Making Health Coverage Decisions

Overview

Health coverage options

What homework you need to do as you navigate health coverage options?

Persons who can help you navigate coverage

Options for Health Coverage

Health Coverage Options

Medicaid

- All Kids/Moms and Babies
- ACA Medicaid
- HBWD
- AABD/Spenddown

Medicare

- Original Medicare
- Medicare Advantage
- Medicare Supplement
- Dual Enrolled

Employer Based Plans

- Own employment or parents?
- Is dependent coverage available?
- Who is a dependent?

Marketplace

- Bronze
- Silver
- Gold
- Platinum
- APTC/CSR

Private insurance

- Meet ACA?
- Limited coverage?
- Tax Credits?

School Insurance

- Full time or Part time student?

Medicaid Options

All Kids

- Up to age 19
- Citizenship status not a factor
- Income up to 318% FPL ($6440/4)
- Premium payment may be needed

ACA Adult

- Age 19-64 and not on Medicare
- Must be U.S. citizen or meet special non-citizen requirements
- Income limit 138% FPL ($2795/4 or $1366/1)

AABD Medicaid

- Age 19 +
- Must be U.S. citizen or meet special non-citizen requirements
- Income limit up 100% FPL ($990/1)
- Resources capped at $2000/1
- Income or resources over limits spenddown option available

HBWD

- Age 19 – 64, employed, paying FICA, SERS, SURS, IMRF, etc.
- Must be U.S. citizen or meet special non-citizen requirements
- Income limit 350% FPL ($3465/1)
- Resource limit $25,000
- Premium payment may be required

Medicaid Eligible

If Medicaid eligible most health coverage is provided through Medicaid Managed Care Plans unless:

- Spenddown
- Medicare (if receive LTSS then Managed Care is required for the LTSS portion of coverage)
- Private health insurance
- DD waiver services

If the person does not live in an area where there is managed care then must enroll in Illinois Health Connect

Medicaid Managed Care Organizations (MCOs)

MCO Services

Care management offered through care coordinator

- Help navigate the health care system, make appointments, secure transportation, ensure prior approvals are authorized, and arrange for other social services

MCOs must maintain and monitor a network of affiliated providers to provide adequate access to all covered services

MCOs have access to care standards set by HFS

If concerns about coverage of care, contact the MCO

Medicare.gov
The Official U.S. Government Site for Medicare

Medicare

- Medicare enrolled after receiving SSDI or Auxiliary DAC benefits for 2 years
- Can be dual enrolled in Medicaid
- May want to consider a Medicare Supplemental plan especially if not Medicaid eligible

Federal Health Insurance Marketplace

https://www.healthcare.gov/

- Created by ACA to serve as One Stop Location to obtain health insurance
- Allows individuals, families business
  - To research health plans
  - Assesses eligibility for Medicaid or
  - Obtain Premium Tax Credits

Marketplace Plans must….

- Provide Essential Health Benefits
- Not exclude due to pre-existing health conditions
- Not charge higher rates due to pre-existing health conditions
- Meet the ACA requirements

Marketplace Plans

Plans available at annual open enrollment or during a Special Enrollment Period (SEP)

Tax credits available to help with cost and possible Cost Sharing Reduction (CSR)

Know the Health Plan Categories: The Metals

Lowest Premiums Highest Out-of-Pocket Costs

CSR if income under 250% FPL $2452/1

Highest Premiums Lowest Out-of-Pocket Costs

BRONZE HEALTHCARE PLAN	SILVER HEALTHCARE PLAN	GOLD HEALTHCARE PLAN	PLATINUM HEALTHCARE PLAN
60%	70%	80%	90%

Average Percentage of Covered Care Paid By the Plan

How the Federally-facilitated and State-Partnership Marketplaces Work

Create an account

Go to HealthCare.gov/get-coverage and provide some basic information. Then choose a password and security questions for added protection.

Apply

Next you'll enter information about you and your family, including your income, household size, other coverage you're eligible for, and more.

Pick a plan

Next you'll see all the plans and programs you're eligible for. You can compare qualified health plans side-by-side.

You'll also see if you can get lower costs on monthly premiums and other savings based on your income.

