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.

Every hospital can have one!

Learn how!

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!

Healthcare is personal. Healthcare is local… but…

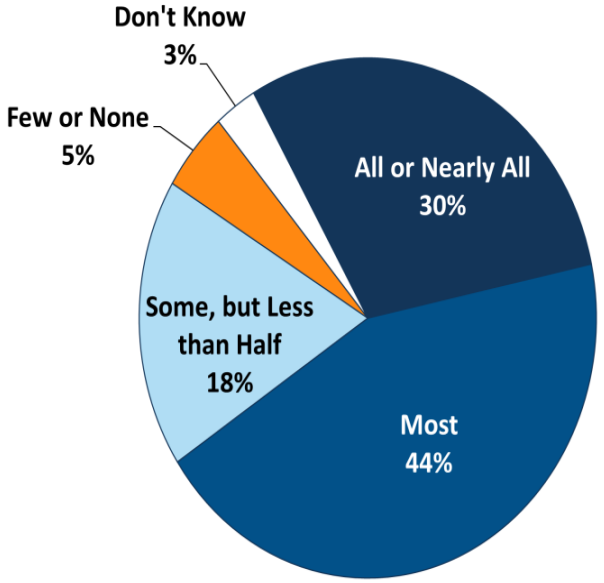
- Healthcare can be complex and too complicated
- WHY? Every insurance has their own rules for coverage.
- WHY? Physician directed care may not be insurance approved.
- WHY? Frustration in ‘thinking there is coverage in my plan’ only to be denied as ‘not medically necessary.’
- WHY? Charges and actual payment do not align.
- WHY? Itemized statements from providers are confusing
- WHY? Changing employer plans are adding new items – like Health Savings Accounts –with limited understanding by the employers. +++++++

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.

THE HENRY J. KAISER FAMILY FOUNDATION

hfma
healthcare financial management association

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

We say…	Consumers said…
Medical home	"It sounds just like a nursing home." "First you go to the medical home, then you go to the funeral home."
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

Additional ‘factors’ influencing the patient experience= confused=hassle factor

- Electronic medical record /EHR – incentive and penalties *Ransomware*
- 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
- 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?**

An Idaho-Based, Family Foundation was created in 2017 – MISSION to meet the local need…

Patient Financial Navigator Foundation Inc.

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one community at a time

The PFNF Advisory Board is committed to attacking and transforming the hassle factor ---thru education & outreach.

- Day Egusquiza, Founder and President

38y in healthcare reimbursement; 20y at MVRMC; 18y owner national consulting company.

- Daryl Wert, Vice President
- Jenyfer Stokes, Director
- Jayme Ketterling, Secretary
- Jodyi Wren, Director
- Jeremy Egusquiza, Director
- Karla Carter, Director
- Rosemary Fornshell, Ad-hoc
- Special thanks to Kody/Facebook and Jeremy/Webpage
- Special thanks to the volunteers

+CSI/strategic partner - location

PAY IT FORWARD - Giving Back. All Volunteer Board.

Collaboration = Be a "Difference Maker." The power of One.

What is the PFNF, Inc

- A not-for-profit Foundation with the focus on transforming the hassle factor …thru **Education. Answers: What happens now—beyond the clinical care?**

Three legs of the Foundation's Outreach Mission: No cost for any service

- **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 in local newspaper.**

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) Innovation lab – creating community specific ed.

More Fun!


HUB
International
Insurance Solutions for
Businesses & Individuals


AARP
ID
Idaho

2018 Projected Community Outreach Education

OUTREACH TO HIGH SCHOOL SENIORS AND COLLEGE STUDENTS/MEDICAL FIELD

- "Insurance 101" – teach Govt and Personal Finance

CONTINUE 3X A YEAR MEDICARE FOCUSED BOOT CAMPS

- "Medicare 101, Social Security Benefits and Assistance for Seniors" Boot Camp- 2x a year

- "Preparing to Turn 65" Boot Camp 1x year Nov 2, 2018

- All class material is posted on the PFNFinc.com Webpage for immediate and ongoing reference.

