Mifflinburg Area School District

# Overview of $250 and $500 Deductible Plan Options

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Presented by

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# Overview

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# Overview

- Mifflinburg ASD currently offers six (6) plans through Central Susquehanna Trust (CS Trust):
  - PPO $0, $250 and $500
  - HMO $0, $250 and $500
- Effective January 1, 2021 the PPO $0 and HMO $0 plans will no longer be offered and members currently enrolled in those plans will need to elect from the remaining plan options:
  - PPO $250, $500
  - HMO $250, $500
- The purpose of this presentation is to provide an overview of the plan designs and the differences in comparison to the $0 plan designs.

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# Common Benefit Terminology

- **Deductible**: an amount participants must pay out-of-pocket for services before the health plan begins to pay for claim expenses
  - Does not apply to all services
  - May be per person or aggregated for family
  - In the case of the $250 and $500 plans, the deductible is applied on a per person basis with a family limit.
- **Coinsurance**: a percentage (%) of cost in excess of the deductible that the participant must pay
  - Does not apply to all services
  - May be per person or aggregated for family
  - In the case of the $250 and $500 plans, the coinsurance is applied on a per person basis with a family limit.
  - Has a maximum limit (in-network)
- **Copayments**: flat dollar ($) amounts due at time of service
  - Typical for office visits (primary care, specialist, urgent care, ER)
  - Typical for prescription drugs

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# Common Benefit Terminology

- **Network**: PPO plans have a network of participating providers. Members who use non-participating (out-of-network) providers may face substantially higher costs.
  - PPO out-of-network benefits are typically subject to greater deductibles and coinsurance.
  - The HMO plan does not cover out-of-network benefits (except in cases of emergency).
  - Non-participating providers may balance bill members for unreimbursed charges.
  - **The PPO $250 and PPO $500 have the same network as the current PPO $0 plan.**
  - **The HMO $250 and HMO $500 have the same network as the current HMO $0 plan.**
- **Balance Billing**: non-participating providers have not agreed to accept the plan payment in full. If the out-of-network allowance is less than the provider's charges, the member may receive a bill for the unpaid balance.
  - Note this is true in the PPO $0 and HMO $0 plans as well

# Summary of **IN NETWORK** PPO Benefits:

| | PPO $0 | PPO $250 | PPO $500 |
|---|---|---|---|
| **Medical Deductible:** | $0 | $250/$750 | $500/$1,500 |
| **Coinsurance:**<br>**Coins. Max.:** | *na*<br>*na* | 10%<br>$400/$1,200 | 10%<br>$500/$1,500 |
| **Office Visit Copay:** | $20 | $20 | $20 |
| **Specialist Copay:** | $20 | $40 | $40 |
| **Urgent Care Copay:** | $50 | $50 | $50 |
| **Emergency Room Copay:** | $100<br>*waived if admitted* | $100<br>*waived if admitted* | $100<br>*waived if admitted* |
| **Rx Deductible:** | $50 per person<br>*retail only* | $50/$150<br>*retail only* | $50/$150<br>*retail only* |
| **Retail Copayments:** | | | |
| *Generic:* | 20%; $25 max | $10 | $10 |
| *Brand Formulary:* | 25%; $50 max | $35 | $35 |
| *Brand Non-Formulary:* | 30%; $50 max | $75 | $75 |
| **Mail Copayments:** | | | |
| *Generic:* | 15%; $15 max | $20 | $20 |
| *Brand Formulary:* | 25%; $50 max | $70 | $70 |
| *Brand Non-Formulary:* | 30%; $50 max | $150 | $150 |
| **Mandatory Mail Order:** | *na* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* |

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*Benefit summary is for illustrative purposes only. The plan document of coverage should be consulted for the official plan of benefits.*
*Copayments are per visit or per Rx.*

# Summary of **IN NETWORK** HMO Benefits:

| | HMO $0 | HMO $250 | HMO $500 |
|---|---|---|---|
| **Medical Deductible:** | $0 | $250/$750 | $500/$1,500 |
| **Coinsurance:** | *na* | 10% | 10% |
| **Coins. Max.:** | *na* | $400/$1,200 | $500/$1,500 |
| **Office Visit Copay:** | $20 | $20 | $20 |
| **Specialist Copay:** | $35 | $40 | $40 |
| **Urgent Care Copay:** | $35 | $40 | $40 |
| **Emergency Room Copay:** | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* |
| **Rx Deductible:** | *na* | *na* | *na* |
| **Retail Copayments:** | | | |
| *Generic:* | $15 | $10 | $10 |
| *Brand Formulary:* | $30 | $30 | $30 |
| *Brand Non-Formulary:* | $50 | $75 | $75 |
| **Mail Copayments:** | | | |
| *Generic:* | $30 | $20 | $20 |
| *Brand Formulary:* | $60 | $60 | $60 |
| *Brand Non-Formulary:* | $100 | $150 | $150 |
| **Mandatory Mail Order:** | *na* | *na* | *na* |

