs is to become more knowledgeable as a health care consumer. Traditionally, patients were told what procedures or treatments were needed, where to receive the treatment and then simply waited for the bill. Many individuals still approach their health care in this way because they do not know about any alternative solutions.

However, today there are options available for patients to get involved in decisions regarding their health care. The more engaged you are with your medical care and treatment, the more money you can save—while still ensuring high-quality care.

The easiest step to take in order to learn health care costs specific to you is to speak with your doctor. If something confuses you, ask questions. If your doctor prescribes a medication, ask if there is a generic version or lower-cost option available. If your doctor recommends a procedure or test, ask if it is truly necessary or if other options exist.

Next, take that information and compare it against data collected from other facilities in your area. It is also a good idea to call local providers with assertive questions in mind (and make sure to take good notes).

Additionally, there are a growing number of online resources set up to help you estimate what a medical service costs before you undergo any procedures. While it's

How to Research Health Care Costs

unlikely you will be able to obtain an exact dollar figure with these methods, there is a good chance you can discern a reasonably precise price range.

Additionally, there are resources to help you find the best value for medical care. Prices vary from facility to facility, so you can realize significant savings by doing some research in advance.

There are also online resources to help you find and compare health care price information. Check out the following resources:

- www.healthgrades.com/ for physician and hospital ratings and quality data, plus cost information for a variety of medical procedures.
- www.newchoicehealth.com/ for estimated costs for various procedures by region or provider. Plus, request a procedure price quote from local providers.
- www.healthcarebluebook.com/ for a suggested, fair price for a service based on a database of rates paid by private insurers.
- http://projects.wsj.com/medicarebilling/ for a searchable database, hosted by the Wall Street Journal, of dollar amounts that doctors and medical providers received in Medicare reimbursements in 2012.
- Also be sure to check with your health insurer—it may offer quality or price comparison tools available for plan members.

KNOW YOUR BENEFITS.

From

1. Wise Use of the Emergency Room

An emergency is **life-threatening** and requires **immediate** care. Call 911. Be sure to bring along identification, insurance cards, and medication and health history information.

Examples of an Emergency:

- Not breathing/having difficulty breathing
- Choking – unable to dislodge item
- Heart attack or stroke
- Broken bones
- Severe bleeding or burns
- Shock

Situations for Routine/Self-care at Home:

- Minor cuts and sprains
- Fever of 102° F or below
- Headache
- Sore throat
- Upper respiratory infection
- Common neck and back pain

Your Home Emergency Kit:

- Assorted bandages
- Sterile gauze pads and tape
- Moleskin
- Thermometer
- Tweezers
- Moist towelettes
- List of emergency numbers
- Flashlight and batteries
- Nasal bulb syringe
- Scissors
- Elastic wrap

Over-the-counter Aids:

- Pain and fever medications (ibuprofen/acetaminophen)
- Antacids
- Antibacterial ointments
- Decongestants
- Antihistamines (avoid if pregnant)
- Sunblock

Wise Use of the Emergency Room

- Anti-itch products
- Anti-diarrheal products

An emergency is **life-threatening** and requires **immediate** care. Call 911. Be sure to bring along identification, insurance cards, and medication and health history information.

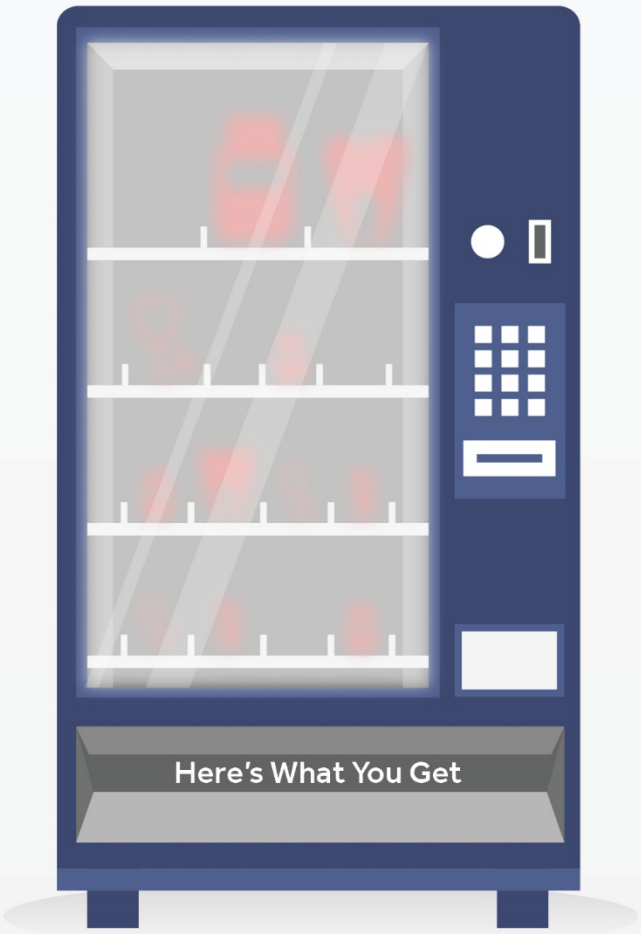
Be Prepared for Emergencies:

- Learn CPR and first aid
- Keep first aid book or card handy
- Have emergency numbers posted
- Know the location of the closest emergency facilities
- Understand your insurance policy
- Have medical history available
- Carry ID and insurance cards at all times

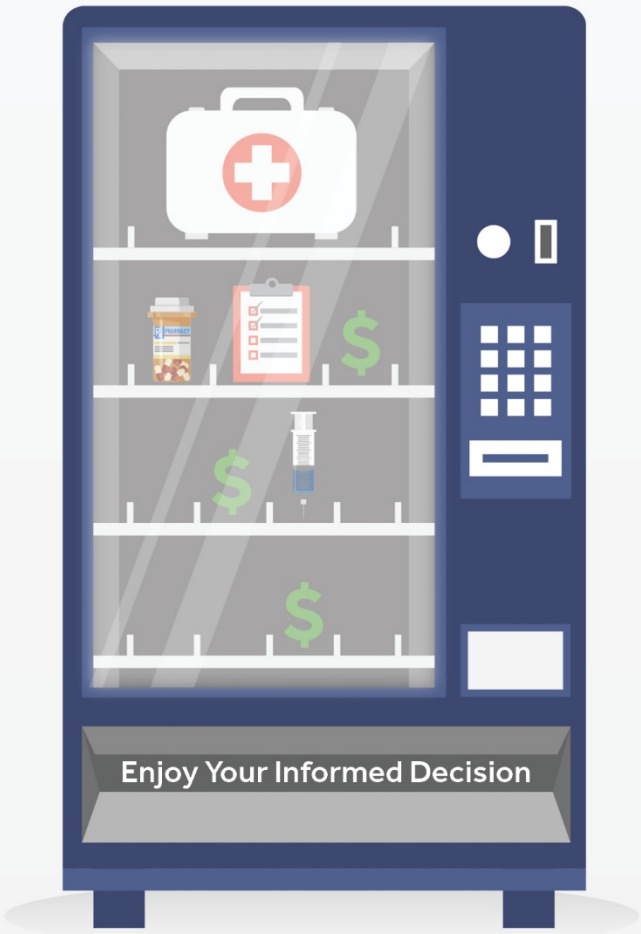
This is What **HEALTH CARE LITERACY** Feels Like

Did you know **low health care literacy** costs the United States over **$100 billion** each year? That affects **everyone**. Stop overpaying on prescriptions or using the ER when you don't have to. Start saving money today by learning more about your health care. Even simple benefits 101 knowledge can help your budget go a long way.