More 2018 Community Outreach

- Partnering with the Small Business Development Center at CSI:

  "All **Employer Healthcare Summits -** 2 x a year.
  Sept 12 5:30-7:30 pm Turf Club

- Presenting "**Insurance 201**" at the community Safety & Business Fest. Employer focused

- Presenting to service groups – updated. "**What does disruption in healthcare look like?" - POWERFUL**

- **Tell your local story, state story, national story.**

Ongoing Education – thru "**HealthCare Buzz**" articles

- Times News /local bi-monthly educational articles
- All articles are available on our webpage:
  - What does out of network look like?
  - What is a portal and why do I care?
  - Turning 65: Initial wellness visit
  - Turning 65: How does a Medicare inpt actually pay?
  - Turning 65: What is a Medicare Supplemental Insurance plan?
  - Turning 65: What are the Medicare options? **
  - Turning 65: When is Medicare a 2nd payer? **
  - Turning 65: Fall Medicare Mgd Care Enrollment

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 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.

DAY EGUSQUIZA

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 Grouper/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 contract 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.

Trusted HealthCare Educator

Participate:

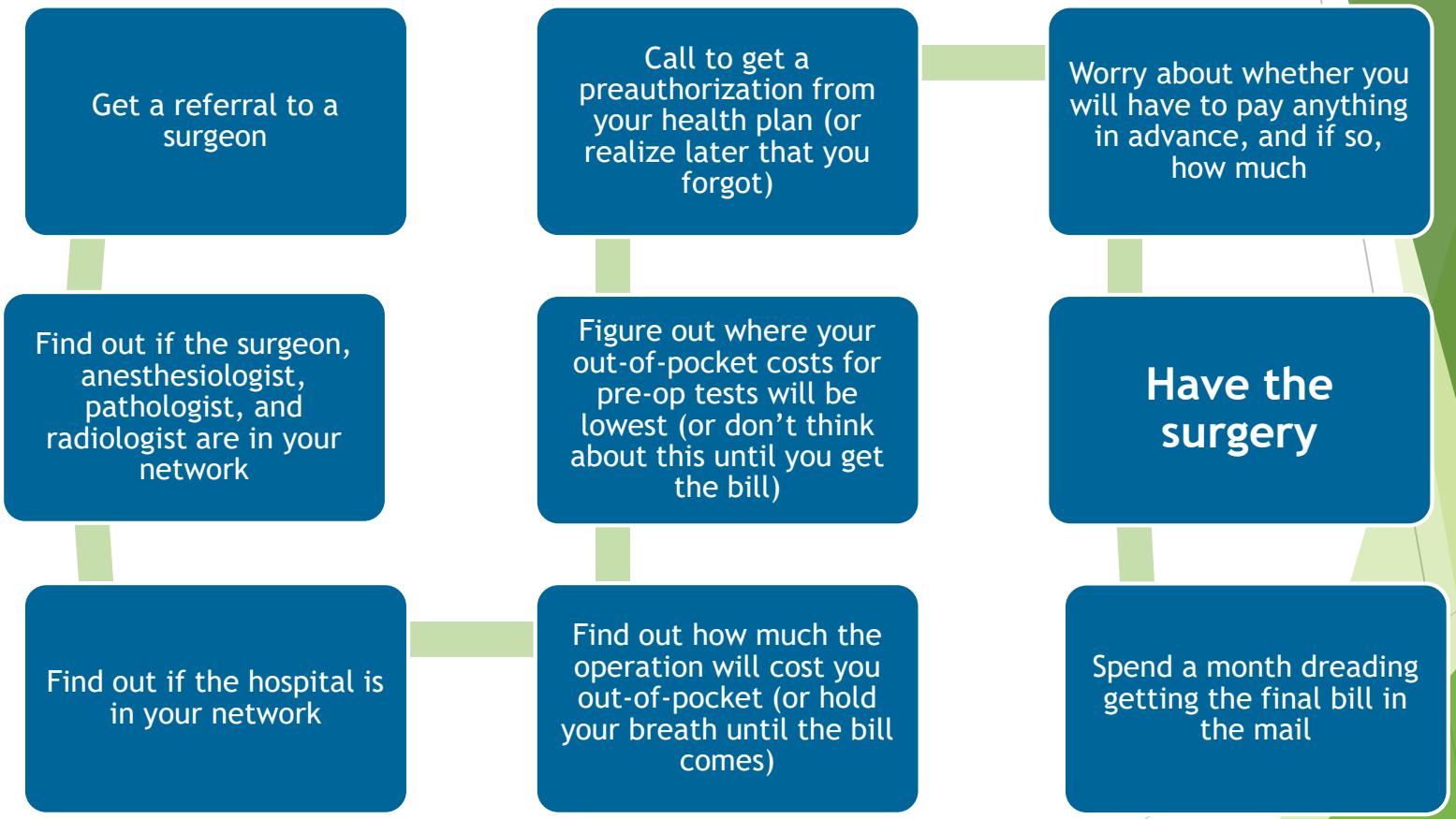
- Office on Aging events
- Wellness Fairs- Have Ins or Medicare booth "Ask the Expert"
- Population Health dialogue/changes = 'translator'
- New transformations in healthcare
- Employer work place insurance initiatives
- Next generation of healthcare –with partners
- School outreach – high school, colleges
- As requested

