



**Patient Financial
Navigator Foundation Inc.**
A Community Outreach Program

Transforming the hassle factor in healthcare-
one patient, one family, one employer,
one community at a time

**Welcome to the
Patient Financial
Navigator Program-
A community outreach program**

Why create the Patient Financial Navigator Community Outreach Program

No one really understands their healthcare insurance until they need it.

No one realizes the 'next steps' once the medical incident has occurred/been ordered.

When a family is in a healthcare crisis, their life is disrupted, scared and vulnerable - coordination/communication is required to reduce the hassle factor.

The Patient Challenges with HealthCare

- No one 'asks' to come to a hospital.
- Patient's lives are impacted - they are scared, they feel out of control, they are lost with the overwhelming factors of cost/unknown, multiple providers, and continuing frustration with 'who knows all of this?'"
- Patients are unaware of the many changes with their insurance, government programs, employer's coverage and all the 'rules' associated with getting services paid.
- Patients historically access hospitals once a year or less.

Healthcare is very personal!

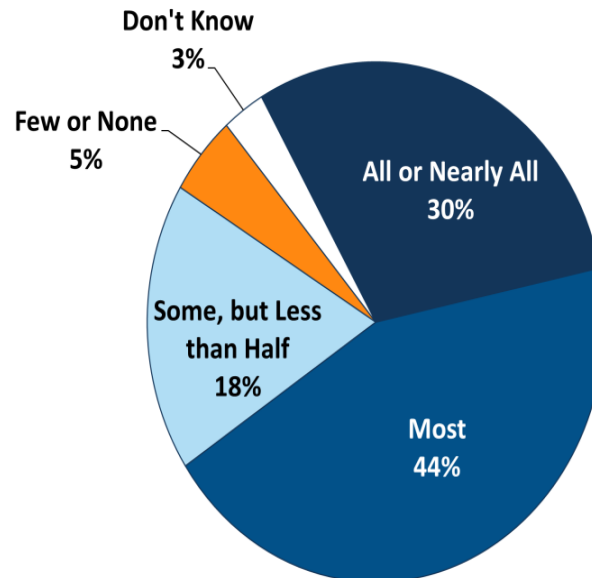
But Patients Don't Speak the Language of Health Insurance Today...



Figure 10

Consumers Needing Help Understanding Basic Insurance Concepts, 2015

Among your Program's clients who considered or purchased QHPs, how many needed help understanding basic insurance terms, such as "deductible" or "in-network service"?



NOTE: Data may not sum to 100% due to rounding.

SOURCE: Kaiser Family Foundation, 2015 Survey of Health Insurance Marketplace Assister Programs and Brokers, August 2015.



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...and They May Not Identify with the Language of Value-Based Care Tomorrow

We say...	Consumers said...
Medical home	<p>“It sounds just like a nursing home.”</p> <p>“First you go to the medical home, then you go to the funeral home.”</p>
Integrated care	“It sounds like a sales pitch in a cheap brochure.”
Accountable	“It’s kind of scary. I am going to go there and something bad is going to happen and someone has to be held accountable for it.”
Value	“It means things are cost effective. They are going to keep the value down. You aren’t getting the best care.”

Source: M. Ross, T. Igus, and S. Gomez, “From Our Lips to Whose Ears? Consumer Reaction to Our Current Health Care Dialect.” *The Permanente Journal*. Winter 2009, Vol. 13, No. 1. <http://www.thepermanentejournal.org/files/Winter2009/dialect.pdf>



