To: Interested colleagues  
From: Mary Shaw  
Date: October 31, 2005 (updated November 1, November 7)  
Subject: CMU’s new Health Care Benefits

I’ve been trying to understand the new CMU health care benefits and how well they address my health care needs. To that end I’ve been having an extended email discussion with Gemma Green <gg18@andrew.cmu.edu> (cc’ing Lori Bell <loribell@cmu.edu>) in Benefits, and I did an analysis of our exposure to the actual costs of getting health care outside the provider’s network, which turn out to be potentially huge. Since your needs may be similar to mine in some respects, you may be interested in what I learned.

Here are the high points:

- CMU is glossing over the costs that we may personally incur if we get medical care outside the network we choose (Highmark or UPMC). Those costs are potentially huge.
- CMU is trying, by verbal encouragement, lower premiums, and the unchangeable default in the toolkit, to steer us to the UPMC plans. However, they are not telling us about the differences between the Highmark and UPMC provider networks. In recent email, the Benefits office told me that the Highmark network is national (through BlueCard) but the UPMC network is local.
- In response to many requests, Comprehensive will be offered!! (updated 11/7).
- CMU is not willing to offer us the new form of health savings account that allows us to deposit funds and roll them over if we don’t use them in a given year.

My interpretation of the available information is that CMU has given us a lot of options that make swings of a few hundred dollars a year in health care costs, they responded to widespread concern about the offerings, but they have not yet fully addressed the concerns of people who are vastly more concerned with managing the risks of potential, though unlikely, costs in the tens of thousands of dollars to get the health care we need if it best provided outside our network.

Also, my long-time optometrist (Mallinger and Eger) has just advised me that they don’t plan to participate in Davis Vision, which CMU has selected as the provider for the next two years. Mallinger and Eger say that the provisions of this plan will prevent them from providing quality care and force them to use lower-quality materials. They are one of the most popular optometry practices in SCS, so this is probably of broad interest.

Attached supporting information:

- Analysis of an example of out-of-network care, suggesting that CMU benefits would cover less than a third of the costs. I’ve shared the spreadsheet with HR and asked them about the assumptions, and they haven’t offered any corrections. This exposure is still present under Comprehensive coverage.
- Summary of my correspondence with CMU Benefits Office
- Article from HealthWatch explaining the new health savings account options
- Letter from Mallinger and Eger Optometric Associates explaining why they don’t intend to participate in Davis Vision, the new CMU optical plan.

There are two issues here: First, what selections we should make now from among the poor choices available, and second, how to get CMU to provide better alternatives in the future. With respect to the first issue, I’m not a health services advisor, but I do believe you should think carefully about the in-network coverage you need. With respect to the second issue, I think CMU needs to hear from everyone who would like to have better options – just a few voices probably won’t make a difference.

On the whole, I am deeply disappointed with these offerings.
The Real Problem with Out-of-Network Health Care

Copayment for out-of-network care has been reduced from 80% to 60% (60% is the part that health insurance covers; we pay 40%, up to an out-of-pocket cap). However, the insurance payment is 60% (formerly 80%) of the “provider’s reasonable charge”, not 60% of the provider's bill. We're responsible for provider’s charges above the “provider’s reasonable charge”, and HR confirms that the out-of-pocket cap does not apply to those charges above the “provider’s reasonable charge”. This analysis is for the PPO. Comprehensive covers 80% rather than 60%, but the problem of amounts above the “provider’s reasonable charge” remains (updated 11/7).

Analysis of my last two years’ health care costs suggests that CMU coverage will pay less than a third of my actual expenses if I get health care out of the provider network! This is a much more serious problem than the (already problematical) reduction from 80% to 60% in the apparent rate. The problem is that the apparent rate applies to only a fraction of the actual cost, the part up to the “provider’s reasonable charge”. HR has not been able to tell me what fraction of the bill exceeds the “provider’s reasonable charge”, but my records show 50%.

Further, the University tells us that the Highmark PPO network is the same as their network for comprehensive plans, though if pushed they will agree that it is “not one for one the same as the comprehensive plan”. I know the networks are not the same, because one of my specialists accepts only the PPO, not comprehensive.

Why does the choice of network matter?