Take it or leave it health care



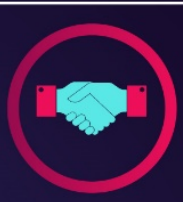
Smart shopper health care



5 WAYS TO CUT YOUR HEALTH CARE COSTS

1. ALWAYS USE IN-NETWORK PROVIDERS, WHENEVER POSSIBLE.

An in-network provider is a provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates. In general, if you visit an in-network provider, you will get your health care at a lower price.



2. ASK THE RIGHT QUESTIONS.

Asking your doctor questions can help you decide what treatment plan is best for both your health and your wallet. Some useful questions to ask your doctor include the following:

- Why is this treatment necessary?
- How much will my treatment cost?

- Can I be treated another way that is equally effective but less costly?

3. KEEP DRUG COSTS DOWN.

By being a wise health care consumer, you may be able to cut your prescription drug costs by up to 90 percent. Strategies to help you save money on prescription drugs include the following:

- Shop around at local pharmacies to find the best price on your prescription.

- Ask your doctor about generic or over-the-counter drug alternatives to brand-name prescriptions.

- Look into discount prescription programs.

4. PRACTICE PREVENTION.

In its broadest definition, prevention includes a healthy lifestyle, exercise, diet and other similar efforts. When preventive care services like physical examinations, screenings and immunizations are combined with a lifestyle that is focused on wellness, significant savings can be achieved. The Trust for America's Health predicts that there is a return of $5.60 for every $1 spent on proven preventive care strategies in America.

5. TAKE CONTROL OF YOUR HEALTH CARE.

Learn to shop for value when it comes to health care. Ask your doctor the right questions, conduct price comparisons, read reviews and review all medical bills carefully. With a little effort, you can ensure that you are getting the best value for your health care dollars.

For more information on cost-saving strategies, contact your HR department.

Get to Know Telemedicine

What is it?

Telemedicine is a form of technology-based communication that allows a doctor and patient to communicate without being in the same physical space.

How does it work?

Through the use of technology, communication is facilitated either in a real-time or delayed setting. Usually a patient is able to communicate from his or her home with a doctor through a live video, audio or patient data transfer system. Doctors can see the patient and assess his or her symptoms, as well as obtain the patient's records and medical history from electronic medical records.

Is telemedicine a substitute for in-person doctor's visits?

No. A virtual appointment is good for a number of mild conditions, but is not suitable for severe symptoms like a high fever or a debilitating cough. Additionally, you should **NOT** use a virtual appointment to seek treatment for situations like a chronic condition, complex conditions, life-threatening conditions, anything requiring a test or hands-on exam, or broken bones, sprains or other serious injuries.

Want more information?

Please see HR for more information on telemedicine offerings.

How to be a Wise Health Care Consumer

With health care costs continuing to rise, it's more important than ever to take responsibility for your medical care choices. Asking questions and researching your options are good ways to start taking control of how much you spend on health care.

Consider Your Plan Options
Making careful health care decisions is vital for keeping your health care costs down. You can control your out-of-pocket costs by carefully reviewing your health insurance plan options and choosing the one that best fits your needs. For example, if you have many medical problems or recurring medication, you might want to pay a higher premium for more coverage and a lower deductible. If you are generally healthy and rarely need to visit the doctor, a high deductible health plan (HDHP) with lower monthly premiums might be the most cost-effective option.

Ask Your Doctor
Patients often accept their doctors' advice without truly understanding what treatment alternatives are available, and what—if any—differences there are in cost and effectiveness among those alternatives. A few simple questions can help you decide what treatment plan is best for both your health and your wallet. Ask questions such as:

- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?
- What are the risks?
- What are the side effects?

Having a conversation with your physician can help you better understand how his or her care and recommendations affect your health and your plan costs.

Saving money on medical care starts with being a well-informed health care consumer.

Make Careful Decisions About Prescription Drugs
Many people incorrectly think that there is a significant difference between generic and brand-name prescription drugs. However, generic drugs are only approved by the Food and Drug Administration (FDA) if they have the same active ingredient, strength, dosage form and route of administration as the brand-name drug.

Generic drugs may contain different inactive ingredients, but the primary difference between generic and brand-name medications lies in the name of the drug and the cost. Generic drugs cost less but still provide the same health benefits as brand-name drugs.

The next time your doctor writes you a prescription, ask if a generic equivalent is available. Your physician can instruct your pharmacist to use a generic substitute.

Choose In-network Providers When Possible
Seeing doctors who are in your insurance plan's network is typically much less expensive than out-of-network health care providers. When you choose a plan, make sure that you have access to the doctors and hospitals you will want to visit when you need care.

How to be a Wise Health Care Consumer

Seek Outpatient Care
Outpatient care is often a less expensive alternative to inpatient care, and it does not necessarily sacrifice the quality of care. If you need to have surgery, ask your doctor if laboratory tests can be done in a clinic rather than in a hospital. In addition, the surgery itself can sometimes be performed in a clinic or an outpatient surgical facility, giving you the ability to recover in the comfort of your home instead of in a hospital. If outpatient care is a reasonable alternative for the specific care you need, it can help you save on out-of-pocket expenses.

Review Benefits and Bills
When you need medical care or medications, review your insurance coverage to understand what costs you will be responsible for. Then, when you receive the bill and Explanation of Benefits (EOB), carefully look it over to ensure that you were charged correctly. Errors can occur in medical billing codes and in coverage, so taking a few minutes to read through the bill could save you money by catching potentially costly mistakes.

In general, being a wise health care consumer means taking the time to learn about your insurance and medical care options, choosing the plan and treatments that are best for you, and reviewing medical bills to ensure the charges are correct.

KNOW YOUR BENEFITS.

From

Why Are Health Care Costs Rising?

Health care costs, and consequently employee health benefit costs, have been growing at an alarming rate in recent years.

As health care costs climb, the amount your employer must pay for your health benefits also increases. Unfortunately, the trend of health benefit costs rising faster than the rate of inflation is expected to continue.

Unpredictable and uncontrollable health insurance rate increases are having a very serious financial impact on many employers and employees. Employers are also passing more of these costs onto employees, as the percentage that employees are asked to pay is also increasing.

Why Are Costs Rising?
Several market conditions working together have led to steep increases. Understanding these factors will help you be aware of the reasons behind any changes your employer decides to make to any benefit or employee contribution (the amount you are required to pay out of your paycheck).

Several factors have contributed to climbing health care costs over the past decade, including the following:

- Demographics
- Expansion of health care providers
- Consolidation of managed care companies
- Government regulation
- Increased utilization and consumer demand
- New medical technology
- Weakening of managed care system
- Health care spending and medical cost inflation
- Increased prescription drug costs

Unpredictable and uncontrollable health insurance rate increases are having a very serious financial impact on many employers and employees.

In addition, Aon Hewitt has identified specific factors that are contributing to the current health care costs and projected figures that continue to rise:

The Aging of America
According to the U.S. Census Bureau, the number of Americans age 65 and older is expected to nearly double by 2025, and the elderly population (80 and older) will increase by 80%. As this population ages, there is a subsequent rise in the occurrence of chronic diseases such as asthma, heart disease and cancer, and the need for more resources to fight these diseases. This leads to the increased use of prescription drugs and other medical services, and an overall increase in health care spending.

The Dramatic Rise of Prescription Drug Costs
Prescription drug costs continue to represent an increasingly large portion of health care expenditures. According to IMS Health, the United States spent nearly $450

Why Are Health Care Costs Rising?

billion on prescription drugs in 2016. Furthermore, in 2014, prescription drug spending in the United States increased 5.8% from 2015.