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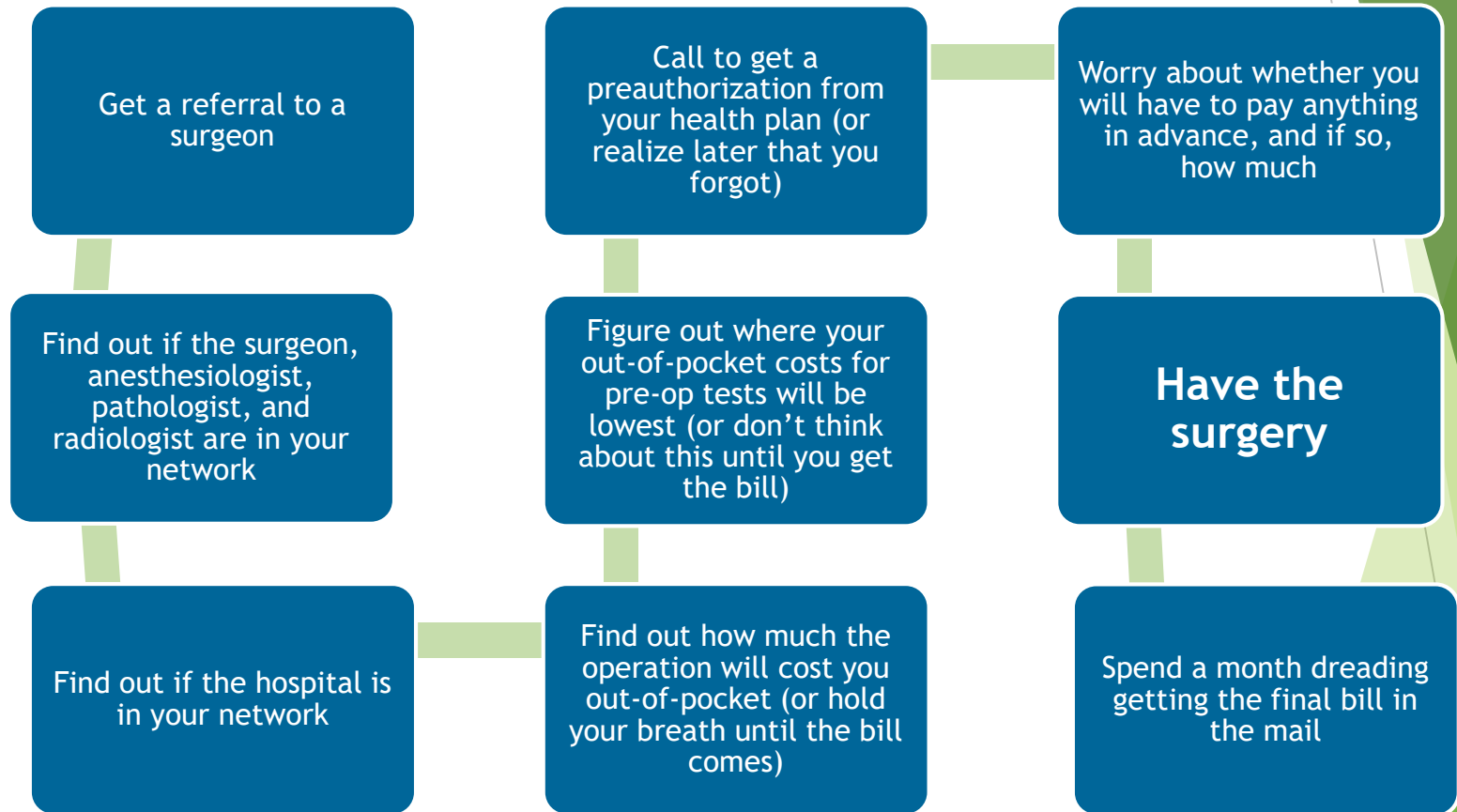
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Additional 'factors' influencing the patient experience= confused=hassle factor

- Electronic medical record /EHR - incentive and penalties
- Integrated systems between providers/doctors and hospitals but safety with data sharing a concern.
- Quality reporting systems -with rewards and penalties
- Physicians new payment system- MACRA & MIP
- Alternative payment systems for hospitals, doctors, long term care, DME , home health - all in the midst of rolling out with the goal of **increased quality, reduced costs and more engaged patients.**
- What about a change to 'privatizing' Medicare? Voucher program -means?