Yes. In recent email, the Benefits office told me that the Highmark network is national (through BlueCard) but the UPMC network is local (see Q/A #12 below). This is not a hypothetical problem. One of our colleagues is covered under UPMC and needs to resolve an orthopedic problem. Several doctors in town have good reputations with this sort of problem, but our colleague has very specific personal requirements about what constitutes a solution to the problem. He saw multiple UPMC doctors, and then was referred to an out-of-network doctor; initially they didn’t know if this doctor could even see him on a flat-fee screening appointment. This doctor suggested a procedure that is specifically appropriate for our colleague; apparently all of the doctors offer some newer procedures, and the older one, while still appropriate in specific situations, is somewhat out of fashion. The problem for our colleague is that the doctor who suggested the older, more appropriate, procedure is not in the UPMC network. Now our colleague faces a dilemma: should he pay out of pocket the amount over the “provider’s reasonable charge” that will be charged by the doctor who is current on the procedure, or should he have it done by an in-network doctor who hasn't done it recently and may have lost proficiency?

How big is the risk of going outside your insurer’s network?

Big. For in-network services, the insurer (UPMC or Highmark) sets a "provider's reasonable charge", which is determined by the insurer based on the UCR (usual, customary, reasonable charge) and mysterious other factors. This is the part of the bill that we and the insurer split. An in-network provider waives the difference between the provider's billed charge and the “provider’s reasonable charge” (in other words, the provider swallows the difference, because no one else is paying these charges). These waived amounts show up on my Highmark statements as, for example, code J4047, “This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount” -- and then the accounting shows that Highmark isn't paying it either. If I were getting the service out-of-network, the provider would bill me for this amount instead of waiving it (actually, he’d probably bill me for the whole thing, and I’d have to ask the insurer to reimburse me for the 60% of the “providers reasonable charge” that is covered by insurance).

To see how much risk I'll be exposed to by going out of network where the J4047-like clauses do not protect me, I recently went back through my 2004 and 2005 medical expenses. To my great alarm, about 50% of my provider's charges are being waived (47% one year, 53% the other). This puts an entirely different light on out-of-network coverage. The attached one-page spreadsheet does the analysis for one example with default plan parameters. The bottom line is that I'm not exposed to a little extra cost, I'm exposed to an enormous amount of extra cost. The insurance coverage of 60% is really 60% of half the actual charges, or under a third of the actual cost. I have asked the benefits office repeatedly to get me the average amounts for Highmark and UPMC; they have not supplied these numbers, so I have to work from my own data.

This means that out-of-network care will be priced out of my reach in exactly the circumstances when I'm most likely to need it -- when the medical care I need is rare and the experts don't happen to be in my network.

The exposure to this vulnerability will be much higher with UPMC than with HighMark, because the HighMark provider network is vastly more extensive. The situation may be even worse if I go outside the Pittsburgh area for medical care, because the UPMC network is essentially local (see Q/A #12 below).
Comparison of costs for In-Network vs Out-of-Network and Local vs Nonlocal Medical Services
Mary Shaw, September 2005

Assume individual, not family. Assume this is the only medical procedure, so deductible and OOP apply in their entirety.

Plan parameters

<table>
<thead>
<tr>
<th>In-network deductible</th>
<th>Out-of-net deductible</th>
<th>In-network Out of Pocket Limit</th>
<th>Out-of-network Out of Pocket Limit</th>
<th>In-network Coinsurance (% paid by insurance)</th>
<th>Out-of-network Coinsurance (% paid by insurance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>250</td>
<td>500</td>
<td>1500</td>
<td>3000</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Observed rate at which provider's billed rate is discounted to get the UCR allowance

Typical % of bill allowed in UCR (see note 1) 50%

Hypothetical example of service at local and distant prices with corresponding UCRs

<table>
<thead>
<tr>
<th>Price billed by doctor in Pittsburgh</th>
<th>Price billed by doctor in another region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pgh Price</td>
<td>OutPrice</td>
</tr>
<tr>
<td>15000</td>
<td>18000</td>
</tr>
</tbody>
</table>

Pgh UCR 7500 Outside UCR 9000

Analysis: Costs that result from applying plan parameters to hypothetical example

