

Slide 1 - Health Insurance Literacy Intro



Health Insurance Literacy

After completing this module, you will be able to

- Describe health literacy
- Interpret how consumers can make informed health insurance decisions
- Access appropriate resources and tools to address literacy challenges

Slide notes

Health Insurance Literacy; After completing this module, you will be able to: describe health literacy; interpret how consumers can make informed health insurance decisions and access appropriate resources and tools to address literacy challenges

Slide 2 - HIL 2

Health Insurance Literacy



What is Health Insurance Literacy?

- Degree to which individuals have the
 - Knowledge to find and evaluate information about health plans
 - Ability to select the best plan for their own (or their family's) financial and health circumstances
 - Confidence about how to use the plan once enrolled



Slide notes

Many of the consumers you assist may have little or no experience with health insurance. This will aid you in ensuring that they can better understand, compare, select, and enroll in health coverage through the Marketplace. The Health Insurance Literacy Expert Roundtable defines health insurance literacy as the "degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and use the plan once enrolled."

Slide 3 - Literacy Important

Health Insurance Literacy



Why is Health Insurance Literacy Important?

- Those with better health insurance literacy generally:
 - Make better plan choices
 - Use their coverage better
 - Reduce avoidable costs
 - Have better health outcomes and quality of life
- Cultural competency closes health care disparities gap

Slide notes

Millions of currently uninsured people are using the Health Insurance Marketplace to find, compare, choose, and enroll in health coverage. This decision process can require performing a number of complex evaluations across several steps with significant cost and coverage implications. Many of the people shopping in the Marketplace may have little or no experience with health insurance. You can help them make an informed decision when selecting a health care plan by helping them to increase their health insurance literacy. People who have a high degree of health insurance literacy properly understand plan information, know how to evaluate options, understand cost implications, and match coverage to their needs. They also know how to select coverage that is appropriate for their health and financial situation and to make use of the plan once purchased. Lastly, they are more likely to get preventive services and/or get care early, when treatment is more effective. This high degree of health insurance literacy results in better health outcomes, improves quality of life for people and reduces avoidable costs. Culture and language may also influence health, healing, and wellness belief systems; how illness, disease, and their causes are perceived; both by the patient/consumer and the behaviors of patients/consumers who are seeking health care and their attitudes toward health care providers; as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures. (Source: DHHS Office of Minority Health)

Slide 4 - Minimum Essential

What is Minimum Essential Coverage



If a consumer has coverage from any of the following, they meet the requirements of the ACA and need not seek additional/different health insurance:

- Employer-sponsored coverage, including COBRA and retiree
- Individual coverage (outside the Marketplace)
- Marketplace coverage
- Medicare (Part A) and Medicare Advantage plans
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP)
- Certain Veterans health coverage (from the VA)

About 85% of Americans already have minimum essential coverage

Slide notes

Minimum essential coverage is coverage that meets a standard that provides essential health benefits. The following provides minimum essential coverage: Employer-sponsored coverage, including self-insured plans, COBRA coverage and retiree coverage; Coverage purchased in the individual market, including a qualified health plan offered by the Health Insurance Marketplace; Medicare (Part A) coverage and Medicare Advantage Plans; Most Medicaid coverage; Children's Health Insurance Program (CHIP) coverage; certain types of Veterans health coverage by the Veterans Administration; If a consumer has coverage from any of the above mentioned, they are covered and don't have to do anything; About 85% of Americans already have minimum essential coverage.

Slide 5 - Minimum Essential 2

Minimal Essential Coverage, continued...



Other insurance options which meet the minimum essential coverage include:

- Most types of TRICARE coverage
- Coverage provided to Peace Corp volunteers
- Coverage under the Nonappropriated Fund Health Benefit Program
- Refugee Medical Assistance (Administration for Children & Families)
- Self-funded health coverage offered to students by universities
- State high risk pools
- Other coverage recognized by the Secretary of Health & Human Services

Slide notes

Most types of TRICARE coverage, coverage provided to Peace Corps volunteers, coverage under the Nonappropriate Fund Health Benefit Program, Refugee Medical Assistance supported by the Administration for Children and Families and Self-funded health coverage offered to students by universities for plan or policy years that begin on or before December 31, 2015; Other coverage recognized by the Secretary of HHS as minimum essential coverage; Minimum essential coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care; and Medicaid covering only benefits such as family planning; workers' compensation; or disability policies.

Slide 6 - Who Are the Uninsured

Who are the Uninsured?



- Majority below 138% of Federal poverty level
- 17% have Spanish language preference
- Nearly 1 in 4 has less than a high school education
- 47.8% are healthy and think they may not need or be able to afford insurance
- 29% have pre-existing conditions and may believe they can't get insurance or afford insurance
- 15% are not actively interested in getting insurance and are unengaged

Source:

<https://data.cms.gov/dataset/The-Number-of-Estimated-Eligible-Uninsured-People-/pc88-ec56>

Slide notes

The majority of the uninsured population is below 138% of the Federal poverty level; Spanish is the language preferred by 17% of uninsured individuals; Nearly 1 in 4 uninsured individuals has less than a high school education; 47.8% are healthy and think they may not need or be able to afford insurance.; 29% have pre-existing conditions and may believe they can't get insurance or afford insurance; 15% are not actively interested in getting insurance and are unengaged.