Take the Hassle Out of the Experience

Hassle Map: Elective Surgery for an Insured Patients- **who knows to do this?**



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map construct developed by Slywotzky (2011).

Source: Based on the hassle-

What is a Pt Financial Navigator program -

- ▶ **Every hospital /health provider can do any or all three of the unique components.**
- ▶ Community Outreach - Boot Camps
- ▶ Employer Outreach - Lunch and Learn for employees
- ▶ Navigator Resource Library- personal pt/family
- ▶ As significant healthcare changes occur along with ongoing 'healthcare buzz' updates=

Three components of this dynamic program- A community outreach program



- **Employer program**
- Build historical info
- Lunch & Learn-onsite education with employers
- HealthCare Buzz
- EOB - how to read
- New healthcare changes-national and local
- Q&A -as requested by the site



- **Community programs**
- Networking with existing services
- Creating unique trainings
- Identify community healthcare legislative changes -educate
- Turning 65 Bootcamp
- National 'new terms:- HSA, ACO, Quality based, Managed, Medicare, etc.
- HealthCare Buzz



- **Navigator Resource library * located at local hospital**
- Employer specific guides
- Medicare & ME
- Traditional vs Mgd
- Translating 'ease'
- What to expect when??
- General Education
- How to appeal?
- Networking with existing services

1st) Example of Community Outreach Education - Boot Camps

- 1) Identify community leaders to participate in the boot camp trainings
- 2) Identify thru existing community services, additional healthcare related 'hassle factor' training.
- 3) Provide education to high schools, colleges, regional and others as requested.
- 4) Join with existing educational efforts - clinical in nature - to add the financial 'translation' for ease of understanding 'what happens now.'
- 5) Innovation lab - creating community specific ed.



Population Health means...

- ▶ As we look to the transforming nature of healthcare - moving from sickness to wellness including quality/value based services with measurable outcomes vs volume/paid for all services with no quality outcomes required PLUS new commercial payer rules...
- ▶ The Navigator Foundation is in the **tent** with a multi-disciplined/clinical approach to healthcare - Population Health - managing the chronic, social-economic determining factors, while remembering the pt didn't ask to get sick, didn't ask to have their life disrupted and didn't ask their insurance to pay so little (high deductibles and co-payments) or no insurance at all. Triple Aim.. 1st=Pt engagement/empowerment.

'Integration of clinical health and financial health for the holistic approach to population health.'

Humana's - Bold Goals program

Major % of market is Seniors- Part C Medicare* (HEALTHCARE BUZZ EX)

- ▶ *65% of Seniors have multiple chronic conditions*
- ▶ *1/3 have diabetes*
- ▶ *1/4 have mental health*
- ▶ *10% live below the poverty level*
- ▶ *6 doctor visits yearly*
- ▶ *27 prescriptions yearly*

High cost to the healthcare system for 'navigating thru' alone. Social-economic issues.

EX) Depressed? Not taking chronic meds.

EX) Can't afford meds = ED is next. (Medicaid?)

*Population Health Colloquium. March 27, 2017 Philadelphia

Upcoming Community Outreach Boot Camps 2017

2nd 2017 Boot Camp:

“Medicare 101, Social Security Benefits, and
Assistance for Seniors” July 6th CSI Fine Arts

3rd 2017 Boot Camp:

“Turning 65” Oct 28th CSI Fine Arts

4th 2017 Boot Camp:

“The Language of Insurance” Feb 3rd CSI

All classes are available on the PFNF
webpage prior to all trainings.
Available for anyone to use..no cost.

2nd) Example of Employer-Specific “Lunch & Learn”

1. Meet with the HR staff to learn about the employer’s insurance plan.
2. Outline the key elements for education to be covered during the 30 min employee ‘Lunch and Learn.’
3. **Hot spots for education (usually): EOB education, out of network, what happens when you are scheduled for a surgery and ‘HealthCare Buzz’ ++ Q&A.**
4. Innovation lab - taking the education to the employer.