While prescription drug spending has been a fairly small proportion of national health care spending compared to spending for hospital and physician services, it has been one of the fastest-growing components, compared to hospital and physician services.

The Consolidation of Insurance Companies
During the economic boom of the 1990s, competition among insurance carriers and managed care companies was fierce. In order to gain market share, many large insurance companies acquired smaller, weaker firms and kept their rates low in order to stay competitive. This practice has taken its toll, leading to dips in profitability and stock prices for a number of large insurance carriers. Now, those companies that have survived are faced with much less competition and are committed to returning to profitability, which has ultimately resulted in increased rates for employers and contributed to greater cost-sharing for employees.

The Weakening of the Managed Care System
Also in the 1990s, employers began offering plans that allowed patients to see out-of-network doctors or those that had less strict referral processes through benefits, such as point-of-service (POS) plans. In addition, many employers making health plan purchase decisions focused on keeping employees happy by ensuring that most doctors in an area were in a chosen network, rather than choosing narrower networks with deeper discounts. All of this has led to a general weakening of the managed care system. With the level of premium increases over the last few years, many employers have backed away from offering such rich benefits, and instead have restricted networks to reduce costs.

Increased Utilization and Consumer Demand
Utilization of many health care services has risen over the last decade. A number of factors such as improvements in medical technology, the influence of managed care, elevated consumer awareness and demand, and a boost in the number of practicing physicians caused health services—like the number of surgical procedures and the number of prescription drugs dispensed—to rise significantly. Other services such as breast cancer screenings, immunizations for children, and diagnostic procedures like CT and MRI have also experienced sharp utilization increases.

What Does It All Mean?
Your employer, like others, is undoubtedly trying to determine how to keep increasing health plan rates from having a serious financial impact on both employees and the company. Many firms absorbed the increasing costs for years to avoid further burdening their employees. Now, most are realizing that they will have to pass portions of the costs on to employees in the form of higher premiums, or benefit designs that require them to pay more out-of-pocket for the medical services they use through increased coinsurance, copayments or deductibles.

Sources: National Coalition on Health Care, U.S. Census Bureau, Centers for Medicare and Medicaid Services, IMS Health, Express Scripts and U.S. Department of Health and Human Services.

Be a Wise Health Care Consumer: 25 Ways to Reduce Your Health Care Costs

Many Americans will hunt for a coupon that saves them 50 cents at the local supermarket. However, when it comes to health care—a far more complex and expensive service—we rarely ask questions or consider all the options that could save us time and money. This list Learn to shop for value when it comes to health care.

2. **Make a deal.** Ask your doctor, hospital or dentist if they will accept less. Studies show that the majority of individuals who bargain succeed.
3. **Know how much it costs.** You'll be more prepared to negotiate discounts when you know the real costs of care. You can find rates on the websites of large insurers like UHC, Cigna and Aetna.
4. **Pay in cash.** You can routinely save up to 10% on your bill by paying in cash up front, and often much more than that. Doctors lose thousands of dollars every year on credit card processing fees, unpaid bills and collection fees.
5. **Look at your bill closely.** You will often find mistakes. Keep track of your visits, tests and medications, and compare them against your bills. Request a corrected bill if you find an error and notify your insurance company.
6. **Follow instructions.** Follow your health care provider's instructions for medications. Ignoring instructions could result in additional prescription costs, extra trips to the doctor or even hospitalization.
7. **Visit a retail health clinic.** Retail health clinics are growing in number. They are popping up in high-traffic retail outlets in metropolitan areas around the country. While these clinics lack the personal nature of seeing a family physician who knows your complete medical history, they offer convenience and low prices.
8. **Stay in-network.** Your medical costs can increase greatly when you visit a provider who is not in your plan's network. Make sure your primary care doctor and any specialists you may need to see are in your network whenever possible.
9. **Ask before you go.** If you must see a specialist who isn't within your network, call your insurance company's pre-certification department and explain why you must use an out-of-network specialist. You can often get your insurance company to agree to pay in-network rates in order to avoid the expensive appeal process. If that doesn't work, ask your specialist to accept the in-network rate.

With these 25 tips, you can learn to shop for value to get the most out of your health care dollars.

10. **Understand what treatment your plan covers.** Check your insurance company's website or call their customer service line to make sure you aren't needlessly paying for health care that is covered by your insurance.
11. **Stay insured.** Despite its costs and limitations, health insurance offers you significant discounts on most health care services, as well as protection from astronomical health costs, should you or a dependent suffer a major health event. If you lose your employer-based health insurance, understand your options for retaining health coverage. First, you may be able to extend your current policy through COBRA, which allows you to keep your current coverage for up to 18 months by taking over the employer's portion of the premiums. Secondly, you may become eligible to enroll in an individual health plan through the Marketplace as part of the Affordable Care Act (ACA), which carries the possibility of several discounts depending on your income.

Be a Wise Health Care Consumer

12. **Fight back.** If your claim has been denied, start with a phone call to customer service. If that doesn't work, follow your plan's appeal process. Remember to document everything and keep copies.
13. **Choose your health plan wisely.** Choosing the plan with the lowest premiums or sticking with the same plan year to year may not be the smartest option. Anticipate your family's medical expenses and look closely at each plan option to find the most appropriate and cost-effective one for you.
14. **Consider an HSA.** Health savings accounts (HSAs) are growing in popularity. They are combined with a high deductible health plan. The high deductible policy protects you from the cost of a catastrophic illness or prolonged hospitalization. You control the savings account and use it for small and routine health care expenses. Although you own and manage the account, employers will often make contributions to HSAs as well. Funds you don't use grow tax-free and can be rolled over from year to year.
15. **Take advantage of flexible spending accounts.** A flexible spending account, or FSA, is an employee benefit program that allows you to set aside money on a pretax basis for certain health care and dependent care expenses. That means you keep more of your money. Your employer may also contribute to your FSA account.
16. **Don't skimp on preventive care.** Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get the preventive screenings recommended for their age in order to detect health conditions early.
17. **Look for free services.** Look for free health screenings and vaccinations in your area. With a little research, you could find free or reduced-price flu shots, Pap smears, prostate exams, cholesterol screenings and more.
18. **Visit a dental school.** Look into local dental schools where you will be treated by dental students who perform the dental treatment while closely supervised by their instructors. Expect to pay about 20% to 60% of what you'd pay for the same treatment by a private dentist. Check this list from the American Dental Association to see if there's one near you.
19. **Don't forget to floss.** Studies have demonstrated that those who floss regularly have a decrease in bad breath, cavity incidence and the risk for periodontal disease. The cost of periodontal disease treatment can range in the thousands of dollars depending on the severity of the conditions.
20. **Look for discount contact lenses.** Discount websites and stores can provide the contact lenses prescribed by your eye doctor, in factory-sealed packaging, at a cost that is up to 70% off what you would pay at the retail level.
21. **Chill out.** According to WebMD, up to 90% of doctor visits are for stress-related conditions. Studies show that relaxation techniques are effective in controlling anxiety, enhancing the immune system and reducing conditions such as high blood pressure, substance abuse and chronic pain.
22. **Quit smoking.** Under the ACA, health insurers are allowed to charge smokers 50% higher premiums for new polices sold to individuals and smaller employer groups. Plus, if you quit smoking you can expect to save approximately $2,000 a year on the cost of cigarettes alone.
23. **Live a healthy lifestyle.** Focus on eating nutritiously, cutting down on fast food and getting more physical exercise. Striving toward a healthier lifestyle and maintaining a healthy weight can drastically reduce future medical conditions and diseases.
24. **Wash your hands.** According to the Centers for Disease Control and Prevention, hand hygiene is the most important factor in preventing the spread of germs. In fact, health experts estimate that 80% of common infections are spread through hand contact.
25. **Get a second opinion.** Save thousands of dollars a year on cutting-edge medical tests, which usually are not covered by insurance, by following the guidelines recommended by the U.S. Preventive Services Task Force.
26. **Think twice about the emergency room.** Don't go to the emergency room (ER) when your regular doctor or an urgent care visit would suffice. If you or your child is feeling ill on Friday, get into the doctor that day to avoid overpaying at the ER during the weekend.