Slide 7 - Valuing in Health Insurance

Value of Insurance



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Explaining the Value of Having Health Insurance

- Essential health benefits
- The value of health insurance coverage:
 - Primary and/or specialty care
 - Inpatient care
 - Emergency care
 - Follow-up care
 - Preventive care

Slide notes

One of the key components to insuring the uninsured is increasing health insurance literacy. For many, the first step toward getting coverage may be understanding the value of health insurance. Major benefits to having health insurance include having access to emergency and follow-up care, immediate "everyday" care (i.e., primary and specialty care) and preventive care.

Slide 8 - Essential Health Benefits

Essential Health Benefits



Essential health benefits include at least these 10 categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Slide notes

The Affordable Care Act provides for the establishment of an Essential Health Benefit (EHB) package that generally includes coverage of EHBs (as defined by the Secretary of the Department of Health and Human Services) The law directs that EHBs be equal in scope to the benefits covered by a typical employer plan and cover at least the following 10 general categories:

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital); 2. Emergency Services; 3. Hospitalization (such as surgery); 4. Maternity and newborn care ; 5. Mental health and substand use disorder services, including behavioral health treatment, 6. Perscription drugs; 7. Rehabilitative and habilitative services and devices; 8. Laboratory Services; 9. Preventive and wellness services and chronic disease management; 10. Pediatric services, including oral and vision care. (pediatric services may be provided by a stand-alone plan)

Slide 9 - Value Immediate Care

Value in Health Insurance



Value: Immediate “Everyday” Care

- Primary care
 - Pediatric health and dental care
 - Coverage for specialty services
 - Women’s health, cardiologist, etc.
 - Prescriptions
- Mental health care and substance use disorder services
 - Laboratory services

Slide notes

Health insurance does more than just provide protection from high medical bills due to a catastrophic event. It also ensures access to care immediately when a consumer needs it for the “everyday” earache, cold, severe headaches, etc. that can impact an adult’s or children’s daily functions. It is also provides access to dental care, prescriptions, and other basic services.

Slide 10 - Inpatient, Emergency, and Followup

Value: Inpatient, Emergency and Follow-up Care



- Inpatient care, i.e. for surgery
- Emergency care
 - Illness, injury, or condition so serious that a reasonable person would seek immediate care to avoid severe harm
 - No prior approval needed whether provider or hospital is in the plan (in the network) or not

The average cost for a 3-day hospital stay is \$30,000.
The average cost for fixing a broken leg is \$7,500.

Slide notes

Health insurance provides coverage for emergency care and protection from high costs when something bad happens. No one plans to get sick or hurt, but most people need to get treated for an illness or injury at some point, and health insurance helps pay these costs. Emergency care is for an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Hospital emergency departments do traditionally care for patients with urgent needs, such as broken bones or head injuries stemming from an accident, regardless of your ability to pay, but your ability to get necessary follow-up care, such as rehab or medical equipment, is going to require you to have health insurance coverage or a fair amount of money to pay for those services and/or equipment.

Slide 11 - Preventive and Chronic

Value: Preventive and Chronic Care Management



- Health insurance for preventive care
 - Prevent illness or detect illness at an early stage, when treatment is likely to work best
- The health care law makes many of these available to no cost to consumer
 - Examples: Flu shots and screening mammograms
- Helps you become well and stay well
- Manage chronic conditions
 - Like diabetes or asthma

<https://www.healthcare.gov/what-are-my-preventive-care-benefits/>

Slide notes

Having health insurance can also help prevent bad things from happening in the first place by paying for a wide range of preventive care, such as flu shots and screening mammograms. Preventive care can detect and treat problems early, so that they don't escalate and require much more expensive treatment later. Preventive care can also reduce the number of workdays missed due to illness. Additionally, preventive care can identify or even avert major health problems that can be life-altering or life-threatening events. The health care law makes many preventive services free –without a co-pay. Depending on your age, you may have access to preventive services such as annual checkups, mammograms, vaccinations, colonoscopies, and prostate cancer screenings at no cost. You may be more likely to stay healthy and catch health problems early, when they're easier and less expensive to treat. Even healthy, young people benefit from preventive and primary care. Sarah Dash, a research professor at Georgetown University's Center on Health Insurance Reforms states that "Contrary to popular belief, young adults have a need for preventive care, checkups and chronic disease management, whether they have asthma, diabetes or another condition. Well-woman care is critically important, too. Young women who might be thinking of starting a family down the road need to take care of themselves in their 20s." Health insurance helps people become well and stay well, keeps them in control of their health and finances, and provides peace of mind. A full list of covered preventive services is available at www.HealthCare.gov. Chronic care management is also covered. This provides for ongoing care for a chronic condition, like diabetes or asthma. For more information on preventive services covered in the Marketplace, visit the link at the bottom of this screen.

Slide 12 - Value: Cost Savings

Value: Cost Savings



- Protection from high medical costs that could put an individual in debt, affect their credit, or cause bankruptcy
- Insurance companies negotiate rates with providers so consumers pay a lower rate (generally a 40% saving from those not insured)
- Peace of mind
- Protecting the health of a family

62.1% of all bankruptcies have a medical cause.