Employer Insurance Costs/Changes

Healthcare spending 2015-16

- Spending averaged \$5141 per individual.
 - Out of pocket rose 3% to aver \$813 per capita
 - Prescription drugs increased 3.5-9%
 - Women of all ages spent \$236 more out of pocket than men.
 - \$649 per capita was spent on brand prescriptions.
 - The price of an ER visit jumped 10.5% to an aver of \$1,863
 - Employers contribute about 73% toward the monthly premium for individuals. 38% for dependents.
*MCO 3-17
- Average Health Savings Account balance for 2015 = \$1844 (Can have up to \$3400/single; \$6750/family)
 - Average contribution by individuals = \$1864
 - Average employer contributions = \$948
 - Average high deductible plan: \$2600-13,100 /family; \$1300-6550 /single
 - Benefit: Amt deferred for tax impact.
 - Con: Family would have to pay premiums, deductible \$, co-insurance \$ AND have enough left to put money in the HSA.

So now you need healthcare - Outpt surgery (Sample) - in network

- Surgeon's office will contact your insurance carrier to get the surgery pre-authorized. Insurance carrier has their own criteria for medically necessary services. Many times requires 'negotiation' with provider and payer.
- Routine bills for an outpt surgery- usually each sent separately:

Surgeon

Anesthesiologist

Pre-op testing
ctr)

Procedure location (Hospital, free standing

IMPORTANT: Validate all of the above are within the network that is part of Cigna's plan. IN NETWORK

Your Medical Plan

SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Commercial Creamery Company - Group #00511766
Open Access Plus



General Services	In-Network	Out-of-Network
Physician office visit <ul style="list-style-type: none"> Includes Naturopathic services 	Primary care physician You pay \$25 copay per visit Specialist You pay \$25 copay per visit	You pay 50% Plan pays 50% after the deductible is met
Urgent care visit <ul style="list-style-type: none"> All services including Lab & X-ray 	Urgent care copay You pay \$50	You pay 50% Plan pays 50% after the deductible is met
Preventive Care	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
Preventive Services	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
Immunizations	Plan pays 100%, no copay, no deductible	You pay 50% Plan pays 50% after the deductible is met
Performance pharmacy plan <ul style="list-style-type: none"> Includes contraceptives - with specific products covered at 100% If a Brand name drug is requested when there is a Generic equivalent, member must purchase the Generic drug, or pay 100% of the difference between the Brand name price and the Generic price, plus the appropriate brand-name copay (unless the physician indicates "Dispense As Written" DAWG) Cigna National Pharmacy Network 	Tier 1: \$5 Tier 2: \$25 Tier 3: \$50 Tier 4: 20% with \$150 member maximum per 30 days prescription Home Delivery 2.5x 90-Day supply at 5x retail copay	Not Covered
Coinurance	You pay 20% Plan pays 80% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Calendar year deductible <ul style="list-style-type: none"> Deductible waived for in-network Lab & X-ray in office or outpatient facility and for office surgery when performed in network. Deductible is not waived for advanced radiology and infertility testing for Lab/X-ray. In-network and out-of-network expenses do not cross accumulate 	Individual \$1,000 Family \$2,000	Individual \$2,000 Family \$4,000

9/1/2015
ASO / CHB State, WA
Open Access Plus - Commercial Creamery Company - 1756086 - Version 5

+ "Balance Billing" from Provider



Medical Claim Details

Viewing: Recent Medical claims to [redacted] in the last 90 days.