<table>
<thead>
<tr>
<th>Local or out of area?</th>
<th>In Pittsburgh</th>
<th>In Pittsburgh</th>
<th>Out of Pittsburgh</th>
<th>Out of Pittsburgh</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Network or out?</td>
<td>In Network</td>
<td>Out of Network</td>
<td>In Network</td>
<td>Out of Network</td>
</tr>
</tbody>
</table>

Graph label: InPit-InNet InPit-OutNet OutPit-InNet OutPit-OutNet

Full price 15,000 15,000 18,000 18,000

Applicable UCR 7,500 7,500 9,000 9,000

Waived by doc per UCR 7,500 7,500 9,000 9,000

Pd by me, amount above UCR 7,500 7,500 9,000 9,000

Deductible 250 500 250 500

Subject to coinsurance up to OOP 6,250 6,250 6,250 6,250

Not subject to coinsurance, per OOP 1,000 750 2,500 2,250

Check: Above 3 should equal UCR

Allocation of UCR

UCR

Insurance pays match to OOP Lim 5,000 3,750 5,000 3,750

Insurance pays above OOP Lim 1,000 750 2,500 2,250

Check: Above 4 should equal Full Price

How the provider's full price is distributed: Accounting of payments

Waived by doc per UCR 7,500 - 9,000 -

Pd by me, amount above UCR - 7,500 - 9,000

Pd by insurance (under + over OOP) 6,000 4,500 7,500 6,000

Pd by me (ded + coinsurance) 1,500 3,000 1,500 3,000

Check: Above 4 should equal Full Price

Total paid by me 1,500 10,500 1,500 12,000

Note 1: The analysis depends on how much of the provider's charge is waived by the doctor (e.g., Highmark's "J4047 This is the difference between the provider's charge and our allowance. Since the provider is in-network, you are not responsible for this amount." Based on my records for 2004 and 2005, this is about 50% (47% one year, 53% the other). I would like better data on the amount for major specialty services of the sort that would take me out of the network.

Summary: Patient pays the red part, insurance the yellow

<table>
<thead>
<tr>
<th>InPit-InNet</th>
<th>InPit-OutNet</th>
<th>OutPit-InNet</th>
<th>OutPit-OutNet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total paid by me</td>
<td>Pd by insurance (under + over OOP)</td>
<td>Pd by me, amount above UCR</td>
<td>Pd by me (ded + coinsurance)</td>
</tr>
</tbody>
</table>

Details, showing effects of UCRs (patient pays both reds)
Correspondence with the CMU Benefits Office

I have sent several messages (9/23, 9/26, 10/3, 10/10, 10/24, 10/27) to Gemma Green & Lori Bell in HR. Gemma Green responded to most of my questions (on 9/26, 10/6, 10/12, 10/27, 11/1). Here are my question s, their initial responses, my followup questions, and their replies to my followup. The follow-ups to several of these questions are still unsatisfactory, and I’m trying to muster the energy to follow up again.