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*Copayments are per visit or per Rx.*

# Summary of **IN NETWORK** Benefits:

| | PPO $0 | PPO $250 | PPO $500 | HMO $0 | HMO $250 | HMO $500 |
|---|---|---|---|---|---|---|
| **Medical Deductible:** | $0 | $250/$750 | $500/$1,500 | $0 | $250/$750 | $500/$1,500 |
| **Coinsurance:** | *na* | 10% | 10% | *na* | 10% | 10% |
| **Coins. Max.:** | *na* | $400/$1,200 | $500/$1,500 | *na* | $400/$1,200 | $500/$1,500 |
| **Office Visit Copay:** | $20 | $20 | $20 | $20 | $20 | $20 |
| **Specialist Copay:** | $20 | $40 | $40 | $35 | $40 | $40 |
| **Urgent Care Copay:** | $50 | $50 | $50 | $35 | $40 | $40 |
| **Emergency Room Copay:** | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* |
| **Rx Deductible:** | $50 per person *retail only* | $50/$150 *retail only* | $50/$150 *retail only* | *na* | *na* | *na* |
| **Retail Copayments:** | | | | | | |
| *Generic:* | 20%; $25 max | $10 | $10 | $15 | $10 | $10 |
| *Brand Formulary:* | 25%; $50 max | $35 | $35 | $30 | $30 | $30 |
| *Brand Non-Formulary:* | 30%; $50 max | $75 | $75 | $50 | $75 | $75 |
| **Mail Copayments:** | | | | | | |
| *Generic:* | 15%; $15 max | $20 | $20 | $30 | $20 | $20 |
| *Brand Formulary:* | 25%; $50 max | $70 | $70 | $60 | $60 | $60 |
| *Brand Non-Formulary:* | 30%; $50 max | $150 | $150 | $100 | $150 | $150 |
| **Mandatory Mail Order:** | *na* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* | *na* | *na* | *na* |

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# Submitted Questions

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# Deductibles and Coinsurance

- The deductible applies per person, up to a maximum per family per calendar year.
- In the case of the $250 deductible plans, the maximum in-network deductible for any individual is $250.
- Also in the case of the $250 deductible plans, the maximum amount a family would pay for in-network deductible expenses is $750 ($250 per person up to $750 for the family).
- Similar to deductibles, coinsurance applies per person, up to a maximum per family per calendar year.
- In the case of the $250 deductible plans, the maximum in-network coinsurance for any individual is $400.
- Also in the case of the $250 deductible plans, the maximum amount a family would pay for in-network coinsurance expenses is $1,200 ($400 per person up to $1,200 for the family).

# Deductibles and Coinsurance

- Example 1: An employee elects family coverage in the PPO $250 (assume 4 family members). One family member has a hospitalization that costs $20,000; there are no other claims by other family members.
  - The $250 deductible applies to the hospitalized individual – out-of-pocket cost of $250.
  - The 10% coinsurance would then be applied to the remaining $19,750. However, the coinsurance is also capped per member ($400) and per family ($1,200). The out-of-pocket coinsurance cost would be $400.
  - The total cost would be $650 ($250 deductible, $400 coinsurance). The member would have no additional in-network medical expenses except for copayments for the rest of the calendar year.

# Deductibles and Coinsurance

- Example 2: An employee elects family coverage in the PPO $250 (assume 4 family members). One family member has a hospitalization that costs $20,000 in April; in August, the same family member is hospitalized again for $10,000.
  - The maximum deductible and coinsurance for the member were paid as a result of the first hospitalization (see example 1 – combined cost of $650).
  - Assuming the member is using in-network providers, the second hospitalization is paid 100% by the plan (no member cost).
  - The member would have no additional in-network medical expenses except for copayments for the rest of the calendar year.

# Total Maximum Out-of-Pocket (TMOOP)

- Scary but impractical number that is required under the Affordable Care Act (ACA)
- The TMOOP is the maximum amount an individual can pay out-of-pocket during the plan year – this figure is set annually by HHS.
- For 2021, the maximum amount is $8,550 for single coverage, $17,100 for "other than single" coverage.
- The TMOOP only applies to in-network services for medical AND prescription drug expenses.