Claim Summary < Previous 2 of 7 Next >

Claim # 161470480900

For: [redacted]

Employer Account Number: [redacted]

Provided By: [redacted]

Claim Received On: 11/16/2016

Claim Processed On: 11/19/2016

Right to Review and Appeal a Claim

EOB

Service(s) From: 11/14/2016 • To: 11/14/2016

Service Date & Type	Amount Billed	Discount	Covered Amount	Copy/ Deductible	What Your Plan Paid	Coinsurance	What I Owe	Stat: Notes
11/14/2016 • DIAGNOSTIC SERVICES	\$137.00	\$28.36	\$108.64	\$0.00 / \$108.64	\$0.00	\$0.00	\$108.64	X 10
TOTALS	\$137.00	\$28.36	\$108.64	\$0.00 / \$108.64	\$0.00	\$0.00	\$108.64	

Amount the provider "absorbed" (arrow pointing to Discount)

\$1,000 deductible all \$108.64 due exempt (arrow pointing to Deductible)

Customize My View (arrow pointing to button)

\$1,000 deductible not met yet (arrow pointing to What I Owe)

The claim information provided reflects our data at the time your claim was processed. Due to ongoing claims processing activities, such as the payment of additional claims or an adjustment to this claim, the information may not show the final customer coinsurance amount, if one applies to your plan.



NOTES

XPC \$28.36 CIGNA/MDA ID PHYSICIANS NETWORK DISCOUNT APPLIED. MEMBER NOT LIABLE.

Claim Summary < Previous 2 of 7 Next >

①

Think like a pt - out of network

(means what to the pt or family?)

- 40 year old has had emergency foot /ankle surgery approx 8 years ago and taken to a Boise hospital. The surgeon specialized in this type of foot surgery. Both in network at that time.
- 3 surgeries later -still problems with rebuilding the foot to allow the pt to walk.
- July 2013, employer changes plans and now the doctor and hospital who employees the doctor is out of network.
- The pt continues to go to the surgeon who does another surgery Oct 2014 and a follow up minor surgery in 2015. Pt was aware of the change but did not know to do anything different as he was in continuing care.
- Insurance pays significantly lower - no adjustment from charges as out of network/no contract. Pt pays all charges except actual payment to doctors, hospitals, tests. Huge financial hit.
- What does the employee or pt know of the a) ramifications of out of network, b) prior notice to get approved and c) appeal rights?

HEALTHCARE BUZZ

Out of network?

“What does out-of-network mean and how does it impact the patient’s payment?”

Health care payments are driven by contracts between payers such as Medicare, Medicaid, primary insurance and health care providers. The contracts

DAY EGUSQUIZA

with the health care providers can be optional — such as commercial insurance — or mandatory for Traditional Medicare and Medicaid with physicians, home health, outpatient services and hospitals.

For the patient and the health care provider to receive the best benefit package, there are steps that are occurring in the background.

1) The health care provider enters into a contract for payment. Inpatient is usually based on a flat fee based on the diagnoses called a Diagnostic Related Group/DRG. For hospitals under 25 beds, referred to as critical access hospitals, their inpatient payment is a different formula.

2) The payer or their broker will work with the employer to sell a package of inpatient, outpatient, home health, skilled nursing, physician and related health care services. The employer determines which package they want to purchase with deductibles and out of pocket co-insurance amounts negotiated. Essential benefits that were part of the Affordable Care Act/Obamacare are also included.

3) Services purchased by the employer thru the insurance plan are considered in-network. All the providers who agreed to take a reduced payment thru the con-

tract are considered in-network.

4) If the patient or family who are covered go to health care provider who is not under contract with the employer’s insurance plan, they will pay a much higher out of pocket as this is considered out-of-network.

5) Example: A patient chooses a surgeon who is not in-network due to a long history with the surgeon.

The patient will owe, at a minimum, a yearly in-network deductible of \$6,000 as well as a 2nd out-of-network deductible of \$6,000 plus the difference between the amount paid by the insurance and billed charges. The health care providers do not have a contract with the provider so full billed charges will likely be due.

ACTION IDEA:

Always ask prior to any health care service — Are you contracted with my insurance? If not, there is an opportunity to work with your insurance prior to the health care service and ask for an exception, but it is rare. Staying within the network allows for the patient’s deductible and co-insurance amount to be the negotiated rate.

