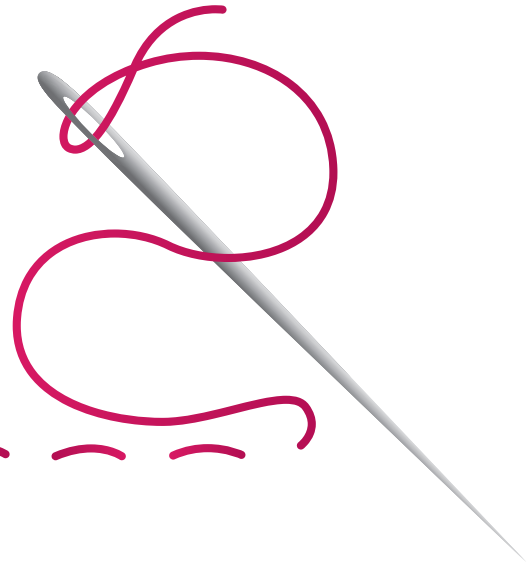
Chapter 1

UNDERSTANDING HEALTH INSURANCE



Understanding Health Insurance

To be an effective advocate for your family's medical needs, you will need to know the basics of health insurance coverage. This chapter will provide some general information on the different types of private and military health insurance plans as well as expected features and timelines for implementation of the Patient Protection and Affordable Care Act (ACA).

Private Health Insurance

If you have health insurance, you have either a traditional plan or some type of managed care plan. No one type of health care plan is better than the other. It really depends on your needs, preferences and budget. The first managed care plans were health maintenance organizations (HMOs). There are also preferred provider organizations (PPOs) and point of service plans (POS). Other types of plans include fee for service, which is also called an indemnity plan, and consumer-driven health plans. Below are some features that are typical of each of the basic plan types.

Managed Care Plans

Closed-Panel Health Maintenance Organization (HMO)

- You pay a set fee, called a premium, which is usually paid monthly.
- The HMO provides you access to services through its own network of doctors and health care facilities.
- You must go to one of the HMO doctors and you will have a co-payment for each visit, although the out of pocket fees are usually low.
- You must select a primary care physician (PCP). Your PCP is the doctor responsible for managing your health care.
- If your plan requires a referral for specialty care, your PCP must approve a referral to a specialist.

Advantages

- Coordinated approach to care and preventative care
- Lower cost
- Little paperwork (you don't have to file claims)

Disadvantages

- Less choice in provider and services
- Must have a PCP
- Need a referral from PCP to see a specialist

Preferred Provider Organizations (PPO)

- You choose your doctor. The plan coverage differs depending on whether the doctor is in the PPO network.
- You will have co-payments and deductibles.
- You can refer yourself to a specialist without getting approval from a primary care physician (PCP).
- If you see a doctor in the plan's network (a preferred provider), the PPO pays 80-100% of the bill.
- If you see a provider outside the plan, the PPO will pay a lower percentage.

Advantages

- Can go to any specialist in the PPO network without approval from a PCP
- Standard co-pays are $10 to $15
- Little paperwork (no filing of claims)

Disadvantages

- Premiums may be higher. And, co-pays and deductibles are higher for using an out-of-network provider
- No PCP is required which may result in lack of care coordination
- Preventative care services may not be covered

More About Health Care Plans

Point of Service Plans (POS)

- Similar to PPO, but includes a primary care physician (PCP) you choose among the POS network of doctors.
- If you see a doctor in the POS network, your bills can be completely covered like an HMO.
- If you see a doctor or other provider outside the POS network, only a percentage of the bill is covered.

Advantages

- Choice in providers and services in and out of the network
- Lower cost when network provider is used
- Little paperwork when network provider used

Disadvantages

- May have to submit your own claims and paperwork
- PCP required
- Higher cost when using provider outside network

Consumer-Driven Health Plans (CDHP)

- Use personal health savings accounts (HSA) and health reimbursement arrangements (HRA) to pay routine health care expenses directly (like having a pre-funded spending account and using special debit card provided by insurer or bank).
- Use a health plan policy for catastrophic medical expenses.
- Can "rollover" unused balance for future expenses.