Enroll

Choose a plan that meets your needs, enroll, and pay your first premium.

You're covered!

May apply or change plan during Special Enrollment Period due to certain qualifying events.

2a

If Medicaid eligible, application stops and application sent to the state. Ineligible sent back to FFM

CMS Product No. 11671
Revised August 2015

Not Eligible for Medicaid: Use the Premium Tax Credit

Choose to Get It Now:
Advance Payments of the Premium Tax Credit (APTC)

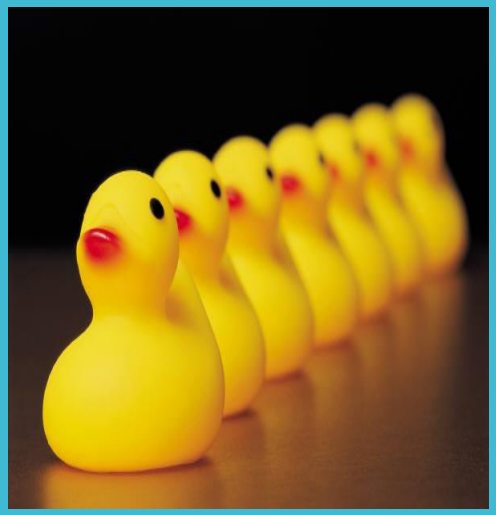
- All or some of the APTC is paid directly to the insurance company on a monthly basis
- The insured pays the difference between the monthly premium and APTC
- The APTC is reconciled when the yearly tax return is filed

Choose to Get It Later

- Don't request any advance payments
- You pay the entire monthly plan premium
- Claim the full amount on the tax return filed for the coverage year

Report all changes in the information provided on the application to avoid owing money. If tax credit received was too low, it could result in a refund.

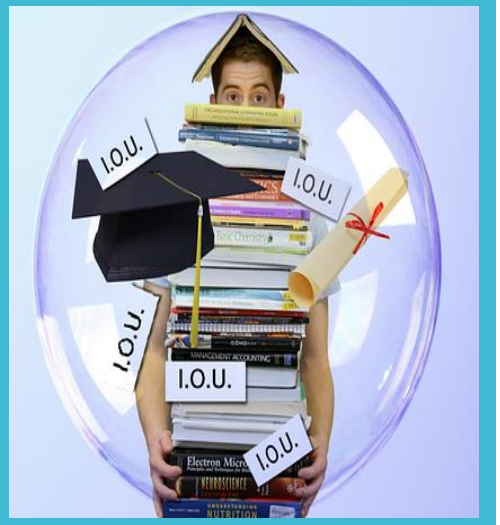
Tax Credit (cont'd)



Persons eligible for APTC

- U.S. citizen or legal resident
- Will file a tax return
- Not eligible to be claimed as dependent on another tax return
- Meets income guidelines

Student Coverage



If attending college student health coverage may be offered

This may be a good option if student attends school outside network area

Check with school to ensure plan meets ACA requirements

Employer Plans

Parents' employer

- Coverage to age 26, OR
- Adult child past age 26 if disabled prior to age 21 (May require proof of tax dependency and subject to employer policy)

Own employment

- May enroll in own plan through employer

Employer Plans ….

Large employers must

- Provide health coverage that includes dependents (Dependent coverage can be full price)
- Plans must cover essential health benefits

NOTE: Employers are exempt if self insured or plan was grandfathered (Self insured is about 60% of all Illinois employers and 85% of large employers)

Small employers not required to provide coverage

Private Insurance

Pros

- Can be sold outside open enrollment
- May have more insurance companies available

Cons

- May not have access to tax credits
- If sold outside open enrollment the plan may exclude conditions, not meet ACA requirements or charge higher premiums

Leverage Insurance Options

You can enroll in Medicaid (excludes All Kids PL 2) and have:

- Employer insurance
- Student insurance
- Private insurance
- Medicare

If enrolled in Medicare and income over Medicaid limits consider:

- Medicaid Spenddown
- Medicare supplement
- Medicare Advantage

If employed and a person with a disability consider:

- Employer insurance
- HBWD Medicaid

What Do You Need to Know?