<table>
<thead>
<tr>
<th>#</th>
<th>My original question</th>
<th>HR first response (some are paraphrased)</th>
<th>My followup</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Why can't we have comprehensive coverage?</td>
<td>We opted not to continue the comprehensive plan because many of the features are replicated by the various PPO options being offered. We thought there were sufficient choices available with three networks, each with four plan options and two prescription choices plus one network HMO.</td>
<td>We would have more selection if CMU had fewer pricing options on essentially similar plans and a couple of other, different, plans for the many of us who want them.</td>
</tr>
<tr>
<td></td>
<td>Update 11/7: Comprehensive and the Highmark HMO will be offered this year!!</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>While it is true that no one 2006 option replicates the current Comprehensive Plan, overall, the PPO options for 2006 do match, if not exceed, many of the in-network features of the current Comprehensive Plan. We do believe that the plans offered do, in fact, give employees a combination of features that makes the options very different from each other. Of course, as we both know, the out-of-network coverage for 2006 will be lower than what is currently offered with any of our current non-HMO plans. As a self-insurer faced with escalating costs for providing health care for its employees, the university has decided in 2006 to focus on in-network care where we can take advantage of greater discounts.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I am not willing to sacrifice genuine access to a national population of doctors. Highmark has an extensive national network, last time I asked UPMC did not. That's why I want comprehensive and why I object to reducing coinsurance from 80% to 60% Update 11/7: Comprehensive and the Highmark HMO will be offered this year!!</td>
<td>It's all about price. UPMC offers deeper discounts</td>
<td>UPMC offers narrower coverage to go with their deeper discounts. This puts us at greater risk of not being able to afford the care we need. For me this is far from hypothetical. With further analysis, I've realized that there is an even bigger problem with out-of-network care -- especially in UPMC -- namely the &quot;provider's reasonable charge&quot;.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UPMC, through the PHCS network, has established relationships with other provider networks outside of the Pittsburgh/Western Pennsylvania area in order to provide in-network services to employees located in other regions of the country. It is my understanding that a UPMC member located in Western Pennsylvania would be considered out-of-network if they sought treatment outside of this area. [sic]</td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>My original question</td>
<td>HR first response (some are paraphrased)</td>
<td>My followup</td>
</tr>
<tr>
<td>---</td>
<td>----------------------</td>
<td>-----------------------------------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>
| 3 | Why can't you provide comprehensive, even at higher rates?  
Update 11/7: Comprehensive and the Highmark HMO will be offered this year!! | Current plans provide overlapping coverage, CMU thinks there's enough choice. | The choices now provided are mostly about prices. Your answer does not respond to the question, which is about risk management. CMU is focused on economizing on the first few thousand dollars of routine health care, not helping us manage the risk of unexpected but very expensive health problems. This is a qualitative change—not long ago I could get the care I needed without restriction. Dropping comprehensive coverage is another giant step backward. What many of us need from CMU is not ways to trade premiums against a few thousand dollars of difference in out-of-pocket maxima. We need insurance that covers us for specialty services best provided out of network. | We do believe that the choices that are available for 2006 offer a variety of plan features beyond price, including a choice of deductibles, coinsurance levels, out-of-pocket maximums as well as networks. It is my understanding that the Highmark PPO BlueCard national network includes a very extensive listing of providers. If you do select Highmark as your carrier, you should be able to find in-network providers for specialty services not only in the Pittsburgh area but also in other areas of the country, so you will not have to resort to non-network providers. |
<p>| 4 | If you can provide HRAs with rollover for some plans, why not for all plans? | Because of the significant legal and administrative requirements associated with the Health Saving Account (HSA) plans which you refer to, we have not included them in our offerings. However, the High Deductible plans we are offering are designed to meet the IRS standards required for an HSA. If you desire to do so, you could fund an HSA independently; you would need to identify a provider willing to work with you as an individual. | I asked about HRA, you answered about HSA and said CMU's HRA will qualify as an HSA. If I understand correctly, HRA/HSA provides all the benefits of FSA, plus rollover of unused funds. I don't understand why you can't offer this to all of us. It would relieve us from making the year-in-advance bet on health care costs, which in the end would save money for very many of us. | The IRS does allow an employer to couple a Health Reimbursement Account (HRA) with any medical plan. However, the university has chosen to offer the HRA only with the High Deductible PPO. By doing so, we are able to offer a plan with a lower monthly contribution rate for employees. At the same time, the HRA can lower the employee's out-of-pocket costs, since the employee can use those funds to pay for deductibles, etc. We believe that this is a win-win situation for many of our employees. |