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.

Take the Hassle Out of the Experience

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



Source: Based on the hassle-map construct developed by Slywotzky (2011).

So now you need healthcare – Outpt surgery - CARPEL TUNNEL

- 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 Procedure location (Hospital, free standing ctr)

IMPORTANT: Validate all of the above are within the network that is part of the 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 • 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 • 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 • 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" DAW) • 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 3x retail copay	Not Covered
Coinsurance	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 • 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 / EHB State: WA
Open Access Plus - Commercial Creamery Company - 1756086 Version# 6

+ "Balance Billing from Provider"

Cigna.

Medical Claim Details

Viewing: Recent Medical claims for [redacted] within the last 90 days.

Claim Summary | < Previous | 2 of 7 | Next >

Compadre

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

Amt the provider "absorbed"

$1,000 deductible all* 108.64 due from pt

Customize My View

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

Service Date & Type	Amount Billed	Discount	Covered Amount	Copay / Deductible	What Your Plan Paid	Coinsurance	What I Owe	See Notes
11/14/2016 - DIAGNOSTIC SERVICES	$137.00	$28.36	$108.64	$0.00 / $108.64	$0.00	$0.00	$108.64	X *C
TOTALS	$137.00	$28.36	$108.64	$0.00 / $108.64	$0.00	$0.00		