Common Characteristics of Coverage Options

Health plans often limit costs by establishing:

- Provider Networks
- Categories of Coverage
- Formularies for prescription coverage

To recruit persons to enroll plans can offer incentives outside the Essential Health Benefits

Choosing a Plan

Questions to Consider

- Will the plan cover all of the health care services you need?
- Will the plan cover a specific service or medicine that you need?
- Will the plan pay for visits to your current doctor?

Source: Families USA

Other Factors to Consider

Medications (type and dosage): Explore the Formulary

- Know your tiers (1, 2, 3)
- Generic/Preferred, Non-Preferred

Doctors and hospitals

- Is the doctor and hospital you use in or out of network?
- Call the providers to find out which plans they accept.

Read the SBC (Summary of Benefits and Coverage)

Summary of Benefits and Coverage

What it is:

- A summary about a health plan's benefits and what it covers
- All plans use the same format and in easy to read language
- It is to be made available before enrollment and renewal

Allows you easily compare plans

SBC Sample

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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Corrected on May 11, 2012

SBC Sample

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013

Coverage for: Individual + Spouse | **Plan Type:** PPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	——————none——————
	Specialist visit	$50 copay/visit	40% coinsurance	——————none——————
	Other practitioner office visit	20% coinsurance for chiropractor and acupuncture	40% coinsurance for chiropractor and acupuncture	——————none——————
	Preventive care/screening/immunization	No charge	40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$50 copay/test	40% coinsurance	——————none——————

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

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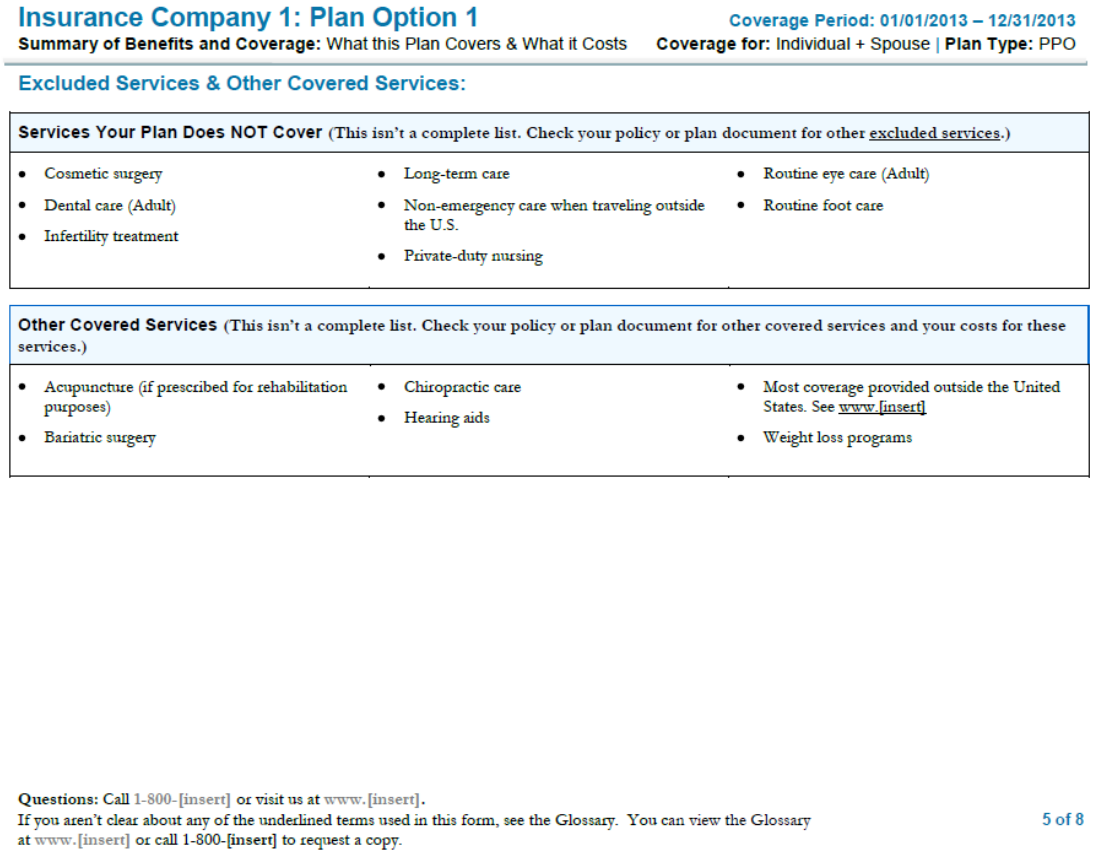
SBC Sample