Read your employer benefit package to get additional information.

Additional examples are available on the PFNFInc.com webpage.

Day Egusquiza, President and Founder of the Patient Financial Navigator Foundation, Inc. has more than 35 years of health care reimbursement and operation’s experience.

Let's look at out of network- Surgery done at out of network hospital

- Surgery done at an out of network hospital.
- Billed charges: \$8000
- Out of network deductible applied: \$2000 individual
- Hospital bills Cigna; Cigna pays 'reasonable amt' that would be paid to IN network providers.
- Amt eligible for payment from Cigna: \$4400
- LESS \$2000 out of network deductible
- LESS 50% out of network coinsurance after deductible: $\$2400 \times 50\% = \1200
- TOTAL AMT PD BY CIGNA:
- $\$4400 - \$2000 \text{ ded} - \$1200 \text{ coins} = \1200 paid to out of network provider/hospital.
- But the hospital is NOT contracted. Therefore, the hospital accepted the \$4400 but left due on the account for the pt to pay:
 - $\$8000 - \$1200 = \$6800$ from pt.
 - **Out of network deductible: \$2000 (Separate from any in network deductible)
 - **PLUS 50% copayment: \$1200
 - **PLUS balance billing due to no contract: $\$8000 - \$4400 = \$3600$
 - TOTAL DUE FROM PT: \$6800**

Making it real - Small Employer Premium “Hits”

- ▶ Small employer in Idaho
- ▶ Premiums have had 23-25% increase each year/3 years.
- ▶ Currently for 2 employees: *Exchange was not cheaper/similar*
 - ▶ \$1200 monthly premiums
 - ▶ High deductible per person: \$7000
 - ▶ 70/30 coinsurance
 - ▶ “Age “ rated ... 60 year old
 - ▶ **Annual \$14,400 in premiums !! UNSUSTAINABLE**
 - ▶ This was before the new GOP plan for up to 5x higher than younger premiums. It is capped at 3x under ACA.
 - ▶ **2012 US census: “Employers with less than 20 employees made up 89% of the employer firms.”**

Health Care Buzz (Ex)

55% of Americans are paying more than last year for insurance.

- 1 of 4 Americans health worsened after delaying care because of cost concerns
- 30% said their health insurance coverage has gotten worse in the past year.
- 1 in 4 lost access to their doctors last year due to insurance networks. (out of network huge costs!!)
- 3 in 10 delayed emergency care in the last year out of fear of costs

DailyFactoid / MCOL 10-16
Morning consult

Biggest changes Doctor's expect to result from Millennial patient habits in coming years.

- Increased use of telemedicine (28%)
- Proliferation of walk-in clinic settings (27%)
- Growth in online scheduling and extended hrs (24%)
- Greater transparency for out of pocket costs (11%)
- Easily portable electronic health records (10%)

Sprocket Rocket 12-6-16

“Millennial patients challenging status quo, over 2900 US doctors say.”

Employment “Norms” in Huge Flux

AARP & MIT Agelab (Population Health 3/17)

- By 2020: 1 in 5 students will be 35 yrs or older.
- By 2020: 10,000 will be turning 65 every day
- By 2020: 1 out of every 5 adults will be over 65; more than under 5 yrs.
- 57 year old's are the primary owner of iPad.
- 50% of over 60 year old's use the internet
- Over 50 years of age = 1/3 of the work force.
- Family Care Giver: 42 M adults , age 45-64, providing care for older family/parents. 17%/ 24 M are providing in addition to their 'day job.'

Multi-generations in the work force.
Norm: 3-4 generations. (BB and Millennials = both approach 'work' differently.)

HealthExecMobile -Multiples

- 18.4% of US adults had a mental illness in the past year.
- 8.6% reported substance abuse/dependence in the past year
- Almost 40% had at least one chronic medical condition during their lifetimes
- 1.2% had all three conditions: mental illness, substance abuse/dependence and at least one chronic medical condition.