$1,000 deductible not met yet

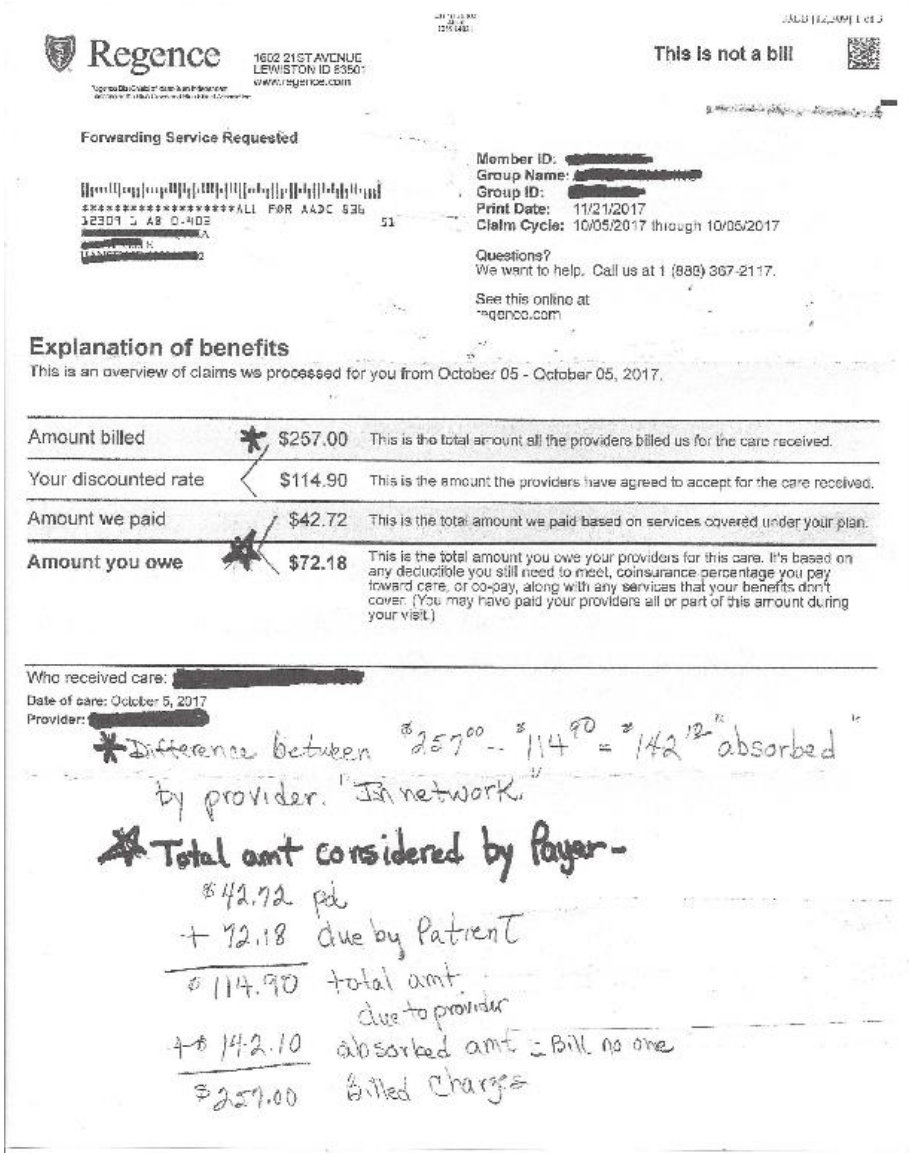
The claim information provided reflects our data at the time your claim was processed. Due to ongoing claims processing activities, such as the payment of additional claims or an adjustment to this claim, the information may not show the final customer coinsurance amount, if one applies to your plan.

NOTES

XPC $28.36 CIGNA/IDA IO PHYSICIANS NETWORK DISCOUNT APPLIED. MEMBER NOT LIABLE.

Claim Summary | < Previous | 2 of 7 | Next >

1



Regence
1602 21ST AVENUE
LEWISTON ID 83501
www.regence.com

This is not a bill

Forwarding Service Requested

[redacted]
**********ALL FOR AADC 536
12309 1 AB 0.402 51
[redacted]

Member ID: [redacted]
Group Name: [redacted]
Group ID: [redacted]
Print Date: 11/21/2017
Claim Cycle: 10/05/2017 through 10/05/2017

Questions?
We want to help. Call us at 1 (888) 367-2117.

See this online at
regence.com

Explanation of benefits

This is an overview of claims we processed for you from October 05 - October 05, 2017.

Amount billed	$257.00	This is the total amount all the providers billed us for the care received.
Your discounted rate	$114.90	This is the amount the providers have agreed to accept for the care received.
Amount we paid	$42.72	This is the total amount we paid based on services covered under your plan.
Amount you owe	**$72.18**	This is the total amount you owe your providers for this care. It's based on any deductible you still need to meet, coinsurance percentage you pay toward care, or co-pay, along with any services that your benefits don't cover. (You may have paid your providers all or part of this amount during your visit.)

Who received care: [redacted]
Date of care: October 5, 2017
Provider: [redacted]

* Difference between $257.00 - $114.90 = $142.12 absorbed by provider. "In network."