What the Plan Does not Cover



Insurance Company 1: Plan Option 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Spouse | **Plan Type:** PPO

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States. See www.[insert]
- Weight loss programs

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

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Understand Insurance Terminology

- Co-pay
- Co-insurance
- Maximum out of Pocket (MOOP)
- SBC (Summary of Benefits and Coverage)

Co-Pays

Small, specific amount of money paid at the time of service.

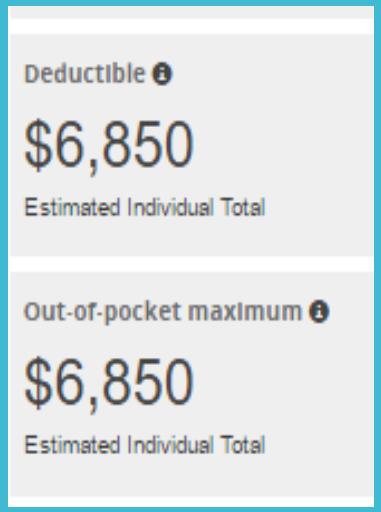
- Generally applies to doctors visits, emergency room, urgent care or prescription drugs.
- Can often be used without meeting a deductible first.

Copays do NOT help you meet your deductible but they do go towards your out of pocket limit.

Jack is expected to pay $15 for Office Visits for general care and $30 for specialist visits. This is his co-pay.

Some policies require the deductible to be met before paying for the Office Visits. See the SBC.

Deductible



The amount for which the member is financially responsible before the insurance policy provides coverage.

- Deductibles are annual and not by claim.
- Deductibles do not carry over if a plan changes.

Jack has a plan that has a $1000 deductible. He has a minor procedure that costs $1000. Since this equals his deductible Jack has to pay the full amount of the bill.

NOTE: Some policies do not require the deductible to be met for doctor visits. See the Summary of Benefits and Coverage to know if this applies.

Co-insurance

Coinsurance is the percentage that the patient pays for covered services after the deductible has been met.

Common coinsurance percentages are 10%, 20%, 30%, 40%.

Jack enters the hospital again. His bill is $2000. His plan pays 80% of the bill and he is responsible for 20%.

Based on this Jack owes $400 on this bill and the insurer pays $1600.

Jack's share of the cost is applied to his Maximum out of Pocket.