Slide notes

For many consumers, they cannot reasonably assess what they get from having health insurance that makes it worth "saving" the monthly premium and just paying out of pocket. For example they might say, "If the deductible is \$6,000 and I'm paying a couple hundred dollars a month, I'm paying more than I would without health insurance." The fact is, even when you do have to pay out-of-pocket to meet your deductible, having health insurance can lower your costs. That's because insurance companies negotiate their rates with providers and that's the rate you will pay. People without insurance pay, on average, 40% more for health care services. Also, preventive services, including immunizations, cancer screenings, cholesterol and blood pressure screenings, and over a dozen others, are not subject to the deductible in Marketplace health plans; According to a Harvard study Medical Bankruptcy in the United States, 2007: Results of a National Study, 62.1% of bankruptcies in the United States have a medical cause.

Slide 13 - Types of Marketplace Plans

Explaining the Types of Marketplace Plans



- Health Maintenance Organizations (HMOs)
 - Have networks
 - Usually use primary care doctors
 - Usually need referrals for specialists
- Exclusive Provider Organizations (EPOs)
 - Have networks
 - Usually don't use primary care doctors



Slide notes

A standard health insurance policy also gives consumers access to preventive care to keep them healthy, like vaccines and check-ups. Many plans also cover prescription drugs. When comparing plans on HealthCare.gov; the type of plan is listed immediately below the name of the plan; look for the initials PPO, P.O.S, HMO, or EPO. Types of plans include the following: Health Maintenance Organizations (HMOs): HMOs usually limit coverage to care from providers who work for or contract with the HMO. An HMO generally won't cover or has limited coverage for out-of-network care except in an emergency. If using a doctor or facility that isn't in the HMO's network, they may have to pay the full cost of the services provided. HMO members usually have a primary care doctor and must get referrals to see specialists.; Exclusive Provider Organizations (EPOs): EPOs generally limit coverage to care from providers in the EPO's network (except in an emergency).

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Explaining the Types of Marketplace Plans, continued...



- Preferred Provider Organizations (PPOs)
 - Have networks
 - Usually use primary care doctors
 - Usually need referrals for specialists
- Point- of- Service plans (POS)
 - Have networks
 - Can go out-of-network but may pay more
 - No referrals needed in-network

Slide notes

PPOs give the consumer the choice of getting care from in-network or out-of-network providers. Consumers pay less if they use providers that belong to the plan's network. They'll pay more if they use doctors, providers, and hospitals outside of the network, and they may have higher out-of-pocket costs for services they receive outside the network. If a consumer has a PPO plan, they can visit any doctor without getting a referral; POS plans let a consumer get medical care from both in-network and out-of-network providers. If they have a POS plan, they can visit any in-network provider without a referral, but they'll need a referral to visit an out-of-network provider. They may pay higher out-of-pocket costs if they use an out-of-network provider.

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Explaining the Types of Marketplace Plans, continued...



- What is catastrophic coverage?
 - Plans with high deductibles and lower premiums
 - You pay all medical costs up to a certain amount
 - Includes 3 primary care visits per year and preventive services with no out of pocket costs
 - Protects consumers from high out-of-pocket costs
- Who is eligible for catastrophic coverage?
 - Young adults under 30
 - Those who obtain a hardship exemption from the Marketplace
 - Those whose individual plan was cancelled and Marketplace plans are unaffordable

Slide notes

A catastrophic plan generally requires consumer to pay all of their medical costs up to a certain amount, usually several thousand dollars. Costs for essential health benefits over that amount are generally paid by the insurance company. Catastrophic plans generally have lower premiums, protect against high out-of-pocket costs, and cover 3 annual primary care visits and preventive services at no cost. They're available only to people under 30 and to people who have received a "hardship" exemption because the Marketplace determined they couldn't afford health coverage. Each member of a family must meet the eligibility requirements to purchase a catastrophic plan.

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How to Choose a Health Plan



- Compare plans based on the coverage needed
 - What is covered and the consumers expected health care needs
 - Consumer's preferences (doctor, hospital, medications, etc.)
 - The costs
 - Marketplace plan categories



Slide notes

Before a consumer starts shopping for health insurance, they should consider what kind of coverage they need. Look carefully at what the plan covers and what it doesn't cover (exclusions or limitations); compare benefits; and compare plans. Discuss premiums, co-payments, deductibles, coinsurance and out-of-pocket limit. See if their doctor is in the plan. Find out about the dollar limits on how much they'll pay for health care services (out-of-pocket maximums).

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Marketplace Plans: The Metal Levels



Plan Type	Plan Pays % of Total Covered Expenses (on Avg) = Actuarial Value	Consumer Pays for Deductibles, Co-pays & Coinsurance (on Average)
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

Higher Premiums & Lower Consumer Cost-Sharing

↑ ↓

Lower Premiums & Higher Consumer Cost-Sharing

Max out-of-pocket annual limit of \$6,350 individual / \$12,700 family (excluding premiums). Lower for households < 200% FPL

100% to 250% FPL also Eligible for Cost-Sharing Subsidies to Reduce Out-of-Pocket Costs. Must enroll in Silver plan for cost-sharing subsidies.