* Total amt considered by Payer-

$42.72 pd.
+ 72.18 due by Patient
$114.90 total amt due to provider
+ $142.10 absorbed amt = Bill no one
$257.00 Billed Charges

Understanding today's insurance world

- Benefit packages include in network and out of network payments.
- In network = Employer or individual insurance plan has contracted with healthcare providers. If you stay in network, there will be a reduction off billed charges. Patient still owes yearly deductible and each visit/hospitalization/outpt service has a co-insurance too.
- Out of network – a penalty as there is no contract so full billed charges are normally due.
- ALWAYS ask before going to see any healthcare provider.

PLUS DISTRUPTIONS IN HEALTHCARE—Lots of new delivery choices… Web-based, individual businesses do their own,etc.

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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?

3rd) Examples from the Onsite/Hospital Navigator Resource Library

1) Thru employer specific meetings, build data base of insuranc 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.
7) Volunteer staffing plus a full time Manager and an unpaid Director/Foundation

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 referral

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 referral

TODAY: Affordable Care Act 2010/ACA aka Obamacare. Previously = nothing similar.

- Mandates major medical insurance for all Americans.
- **Exchange/Marketplace - Myidaho** for any employer, self employments under 50 employees-usually 'small.'.
- Allows for subsidies with premiums so lower income individuals can get insurance.
- Insurance companies are 'made whole/or close to whole ' thru federal money/taxes. Rates are determined by the Insurance companies.
- Examples of under 50 employees who are not mandated to offer medical insurance.
- **CPAs, builders, electricians, individual business owners, small businesses/2-50 employees, farmers, early retirees/prior to turning 65**

With the Small Business Development Center/SBDC, created a **Small Employer Insurance Work Group.** Small employers – under 50 employees up to 200 …

Census Bureau's statistics of US Business 2012

- Employer firms with fewer than 500 workers employed 48.5% of private sector payrolls in 2011
- And Employer firms with fewer than 100 workers employed 34.4% of private sector payrolls
- And Employer firms with less than 20 workers employed 17.5% of private sector payrolls.

"American Business is Overwhelming Small Business" 2012 Census Bureau

- 5.73M employer firms in the US firms with fewer than 500 workers accounted for 99.7% of those businesses
- And businesses with less than 20 workers made up 89%.
- Add in the number of non-employer businesses – there are 23M in 2013 – then the share of businesses with less than 20 workers increase to 97.9%

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*
  - $1220 monthly premiums
  - High deductible per person: $7200
  - 70/30 coinsurance
  - "Age " rated … 60 year old
  - **Annual $14,600 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.

Affordable Care Act 2010 created "ESSENTIAL BENEFITS" - Commercial Ins.

- Every employer's insurance plan must offer essential benefits – a standard of insurance coverages

10 Essential Benefits	
Ambulatory Patient services	Emergency Services
Hospitalization	Maternity & Newborn care
Mental health, substance abuse including behavioral treatment	Prescription drugs
Laboratory services	Rehabilitative services
Preventive and wellness	Pediatric services

Other ACA major changes/protections

- **Patient protections** –
  - Coverage for those **with pre-existing conditions.** No cancellations or higher premiums *THINK CANCER, DIABETES.
  - **No life-time limits** on essential health care
  - Children can stay on their **parent's insurance until 26**. Even if they get married, go out of state to college, to work, etc. YAHOO!

Healthcare Impacts:

Medical devices are taxed

Healthcare providers take a reduced payment to help pay for the subsidies.

Expanded use of **health savings accounts/HSA- Pre-tax benefit**

ER is not the place for routine healthcare. Average bill- think $3000-minimum care.

- 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%."

Thanks for Joining Us in this Educational Journey…

Day Egusquiza, President

AR Systems, Inc

Patient Financial Navigator Foundation, Inc.

PO Box 2521

Twin Falls, Idaho daylee1@mindspring.com

All training material found at: PFNFInc.com

AR Systems, Inc.

Education
Compliance
Commitment

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