KNOW YOUR BENEFITS.

From

Health Care Claims: Solutions to Common Problems

Have you ever had a health insurance claim denied unexpectedly or had a claim delayed for weeks with no explanation? Due to the confusing nature of medical billing and insurance claims, people often don't dig deeper into such issues despite their frustration. However, often a simple mistake is the root of a denied or delayed claim and there may be an easy solution.

Problem: Your claim is denied or delayed because you did not provide your current health plan information during your health care visit.
Solution: Always make sure you have your current health plan information with you, and remember to give your provider updated information when you have a plan change. When you receive a new health insurance card, dispose of old cards so you won't accidently use the wrong one. If you lose your card, contact HR to get a new one. If a claim is denied, check if this was the problem.

Problem: The insurance company is unsure if your injury is work-related, and thus spends months investigating.
If you have a work-related injury, it is important that you alert your doctor during the visit that it happened at work. In addition, even if it was not work-related, always promptly answer any questions your doctor or insurer has about your claim. A simple returned phone call can save you weeks or months in delay.

Problem: Your health care provider coded a claim wrong (such as attributing a claim for circumcision to the mother, not the newborn).
Solution: If your claim gets denied unexpectedly, call the insurance company and check if it was coded correctly. If not, ask your provider to fix the error and resubmit your claim. In addition, know how different treatments are covered under your plan. For example, certain therapies may be covered only if "medically necessary"—so make sure your provider indicates it as such when submitting your claim.

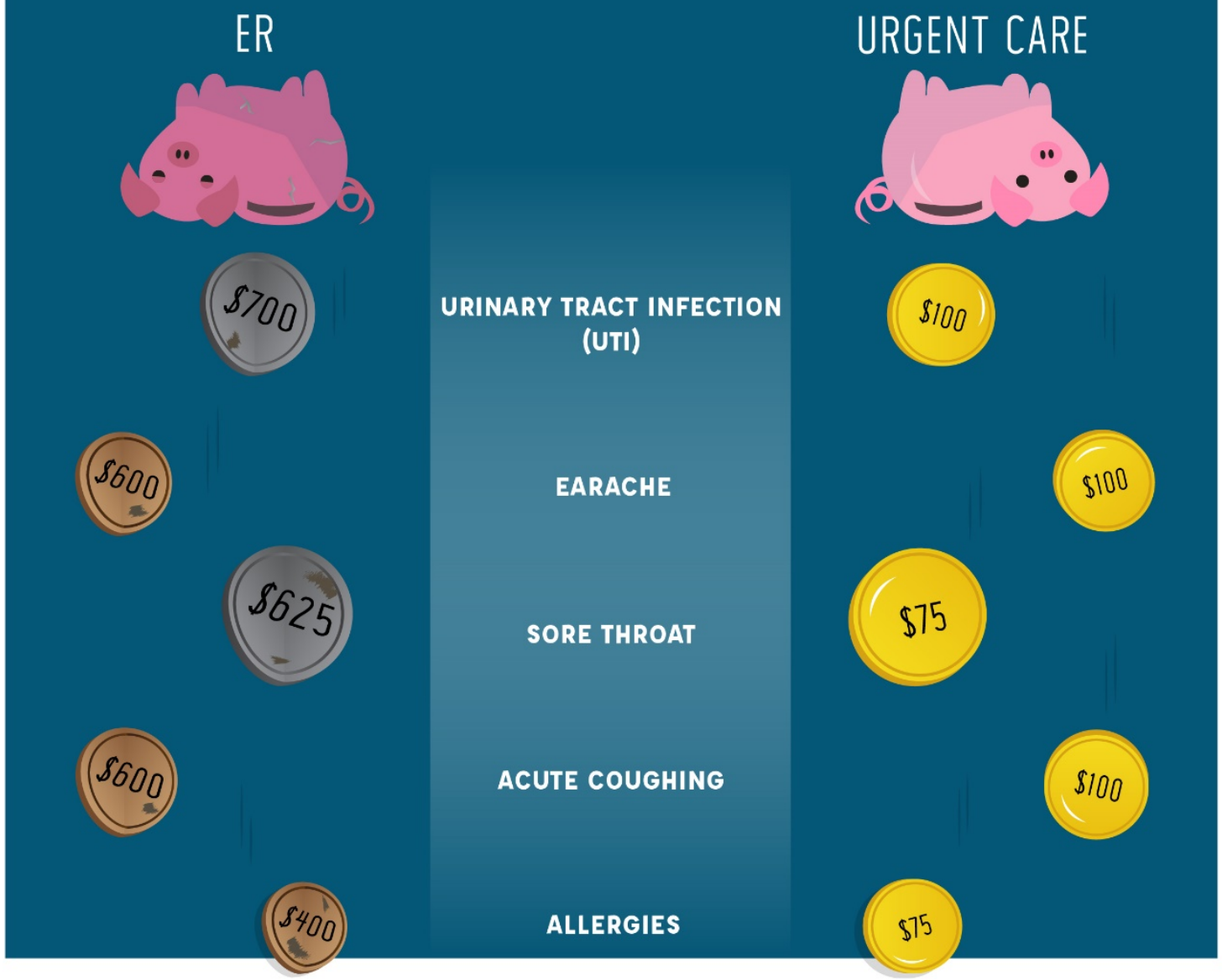
Problem: There may be confusion if your dependents are covered under two plans.
Solution: If your dependents are covered under both your and your spouse's plan, you need to find out which plan is the primary provider. This is typically the plan of the parent whose birthday comes first in a calendar year—but double check with your insurer. Otherwise, claims may be delayed while the two insurance companies argue over who is responsible to pay.

If your doctor recommends a treatment, check first if it is covered and what amount you are responsible to pay.

Problem: You misunderstand your benefits, resulting in confusion when your claim is denied.
Solution: Learn as much as you can about your health plan! Read the plan documents and tap into any other resources available, such as the insurance company's website. If you have questions, ask HR or your insurance company before you see the doctor, to make sure you understand your coverage. If your doctor recommends a treatment, check first if it is covered and what amount you are responsible to pay.

COST COMPARISON: ER vs. URGENT CARE

Billions of dollars are wasted each year because patients visit the wrong health care centers during non-emergencies. Perhaps individuals are unaware of the cost differences, or maybe they simply don't know where to go at the time. The following illustration is an estimation of some common illnesses. It provides a comparison between emergency room (ER) and urgent care costs.