Slide notes

Plans in the Marketplace are primarily separated into 4 health categories ; Bronze, Silver, Gold, and Platinum - based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category chosen affects the total amount they'll likely spend for essential health benefits during the year; The health plan categories are as follows; Bronze level, a health plan that has an Actuarial Value (AV) of 60%; Silver level, a health plan that has an AV of 70%; Gold level, a health plan that has an AV of 80%; Platinum level, a health plan that has an AV of 90%

Slide 18 - Slide 18

Comparing Health Plans



- Review plan information
 - See if consumer's doctor is in the plan (in network)
 - See if consumer's prescription drugs are covered (plan formulary or list of covered drugs)
 - What is the cost?
 - Does the plan's pharmacy network have a convenient pharmacy?
 - Check plan rules
 - Does the consumer need a referral (primary care doctor refers consumer or pre-authorization) before they can see a specialist or can they go to one directly?

Slide notes

When comparing health plans, review the plan information; See if consumer's doctor is in the plan (in network); See if consumer's prescription drugs are covered (plan formulary or list of covered drugs); What is the cost? ; Does the plan's pharmacy network have a convenient pharmacy?; Check plan rules; Does the consumer need a referral (primary care doctor refers consumer, or pre-authorization (plans permission)) before they can see a specialist or can they go to one directly?

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College Students Health



- May continue to be covered by parent's health plan until age 26
- Student health plan
 - Could provide minimum essential coverage
 - Can choose Marketplace coverage instead
 - May qualify for lower costs based on income (must file a tax return)
- Catastrophic health plan option if under 30
- May qualify for Medicaid if low income

Slide notes

Young adults can stay on their parents' plan, if it offers dependent coverage of children, until age 26. College students have several choices for health coverage. College students covered by their school's student health plan, in most cases are considered covered under the health care law. College students won't have to pay the penalty that people without coverage must generally pay. College students must check their student health plan to see if it qualifies as coverage under the health law. Even if they have access to a student health plan, they can choose to buy a health plan through the Marketplace instead. College students may qualify for lower costs based on their income. Apply to the Marketplace to find out if they qualify for lower costs, or use quick plan and cost preview tool first. If they don't have to file a federal tax return (income too low), they won't have to pay the penalty, even without coverage.

Slide 20 - Slide 20

Explaining Costs



- People will ask you “How much will it cost?”
- You will need to explain
 - Premiums
 - Deductibles
 - Copayments
 - Coinsurance
 - Out-of-Pocket Limit/Maximum
- A glossary of health coverage and medical terms can be found at
 - <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>

Slide notes

One question you will be asked frequently is “how much will my health care cost?” Often, the answer is “it depends.” In order to best help someone understand the different types of costs, you will need to explain the following terms and how they contribute to the differences in costs from plan to plan.

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Example of How to Explain Cost Sharing



Example: Jane's Health Insurance Plan
 Deductible \$1,500 • Coinsurance 20% • Out-of-Pocket Limit \$5,000

Jan. 1 Dec. 1

Jan. 1	Mid-Year	Dec. 1												
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20%	80%													
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0%	100%													
<p>First Office Visit Costs \$125 Jane has not met her \$1,500 deductible yet, so she pays \$125 and the plan pays \$0.</p>   	<p>Mid-Year Office Visit Costs \$75 By now, Jane has met her deductible, and coinsurance begins: she pays \$15 and the plan pays \$60.</p>   	<p>Last Office Visit Costs \$200 After many visits, Jane has paid \$5,000 – her out-of-pocket limit. The plan now pays \$200 and she pays \$0.</p>												

Slide notes

Deductible: In addition to a monthly premium, health plans often require individuals to meet a yearly deductible. The deductible is the amount that must be paid for covered care before an individual's health insurance begins to pay its share. Some plans have a single deductible for all services, while some have separate deductibles for benefits such as prescription drugs; **Copayment:** The copayment is a fixed amount paid for a covered health care service.

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Marketplace Affordability



- Financial help is available for eligible families and individuals
 - Premium tax credits to lower the monthly premiums they pay
 - Reduced cost sharing to lower out-of-pocket spending for health care costs

Consumers must file a tax return and will need proof of income

Slide notes

In the Marketplace consumers may be eligible to receive premium tax credits that can lower their monthly premiums, or cost-sharing reductions that can lower their out of pocket costs. Consumers will see the amount of tax credit they're eligible for when they fill out their Marketplace application. Monthly premium prices shown for insurance plans reflect the tax credit, if they qualify. Coverage may be more affordable for eligible lower and middle income consumers who aren't eligible for other programs to buy insurance, as a result of the new tax credits (refundable premium tax credits and advance payment of premium tax credits) and reduced cost sharing.

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Explaining Ways to Use a Premium Tax Credit



**Choose to Get It Now:
Advance Payments of the Premium Tax Credit**

- All or some of the premium tax credit is paid directly to your plan on a monthly basis
- You pay the difference between the monthly premium and advance payment
- You reconcile when you file your tax return for the coverage year*

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 you file for the coverage year

*You should report all changes in the information you provided on your application to avoid owing money after reconciliation on your tax return.