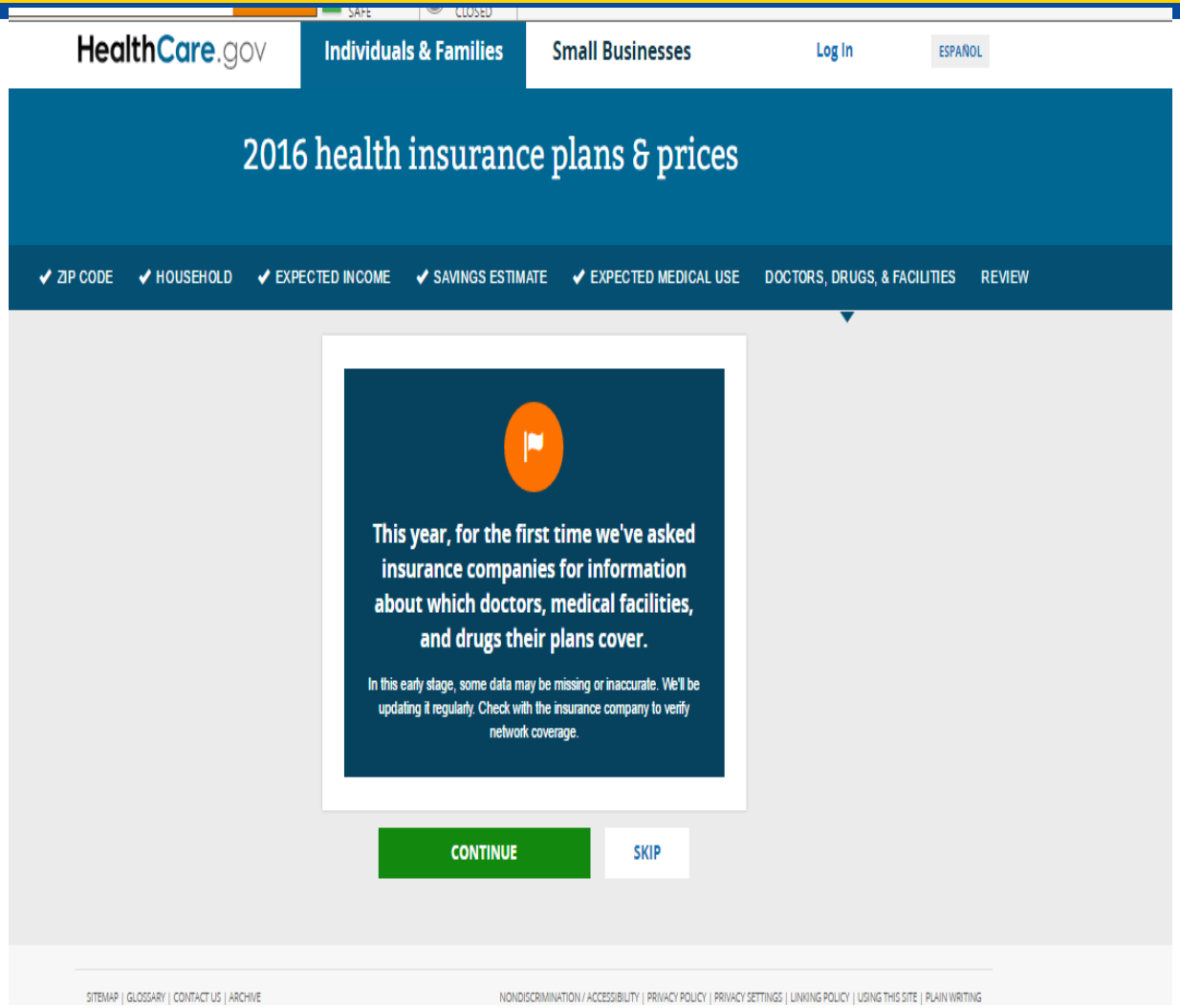
What needs to be done before buying a plan?

- **Know the types of plans available at the Marketplace**
  - Levels of Coverage (Bronze, Silver Gold, Platinum) and how this affects cost
  - Explore the Marketplace website and use tools