Employee's Guide to Health Plans

	Definition	Primary Care Physician (PCP)	Network of Providers	Referrals	Deductibles, Coinsurance, Copayments, Claim Forms
Fee-for-service (FFS)	Health coverage that reimburses health care providers for services for employees. Tends to be the most costly for employers.	Not required; employees can choose any provider.	No network; employees can choose any provider.	Not required.	Deductibles and coinsurance may be required. Claim forms may be used.
Health Maintenance Organization (HMO)	Covers services performed solely by providers in a network. This tends to be a low cost system, but is more restrictive than other plans.	Required; the PCP coordinates all medical care and must make referrals to specialty providers for employees.	Services by out-of-network providers are not typically covered under the plan.	Required; PCP coordinates all medical care.	May require employee cost sharing through deductibles, copays or coinsurance.
Preferred Provider Organization (PPO)	Has a network of providers, but also allows use of medical providers outside of the plan's network (typically with greater employee cost-sharing). Referrals may not be required. Is more flexible than an HMO, but also more expensive generally.	Not typically required. Some PPO vendors offer incentives for employees to visit a PCP to coordinate medical care.	There is a network, and the plan allows for use of out-of-network providers with greater cost sharing by employees.	May not be required.	Coinsurance, deductibles and copays are the standard; usually lower when using in-network providers.
High Deductible Health Plan (HDHP)	A high deductible health plan is often paired with a tax-advantaged account to pay for medical expenses. The most prominent options are health reimbursement arrangements (HRAs) and health savings accounts (HSAs) used in conjunction with savings accounts.	Not required but there are incentives for using providers that are reasonably priced.	Not required but are offered to bring savings to employers and employees.	Not required.	Typically low or no coinsurance after the deductible is met. Deductibles are substantially higher than other plans.

Employee's Guide to Health Plans

Health Savings Account (HSA)	An HSA is a tax-advantaged account used to pay for qualified medical expenses. An HSA must be used in conjunction with an HDHP. An advantage of an HSA is that the funds remaining in the account at the end of the plan year are rolled over into the account for the next year.	Not Required. They may be used to pay for any qualified medical expense.	Not required. They may be used to pay for any qualified medical expense.	Not required. They may be used to pay for any qualified medical expense.	N/A
Point-of-service Plan (POS)	Plan combines elements of an HMO and PPO. Each time employees need health care, they can choose how it will be received. If an employee initially sees a PCP and stays in-network, then more substantial benefits will be received versus not seeing a PCP first.	Required when accessing HMO-like benefits of the plan. Not required when accessing PPO-like benefits of the plan.	Employees must stay in-network.	Required for the HMO portion of the plan; not required for the PPO portion.	No deductibles; minimal coinsurance or copays for HMO portion. Deductibles, coinsurance and copays are typical for the PPO portion—lower for in-network providers.
Health Reimbursement Arrangement (HRA)	A health reimbursement arrangement is a program that allows employers to set aside an amount of funds to reimburse participating employees for medical expenses. An HRA is often combined with another health plan.	May not be required. Subject to the paired health plan and employer.	May not be required. Subject to the paired health plan and employer.	May not be required. Subject to the paired health plan and employer.	N/A
Health Flex Spending Account (Health FSA)	A health flex spending account is an account set up through a health plan that allows employees to contribute funds that are not subject to payroll tax. Any unused funds are lost after a grace period. Employers also have the option of allowing employees to carry over up to $500 of unused funds from one year to the next.	May not be required. Subject to the paired health plan.	May not be required. Subject to the paired health plan.	May not be required. Subject to the paired health plan.	N/A

KNOW YOUR BENEFITS.

From

Be a Wise Health Care Consumer: Reduce Your Prescription Drug Costs

If you take prescription medication, you can cut costs up to 90% by becoming an informed consumer and using the same buying techniques that you use when shopping for other goods and services. As more individuals comparison shop for drugs, more retailers will compete to win their business, which will drive prices lower. These strategies can help you become a savvy prescription drug consumer.

Price comparisons. Drug prices are not uniform; you can save a considerable amount of money by shopping around.

Drug substitution. When your doctor prescribes a drug, ask if a cheaper alternative is available.

Bulk buying. As you may know from your everyday shopping, it's cheaper to buy in bulk. The same is true for drugs. Buying larger quantities at a time generally reduces the per-dose cost of drugs. This is especially true for generics purchased by mail.

Mail-order Pharmacies. Mail-order and Internet pharmacies offer the best deals on prescription drugs, especially for patients with chronic conditions.

Pill splitting. Many prescription drugs are available at increased dosages for similar costs as smaller dosages. Prescribing half as many higher-strength pills and having the patient split them to achieve the desired dosage can reduce the cost of some medications as much as 50%.

However, pill splitting is not safe for all medications. If a pill is FDA-approved for pill splitting, it will say so on the label or informational insert that comes with the prescription. The FDA recommends pills only be split if FDA-approved and after consulting with your doctor to ensure it is safe.

Over-the-counter drugs (OTC). Ask your doctor if an OTC drug will work just as well as a prescription drug. Today there are hundreds of OTC drugs that were previously only available by prescription.

Generally, employers who have self-funded plans will set up special funds to earmark corporate money to pay for employee medical claims.

Generic medications. Generic medications work as well as brand-name drugs and can cost 20% to 80% less. This applies for both prescriptions and OTC drugs.

Pharmaceutical company assistance programs/state drug assistance. Many drug companies and states offer drug assistance programs for the elderly, low-income and/or people with disabilities.

Medicare drug plans. Seniors can combine smart shopping techniques with the Medicare drug plan. All the information you need is available at www.Medicare.gov.

Samples. Drug companies give thousands of samples to doctors every year. Your doctor may be able to provide you with weeks' worth of the medication at no charge.

Stay on your meds. If you take medication regularly, don't skip doses or go off your meds to save money. Sticking to your medication schedule will help you avoid health complications that will cost more money in the future.

Discount prescription cards. Look into a discount card, either through a drugstore chain or a national plan. They can provide additional discounts on your prescriptions for a small monthly or annual fee.

HEALTH CARE RESOURCE GUIDE

Provided by Horst Insurance

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INTRODUCTION

It's no secret that the price of health care in the United States has increased over the past several decades. While there is no single reason for the explosion in health care prices, there are a few surprising contributing factors—none more so than consumers themselves.

Luckily, a new trend in the industry, called consumer driven or consumer directed health care (CDHC) continues to transform the health care system one step at a time. CDHC is based on the premise that the consumer is gaining information, taking responsibility and becoming more in touch with the true cost of health care. With health care costs continuing to rise, it's more important than ever to take responsibility for your medical care choices. Asking questions and researching your options are good ways to start taking control of how much you spend on health care.

Becoming more informed on health care-related topics, however, can be a time-consuming, confusing and difficult task. is committed to making health care easier to understand. This guide provides information on general health care and health insurance topics and is designed to help you take the guesswork out of health care and health insurance.

TYPES OF INSURANCE PLANS

Making careful health care decisions is vital for keeping your health care costs down. You can control your out-of-pocket costs by carefully reviewing your health insurance plan options and choosing the one that best fits your needs. For example, if you have many medical problems or need recurring medication, you might want to pay a higher premium for more coverage and a lower deductible. If you are generally healthy and rarely need to visit the doctor, a high deductible health plan (HDHP) with lower monthly premiums might be the most cost-effective option.

It's important to understand the key differences between plans in order to choose the one that's best for you. The three most common types of health insurance plans include the following:

1. Preferred provider organizations (PPOs)
2. Health maintenance organizations (HMOs)
3. High deductible health plans (HDHPs) with a health savings account (HSA)

Side-by-side Comparison

The chart below compares PPOs, HMOs and HDHPs side-by-side.