Slide notes

If a consumer enrolls through an Individual Marketplace, they may be eligible to receive premium tax credits which can be used to reduce the cost of monthly premiums for themselves and for any tax dependents. Consumers can choose to receive a portion of the credit each month as an advance payment of the premium tax credit; with reconciliation at the end of the year; or to receive the tax credit on their federal tax return filed for the coverage year. Advance payments are paid directly to QHP issuers on a monthly basis. Individuals eligible for a premium tax credit who do not receive an advance payment of the premium tax credit may claim the credit on their income tax return filed for the coverage year.

Slide 24 - Slide 24

Explaining a Plan's Network



- A network is the facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services
 - 👨‍⚕️ Doctors, surgeons, therapists, nurse practitioners, etc.
 - 🏥 Hospitals
 - 📄 Pharmacies
 - 🧪 Labs
- Check the plan's website or call the plan

Slide notes

It will be important to explain the concept of networks; A network is the facilities, providers and suppliers a consumers health insurer or plan has contracted with to provide health care services.

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The Difference Between Getting Services In-Network and Out-of-Network



<p>In-Network</p> <p>✓ Plan discounts</p>	<p>In Preferred Network</p> <p>\$</p> 
	<p>In Non-Preferred Network</p> <p>\$\$</p> 
<p>Out-of-Network</p> <p>✓ Possibly no discount</p> <p>✓ May have to pay 100% out-of-pocket</p>	<p>Out-of-Network</p> <p>\$\$\$\$</p> 

Slide notes

In-network; The health care providers (doctors, hospitals and pharmacies) a consumers health insurance plan has contracted with to provide health care services at a discounted rate; Preferred network: Some plans have a smaller group of providers that have agreed to even lower rates; In-network copayment: A fixed amount (for example, \$15) a consumer pays for covered health care services to providers who contract with their health insurance or plan; In-network co-payments usually are less than out-of-network co-payments; In-network coinsurance: The percent (for example, 20%) a consumer pays of the allowed amount for covered health care services to providers who contract with their health insurance or plan; In-network coinsurance usually costs them less than out-of-network coinsurance; Out-of-network: Health care providers (doctors, hospitals and pharmacies) that do not contract with a consumers health plan; Out-of-network copayment: A fixed amount (for example, \$30) a consumer pays for covered health care services from providers who do not contract with their health insurance or plan; Out of network co-payments usually are more than in-network co-payments; Out-of-network coinsurance: The percent (for example, 40%) a consumer pays of the allowed amount for covered health care services to providers who do not contract with their health insurance or plan. Out-of-network coinsurance usually costs a consumer more than in-network coinsurance; A consumer's plan may not pay any costs for out-of-network services.

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Explaining Formularies and Tiers



- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

Tier Structure Example		
Tier	Copayment You Pay	Prescription Drugs Covered
1	\$	Most generics
2	\$ \$	Preferred, brand-name
3	\$ \$ \$	Non-preferred, brand-name
Specialty	\$ \$ \$ \$ or high coinsurance	Unique, very high-cost

Slide notes

Each drug plan has a list of prescription drugs that it covers called a formulary. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Slide 27 - Slide 27

Explaining Rules Plans Use to Manage Access to Drugs



Prior Authorization	<ul style="list-style-type: none"> ▪ Doctor must contact plan for prior approval before drug will be covered <ul style="list-style-type: none"> • Must show medical necessity for drug
Step Therapy	<ul style="list-style-type: none"> ▪ Type of prior authorization ▪ Must first try similar, less expensive drug ▪ Doctor may request an exception if <ul style="list-style-type: none"> • Similar, less expensive drug didn't work, or • Step therapy drug is medically necessary
Quantity Limits	<ul style="list-style-type: none"> ▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Doctor may request an exception if additional amount is medically necessary

Slide notes

A consumer may need drugs that require prior authorization. This means before the plan will cover a particular drug, their doctor or other prescriber must first show the plan they have a medically necessary need for that particular drug. Step therapy is a type of prior authorization. In most cases, a consumer must first try a less-expensive drug on the plan's drug list that has been proven effective for most people with their condition before they can move up a step to a more expensive drug. However, if they have already tried a similar, less expensive drug that didn't work, or if the doctor believes that because of their medical condition it is medically necessary to take a step-therapy drug (the drug the doctor originally prescribed), they can contact the plan to request an exception. If the request is approved, the plan will cover the originally prescribed step-therapy drug. For safety and cost reasons, plans may limit the quantity of drugs they cover over a certain period of time. If consumer's prescriber believes that, because of the consumer's medical condition, a quantity limit isn't medically appropriate, the consumer or their prescriber can contact the plan to ask for an exception. If the plan approves their request, the quantity limit won't apply to their prescription.

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Explaining How to Use Health Insurance



- When you need care, call the doctor's office
 - Set up an appointment
 - Confirm that they accept your insurance
- Take insurance card to the doctor's office
- At your doctor's visit, pay your share
- Take advantage of preventive benefits
- Call your insurance plan with coverage questions
- Contact the plan if you want to change your primary care doctor

Slide notes

When a consumer needs care, call the doctor's office to set up the appointment for them or their family and confirm that the doctor's office accepts their insurance; At the doctor's office, the consumer will need to take their or their family member's insurance cards and pay their co-pay (sometimes, insurance will cover all costs, sometimes there will be a co-pay, or a consumer may be responsible for all costs for care that is not covered under the plan); The consumer should take advantage of the preventive benefits to help keep them healthy; Whenever they have questions about coverage, costs, etc., they can always call their insurance plan; If they decide they want to change their primary care doctor, depending on the type of plan they are in, they may need to contact the plan to make that change.