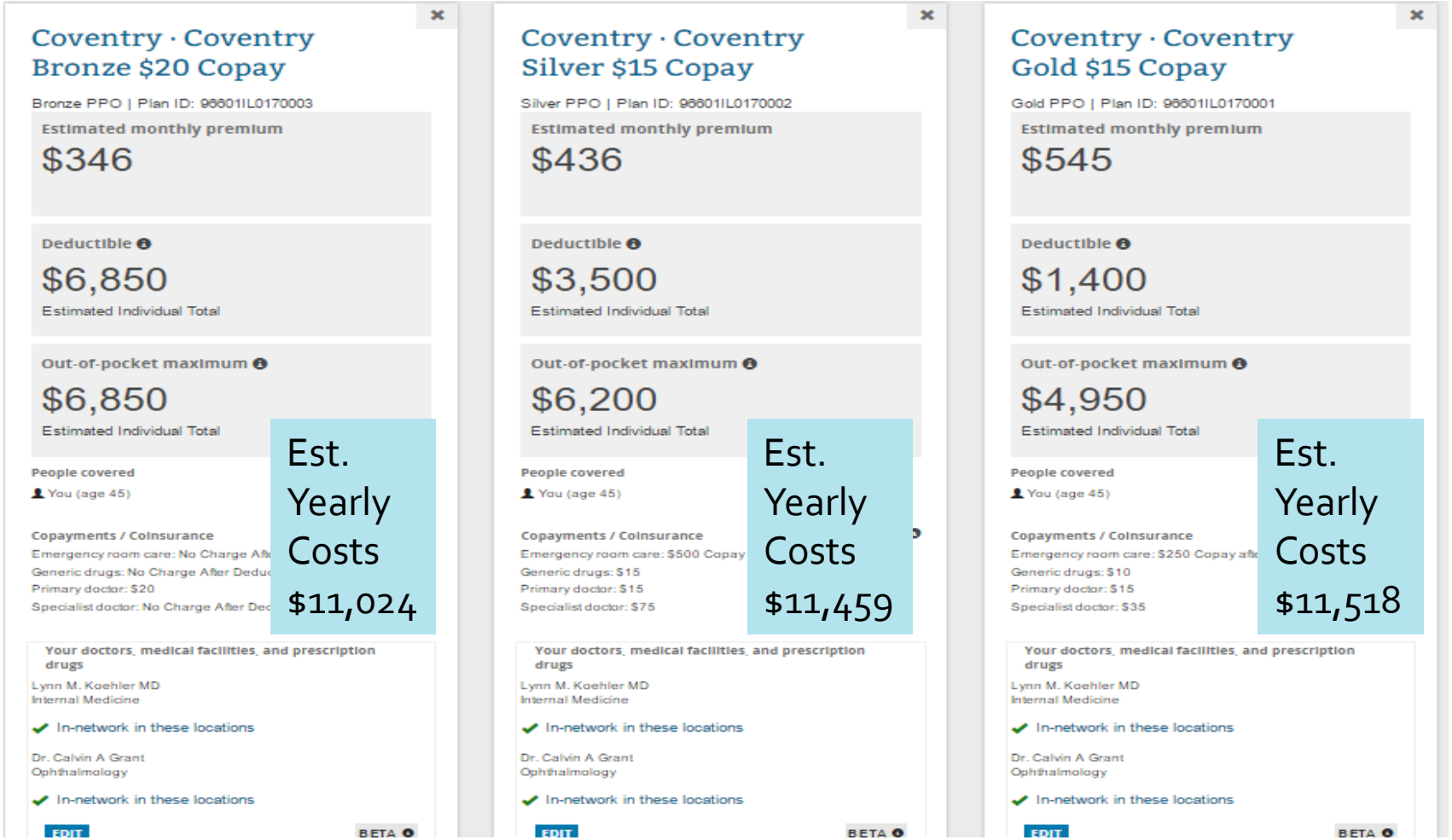
Search the Plans

Can search for plans based on:

- Providers
- Medical Facilities
- Prescriptions



Compare the Plans



Coventry · Coventry Bronze $20 Copay

Bronze PPO | Plan ID: 96601IL0170003

Estimated monthly premium
$346

Deductible
$6,850
Estimated Individual Total

Out-of-pocket maximum
$6,850
Estimated Individual Total

People covered
You (age 45)

Copayments / Coinsurance
Emergency room care: No Charge Afte
Generic drugs: No Charge After Deduc
Primary doctor: $20
Specialist doctor: No Charge After Ded

Your doctors, medical facilities, and prescription drugs
Lynn M. Koehler MD
Internal Medicine
In-network in these locations
Dr. Calvin A Grant
Ophthalmology
In-network in these locations

EDIT BETA

Est. Yearly Costs $11,024

Coventry · Coventry Silver $15 Copay

Silver PPO | Plan ID: 96601IL0170002

Estimated monthly premium
$436

Deductible
$3,500
Estimated Individual Total

Out-of-pocket maximum
$6,200
Estimated Individual Total

People covered
You (age 45)

Copayments / Coinsurance
Emergency room care: $500 Copay
Generic drugs: $15
Primary doctor: $15
Specialist doctor: $75

Your doctors, medical facilities, and prescription drugs
Lynn M. Koehler MD
Internal Medicine
In-network in these locations
Dr. Calvin A Grant
Ophthalmology
In-network in these locations

EDIT BETA

Est. Yearly Costs $11,459

Coventry · Coventry Gold $15 Copay

Gold PPO | Plan ID: 96601IL0170001

Estimated monthly premium
$545

Deductible
$1,400
Estimated Individual Total

Out-of-pocket maximum
$4,950
Estimated Individual Total

People covered
You (age 45)