- **The PPO $0 and HMO $0 plans have the same TMOOP limits as the other plans.**

# Total Maximum Out-of-Pocket (TMOOP)

- Practically speaking, members will not face in-network out-of-pocket expenses that approach the TMOOP.
- When using services in-network, a member must first pay the deductible and then the coinsurance.
  - In the case of the PPO/HMO $500 plan, this is $500 deductible plus $500 coinsurance - $1,000.
- After the deductible and coinsurance are met, the only in-network expense for the member would be applicable copayments.
- A member would have to have a staggering number of copayments to reach the TMOOP.

# TMOOP: $8,550 Single; $17,100 Family

| | PPO $0 | PPO $250 | PPO $500 | HMO $0 | HMO $250 | HMO $500 |
|---|---|---|---|---|---|---|
| **Medical Deductible:** | $0 | $250/$750 | $500/$1,500 | $0 | $250/$750 | $500/$1,500 |
| **Coinsurance:** | *na* | 10% | 10% | *na* | 10% | 10% |
| **Coins. Max.:** | *na* | $400/$1,200 | $500/$1,500 | *na* | $400/$1,200 | $500/$1,500 |
| **Office Visit Copay:** | $20 | $20 | $20 | $20 | $20 | $20 |
| **Specialist Copay:** | $20 | $40 | $40 | $35 | $40 | $40 |
| **Urgent Care Copay:** | $50 | $50 | $50 | $35 | $40 | $40 |
| **Emergency Room Copay:** | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* | $100 *waived if admitted* |
| **Rx Deductible:** | $50 per person *retail only* | $50/$150 *retail only* | $50/$150 *retail only* | *na* | *na* | *na* |
| **Retail Copayments:** | | | | | | |
| *Generic:* | 20%; $25 max | $10 | $10 | $15 | $10 | $10 |
| *Brand Formulary:* | 25%; $50 max | $35 | $35 | $30 | $30 | $30 |
| *Brand Non-Formulary:* | 30%; $50 max | $75 | $75 | $50 | $75 | $75 |
| **Mail Copayments:** | | | | | | |
| *Generic:* | 15%; $15 max | $20 | $20 | $30 | $20 | $20 |
| *Brand Formulary:* | 25%; $50 max | $70 | $70 | $60 | $60 | $60 |
| *Brand Non-Formulary:* | 30%; $50 max | $150 | $150 | $100 | $150 | $150 |
| **Mandatory Mail Order:** | *na* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* | *Allowed 3 retail fills. On 4th fill, member must use mail order pharmacy or be responsible for 100% of the drug cost.* | *na* | *na* | *na* |

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# Total Maximum Out-of-Pocket (TMOOP)

- One question that was received was: why is the Maximum Out-of-Pocket so much larger on the HMO than the PPO?
- The limits are actually the same, but since the Rx benefit for the PPO is not provided through Capital BlueCross the summaries are confusing.
- The HMO summary shows a TMOOP of $8,150 single / $16,300 family.
  - Note: This combines both medical and Rx out-of-pocket expenses
- The PPO highlight sheet shows a TMOOP of $4,075 single / $8,150 family.
  - Note: This is ONLY the medical limit. The same limit applies separately to Rx.
- When the PPO Medical and Rx limits are combined, the TMOOP matches the HMO plan.

# Qualified High Deductible Plans (QHDHPs)

- Plans that can be paired with a Health Savings Account
- Minimum deductible for 2020 of $1400 single, $2800 family (applies to medical and Rx). Minimum may change annually – set by IRS.
- Available through CS Trust only on a full replacement basis
- Mifflinburg could offer a QHDHP; however, this would require that all members of the bargaining unit participate in the QHDHP – the PPO $250/$500 and HMO $250/$500 options cannot be offered as alternate choices.
- The issue with having a QHDHP "choice" is the "selection cost" – this negatively impacts the rates of other plans and other districts participating in Central Susquehanna Trust

# Payroll Deduction Cost for $250/$500 Plans

- Payroll deduction costs will vary based on several factors.
- Different employee groups – Act 93/Professional, Support – have different premium-sharing arrangements.
- CS Trust rates will change as of 7/1/2021, which could impact the plan cost under the Act 93/Professional arrangement.
- Based on the 2020-21 rates, the Act 93/Professional payroll deduction cost would be $0 for the PPO $250, PPO $500, HMO $250 and HMO $500 plans. Due to the cost-sharing structure, future rate increases could impact the per pay cost for the Act 93/Professional group.
- For the Support staff, the payroll deduction cost would be $35.00 per month ($17.50 per pay) for the PPO $250, PPO $500, HMO $250 and HMO $500 plans (the cost does not vary by plan).

# Thank you for your time and attention.

Please forward any remaining/outstanding questions to the District for follow-up

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