Slide 29 - Slide 29

Reading Your Insurance Card

Protect your card, protect your coverage

The card looks the same for everyone in the plan, even if they get a tax credit.

REGULATORY HEALTH LINK
Division

INSURANCE COMPANY NAME	COVERAGE TYPE
MEMBER NAME: JOHN DOE MEMBER NUMBER: XXX-XX-XXXX	EFFECTIVE DATE: XX-XX-XXXX
GROUP #: XXXXXX-XXX-XXX	PRESCRIPTION GROUP #: XXXXX
PCP CO-PAY: \$15.00 SPECIALIST CO-PAY: \$25.00 EMER. ROOM CO-PAY: \$75.00	PRESCRIPTION CO-PAY: \$15 GENERIC \$20 NAME BRAND
MEMBER SERVICES: 1-800-XXX-XXXX CLAIMS/INQUIRIES: 1-800-XXX-XXXX	

Call your plan if you have questions.

Slide notes

It is important for a consumer to protect their insurance card; Don't let anyone else use it or they could lose their coverage; A consumer should not provide their insurance information to anyone who contacts them directly if they didn't contact them first. A consumer will take their card with them when they receive health care, and when they get prescriptions filled. It identifies the consumer as a member of the plan, and gives providers information, such as how much their copays are. The telephone number and web address are usually on the card and a consumer can contact the plan when they have questions; If they get a lower premium because of their income and household size, their ID card will look the same as everyone else who gets insurance from the consumers insurance plan.

Slide 30 - Slide 30

Explaining How Bills Get Paid



- Confirm your doctor is in-network
 - Network providers bill the health plan directly
 - Out-of-network providers may not
 - You may need to do it so check with the plan for its process
- Review your bill
- Review your explanation of benefits (sent by plan listing what services you got, the costs, and what the insurance company paid)
- Review the coverage, benefits and appeals sections of your health plan contract

Slide notes

A consumer will confirm with both their health plan and medical provider that medical provider is part of their plan's network; Network providers bill the health plan directly. Out-of-network providers don't have to bill the health plan, so a consumer may need to do it; For in-network providers -Compare their bill with the explanation of benefits and pay what the health plan states is their responsibility to the medical provider. Check for accuracy; For out-of-network providers - a consumer will contact their health plan to get claim forms and due dates. A consumer may have to pay the medical provider first and then wait for their health plan to reimburse them; If possible, a consumer should ask their health plan about this process before they pay their medical provider; A consumer should review the coverage, benefits and appeals sections of their health plan contract.

Slide 31 - Slide 31

Explaining Marketplace Appeals



- Consumers need to know they have the right to appeal some plan decisions
- Decisions that can be appealed
 - Whether you're eligible to buy a Marketplace plan
 - Whether you can enroll outside of the regular open enrollment period
 - Whether you're eligible for lower costs
 - The amount of savings you're eligible for
 - Whether you're eligible for Medicaid or CHIP
 - Whether you're eligible for an exemption

Slide notes

If a consumer doesn't agree with a decision made by the Marketplace, they have the right to file an appeal. A consumer can appeal the following kinds of Marketplace decisions; Whether they're eligible to buy a Marketplace plan; Whether they can enroll in a Marketplace plan outside the regular open enrollment period; Whether they're eligible for lower costs based on their income; The amount of savings they're eligible for; Whether they're eligible for Medicaid or the Children's Health Insurance Program (CHIP); Whether they're eligible for an exemption from the individual responsibility requirement (also known as the individual shared responsibility payment); Here's important information to consider when planning an appeal; The consumer can have someone else file or participate in their appeal; That person can be a friend, relative, lawyer, or other person. Or they can handle the appeal themselves; If they file an appeal, they may be able to keep their eligibility for coverage while their appeal is pending; They'll get a letter that describes their options; The outcome of an appeal could change the eligibility of other members of the consumers household; Depending on their state and their eligibility results, they may be able to appeal through the Marketplace; Or they may have to file an appeal with their state Medicaid or CHIP agency. They'll get a letter that states that their appeal request was received, provides a description of the appeals process, and includes instructions for submitting additional material for consideration, if necessary. A consumer may get a letter asking for more information or documentation, like a copy of a passport. In general, the appeal response must be made and mailed within 90 days.

Slide 32 - Slide 32

Explaining How to Appeal



- Two ways to appeal are explained in your eligibility determination notice
 - Writing a letter to the Marketplace
 - Completing and mailing an appeal request form
 - Available at <https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/>
- Expedited appeals available in certain circumstances

Slide notes

A consumers eligibility determination letter will explain how to file an appeal; In general, they can appeal their eligibility results in two ways; Write a letter to; Health Insurance Marketplace and mail in an appeal request form located at the link on this page; A consumer can file an expedited appeal if the time needed for the standard process would seriously jeopardize their life or their ability to attain, maintain, or regain maximum function. A consumers expedited appeal should specifically explain how a standard appeal would jeopardize their life or their ability to attain, maintain, or regain maximum function. A consumers expedited appeal will be processed as quickly as possible. A final decision must be made as quickly as their medical condition requires.