Advantages

- Offers tax deductions or the benefit of pre-tax dollar contributions
- Lower monthly premiums

Disadvantages

- High deductibles for people with chronic conditions
- May not have ready access to information about health products and services when making critical health decisions

Fee for Service

- You can use any doctor you like. Your provider or hospital will bill your insurance company.
- The insurance company will pay for the service covered in your policy minus any deductibles, co-pays, etc. that may apply.
- An explanation of benefits will be provided to you by the insurance company listing what they paid and the remainder that you owe to the provider.
- The insurance company might pay a claim based on what they decide is "reasonable and customary." You will be responsible for the difference between what is charged and what the insurance company considers reasonable.

Advantages

- You select your own provider or hospital
- You are covered regardless of where you live or work
- PCP not required

Disadvantages

- More paperwork (you may receive a bill each time you get health care that you have to file to get reimbursed)
- More out of pocket costs (premiums, co-pays, deductibles as high as $1,500) and you have to pay the difference between what is paid by health plan (up to 80%) and what is owed to provider

Group vs. Individual Coverage

Most people get health insurance through their job which is a type of group insurance. An individual policy is one that you purchase on your own to cover just you or you and your family.

Group Plans

Typically, there are specific times when you are allowed to enroll in a group health plan:

- **When You Are Hired**
  Complete simple application when you start your new job
- **During Open Enrollment**
  Usually during the same month each year
- **If You Have Other Health Coverage That Ends**
  Usually within 30 days in which to enroll

If you, or a family member, have a medical problem, the medical condition cannot make you ineligible for coverage. But, you might pay a higher premium. Check with your new employer to see if there are higher fees or a waiting period.

As a general rule, if your employer changes insurance companies, the new insurance company must insure everyone in the group. Sometimes, your deductibles and co-pays will change. When your coverage changes, study the new policy carefully. Don't assume the benefits are the same.

If your employer does not offer a group health insurance plan, check to see if any of the organizations you belong to (labor union, service club, special interest group, school) offer a group plan. Additional options are noted in the section below on the Patient Protection and Affordable Care Act.

There are two types of group plans: 1) insured, and 2) self-funded. Different laws govern the two types of plans.

- **Fully Insured Plans** are structured so that the employer purchases coverage from an insurance company directly, and the insurance company assumes the financial risk to pay claims. In Virginia, these plans are regulated by the Bureau of Insurance.
- **Self-Insured Plans** (or self-funded plans) are different in that the employer acts as the insurer; the employer actually pays the bills for its employees' healthcare and assumes all risks. These plans are subject to the Federal Employment Retirement Act (known as ERISA) and regulated by the U.S. Department of Labor.

Individual Policies

If you cannot get insurance through your employer or other organization, you will need to shop for your own individual plan. This is a good option if you are self-employed, but is more expensive than a group plan.

If you are buying an individual policy, the insurer will review your medical history and decide what your medical future may hold (this is called "underwriting"). Typically, the insurer will charge you higher premiums, or choose not to cover you at all if they determine your medical future is likely to involve expensive medical treatment. Additional options are noted in the section on the Patient Protection and Affordable Care Act.

In some instances, the insurer may offer you a policy with a "rider." A rider is extended coverage on a plan that might increase or decrease the scope of coverage. For example, a plan with no pharmacy benefits might include a rider for prescription coverage.

How Much Does Insurance Cost?

Premiums

In any insurance plan, you or your employer will pay premiums monthly, quarterly, or yearly. If you have your own health insurance plan, you will pay the premiums yourself. If your coverage is through an employer, the premium is paid for you, although some or all of it may be deducted by your employer from your paycheck.

What an insurer chooses to charge for your premium is dependent on a number of factors. For an individual plan, people who are young, healthy, do not smoke, do not drink, do not engage in high-risk behavior, and have a clean medical history, pay the lowest premiums. They are considered low-risk for having to use medical services. People with increased health risks and women of child bearing age pay higher premiums since they are more likely to have costly medical bills.

Deductibles

Almost all health insurance plans have deductibles. This is the amount of money you pay before your insurer will start to pay your medical bills. Your insurance deductibles apply to your total medical expenses in any one calendar or policy year. Each family member may have their own deductible, or there may be an overall family deductible.

Co-Insurance

Co-insurance is the percentage of the bill you pay after the deductible is met. Typically, if you have co-insurance, it is 20% of the remaining expenses.