Copayments / Coinsurance
Emergency room care: $250 Copay afte
Generic drugs: $10
Primary doctor: $15
Specialist doctor: $35

Your doctors, medical facilities, and prescription drugs
Lynn M. Koehler MD
Internal Medicine
In-network in these locations
Dr. Calvin A Grant
Ophthalmology
In-network in these locations

EDIT BETA

Est. Yearly Costs $11,518

Provider Networks

Questions to ask about a plan's provider network:

- Does the network include providers that are easy to get to?
- Does it include doctors, specialists, and hospitals that you want to go to?
- Does it include providers that speak your preferred language?
- If you have a disability, does the plan include providers that have the accessibility equipment you need?
- Do the plan's rules about when it will cover care from an out-of-network provider or without a referral seem fair?

Source: Families USA

Manage Health Coverage Transitions

Special Enrollment Periods (SEP)

What is a SEP?

- A time outside yearly Open Enrollment Period that allows person to enroll in health coverage.
- The SEP is open for up to **60 days** following a qualifying life. If that window is missed the next chance to enroll is at the next Open Enrollment.

Examples: Qualifying Life Events

- Marriage or divorce
- Birth or adoption of a child
- Move from another state
- Transitions from other health coverage (lost job, parents coverage ending, Medicaid cancels)

Example

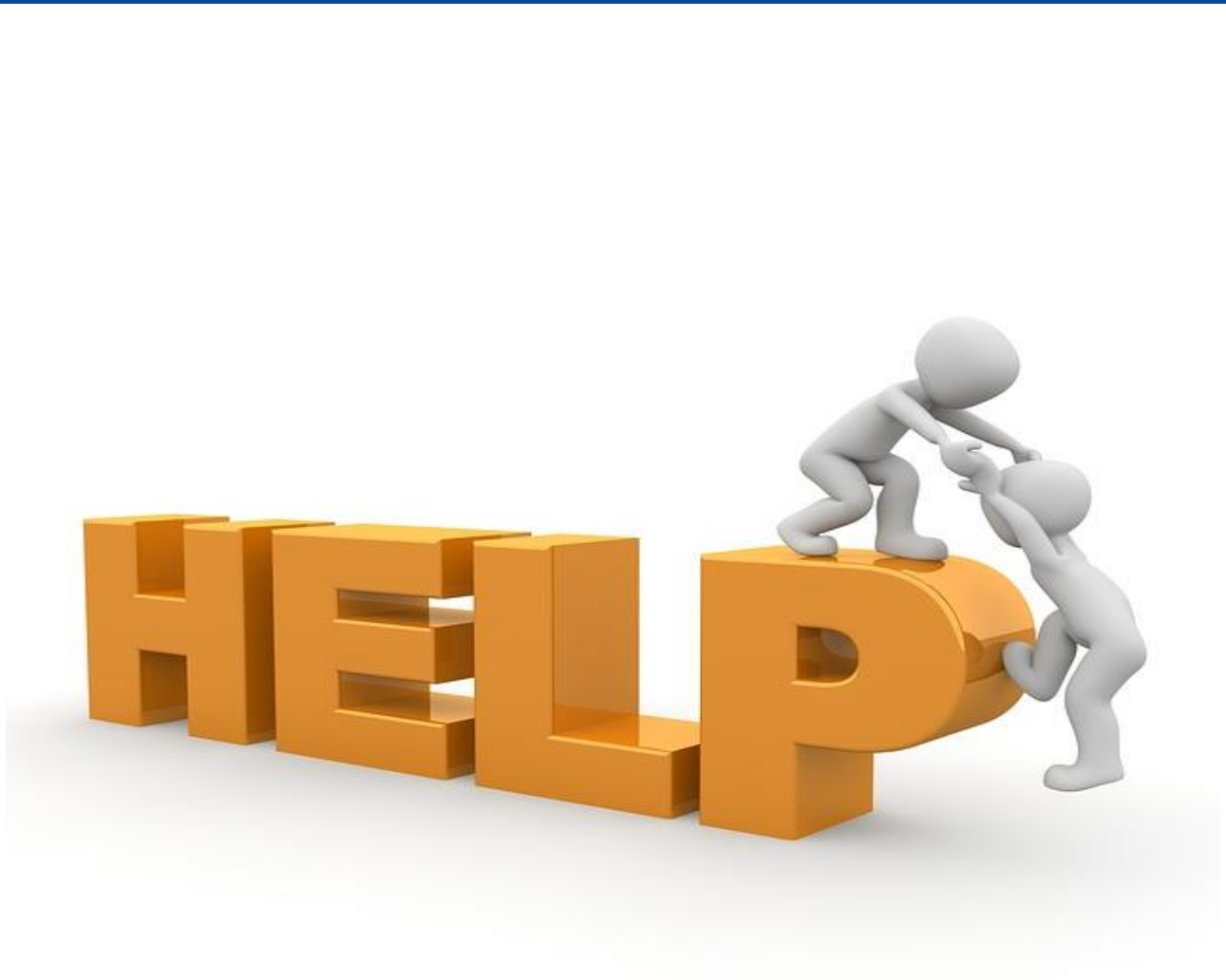
- Josh turns 19 in July so his All Kids coverage is ending for August. His parents are both retired and enrolled in Medicare.