Slide 33 - Slide 33

Explaining How to Protect Yourself from Fraud



- You need to be informed
 - Look for official government seals, logos, and navigator and assister certifications
 - Navigators and assisters won't ask for money
- Protect your personal information
- Ask questions and verify the answers you get
- Report anything suspicious to the Health Insurance Marketplace consumer call center at 1-800-318-2596
 - (TTY users should call 1-855-889-4325)

Slide notes

Be informed. Visit HealthCare.gov, the official Marketplace website, to learn the basics and compare insurance plans carefully before a consumer makes their decision; Look for official government seals, logos, and navigator and assister certifications; Open Enrollment ends January 31, 2016; No one can enroll a consumer in a health plan in the Marketplace after Open Enrollment ends unless the consumer has special circumstances.

Slide 34 - Slide 34

Explaining Reportable Changes in Household or Circumstances



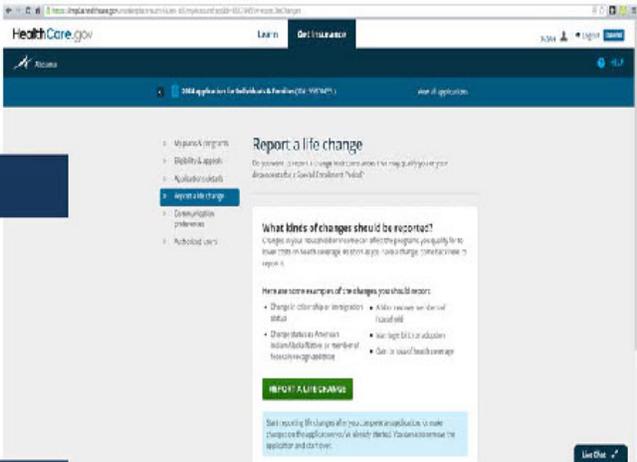
- New person on the application (e.g., birth, marriage)
- Moves
- Loss of access to other coverage (e.g., employer coverage)
- Release from incarceration
- Change in citizenship or immigration status
- Removal of a person from the application (e.g., death, divorce)
- Become incarcerated
- New access to other coverage (e.g., employer coverage)
- Pregnancy
- Change in tax filing status/tax household composition
- Change in status as an American Indian/Alaska Native or tribal status
- Change in disability status
- Correction to name, date of birth (DOB), or Social Security number (SSN)
- Increase or decrease in income
- Change in contact information, like:
 - Email address
 - Phone number
 - Add or remove phone text alert
 - Mailing of paper notices

Slide notes

The following changes can be reported to the Marketplace by using HealthCare.gov; Type of Life Change/Change in Circumstance; New person on the application (e.g., birth, marriage); Moves; Loss of access to other coverage (e.g., employer coverage); Release from incarceration; Change in citizenship or immigration status; Removal of a person from the application (e.g., death, divorce); Become incarcerated; New access to other coverage (e.g., employer coverage); Pregnancy; Change in tax filing status/tax household composition; Change in status as an American Indian/Alaska Native or tribal status; Change in disability status; Correction to name, date of birth (DOB), or Social Security number (SSN); Increase or decrease in income; Change in contact information (report to insurer too), like; Email address; Phone number; Add or remove phone text alert ; Mailing of paper notices

Slide 35 - Slide 35

Where to Report Changes





Online

By Phone

**Contact the Marketplace Call Center at 1-800-318-2596
(TTY: 1-855-889-4325)**

Slide notes

If these changes qualify a consumer for a special enrollment period to change plans, in most cases they have 60 days from the life event to enroll in new coverage. If the changes qualify them for more or less savings, it's important to make adjustments as soon as possible; A consumer can report these changes Online at healthcare.gov by logging in to their account (or create an account if they don't have one) and Select their application, then select "Report a life change" from the menu on the left.

Slide 36 - HIL Scenario 1

Health Insurance Literacy - Scenario 1



Ms. Hayes is single and lives alone. She is currently employed by a company that offers health coverage; however, she opted not to select any coverage and does not have minimum essential coverage (MEC) elsewhere.

How will she be penalized on her 2016 federal tax return?

She will pay a fee of \$695 or 2.5% of her annual household income whichever is greater due to not having MEC.

Slide notes

Ms. Hayes is single and lives alone. She is currently employed by a company that offers health coverage; however, she opted not to select any coverage and does not have minimum essential coverage (MEC) elsewhere.

How will she be penalized on her 2016 federal tax return? She will pay a fee of \$695 or 2.5% of her annual household income whichever is greater due to not having MEC.

Slide 37 - HIL Scenario 2

Health Insurance Literacy - Scenario 2



Anne has been seeing the same Primary Care Physician (PCP) for 10 years. She has also used the same local pharmacy for the same period of time.

What should she consider before selecting a new plan on the marketplace?