Example of Co-Insurance:

You break your leg. You go to hospital for care. If the hospital visit was your first medical visit that year, you would have to pay a deductible. After the deductible is paid, the insurer will pay 80% of the remaining claim, you pay the remaining 20%.

$5000 hospital bill - $250 deductible = $4750 bill
$4750 x 20% co-insurance = $950
You pay $250 + $950 = $1200
Your insurer pays $3800

Co-Payments

A co-payment refers to a specific charge you pay every time you get a specific service (such as $25 for every doctor visit, $20 for every prescription filled). Co-pays are separate from deductibles and co-insurance. Your health plan may require that you pay all three.

Out-of-Pocket Maximum

If you have a serious or chronic medical problem, you have the potential for having large medical bills. Most policies have what is called an "out-of-pocket maximum." This is the highest dollar amount a member will pay in co-payments, deductibles, and co-insurance combined, usually on a calendar year basis. After you reach that maximum level, the insurer will pay all of your medical expenses.

Lifetime Maximums

Many policies also have lifetime maximums. This lifetime maximum is the total amount your insurer will pay out over the life of an insured person. If you have reached your maximum for out-of-pocket costs and the insurance company is paying 100% of your bills, don't assume that all of your future medical expenses will be taken care of. Lifetime maximums (even those of $2 million) can accumulate rapidly if you or a family member has a serious illness.

The Insurance Policy

The Policy

Insurers are required to provide information that explains the care and services covered under your policy. The "full policy" (which is the contract you have with your insurer) describes all of the services, charges, exemptions and limits on services under your plan. Either you or your employer received a copy of the policy when you got coverage. Federal law requires group health insurance plans to provide you with a copy of your policy, or summary, within 90 days after you join the plan.

Don't Be Misled

Many insurers will provide a glossy brochure that highlights the main benefits and exclusions in the policy. This is not the policy but a marketing tool designed to convince you to enroll in the plan.

Benefits & Exclusions

Every plan has benefits and exclusions. These are the sections of the policy that will tell you about the covered services (benefits) and the specific conditions or procedures for which the plan will not provide benefits (exclusions). If you still have questions after reading the policy, call your employer's human services coordinator or your insurance agent.

Provider List

Managed care organizations will offer you a provider directory that includes the clinics, specialists, and doctors covered under the plan. The directory is a quick way to see if your current physician is covered under the plan.

Policy Provisions

It pays to know about your insurance.

- **Who makes the decisions?** Ideally, you want to have insurance where you and your doctor make final decisions regarding your care. However, insurance plans usually have their own medical doctor who may review and make final coverage decisions.
- **Are there waiting periods?** Look to see if there are any waiting periods.
- **Do you have notification requirements?** Many policies require that you notify the plan before you have a surgical procedure (that you planned in advance) and if you are admitted somewhere for emergency treatment. Notification requirements are also known as pre-approval, prior authorization, or pre-authorization. If you don't notify the plan as required, there is a good chance they will not pay the claim.
- **How much do you pay?** Know how much your plan premium, co-payments, deductibles, and co-insurance rates are.
- **Is there a limit on my hospital stay?** Read your policy to find out if your policy limits the number of days you can stay in the hospital. This is especially important if you have, or develop, a serious medical problem that requires a long period of hospitalization.
- **How do I appeal a claim that has been denied?** Read your policy to find out how your insurer handles the appeal process. Additional information can be found at the end of this chapter.

Is the Service Medically Necessary?

A service may be covered by your health plan but still not be considered medically necessary for your child. Determining medical necessity can be complicated, and each health plan has its own definition. Most plans use the same general principles in determining medical necessity:

- Is the service reasonable and necessary for diagnosis or treatment?
- Is the service appropriate for the child's age, developmental status, and medical needs?
- Will the service help improve treatment, function, ability, and/or prevent deterioration?
- Is there any equally effective, less costly alternative that has not been tried and would achieve the same outcome?

C.O.B.R.A.