- Based on Josh's income his choices are:
  - ACA Adult Medicaid
  - AABD Medicaid

  } Can apply anytime

  - **Marketplace – must apply within 60 day SEP window**

Who Can Help?



Resources

Medicaid: EnrollHFS.Illinois.gov @ 1-877-912-8880

The Arc of Illinois Family to Family Health Information and Education Center 866-931-1110 toll free familytofamily@thearcofil.org

The insurance company: Get a reference number for the call

Get to know OCHI (Office of Consumer Health Information)

What is the Office of Consumer Health Insurance?

- The Office of Consumer Health Insurance (OCHI) is a consumer assistance office that helps with health insurance problems and questions.

OCHI can:

- Explain rights as a health care consumer;
- Answer questions about health insurance;
- Help consumers understand the coverage provisions of their specific health care plan; and
- Assist when there is a problem or complaint.

To contact the OCHI, call at (877) 527-9431.

Who can Help you?

Preferred:

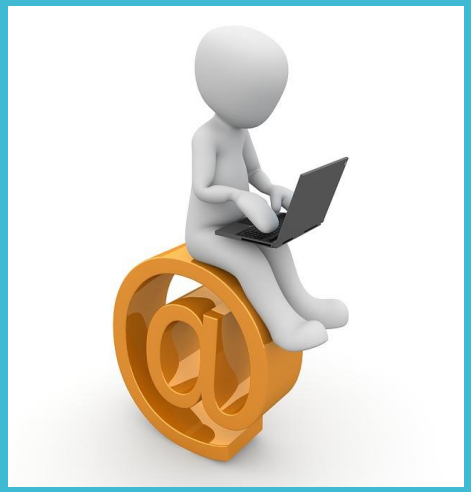
- Navigators/CAC
- Brokers/Agents

Other options:

- Local Social Service providers
- Friends

There should be no fee charged for the help.

Ways to Link to the Marketplace?



Use the website and navigate on-own

Call the Marketplace Call Center toll-free at 1-800-318-2596. TTY users should call 1-855-889-4325.

You can also visit Localhelp.healthcare.gov to find help in your area.

Know Your Rights

Call to verify coverage and providers (get reference number for all calls)

Appeal with insurer (essential to do if enrolled in Medicaid as appeal will not advance until this is done)

File a Complaint with the Illinois Department of Insurance
https://mc.insurance.illinois.gov/messagecenter.nsf

Request an External Review through Illinois Department of Insurance
https://mc.insurance.illinois.gov/messagecenter.nsf

Other Resources

- Consumer Reports Health Insurance Buying Guide:
  - http://www.consumerreports.org/cro/2012/09/your-health-insurance-buying-guide/index.htm
- Optum Financial Services: Decision Makers Guide
  - http://www.optumhealthfinancial.com/individualsfamilies/decisionmakerguide.html
- **Got Transition: 6 Core Elements of Healthcare Transition**
  - http://www.gottransition.org/resources/