	PPO	HMO	HDHP WITH AN HSA
DEFINITION	A network of providers who enter into an agreement with insurance companies to offer substantially discounted fees for covered health care services. If you choose a provider who is in the PPO network, your copayments and deductibles will also be lower.	A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Premiums are paid monthly, and a copayment is due for each office visit and hospital stay. HMOs generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage.	A health plan that has a high deductible but a low premium. Insurers will not cover most medical expenses until the deductible is met. HDHPs are often designed to be compatible with HSAs. HSAs are tax-advantaged accounts that can be used to pay for qualified out-of-pocket medical expenses before the HDHP's deductible is met.
PRIMARY CARE PHYSICIAN (PCP)	Not typically required. Some PPO vendors offer incentives for employees to visit a PCP to coordinate medical care.	Required; the PCP coordinates all medical care and must make referrals to specialty providers for employees.	Not required but there are incentives for using providers that are reasonably priced.
NETWORK OF PROVIDERS	There is a network, and the plan allows for use of out-of-network providers with greater cost-sharing by employees.	Services by out-of-network providers are not typically covered under the plan.	Not required but are offered to bring savings to employers and employees.
REFERRALS	May not be required.	Required; PCP coordinates all medical care.	Not required.
DEDUCTIBLES, COINSURANCE, COPAYMENTS AND CLAIM FORMS	Coinsurance, deductibles and copays are the standard; usually lower when using in-network providers.	May require employee cost-sharing through deductibles, copays or coinsurance.	Typically low or no coinsurance after the deductible is met. Deductibles are substantially higher than other plans.
HSA ELIGIBLE?	Maybe, contact your plan administrator	Maybe, contact your plan administrator	Yes

IN-NETWORK VS. OUT-OF-NETWORK CARE

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

IN-NETWORK PROVIDER—

A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates

OUT-OF-NETWORK PROVIDER—

A provider who is not contracted with your health insurance company

In general, if you visit an in-network provider, you will get your health care at a lower price. If you have a PPO or HDHP, there is likely some coverage for using an out-of-network provider. However, if you have an HMO, this is likely not the case, unless you have an accidental injury or medical emergency, or you obtain preapproval from your provider to use an out-of-network provider.

If you decide to go out of network voluntarily, there are several resources that can help you make the best financial decisions, such as www.fairhealthconsumer.org. This nonprofit is dedicated to helping consumers receive and estimate health care cost information.

CALLING THE PHYSICIAN DIRECTLY AND DOUBLE-CHECKING WITH YOUR INSURANCE COMPANY IS THE BEST WAY TO ENSURE THAT THE PROVIDER IS IN NETWORK. IF YOU ARE RECEIVING SURGERY, MAKE SURE TO ASK IF THE SERVICE IS COMPLETELY IN NETWORK. OFTEN TIMES, THINGS SUCH AS ANESTHESIA ARE NOT COVERED EVEN THOUGH THE PRIMARY PHYSICIAN IS IN NETWORK .

Billing and Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

IN-NETWORK BILL

Provider
The patient receives treatment. The doctor then sends the bill to the insurance company.

→

Network
Appropriate discount for using an in-network provider is applied.

→

Bill
The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.

→

Insurance Company Payment/Explanation of Benefits
Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.

→

Patient
Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

OUT-OF-NETWORK BILL

Provider
The patient receives treatment. The doctor then sends the bill to the insurance company.

→

Bill
The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.

→

Insurance Company Payment/Explanation of Benefits
Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.

→

Patient
Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

HEALTH CARE AND HEALTH INSURANCE TERMINOLOGY

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
    - **Example:** *John's second surgery occurs in the same plan year as his first surgery and costs a total of $3,200. Because he has only paid $800 toward his $1,000 annual deductible, John will be responsible for the first $200 of the second surgery. After that, he has met his deductible and his carrier will cover 80% of the remaining cost, for a total of $2,400. John will still be responsible for 20%, or $600, of the remaining cost. The total John must pay for his second surgery is $800.*
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay
    - **Example:** *John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100% of his first surgery.*
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.

- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100% of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.

- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

HEALTH SPENDING ACCOUNTS

Health spending accounts are tax-advantaged accounts that allow you to set money aside to pay for qualified medical expenses like deductibles, copays and out-of-network care. There are three main types of health spending accounts.

1. **HSAs**—Health savings accounts
2. **HRAs**—Health reimbursement arrangements
3. **FSAs**—Flexible spending accounts

Each type of health spending account functions differently and provides different benefits to the user. The chart below compares each type of health spending account side-by-side.

	HRA	HSA	FSA
WHO MAY CONTRIBUTE?	Employer only	Employer or employee	Employee or employer
MAXIMUM ANNUAL CONTRIBUTION	None	• $3,500 (single) for 2019 • $7,000 (family) for 2019	• Capped at $2,700, including employee contributions
TAX-ADVANTAGED?	Yes	Yes	Yes
FUND CARRYOVER?	No	Yes	$500 or grace period
PORTABLE AFTER TERMINATION?	No	Yes	No
WHO OWNS THE ACCOUNT?	Employer or third-party administrator	Employee	Employer-established benefit plan

SHOPPING TIPS

Consumer driven health care, or consumerism, revolves around the idea that consumers should be able to make informed choices about their medical care based on price and quality information. The eventual goal is for well-informed health care consumers to compare prices—choosing more wisely and ultimately lowering overall health care costs for everyone. However, the apples-to-apples comparison used for most products or services is mostly useless in the health care marketplace. Learn to shop for value when it comes to health care. With a little effort, you can save thousands of dollars on your medical bills.

Use the following six tips to become a smarter health care shopper.

1. ASK QUESTIONS

Patients often accept their doctors' advice without truly understanding what treatment alternatives are available, and what—if any—differences there are in cost and effectiveness among those alternatives. A few simple questions can help you decide what treatment plan is best for both your health and your wallet. Ask questions such as the following:

- Why is this treatment necessary?
- What is the CPT code of this treatment?
- How much will my treatment cost?
- Can I be treated another way that is equally effective but less costly?

2. COMPARE PRICES

Once you know more about the treatment you will be receiving, you should spend some time "shopping around" for the best quality and best priced treatment options. Most consumers spend time comparison shopping for new electronics or cars, but may find the concept of shopping around for health care strange. This can be accomplished by doing cost comparisons, understanding differences in quality of service and using a personal cost-benefit equation to determine whether the expense is worthwhile. Some ways to find out the prices of certain services include the following strategies:

- **Call around.** Call local hospitals, doctors and clinics and ask for an estimated quote for the treatment you need. Make sure to check that the providers you are calling are considered in-network providers.
- **Use a price comparison tool.** Ask your employer if they have any price comparison tools, like Amino. These type of tools allow you to enter information like your treatment's CPT code or your location and then use that information to find local doctors and estimated procedure prices. Your insurance carrier may provide a price comparison tool as well.
- **Look at your insurer's website.** Large insurance companies like UnitedHealthcare, Cigna and Aetna list rates of health care services on their websites.

Remember that these tools and the prices you obtain may only be estimated costs of services. Make sure to confirm pricing of a treatment before you contract a doctor or hospital to perform a service.

3. PAY WITH CASH

You may be able to save some money by paying with cash up front. Doctors lose thousands of dollars every year on credit card processing fees, unpaid bills and collection fees. Ask your doctor or hospital if they offer a discount for self-pay patients. Self-pay patients are patients who don't have health insurance or are choosing to not use their insurance. Sometimes, using your insurance to help pay for a service may save you more money than paying with cash.

Carefully evaluate if it would be more cost-effective for you to pay with cash and forego any insurance-related discounts, or if it would be better to pay with your insurance.

4. USE OUTSIDE RESOURCES

Finding exact prices beforehand is notoriously difficult in the health care industry; however, a host of resources have become available online in recent years, allowing you to at least obtain a rough estimate for a service, or to compare one facility and region against another.

