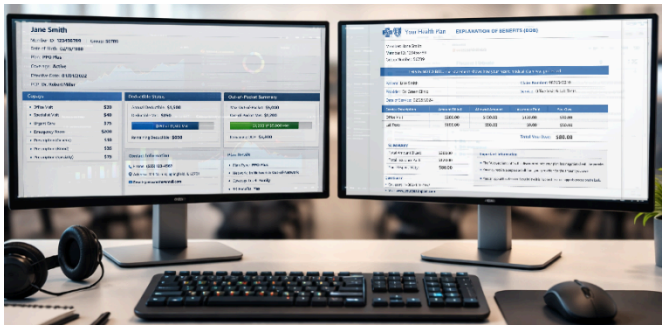
Member Services: Cost Sharing Scenario

Overview of Learning Activity

Following initial training in the eLearning course on cost sharing, employees will complete the following learning activity. This is a scenario-based learning experience, where learners must apply their knowledge of cost sharing to do the following: 1) interpret the current status of a plan member using the member's profile (e.g., What is the remaining amount left on the deductible?); 2) interpret various elements of an explanation of benefits (EOB; e.g. What is the member responsibility for the doctor visit?); and 3) satisfactorily answer member questions using information from both documents. Learner's performance answering member questions determines the trajectory of the activity – correct answers will lead to positive outcomes and quicker completion of the activity while incorrect answers will lead to negative outcomes and will require more time to completion.

Scenario Description



In the scenario, the learners will be provided a member profile and an EOB. These artifacts will initially appear as large 'thumbnails' overlaid on the image of two computer monitors. This design was used to reflect the real-world working environment employees will work in. Clicking on one monitor screen or another will display the insurance artifact full screen.

Learners will use the two resources to answer questions from callers. The module will provide immediate, explanatory feedback for each learner response, and will also show an image representing the emotion of the caller. The feedback messages and emotions reveal the consequences of effective or ineffective communication.

Storyboard

Title:

This slide will be very simple, and show the name for the scenario – On the Line: Explaining Member Costs – and the byline – Can you help members understand their EOB? Learners begin the scenario by clicking the 'Get Started' button.

Member Services: Cost Sharing Scenario

Question 1:

Jane, a confused member, calls in with a question. Review her member profile and explanation of benefits to answer her question.

“My EOB says I owe $80, but my office visit copay is only $30. Why?”

A. (Correct)
Because the **$30** is for the office visit, and the other **$50** is for lab tests.

> Feedback: Jane responds:
>
> **“Oh, ok. I can see now that $50 is listed next to lab tests.”**

B. (Incorrect)
Because both charges were applied to your remaining deductible.

> Feedback: Jane responds, with disappointment in her voice:
>
> **“I still don’t understand. I know that whatever I pay goes toward my deductible, but that doesn’t explain why I’m spending more than my regular copay.”**

C. (Incorrect)
Because you must pay the difference between the billed amount and insurance payment.

> Feedback: Jane responds, in an irritated tone:
>
> **“That just doesn't make any sense. I thought I was only responsible for my copay and anything that wasn't considered a covered expense.”**

Question 2:

Jane continues:

"But, I'm still confused. Why isn't my plan paying for the lab tests?"

A. (Incorrect)
Because lab tests always require prior authorization before the plan will pay.

> Feedback: Jane responds, noticeably frustrated:
>
> **“I don’t think that’s right – the documents I got never said I needed to get prior authorization for lab tests.”**

B. (Incorrect)

Because the provider billed more than the plan allows for lab services.

Feedback: Jane sounds unconvinced when she responds:

"But the EOB says that the allowed amount for lab tests is $50."

C. (Correct)

Because lab tests are not covered until your deductible is met.

Feedback: Jane seems satisfied with your answer, responding:

"Oh, ok! So the plan will start paying for those tests once I reach my deductible – that makes sense."

Question 3:

Jane still has questions. She goes on to ask:

"So, when will I meet my deductible?"

A. (Incorrect)

You still have $3800 on your deductible.

Feedback: Jane sounds shocked, responding:

"That's ridiculous! My deductible can't be that high!"

B. (Incorrect)

You have $1500 left to pay toward your deductible.

Feedback: Jane is definitely frustrated now:

"No, that's my total deductible. I've already spent money toward it – I need to know how much is left to pay."

C. (Correct)

You have $650 left to pay toward your deductible.

Feedback: Jane is very happy to hear that:

"That's awesome! I thought I had a lot more left to go!"

Question 4:

Keith is worried about his costs listed on the explanation of benefits. He asks:

"Why do I owe $80 for the stress test when my deductible has already been met?"

A. (Incorrect)

The stress test is subject to a $50 specialist copay, and the remaining balance is not covered.

> Feedback: Keith is exasperated and replies:
>
> **“I’m not even talking about the office visit charges! I’m talking about the charges for the stress test.”**

B. (Correct)

The stress test is subject to 20% coinsurance, so Keith owes 20% of the allowed amount ($400), which equals $80.

> Feedback: Keith sounds like he appreciates your answer:
>
> **”Ok, that makes sense. So I still have to pay a portion of the cost even after my deductible is met.”**

C. (Incorrect)

The stress test was processed as OON - Keith is responsible for the remaining balance after insurance payment.

> Feedback: This answer seems to have confused Keith:
>
> **“That can’t be right. I double-checked to make sure that this doctor was in network before I made the appointment.”**

Question 5:

Keith continues to his next concern:

“My plan paid $320 for the stress test. How do I know that amount is correct?”

A. (Correct)

The stress test is subject to 20% coinsurance, so the plan pays the other 80% of the $400 allowed amount, which is $320.

> Feedback: Keith is satisfied with your answer:
>
> **”Ok, that sounds right.”**

B. (Incorrect)

The stress test is covered by the $50 specialist copay, so the plan subtracts that copay from the billed amount.

Feedback: Keith is totally confused and replies:

“But my understanding is that the copay is for the office visit, not for the stress test.”

C. (Incorrect)

The plan paid 80% of the billed amount, because the deductible has already been met.

Feedback: Keith sounds doubtful, responding:

“I thought the plan only paid a portion of the allowed amount, not the billed amount.”

Question 6:

Keith has another question:

“Why do I owe different amounts for these cardiology services if they were all done at the same visit?”

A. (Incorrect)

Because only one service per visit is fully covered, and the rest become the member’s responsibility.

Feedback: Keith is becoming very frustrated after your answer:

“Your explanation doesn’t make any sense. None of the services billed were fully covered.”

B. (Incorrect)

Because services performed on the same day are automatically applied to the deductible first.

Feedback: Your answer has concerned Keith:

“But I thought I had already met my deductible!”

C. (Correct)

Because each service is processed according to its own benefit rule, so the specialist visit uses a copay while other procedures may use coinsurance.

Feedback: Keith is satisfied with your answer:

”Ok, that sounds right.”

Results:

This slide will show a ‘Congratulations’ message if the learner answered at least four out of six questions correctly on their first attempt, and will allow the learners to exit the course by clicking the ‘Exit Course’ button. Otherwise, it will show a ‘Needs Work’ message, and instruct the learner to try the scenario again.