"COBRA" (Consolidated Omnibus Budget Reconciliation Act) applies to group health insurance plans sponsored by employers with 20 or more employees. Under COBRA, if you have lost your group health insurance, you are able to continue your former employer's health coverage for you and your dependents for at least 18 months. This period may be extended up to 36 months, depending upon the "qualifying event" causing your group coverage to end. If you wish to continue your group health insurance under COBRA, you must notify your employer within 60 days of receiving notice of your COBRA eligibility.

Some Important Things To Know:

- Under COBRA, you must pay the entire employer premium on a monthly basis, plus an administrative fee, to continue your health coverage under your former group plan. COBRA can be expensive, but typically costs less than the same coverage under an individual plan.
- Your COBRA coverage must be identical to the health coverage you had before.
- Under COBRA, you can be charged up to 102% of the premium to continue your health coverage under your former employer's plan.
- If your former employer switches health plans while you are under COBRA, you may switch plans or stay with the old one.

Additional COBRA options exist for spouses and dependent children.

It is the employer's responsibility to notify the health plan administrator within 30 days in the case of an employee's job termination, hours of employment, eligibility for medicare or reduced death.

It is your responsibility (or your family's) to notify the plan administrator within 60 days in the case of divorce, legal marital separation or child's loss of dependent status.

COBRA is complicated. Your employer's human resources office should have a booklet that explains how COBRA works in detail. This information is also available from the Virginia Bureau of Insurance (1-800-552-7945).

Military Health Insurance

TRICARE is the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families. TRICARE offers three plans:

- TRICARE Prime (managed care option)
- TRICARE Extra (preferred provider option)
- TRICARE Standard (fee for service option)

Active duty service members are required to enroll in TRICARE Prime. Active duty family members are encouraged, but not required to enroll in TRICARE Prime.

In the past, TRICARE ended at age 21, or age 23 for full-time college students. But in April of 2011, the Department of Defense announced its introduction of the premium-based TRICARE Young Adult Program (TYAP) which extends medical coverage to eligible military family members to the age of 26 (in accordance with the Affordable Care Act).

TRICARE Prime offers lower out-of-pocket costs than any other TRICARE option. Under TRICARE Prime, active duty members and their families do not pay annual deductibles or make co-payments for care within the TRICARE network. TRICARE Prime enrollees receive most of their care from military providers or civilian providers who belong to the TRICARE Prime network. Enrollees are assigned a care manager who manages their care and provides referrals to specialty care.

TRICARE Extra and TRICARE Standard are available for all TRICARE-eligible persons who elect or are not able to enroll in TRICARE Prime. Active duty service members are not eligible for Extra and Standard. TRICARE Extra and Standard enrollees are responsible for annual deductibles and co-insurance (cost shares). This means that, after deductibles have been met by the enrollee, a certain percentage of the cost of care will be paid by the government, with the remaining to be paid by the patient. The current cost share percentages, as of this printing, are shown on the next page.

More About Military Health Insurance

Active Duty Family Members

TRICARE Prime

- Annual Deductible: None
- Annual Enrollment Fee: None
- Civilian Outpatient Visit: $0
- Civilian Inpatient Admission: $0

TRICARE Extra

- Annual Deductible:
  E-5 and above - $150 per individual or $300 family
  E-4 and below - $50 per individual or $100 family
- Annual Enrollment Fee: None
- Civilian Outpatient Visit: $16.85/day or
  $25 per admission (whichever is greater)
- Civilian Inpatient Admission: $16.85/day or $25 per admission (whichever is greater)

TRICARE Standard

- Annual Deductible:
  E-5 and above - $150 per individual or $300 per family
  E-4 and below - $50 per individual or $100 per family
- Annual Enrollment Fee: None
- Civilian Outpatient Visit: $16.85 per day or $25 per admission (whichever is greater)
- Civilian Inpatient Admission: $16.85 per day or $25 per admission (whichever is greater)

Retirees, Their Family Members & Others

TRICARE Prime

- Annual Deductible: None
- Annual Enrollment Fee:
  $230 per individual or $460 per family
- Civilian Outpatient Visit: $12
- Emergency Care: $30
- Civilian Inpatient Admission:
  $11 per day (minimum) or $25 for admission

TRICARE Extra

- Annual Deductible:
  $150 per individual or $300 per family
- Annual Enrollment Fee: None
- Civilian Outpatient Visit: 20% of negotiated fee
- Emergency Care: 20% of negotiated fee
- Civilian Inpatient Admission:
  Lesser of $250 per day or 25% of negotiated charges plus 20% of negotiated professional fees