Anne will need to consider her PCP and pharmacy is covered as part of the network plan so that she can continue to see the same physician and use the same pharmacy

Slide notes

Anne has been seeing the same Primary Care Physician (PCP) for 10 years. She has also used the same local pharmacy for the same period of time.

What should she consider before selecting a new plan on the marketplace? Anne will need to consider whether her PCP and pharmacy is covered as part of her network plan so that she can continue to see the same physician and use the same pharmacy.

Slide 38 - HIL Scenario 3

Health Insurance Literacy - Scenario 3



Brandon is 22 years old and recently graduated from college. He lives with his parents who are both fully employed with health coverage. He is currently pursuing a career in information technology. However, he has not been able to find a job and has no health insurance.

What are his options in regard to health insurance?

The Affordable Care Act (ACA) allows parents to carry dependents until the age of 26. Brandon's parents can add him to their insurance so that he will have minimum essential coverage.

Slide notes

Brandon is 22 years old and recently graduated from college. He lives with his parents who are both fully employed with health coverage. He is currently pursuing a career in information technology. However, he has not been able to find a job and has no health insurance.

What are his options in regard to health insurance? The Affordable Care Act (ACA) allows parents to carry dependents until the age of 26. Brandon's parents can add him to their insurance so that he will have minimum essential coverage.

Slide 39 - HIL Scenario 4

Health Insurance Literacy - Scenario 4



Barbara is originally from Germany and German is her native tongue. Although she speaks English, her language preference is German because she is able to more easily understand it.

Who can she call to assist her with the Marketplace in German?

CMS provides free interpreter services in 150 languages and are available by calling 1-800-318-2596

Slide notes

Barbara is originally from Germany and German is her native tongue. Although she speaks English, her language preference is German because she is able to more easily understand it.

Who can she call to assist her with the Marketplace in German? CMS provides free interpreter services in 150 languages and are available by calling 1-800-318-2596

Slide 40 - HIL Scenario 5

Health Insurance Literacy - Scenario 5



Ed is a licensed In-Person Assister. During Open Enrollment one of the most frequent questions he is asked by local consumers is “Where can I go to the doctor?”

How should Ed answer this question?

It is important that Ed explains the concept of networks. The way to determine a plan’s network is to check the plan’s website or to call the plan directly. Consumers can find out if a specific doctor is part of the plan’s network.

Slide notes

Ed is a licensed In-Person Assister. During Open Enrollment one of the most frequent questions he is asked by local consumers is “Where can I go to the doctor?”

How should Ed answer this question? It is important that Ed explains the concept of networks. The way to determine a plan’s network is to check the plans website or to call the plan directly. Consumers can find out if a specific doctor is part of the plans network.

Slide 41 - HIL Scenario 6

Health Insurance Literacy - Scenario 6



Ed recently assisted Tai with getting health insurance for the first time in her life. Tai informed Ed that she often has sneezing fits during the evening hours and has considered going to the Emergency Room for medical attention.

What should Ed explain to her about emergency care?

Emergency care should be utilized for an illness, injury, or condition that a reasonable person would seek immediate care to avoid severe harm. Ed should explain to Tai the purpose of emergency care and allow her to make an informed decision as to where she should seek treatment.

Slide notes

Ed recently assisted Tai with getting health insurance for the first time in her life. Tai informed Ed that she often has sneezing fits during the evening hours and has considered going to the Emergency Room for medical attention.

What should Ed explain to her about emergency care? Emergency care should be utilized for an illness, injury, or condition that a reasonable person would seek immediate care to avoid severe harm. Ed should explain to Tai the purpose of emergency care and allow her to make an informed decision as to where she should seek treatment.

Slide 42 - HIL Scenario 7

Health Insurance Literacy - Scenario 7



Seth was suffering from severe chest pains and shortness of breath while driving home from work.

His doctors office is closed, what options are available for him?

Seth's symptoms have the potential to be life threatening. In this instance he should seek immediate care at his local emergency room.

Slide notes

Seth was suffering from severe chest pains and shortness of breath while driving home from work.

His doctors office is closed, what options are available for him? Seth's symptoms have the potential to be life threatening. In this instance he should seek immediate care at his local emergency room.

Slide 43 - HIL Scenario 8

Health Insurance Literacy - Scenario 8



Chantel is setting up her first doctor's appointment since receiving coverage.

What does she need to confirm with the doctor's office before her appointment?

Chantel needs to confirm that they accept her new insurance coverage. She also needs to take her insurance card with her so they can place a copy on file. She needs to find out if she has a co-pay that she is responsible for at the time of the visit.

Slide notes

Chantel is setting up her first doctor's appointment since receiving coverage.

What does she need to confirm with the doctor's office before her appointment? Chantel needs to confirm that they accept her new insurance coverage. She also needs to take her insurance card with her so they can place a copy on file. She needs to find out if she has a co-pay that she is responsible for at the time of the visit.

Slide 44 - Final Slide

Health Insurance Literacy



Congratulations! You have successfully completed this segment.

The slide features a white background with a light blue header and footer. A large blue rectangular box is centered on the slide, containing the congratulatory message. The logo for the Regulatory Health Link Division is positioned in the top right corner of the slide area.

Slide notes

Congratulations! You have successfully completed this segment.