- Pricing Healthcare—This website lists the "cash" rates for hospitals and surgery centers.
- Healthcare Bluebook—This website lists "fair" prices for services based on ZIP codes.
- New Choice Health—This website offers to match consumers to low-cost providers, based on their location.
- Goodrx.com—This website compares cash prices for prescription drugs at local pharmacies and retailers.

5. GET REFERRALS

Sometimes, the best advice comes from people you know. Ask friends, family or co-workers for a referral. These people will not only be able to tell you if the doctor, procedure or hospital was expensive, but they will also be able to tell you about the quality of care they received. When it comes to your health care, quality is key.

6. KEEP LEARNING

Staying up to date on health care topics is beneficial for your physical, financial and mental health. You will feel more confident in making major health care decisions if you are well-informed.

THE IMPORTANCE OF PREVENTIVE CARE

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. Preventive care occurs before you feel sick or notice any symptoms and is designed to prevent or delay the onset of illness and disease.

In its broadest definition, prevention includes a healthy lifestyle, exercise, diet and other similar efforts. Preventive care in a medical setting includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations. Regular health evaluations will help keep you healthy and prevent more serious problems later.

Preventive care can save you money in two ways. First, preventive care helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

When preventive care services are combined with a lifestyle that is focused on wellness, significant savings can be realized. The Trust for America's Health predicts that there is a return of $5.60 for every $1 spent on proven preventive care strategies in America. Ultimately, preventive care provides the benefit of saving lives and improving the quality of your health for years to come.

FOR MORE INFORMATION

Being a wise health care consumer means taking the time to learn about your insurance and medical care options, choosing the plan and treatments that are best for you, and reviewing medical bills to ensure the charges are correct.

is dedicated to providing you with the necessary tools to help you make the most informed health care decisions. If you need additional information on any specific topic, please let us know. We will work to provide you with additional resources as requested.

KNOW YOUR BENEFITS.

From

Making the Most of Your Health Care Dollars: Comparison Shopping

Every day consumers make important decisions that affect their family's health and health-related financial security. Making these choices can be stressful and overwhelming, especially if a family member is ill or considerable medical expenses are involved.

Often, it may seem like you don't have a choice when faced with the cost of medical procedures, but that is not always the case. Many consumers today are taking more responsibility for their health care, which includes seeking more information about the cost of health services and making informed decisions regarding their care.

This movement is called consumer driven health care. You may already participate in a consumer driven plan, if your employer offers a high-deductible health plan (HDHP) coupled with a health savings account (HSA).

Comparison Shopping

Consumer driven health care, or consumerism, revolves around the idea that consumers should be able to make informed choices about their medical care based on price and quality information. The eventual goal is for well-informed health care consumers to compare prices—choosing more wisely and ultimately lowering overall health care costs for everyone. However, the apples-to-apples comparison used for most products or services is mostly useless in the health care marketplace.

To date, lawmakers and health insurance companies have placed a great deal of emphasis on developing consumer driven insurance products, but price transparency, an important aspect, has been mostly overlooked. Generally, the prices of health care services are not made public, making comparison shopping seem impossible. For realistic comparison shopping between hospitals, for example, you need to know in advance what the bottom line price would be for an all-inclusive bill, including hospital and physician fees. However, it's hard to hunt for bargains when the prices of various tests, treatments and procedures differ significantly depending on a variety of factors, such as the type of health insurance you have, whether you have surgery at a hospital or freestanding surgery center, and whether your surgeon or anesthesiologist participates in your health plan's network.

Consumer driven health care, or consumerism, revolves around the idea that consumers should be able to make informed choices about their medical care based on price and quality information.

The goal of price transparency in health care is to help buyers have an easier time determining which providers have the lowest prices. Good information on provider quality is also important, so consumers aren't compelled to simply choose the "cheapest" alternative, but rather make choices that provide the best quality health care for the best value.

Unfortunately, true price transparency—where consumers have realistic information about provider cost and quality at their fingertips—is unlikely in the near future. However, the growth of consumerism in health care and the growing prevalence of HSAs as an integral part of employer-sponsored health benefits are likely to put pressure on hospitals, physicians and other health care providers to make their prices more readily available.

Many health insurance companies are offering consumer driven health plans and taking steps to encourage plan members to shop around for medical services. Many

Making the Most of Your Health Care Dollars: Comparison Shopping

have begun offering online tools and resources to compare and evaluate cost and quality for various health services. Find out if your health insurer offers any similar tools on their website.

Take Action Today
If your company offers a consumer driven plan such as an HSA paired with an HDHP, consider choosing this plan during your next enrollment period.

If you're currently enrolled in a consumer driven health plan with a carrier that makes price information available, use this information to begin the task of comparison shopping. If you want to be a health care bargain hunter, but don't know where to start, ask your health plan what tools it offers for comparing prices. Even if you are not in this type of plan or don't have resources available through your insurer, you can still make smarter choices about your health care. Don't be afraid to pick up the phone and call around, and remember to be assertive with your questions and take good notes.

The following are some of the charges that you want to focus on when gathering information:

- *Provider charge* - This is the list price for the service that a hospital or health care provider would bill a patient who pays by himself or herself, without any discounts.
- *Contracted price* - This is the maximum amount that a provider or network can receive for an insured patient covered by a private health care plan or public program.
- *Maximum allowable payment* - This is the maximum amount that can be paid for out-of-network services from a private health care plan or public program.

Below are additional online resources you can use to find health care price and quality information.

HealthGrades Inc., www.healthgrades.com
This website provides physician, hospital and nursing home ratings and quality data, plus cost information for a variety of medical procedures ranging from gastric bypass to cataract surgery.

New Choice Health, www.newchoicehealth.com/
This site provides estimated costs for various procedures, organized by region or provider, reviews of health care facilities, plus the ability to request a procedure price quote from local providers.

URAC, www.urac.org
The "consumer" section of URAC's website provides a list of its accredited health care organizations.

Agency for Healthcare Research and Quality (AHRQ), www.ahrq.gov
The "consumers and patients" section of this website provides information on topics including choosing quality care, understanding medical conditions and comparing medical treatments.

HealthCare.gov, www.healthcare.gov/choose-a-plan/find-provider-information/
Find local hospitals, nursing homes and other facilities, and compare on a variety of quality measures.

KNOW YOUR BENEFITS.

From

Telemedicine Basics

As technology evolves, doctors are finding more ways to efficiently and conveniently care for their patients. One such method is through the use of telemedicine—a form of technology-based communication that allows a doctor and patient to communicate without being in the same physical space. Although telemedicine is not a complete replacement for direct patient care, it can be a useful tool for a variety of medical services, such as evaluation, diagnosis and prescribing treatment.

How Telemedicine Works
Through the use of technology, communication is facilitated either in a real-time or delayed setting. Usually a patient is able to communicate from his or her home with a doctor through a live video, audio or patient data transfer system. Doctors can see the patient and assess his or her symptoms, as well as obtain the patient's records and medical history from electronic medical records.

Telemedicine is not a full replacement of the care a patient can receive in a doctor's office; however, it can provide several benefits. Patients can stay in the comfort of their own homes and potentially prevent further illness from exposure to germs in a hospital or clinic. Many medical experts believe that patients who have difficulty traveling or who live in a rural area might have an easier time accessing medical care through telemedicine because telemedicine eliminates the need for travel in many situations. In addition, patients who are recovering from illness or injury at home can be monitored by their doctors through telemedicine visits.