TRICARE Standard

- Annual Deductible:
  $150 per individual or $300 per family
- Annual Enrollment Fee: None
- Civilian Outpatient Visit:
  25% of allowable charges for covered service
- Emergency Care:
  25% of allowable charges for covered service
- Civilian Inpatient Admission:
  Lesser of $535 per day or 25% of billed charges plus 25% of allowable professional fees

Extended Care Health Option

The Extended Care Health Option (ECHO) is a program that is available only to families of active duty service members enrolled in the Exceptional Family Member Program whose family member(s) has substantial needs. ECHO supplements limited benefits, or benefits not available through TRICARE and includes, but is not limited to, items such as special education, durable equipment, training to use assistive technology devices, rehabilitative care, and respite care.

Conditions that are eligible for ECHO include:

- Moderate to Severe Intellectual Disabilities
- Serious Physical Disability
- Extraordinary Physical or Psychological Condition of such Complexity that the Beneficiary is Homebound

More About Military Health Insurance

Exceptional Family Member Program

The Exceptional Family Member Program (EFMP) is a mandatory enrollment program that works with military and civilian agencies to provide comprehensive and coordinated community support, housing, educational, medical and personnel services to active duty personnel who have children with disabilities.

The EFMP specialist may look different in each branch of the military, but their role is similar – to assist with enrollment, provide resources and referrals, and ensure access to vital medical, educational and community services.

Health Insurance Portability & Accountability Act

The U.S. Department of Health and Human Services' Office for Civil Rights has the responsibility for enforcing the Health Insurance Portability and Accountability Act (HIPAA) of 1996. A major goal of HIPAA's privacy rule is to assure that your health information is properly protected while allowing the flow of health information needed to provide you with high quality health care.

Protected health information includes demographic data that relates to your past, present or future physical or mental health or condition; payments for providing your health care; and anything that would identify you (i.e., name, address, social security number).

Patient Protection & Affordable Care Act

In March 2010, President Obama signed comprehensive health reform, the Patient Protection and Affordable Care Act (ACA), into law. The law expands health care coverage, controls health care costs, and improves the health care delivery system. Because implementation is just beginning at the time of the printing of this book, the graphic on the next page is an attempt to provide a snapshot of major ACA provisions and timelines.

The things that are most important to know about ACA as it relates to children and youth with special health care needs and disabilities are:

- Insurance Plans Cannot Deny Coverage Based on Pre-Existing Conditions (A Health Care Need that was Present Before a Person Joined the Health Care Plan, like Cerebral Palsy)
- Exchange Plan Options will be Offered for Uninsured Children with Special Health Care Needs/Disabilities who were Previously Denied Coverage Based on Pre-Existing Conditions
- No Annual or Lifetime Benefit Caps
- Coverage of Young Adults up to Age 26 on their Parent's Policy even if the Young Adult No Longer Lives at Home
- Requirement for Preventative Care at no cost and Prohibition of Charging Co-Pays, Deductibles and Co-Insurance for Preventative Care