| 5 | Which of the 14 Highmark plans is CMU offering? I need this to check doctor participation. | You think it's PPOBlue, but this did not sound definitive. | Please provide definitive information, as not all doctors participate in all plans. | We have confirmed with Highmark that for 2006 the local network will be PPOBlue. If you wish to search for a participating physician or facility outside of the Pittsburgh area which is affiliated with Highmark, please use the BlueCard section of their web site and select PPO as the plan type. |
| 6 | The rollout schedule doesn't support individual planning very well. | Prices will be up by September 30, but tools will not be available until late October. | Looks like I'll build my own spreadsheet | |</p>
<table>
<thead>
<tr>
<th>#</th>
<th>My original question</th>
<th>HR first response (some are paraphrased)</th>
<th>My followup</th>
<th>HR reply to followup (some details elided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Preventive care is confusing and I don't seem to get the benefit. What is it, really? Update 11/7: Based on things Highmark said at the health fair, it appears that if there’s a diagnosis at the annual physical, it isn't “preventive” any more. If you’re getting a maintenance prescription renewed or have a chronic condition, this will probably result in a diagnosis, to your annual physical won’t be covered.</td>
<td>Other people are also confused, and you're trying to get clear definitions.</td>
<td>I look forward to the clarification</td>
<td>The Preventative Care schedules for all three carriers will be available on the HR Web site early next week.</td>
</tr>
<tr>
<td>8</td>
<td>What became of lifetime benefit caps?</td>
<td>Except for drug and alcohol (is that all?), no lifetime caps either in network or out.</td>
<td>Thanks</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>At the SCS presentation you said that the out-of-pocket limit did not include the deductible. However, the (old) Highmark benefits book says, &quot;The out-of-pocket limit refers to the specified dollar amount of deductible or coinsurance you pay out of your pocket for eligible health care expenses before your program begins to pay 100% for additional expenses.&quot; Has there been a change, or did I misunderstand what you said at the meeting?</td>
<td>The out-of-pocket maximums do include the deductibles. For example, under the PPO Option 1 for Employee Only coverage, the out-of-pocket maximum would be $250, which is the Deductible amount for an individual.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>The “provider's reasonable charge” is based on the UCR. The definition of UCR seems to set the UCR for each provider, depending in part but not completely on local market conditions. Is it safe to assume for purposes of analysis that the UCR for a given procedure is pretty much the same all over the local service area? If not, how much variation is there?</td>
<td>The UCR does depend on the local market and it varies by carrier. My understanding is that each carrier calculates their average cost for all the in-network claims for a particular procedure in a particular area to arrive at the UCR. But other factors play a role in determining the UCR including what fees a particular carrier negotiates with particular providers and facilities for the use of those providers and facilities in a particular area.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>My original question</td>
<td>HR first response (some are paraphrased)</td>
<td>My followup</td>
<td>HR reply to followup (some details elided)</td>
</tr>
<tr>
<td>----</td>
<td>------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11</td>
<td>How is &quot;provider's reasonable charge&quot; determined for out-of-network (&quot;non-participating&quot;) providers? Since they're not participating, they have presumably not negotiated rates. Are there standard UCRs that apply? Since I'm responsible for charges in excess of the &quot;provider's reasonable charge&quot; as well as 40% of that charge, I'd like to know how it is computed.</td>
<td>The carrier would use the UCR that they have determined for a particular procedure, for a particular area as the &quot;provider's reasonable charge&quot;. There are no standard UCRs. Each carrier would use the UCRs that they have calculated. UCRs definitely vary by location, as well as provider and facility.</td>
<td>Clarification 11/7 A colleague reports that Barbara Smith advised him that For both UPMC and Highmark, if you are out of town and experience an emergency you are fully protected after the out of network deductible and the copay. If you voluntarily go out of network and it is not an emergency you are responsible for amounts over the UCR.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>How is “provider’s reasonable charge” determined for services outside the local service area? The comprehensive plan provided &quot;BlueCard&quot; services for services outside the local service area. Will this plan with the same terms be continued under any of the new health care plans? Which ones? BlueCard coverage amounts are based on &quot;The negotiated prices that the on-site Blue Cross and/or Blue Shield Plan (&quot;Host Blue&quot;) passes on to us.&quot; For in-network providers, is this is treated just like &quot;provider's reasonable charge&quot; for local charges?</td>
<td>Yes, outside of the Pittsburgh/Western PA area, the BlueCard would apply. Yes, that is correct.</td>
<td>It wasn't clear whether this is only for Highmark plans or whether BlueCard is also available with UPMC coverage. If BlueCard is available with UPMC, it seems like that would make the national Highmark network available to people who select UPMC, at least outside the Pittsburgh area. That seems a little odd -- so, is BlueCard available only with Highmark, or also with UPMC? What are the relative sizes of the national networks for Highmark and UPMC, particularly of specialists?</td>
