What To Consider When Enrolling in a Health Insurance Plan

National Policy Matters

The Arc

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Introduction

Discriminatory insurance practices have made health insurance unaffordable for many people with disabilities or inadequate to meet their needs. The Affordable Care Act (ACA) will help uninsured people with disabilities access more affordable private health insurance coverage. Beginning in October 2013, uninsured individuals will have the opportunity to enroll in private health insurance through the marketplaces established by the state or federal government.

The ACA did a number of things to make it easier to compare the different health care plans offered in the marketplace. The ACA created a streamlined application process to make enrolling easier. It also required a glossary of health insurance terms and sample summary of benefits to make sure that the plans are using common terms and to make it easier to compare the plans.

► Costs—Common terms in health insurance

When comparing health insurance plans, there are many types of costs to consider.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for service. You pay co-insurance plus any deductibles you owe.

Co-pays: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.

Network: The facilities, providers, and supplies your health insurer or plan has contracted with to provide health care services.

Out-of-pocket limits: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover.

Some health insurance or plans don't count all your co-payments, deductibles, co-insurance payments, out-of-network payments of other expenses toward this limit.

Premium: The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

► Help paying for plans

Help will be available to moderate and low income people to afford their coverage through significant premium tax credits and cost sharing reduction. Consumers will receive information about whether and how much savings they will be entitled to when they apply for coverage.

► Plan levels ("metal tiers")

Plans will be divided by tiers based on the average amount that the plan is expected to pay for covered health care services. The higher the amount (known as actuarial value), the more the plan will pay. To make comparing the plans easier, the plans will be organized into what is known as the "metal tiers" - platinum, gold, silver, and bronze. For people with many medical needs, it may be more cost effective to choose

a plan with more coverage (i.e. in the platinum or gold tier) even though the premiums might be higher for those plans. Figuring out the true cost of a health insurance plan depends on what health services each individual needs and what cost sharing is imposed on those services.

► Essential health benefits (EHB)

The ACA did not specify the services a health plan would have to cover, but did provide that the plan be similar to a "typical employer plan" and that it include 10 categories of essential health benefits (EHB). The 10 categories include a number of benefits that will be important to people with disabilities, such as rehabilitative and habilitative services and devices. States and insurance companies have flexibility to design many different types of plans. The Arc is closely monitoring how plans will provide habilitation services since many private health insurance plans have not traditionally provided this benefit. This provision could be particularly helpful to youth with I/DD who need therapies and other health services to acquire and maintain skills. The Arc's website has more information about EHB and habilitation.

► Plan service limits

Insurance companies will not be able to offer plans in the marketplaces that include annual dollar limits or lifetime caps. However, they will be able to include limits, such as caps on the number of office visits for therapy services. A plan may seem affordable when looking at the monthly premiums, but out-of-pocket costs can rise quickly if a plan places limits on specific services the individual needs. People with significant medical needs must look very closely at the plan design, in addition to the cost.

► Prescription drug plans

It will also be important to carefully review the prescription drug benefits offered by the various plans. The plan formulary (the list of covered prescription drugs) will reveal important information about which drugs are covered and what co-pays apply.

► Provider networks

If a person needs to see a specific doctor or specialist, the list of doctors included in the plan's network of providers should be carefully reviewed. It will likely cost the person significantly more to use doctors that are not part of network. Those out-of-pocket costs for going outside a plan's network will not count toward the limits the law provides on out-of-pocket costs.

Getting Ready to Enroll

1 Step One—What are your health care needs?

Enrolling in a health plan is a multi-step process. The first step is to think through your health care needs, both current and anticipated needs. Here are some questions to get you started:

- What medications am I taking or may need?
- What doctors and specialists am I seeing?
- What pharmacies or other health care providers need to be part of the plan network?
- Do I need durable medical equipment (DME) such as: oxygen equipment, wheelchairs,

crutches or blood testing strips for diabetes?
- Do I need therapy services (physical, occupational, behavioral health, speech, etc.)?
- Do I need home health services?
- Do I need mental health services?
- Do I have any chronic diseases? What do I need to help me manage them?
- Do I need long term services and supports, for example, help getting dressed, taking medication, preparing meals, and getting in and out of bed?

2 Step Two—What does the health insurance plan cover?

- Are my medications on the plan formulary (the list of medications the plan covers)?
- What are the copays?
- Are there other limits on the availability of the medication?
- Are my doctors, pharmacists, specialists or other health care providers part of the plan's network? Double check with your physician's office that they take the plan you are considering as this information can change at any time.
- Do I need referrals to see my doctors?
- What medical devices and supplies are part of the plan's DME benefit?
- Are there plan limits on the therapy services or other health services?
- What type of habilitative services are being covered?
- Does the plan limit the home health, mental health or chronic disease management services (if needed)?

3 Step Three—What cost sharing is involved?

- What is the monthly or annual premium for the plan?
- What co-pays, deductible and co-insurance apply to the plan?
- Will I have to pay for any needed services out-of-pocket?

4 Step Four—Think about Medicaid

- Am I potentially eligible for Medicaid?
- Would benefits available to Medicaid beneficiaries better meet my needs?
- Is my state expanding Medicaid?

5 Step Five—Enrolling

1. **If you need more help:** Some people may need assistance with thinking through their health care needs and researching and comparing plans. There are different programs available to help people navigate the system.
2. **If you think you may need long term services and support** (for example, help getting dressed, taking medication, preparing meals, and getting in and out of bed) or the plans seem inadequate for your needs, be sure to investigate Medicaid eligibility.

> You should also be sure to check "yes" to the question on the streamlined application form that asks "Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?" This may help the state Medicaid agencies to take a closer look at whether you might qualify for Medicaid which provide long term services and supports.

3. **If you are ready to enroll**, here are the items you should have ready to complete the online application.
4. **Enrollment** and other information is available at www.healthcare.gov. There is a 24 hour assistance line at 1-800-318-2596.

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