Community Living Assistance Services & Supports Provisions

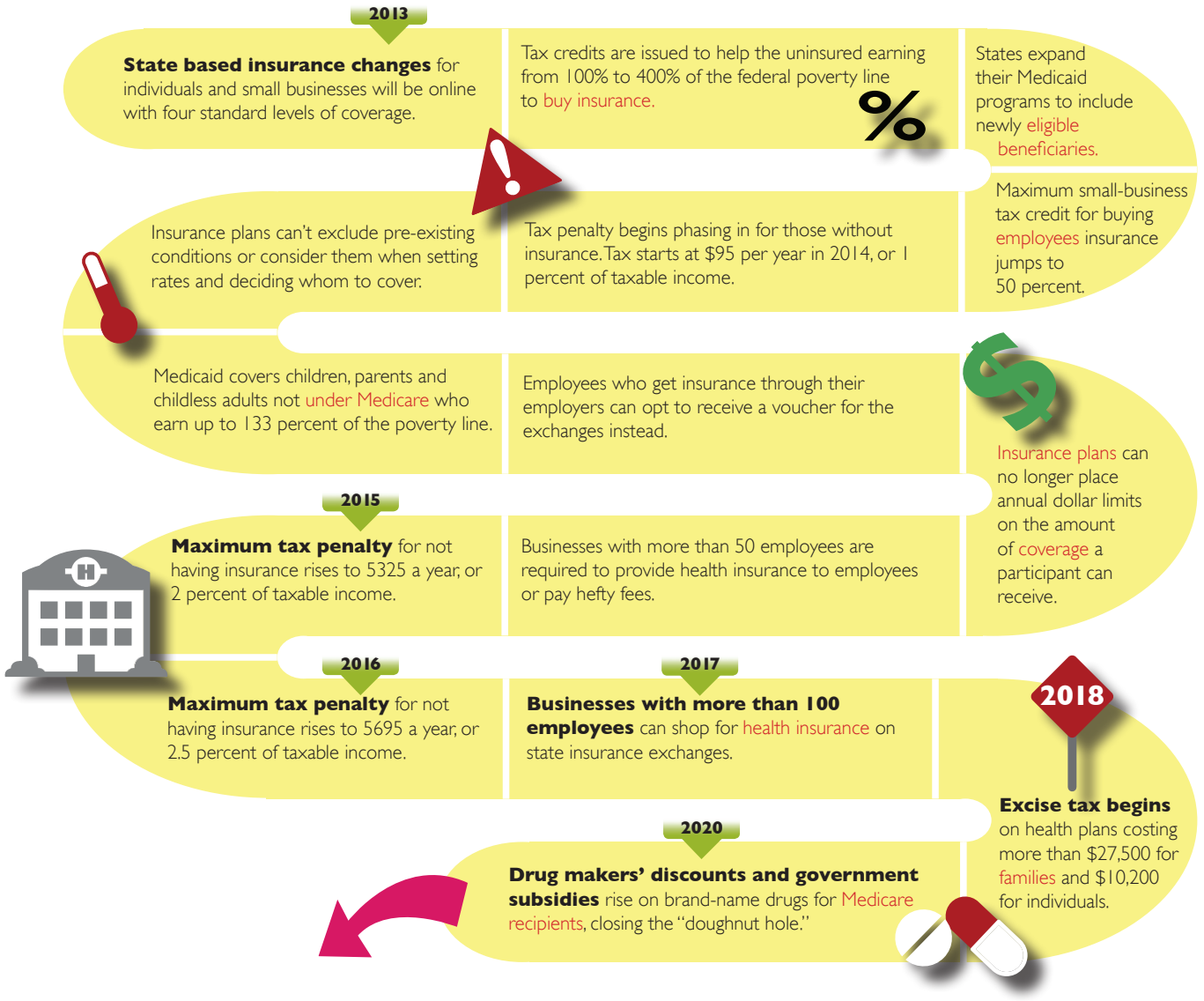
One provision of the ACA is a federally administered voluntary long-term care insurance program called the Community Living Assistance Services & Supports (CLASS) program that is intended to provide people with disabilities tools that allow them to maintain their personal and financial independence and live in the community. Once established, employed individuals aged 18 and older could voluntarily enroll in the CLASS program. Benefits would include a cash benefit that can be used to purchase things like home modifications, assistive technology, respite care, and transportation; advocacy services; and assistance with accessing and coordinating long term care services.

Health Care Reform Timeline

This timeline will you keep track of when the law's key changes will occur

Health Care Reform Timeline

(Continued)



From the Administration on Developmental Disabilities

How To File Insurance Appeals

You can avoid many of the most common insurance problems by making sure you understand your health plan. But even the most sophisticated consumer can run up against a bewildering denial of service or payment for services.

Private Health Insurance

Informal Resolution

When you have a dispute with your insurance company, first try to resolve it informally.

- Try to approach your insurer in an open and friendly manner
- Threats of legal action may cause the insurer to react defensively
- Investigate the facts of your case – denials should be made based on provisions written in your policy.
- Call a customer services representative at your insurer's office and ask why the claim was denied. Ask for it in writing. Check the reason against the provisions in your policy. If the denial is not based on written policy provisions, you have a good chance of having it reversed.