<td>BlueCard is only available with the Highmark options. The BlueCard is Highmark's link to the Blue Cross/Blue Shield (BC/BS) national network. Locally, Highmark has a contractual agreement with the UPMC Health System of providers and facilities to be part of Highmark's network. Highmark says 95% of providers are in the BlueCard national network. The UPMC Health Plan does not have a national network in the same sense as the BlueCard network. UPMC's networks are based on your primary residence. If you live in Western Pennsylvania, your &quot;in-network&quot; is limited to the Western Pennsylvania area. If you seek treatment outside of this area, you would be considered out-of-network. (By the way, the HealthAmerica networks also function in this manner.)</td>
</tr>
<tr>
<td>#</td>
<td>My original question</td>
<td>HR first response (some are paraphrased)</td>
<td>My followup</td>
<td>HR reply to followup (some details elided)</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>13</td>
<td>For in-network services outside the Pittsburgh area, how is “reasonable charge” determined? In particular, the &quot;provider's reasonable charge&quot; is used for two things: First, to get the provider to waive charges in excess of the &quot;provider's reasonable charge&quot;; second, as the amount that's being split 80/20 for coinsurance. Please confirm that the same number is always used for both purposes. (If the former were larger than the latter, I could wind up responsible for the difference in addition to my coinsurance -- I have been told in the past that this could happen.) What about out-of-network services outside Pittsburgh?</td>
<td>My understanding is that the &quot;provider's reasonable charge&quot; is the UCR. So, yes, the same number should be what the carrier is using for both purposes. And, yes, you may be responsible for additional charges since an out-of-network provider may bill you for their charges in excess of the UCR. The &quot;provider's reasonable charge&quot; and the UCR are the same. Each carrier calculates their average cost for all their in-network claims for a particular procedure in a particular area to arrive at the UCR. Other factors that play a role in determining the UCR include what fees a particular carrier negotiates with particular providers and facilities in a particular area. Once a carrier establishes the UCR, they use that same figure to calculate either the in-network or out-of-network coinsurance costs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>For in-network services, what is the average percentage of the doctor’s billed charge that is non-billable because the provider is in-network? (This is an indicator of the out-of-network charges not covered by insurance).</td>
<td>(on 10/12) “I am also still waiting to hear back from both Highmark and UPMC regarding the fraction of the providers initial charges that are disallowed/waived.” (11/7) At the Health Fair I was unable to get either Highmark or UPMC to answer this question. Highmark was particularly unhelpful – the rep said that the percentage varies from case to case and claimed that it wasn’t possible to know even an approximate average.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>My original question</td>
<td>HR first response (some are paraphrased)</td>
<td>My followup</td>
<td>HR reply to followup (some details elided)</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>15</td>
<td>One of my colleagues says the out-of-network charges over the UCR are not a big deal because the out-of-pocket limit applied to those charges as well as the shared charges below the UCR. That is, he thinks that if I go out of network Highmark would pay 60% of the UCR and I would pay 40% of the UCR plus the remainder of the out-of-network provider's charges, but only until I have paid the out-of-pocket maximum. Then, he thinks, Highmark would pay the entire UCR and also the charges in excess of the UCR. I have been under the impression that I am completely responsible for out-of-network provider's charges in excess of the UCR, always, without regard to deductibles, out-of-pocket limits, or anything else. Which is correct, please? If my colleague is correct, I'm much less concerned about the possibility of unbounded charges.</td>
<td>Unfortunately your colleague is not correct. There are Out-of-Pocket maximums for Out-of-Network services. (For example, under the PPO Option 1 the Out-of-Network Annual Out-of-Pocket Max for an individual is $3,000.) However, this max does not apply to the out-of-network charges that are over the UCR.</td>
<td>Thanks for clarifying that the out-of-pocket cap does not apply to out-of-network costs in excess of the UCR. Many of us would very much like insurance to cover these unlikely, but potentially very costly, expenses. How can CMU help us manage these risks? (11/7: note that the high deductible PPO does not have an out-of-pocket maximum for out-of-network coverage, even for amounts under the UCR)</td>
<td></td>
</tr>
</tbody>
</table>
HRA, HSA, and HCFSA
The relation among these is pretty confusing. HCFSA or FSA is what we’ve had for years – set aside pretax dollars in an account, get reimbursed for medical expenses from the account, lose any funds you don’t use in the year you set them aside. HRAs are funded by the employer; CMU is offering a small HRA with the high-deductible option. I haven’t been able to get good information on HSAs, but they have the advantage that you can carry unused funds over to a future year, and as far as I can tell they have no disadvantages relative to FSAs. CMU is not offering a HSA – they claim it’s too complicated (see Q/A #4 above).

Here’s an article that appeared on HealthWatch October 9.

Choosing health care for 2006
What to ask as high-deductible plans enter the mix
By Kristen Gerencher, MarketWatch
SAN FRANCISCO (MarketWatch) -- Workers may face new tradeoffs in their 2006 health-care decisions as high-deductible plans take their place among traditional programs offered by employers.

Conventional coverage such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are still the dominant plan types. But more employers for the first time will offer high-deductible health plans with a savings account attached during upcoming open-enrollment periods, benefits experts say.

"It is going to be a big transition year," said Paul Fronstin, director of the health research program for the nonprofit Employee Benefit Research Institute. "It's the year in which large employers start offering HSAs."

Health savings accounts, or HSAs, allow workers who accept high-deductible plans of at least $1,000 for individuals and $2,000 for family coverage to sock away and invest money tax-free, as long as the funds are used to pay for qualified medical expenses. Typical PPO-like coinsurance kicks in if workers spend all of their upfront money, and the account is portable from job to job.

Health reimbursement accounts (HRAs) are another form of high-deductible plan, but unlike HSAs, HRAs are funded solely by the employer. Balances roll over from year to year but employees don't own the fund -- if they leave the company, they can't take funds accrued in the HRA.

Many employers have shied away from HSAs, which have been on the market only a little more than a year, as they worked through administrative and regulatory questions. But this year, more big companies will offer them as an option, and more cash-strapped small employers will replace their current plans and make it the only health-care choice, Fronstin said.

Proponents hope the HSAs and HRAs, dubbed "consumer" health plans because they aim to control costs by giving users more discretion in seeking care, will make workers more price-sensitive, likely to shop around and motivated to take better care of themselves.

After several years of double-digit gains, annual health-care premiums grew 9.2% on average in 2005, according to the Kaiser Family Foundation.

Evaluating HSAs
Consumers confronting the choice of an HSA for the first time will need to weigh the risks and the benefits versus their current coverage.

The plans aren't for everyone, but they do have advantages for some, said Tom Billet, a senior consultant for Watson Wyatt. "The more upfront cost-sharing the employee can bear, typically the less they will have to pay out of their paycheck" in premiums.

Workers should view the choice as a budgeting issue, said Johan DeKeyzer, a health-care consultant for Hewitt Associates.

"They might be paying $200 a month for a PPO plan and $50 for high-deductible HSA plan and could put the difference aside into the HSA to cover expenses not covered by the high-deductible plan," he said. "If you're a healthy person, it would benefit you to put aside funds for when you do become ill or need health care."

Workers considering an HSA need to ask themselves, and in some cases their employer or insurer, the following questions, experts said:
a. How much did I pay out of pocket for care during the past year? Is it realistic to think I can change my
behavior enough to yield savings?
b. What expenses count toward the deductible? Is a maintenance drug considered preventive? While workers
are supposed to have preventive care covered under the plan instead of paying it out of the deductible, there are gray
areas in what the IRS and some of the underlying insurance plans consider preventive care.
c. Am I solely responsible for contributions or will my employer contribute? Will my employer match what I
put in? How much risk do I want to accept, especially in the beginning of the year when my balance is low?
d. Do I have enough income to pay 100% of the deductible if I need to?
e. How important is the idea of building up a balance to cover Medicare Part B and D premiums and long-
term care after I retire?
f. What kind of investment choices do I have? What are the fees? "If you're going into this thing with the
idea that you'll drain money out continuously, look at the fees he vendors are charging," said Barry Barnett, a principal
for PriceWaterhouseCoopers' human resource solutions.
g. What support tools or services, such as price-comparison data or an advice hotline, are available and how
effective are they?

Keep in mind that the IRS doesn't allow eligible spouses to hold a joint HSA. As of 2005, annual out-of-pocket
expenses for HSAs -- deductibles, co-payments and other amounts excluding premiums -- can't exceed $5,100 for
individual coverage or $10,200 for family coverage. The IRS will update limits on these as well as contribution levels
for 2006 by mid-December.

If two married people both have coverage, they should compare plans, and individuals need to consider similar
factors: which plan offers more comprehensive benefits, a wider network of providers and lower overall costs, taking
into account your personal and family situation.

Other changes

Workers also may find more financial incentives to take health risk assessments. These are surveys employees
take to help them gauge their risk of illness and injury. Employers can't use them to discriminate against workers with
certain conditions because their confidentiality is protected by law.

"It's a reward structure to say, 'If you do this test, and I don't care what the results are, I'll do something for
you,'" Barnett said.

For their part, flexible spending accounts (FSAs) that are funded with pretax earnings and have to be used
within 12 months remain helpful tools for offsetting predictable out-of-pocket health expenses. But they don't pair
well with HSAs, and many people choosing the new option likely will forgo FSAs, Fronstin said.

"You have to use the money in the HSA before you can use the money in the FSA," he said. "You have to use
money that does roll over before you use the money that doesn't roll over."

The biggest changes for Cigna Corp.'s 26,000 employees during this year's open enrollment include a total
conversion to high-deductible plans, mandatory health-risk assessments and a 10% break on premiums for
nonsmokers, said Catherine Hawkes, director of Cigna's total health and productivity.

The health-benefits company already has 40% of its workers enrolled in high-deductible plans for 2005, most
of them in HRAs, she said. But they'll have the choice of two HRAs and an HSA for 2006.

For in-network coverage where the employer has negotiated rates with providers, single HSA plans will have a
deductible of $2,000 and families will pay $4,000 up front, Hawkes said. The out of network HSAs will carry
deductibles of $3,000 and $6,000 respectively.

Cigna also is contributing to workers' HSAs for the first time in the amount of $200 for single employees and
$400 for family plans, she said. And workers will be able to choose from six mutual funds instead of the low-interest-
bearing account currently in use.

Kristen Gerencher is a reporter for MarketWatch in San Francisco.
A provider’s critique of the new CMU optical plan
This is a letter from Mallinger and Eger Optometric Associates, distributed in their waiting room. Dr Mallinger has been my optometrist for upwards of a couple of decades, and I stayed with him through various periods when my vision care could have been free from other providers. I value his care because he takes the time to understand my specific vision requirements and to work with me to get prescriptions just right. I have recommended him to many of my colleagues, and I believe he is one of the two most popular optometrists among members of the School of Computer Science. I think this statement from a popular provider deserves to be heard. Given the nature of university work, I believe it is false economy for the university to compromise on the quality of vision services.

Dear Friends:

If you have any type of Blue Cross and Blue Shield (BCBS) vision insurance plan, you may soon have your routine vision care plan switched to BCBS-owned Davis Vision. For the following reasons, Mallinger and Eger Optometric Associates have decided not to participate in Davis Vision.

Our primary concern involves the negative effect this will have on the quality of patient care. In order to compensate for reimbursements far below the average plan for a routine eye examination and glasses, we would be forced to see more patients in the same period of time. It is obvious that this would lead to a compromise in the quality of the exam. We do not feel that the quality of your care is negotiable.

Additionally, we are concerned about the quality of materials that we would be forced to provide under Davis. BCBS owns the optical laboratories, the lenses and the lower quality frames that are required to be utilized. We currently work very closely with our optical labs to assure that your custom glasses are done to the utmost specifications. Because we have prided ourselves on the quality of the materials we provide, we feel that we cannot relinquish the control over the lab that we use, nor the type and quality of lenses and frames that we prescribe for you.

Last, but not least, we are concerned about the impact this will have on our city. There are three privately owned optical laboratories in Pittsburgh. They estimate that Davis vision will cause them to lose 20 to 50% of their businesses. This will ultimately translate into local jobs lost and an increased dependence on unemployment programs. We will not participate in a plan that would be a detriment to our city.

Overall, we cannot participate in a program that is in such disagreement with our philosophy or practice and patient care. We do apologize for any inconvenience this causes you. If you have an impact on your workplace’s particular vision plan, please voice your disapproval of Davis Vision. We thank you sincerely for your loyalty as patients and friends. We hope to serve you for years to come.

Sincerely,

Dr. Bernard Mallinger, Dr. Maria Eger
and the Staff of Mallinger and Eger Optometric Associates