While telemedicine can reduce barriers to receiving medical care, there are some limitations. One main restriction on telemedicine is licensing regulations. In some states, doctors are required to have a license in the state in which they physically practice, as well as in the state in which the patient is located. Additionally, doctors are limited in the kinds of care they are allowed to provide to a new or existing patient. For example, the doctor may not be able to treat a new condition without scheduling a face-to-face follow-up appointment.

Telemedicine is a form of technology-based communication that allows a doctor and patient to communicate without being in the same physical space.

How to Prepare for a Telemedicine Appointment
As you prepare for a telemedicine appointment, you should consider several things.

- You will probably need access to a laptop, phone or tablet, as well as an internet connection.
- Because there is physical separation in telemedicine, any information you are able to provide, such as personal medical records and family medical history, can be helpful to your doctor.
- If you are recovering or being cared for at home, it might be helpful to include caregivers in the visit.

For many patients, obtaining medical care can cost a great deal in time, resources and money. Telemedicine is a service that can help reduce the barriers of time and distance to a hospital or doctor's office.

For more information on telemedicine, contact a HR representative.

KNOW YOUR BENEFITS.

From

Medical Care Choices

Health care costs are rising significantly, greatly impacting the price you and your employer pay for your health benefits. takes its responsibility to provide you with quality, affordable benefits seriously. You, too, must think carefully about how you use those benefits. Managing your personal health care expenses is one way you can help to keep costs down.

The role you play in managing health care costs is simple: Spend your health care dollars wisely. Each time you go to a medical provider or receive medical services you generate a claim that must be paid for through your employee health benefits. Essentially, the costs of your claims, and all your coworkers' claims, determine the price you and your employer pay for your health benefits. In the end, decisions you make directly affect the year-to-year increases in your health benefits cost.

Making Wise Choices
When you have an illness or suffer a minor injury, you want to feel better—fast. Your health plan provides coverage for treatment that can be received in a variety of settings, such as your doctor's office, a hospital or an urgent care center. However, every setting is not appropriate for every kind of care. Your responsibility is to know which setting provides the best, most cost-effective care for your condition.

The first step is to become familiar with your benefits—don't wait until you are sick or injured. Review your benefits and know your copayments and coinsurance amounts for an office visit, urgent care facility or a hospital emergency room. And, remember to learn about what is required of you if you need to seek medical care when you are out of town.

Office Visits
For most illnesses or injuries, the best choice for medical care may be a visit to your general practitioner or primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. For most illnesses and injuries, and for regular checkups and preventive care, your doctor can provide the most cost-effective care.

The role you play in managing health care costs is simple: Spend your health care dollars wisely.

Urgent Care
Many situations require immediate care that you might not be able to receive in your doctor's office, yet these situations might not be serious enough to require the services of a hospital emergency room. In these situations, a walk-in clinic or urgent care center may be an appropriate choice.

Below are some guidelines for determining when going to an urgent care center is appropriate.

- You have telephoned your doctor or nurse practitioner and he or she recommends that you go to an urgent care center.
- Your symptoms or injury have occurred outside of your physician's regular office hours and are too severe to wait until the next regular office hours, yet they are not severe enough to warrant a visit to the emergency room.
- You do not have a regular doctor or primary care physician.
- You are out of town.

Medical Care Choices

- You are unable to reach your doctor or nurse practitioner by phone.

Remember, care received in an urgent care facility is costly, yet it is much less expensive than an emergency room. Your best choice for non-urgent situations, however, is always a scheduled appointment with your doctor.

Emergency Room Care
A visit to the hospital emergency room is the most expensive type of outpatient care. Emergency rooms should only be used for true emergencies, as they are staffed, equipped and best suited for medical emergencies. Going to an emergency room for non-emergency care is a poor use of your health benefits and can be very costly. Some examples of situations where emergency room care is appropriate are as follows:

- A major injury, such as a broken bone
- A wound that continues to bleed vigorously despite application of pressure
- Decreased mental activity or awareness, or disorientation
- Shortness of breath
- A cold sweat accompanied by chest pain, abdominal pain or lightheadedness
- Severe pain

The next time you are faced with deciding where to go to receive medical care, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay. Choosing the most cost-effective options will go a long way toward ensuring that your employer can continue to provide you and your family with the quality, affordable health benefits you rely on.

KNOW YOUR BENEFITS.

From

How to Read Your Medical Bill

Medical bills are becoming increasingly complex and difficult to read. Charges from clinics and hospitals tend to be lumped together instead of itemized – making it very difficult to see exactly what you are paying for. With many medical facilities going paperless, many patients are not even receiving the statements regarding the amount the insurer paid. This increases your chance of being overcharged.

Controlling Costs
A big step in controlling your health costs is understanding how to read your medical bill. Many medical bills contain billing errors and items that are priced much higher than their actual cost, so carefully reviewing your bills can save you a lot of money.

How it Works
When you receive your medical bills there are three documents that you need to compare to help you understand if you are being billed only for the services you received:

- A list of services performed – this document is given to you when you leave the doctor's office or health facility.
- The bill from the doctor or health facility – this is a list of services performed with the charges associated with each service (which should match the list of services performed document given to you when you leave the facility). Many health systems are no longer issuing itemized bills, which will help you find obvious errors much easier. You have the right to request an itemized bill from the facility.
- Explanation of benefits (EOB) from your insurance provider, Medicare or other payer, explaining how much of the bill was paid by insurance.

Start by reading over each of the documents individually and noting any charges that you don't understand or items that you don't think you should have been charged for.

These bills use codes for each of the services provided, which can make it even more difficult to read. To better understand what these codes mean, use a medical dictionary or encyclopedia (www.medilexicon.com). Then compare the documents against each other, making sure that the charges match up.

A big step in controlling your health care costs is understanding how to read your medical bill.

Checking for Errors
Make sure there are no data entry errors including numbers with an accidental zero added on (e.g., "10" instead of "1" X-ray). Also check for duplicate listings of procedures and medications that you do not think were administered.

If you find suspicious charges, don't hesitate to contact the health care facility billing department.

A Proactive Approach
There are a few best practices that you can use before your procedure or appointment.

- Verify with the receptionist how your visit will be coded.
- Write down notes as you are treated, noting exactly what services are performed. Consider bringing a friend or family member to do this for you if you will be unconscious.

How to Read Your Medical Bill

- If you're going to be charged for a hospital stay, call the billing department before your procedure to ask if there are any supplies you can bring with you to avoid high charges such as a box of tissues, extra blankets or pajamas.

Well-being 101

Your well-being is dependent upon a lot of different factors, and achieving total overall well-being is a bit more complicated than it may seem.

Well-being refers to being in a state of alignment and overall happiness and health. It encompasses many different facets of your life, but we want to help you focus on four specific concepts.

Physical well-being

Physical well-being focuses on how well your body functions. This can include eating healthy, being active, avoiding destructive behaviors and substances, getting enough sleep and taking care of yourself when you're ill.

Mental well-being

Mental well-being focuses on how good you feel about yourself, as well as how you feel emotionally and psychologically. This can include coping with stress, working productively and exhibiting self-esteem and confidence.

Financial well-being

Financial well-being focuses on your relationship with finances and saving for your future. This can include investing in your retirement, budgeting and reducing debt.

Social well-being

Social well-being is multifaceted and focuses on your relationship with your peers, your community and the environment. This can include volunteering, living sustainably and joining workplace clubs to meet other co-workers.

If you're interested in improving any facet of your well-being, don't hesitate to reach out. Contact HR for more information about available initiatives related to these tenants of well-being.