AND more than 50% of Americans now have at least ONE chronic health condition, mental disorder or substance use issue. (Taylor & Francis group news – “*Psychology, Health, and Medicine*” Oct 2016.)

Employees/Pts look different – ages (3-17)

- **Baby Boomers** 51-69 74.9 M
- **Generation X** 35-50 74.2 M – to

Surpass BB by2028

- **Millennials** 18-24 75.4 M –
HAVE surpassed BB

Plus more working past 65...

“More Americans age 65 & over are still punching the clock and the last time the percentage was this high was when John F Kennedy was in the White House, 1962. “

*“Last month, **19% of Americans age 65** and over were still working, according to government data released Fri. That’s the highest rate since, 1962 and it caps a long trend higher since the figure bottomed out at 10% in 1985.”*

Why? Some work to feel engaged. Others do not have enough money to retire. Employee Benefit Institute survey: Nearly 1/3 of all workers with less than \$10,000 in savings will work until 70. *Associated Press 5-7-17

Medicare Secondary Payer

Older workers care giving for other adults

PS By 2020 - 10,000 people will be turning 65 daily! WOW!

3rd) Examples from the Hospital Navigator Resource Library



- 1) Thru employer specific meetings, build data base of insurance plans, how to read the EOB, deductibles, etc.
- 2) 1 on 1 intervention with the patient/family - complete work paper
- 3) Create glossary of terms
- 4) Create reference guide for additional community resources
- 5) Create networking 'handoffs' with existing hospital team - payment options, social work, estimates, patient experience, physician offices, others
- 6) Innovation Lab: After Hours Q&A - Weds 5:00 -6:00 p.m.; using patient portal; tracking and trending improvements/feedback; integration with medical community; face to face and automation.

Think like the family who is scared with a new ER visit w/insurance, employer specific

- Daughter has just been admitted thru the ER. (Inpt vs obs means what to the pt?)
- Parents are scared and distraught about the health of their daughter with the unplanned 'admit.'
- As comforting as the care givers are, the financial questions loom large. What happens now?
- Who has insurance? What was done with the insurance? What is my coverage? "I have never had to use it before, so I don't know anything!"
- **Think Pt Financial Navigator Program**

Think like a patient - Medicare Part C/Managed Care - comes to the ER

- 86 year old with Humana. What is done in the ER to inform the pt this is not traditional Medicare?
- If the pt is ‘admitting/obs or inpt’ - what happens so the pt understands the difference between Traditional Medicare and Part C/Mgd Medicare?
- Now they are in a bed, what happens so the 86 year old understands their out of pocket, what coverage there is with Humana that may be different than Traditional, is this obs or inpt? Who has this information for our sick, confused Sr who does not have anyone to ask?
- Care givers/family - who do they ask about the above?
- **Think Pt Financial Navigator Program**

Included in Every Event/Training- “HealthCare Buzz”

- Factoid: Health Exec Mobile Mon, March 27, 2017

“Although only 4% of all doctors are emergency physicians, they provide care for:

28% of all acute care visits

50% of all Medicaid and CHIP (children) visits

67% of all acute care to the uninsured patients.

- Healthcare Bulletin. The Slate Group. March 30, 2017

“An annual health survey conducted by states and Medicare/CMS found that the full ACA reduced the uninsured rate by 44% while also reducing the number of people without a primary care doctor by 12% and those not having an annual check up by 10%.”

It is all doable..



- Have the vision and the passion to make a difference in the hassle factor in healthcare
- Remember - all the automation does not replace the human touch.
- Remember - our families are the core of healthcare.
- It is very personal!

Thanks, Day Egusquiza
Founder/President

Webpage: [Http://PFNFInc.com](http://PFNFInc.com)

Like us on [Facebook.com/PFNFInc](https://www.facebook.com/PFNFInc)



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