Keep a record of when you called, with whom you spoke, and what was said. This paper trail may be important if your complaint is not resolved quickly and to your satisfaction. There are forms to assist you in Chapter 10.

Internal Grievance

If your initial contact with the insurer did not resolve the issue, you will need to get their attention by writing a letter. Read your policy for specific instructions on how to file your complaint. Some sample letters are included in Chapter 10 of this notebook.

- Send a letter by registered mail asking for an explanation of the medical reasons your claim was denied, the names of those responsible for making the decision to deny the claim, whether these individuals have medical expertise relevant to your problem, and the specific section of your insurance policy they are relying on to deny the claim
- Include copies of letters from your doctors
- If you have a second opinion, include a copy

Typically, the insurer has five business days to acknowledge receipt of your written grievance. Usually, a plan's appeal board (made up of physicians and administrators) reviews your grievance and makes a decision within 30 days (self-funded plans have 60 days). All insurance plans are required to provide you with a written reason why a service is denied or not covered.

Do not be surprised if your first grievance is denied. Don't give up! An initial denial does not mean you've come to a dead-end. Be persistent. Do not accept "no" if you feel you are right.

File a complaint with the Virginia Bureau of Insurance if you do not receive a written explanation from your insurer listing the specific reason for the denial (www.state.va.us/scc/division/boi). If an appeal of benefits is denied by the health plan you have through your employer, you should talk to your human resources coordinator about contacting the insurer on your behalf.

More About How To File Insurance Appeals

More About Private Health Insurance

Independent Review

If you have exhausted your insurer's grievance procedure, you might want to pursue an independent review. In this process, someone from outside the insurance company reviews the merits of the grievance. Typically you have up to four months to request an independent review after you have followed all the other steps. The independent review organization has 30 business days to make its decision. Once this decision is made, it is binding on both you and the insurer. This means that you cannot take the insurance company to court if you disagree with the decision.

It is important to note, that if you are covered through Medicaid or another federal insurance plan, or if you are covered through your employer's self-funded insurance plan, you cannot request an independent review.

Arbitration

Sometimes, if your appeal is denied, your insurance company will require you to go through arbitration before going through an independent review or the courts. For plans that do not have arbitration, you may choose to bypass any further appeals altogether and go directly to court. If you choose arbitration, consider hiring an attorney to present your case.

Court Action

Most employer sponsored health plans are protected from certain lawsuits challenging claim denials. There are some cases when going to court may be helpful. Contacting an attorney should be your last step. Attorneys can be expensive. Some attorneys will take a case on a contingency basis where you only pay if the attorney wins your case. Many attorneys won't take this type of case unless the claim is financially rewarding.

More About How To File Insurance Appeals

Military Health Insurance

Beneficiaries who disagree with certain decisions related to their benefits made by TRICARE Management Activity or by a TRICARE contractor have the right to appeal that decision. The appeals process varies, depending on whether the denial of benefits involves a medical necessity determination, provider authorization, etc.

Any TRICARE beneficiary or parent/guardian of a beneficiary who is under 18 years of age can appeal one of the following decisions:

- A decision denying TRICARE payment for services or supplies received
- A decision denying preauthorization for requested services or supplies
- A decision terminating TRICARE payment for continuation of services or supplies that were previously authorized

Decisions related to the eligibility as a TRICARE beneficiary cannot be appealed as eligibility is determined by enrollment in the Defense Enrollment and Eligibility Reporting System. Beneficiaries must address decisions regarding eligibility through their service branch.

All beneficiaries must:

- Meet all required deadlines (typically within 90 days of the date on the explanation of benefits or decision)
- Send appeals in writing with signatures
- Include copies of all supporting documents in the appeal
- Keep copies of everything

Once an appeal letter has been submitted in writing within established timelines, the TRICARE contractor will review the case and issue a reconsideration decision. If you disagree with the reconsideration decision, the next level of appeal is the national quality monitoring contractor. Again, your appeal must be submitted in writing within 90 days of the date of the reconsideration decision, and the national quality monitoring contractor will review the case and issue a second reconsideration decision. If the amount of the dispute is less than $300, the reconsideration decision by the national quality monitoring contractor is final. If you still disagree with the decision, and if the disputed services are more than $300, you can request that TRICARE Management Activity schedule an independent hearing.

Notes: