A Parent's Guide to Health Insurance

HEALTH INSURANCE OVERVIEW

Boston Children's Hospital
Social Work Department Transition Committee

RESOURCES

BOSTON CHILDREN'S HOSPITAL'S PATIENT FINANCIAL SERVICES CUSTOMER SUPPORT DEPARTMENT:
Boston Children's resource center for finance and billing assistance.
childrenshospital.org/patient-resources/customer-service/financial-and-billing-matters 617-355-3397

COMMONWEALTH OF MASSACHUSETTS' CENTER FOR HEALTHCARE FINANCING ENHANCED COORDINATION OF BENEFITS (ECOB) PROGRAM:
The ECOB works with MassHealth to help supplement its members' health care coverage with private insurance.
ecob@umassmed.edu 800-462-1120 option #5

DISABILITY LAW CENTER:
The Disability Law Center is the protection and advocacy agency for Massachusetts residents with disabilities.
dlc-ma.org 617-723-8455

HEALTHCARE.GOV:
An interactive website that helps with coverage options.
healthcare.gov 800-318-2596

HEALTH INSURANCE RESOURCE CENTER:
A wealth of general and state-specific information, including glossary of health care terms.
healthinsurance.org

MEDICARE.GOV:
The official U.S. government website for Medicare.
medicare.gov 800-633-4227

SOCIAL SECURITY ADMINISTRATION:
Website detailing benefits for people with disabilities.
ssa.gov/disability 800-772-1213

If you do not have insurance and/or are unsure of how to get it, the following resources may be helpful:

HEALTH CARE FOR ALL:
A public organization that provides information on accessing healthcare, legal support, community organizing and public education.
hcfama.org 800-272-4232

MASSACHUSETTS HEALTH CONNECTOR:
A state-based health insurance marketplace that makes shopping for affordable health and dental coverage easier for Massachusetts individuals, families and small businesses.
betterhealthconnector.com 877-623-6765

Printed March 2016. All information contained in this brochure is current as of the print date. Please check with your insurance provider for information specific to your plan and benefits.

THE AFFORDABLE CARE ACT OF 2012 made big changes to our health care system and to the way that insurance works. Changes to make health insurance more available are being phased in each year. This website can help you keep track of these changes and how they may affect you: ***healthcare.gov***

WHAT IS HEALTH INSURANCE?

It's a way to pay for health care. It protects you from paying the full costs of medical services when you're injured or sick.

NOTE: Each health insurance plan is different and covers different medical costs. You can get health insurance from a number of sources, such as:

- Employers
- Private Health Insurance Agencies
- State Exchanges
- College/University Plans
- Through a Parent's Plan (if you are age 26 and under)

WHY IS HEALTH INSURANCE IMPORTANT?

Health insurance is important because it:

PROTECTS YOU from unexpected, high medical costs

ALLOWS YOU TO PAY LESS for certain health care services associated with your health insurance plan

GIVES YOU ACCESS TO FREE CARE TO PREVENT CERTAIN ILLNESS, like vaccines, screenings and check-ups

With certain health insurance plans, you don't have to pay fees that many people who don't have health insurance coverage must pay. Massachusetts also has an "individual health insurance mandate," which requires most adults to have health insurance if it is affordable to them and that meets certain coverage standards.

WHAT IS PRIVATE HEALTH INSURANCE?

Private health insurance is usually offered through your employer (where you work). Some employers offer only one type of health insurance plan, while others may let you choose from more than one. Some people have to buy their own private health insurance, instead of getting it through an employer. This usually costs more since an employer doesn't share the cost. Examples of private health insurance companies include Harvard Pilgrim Health Care, Blue Cross Blue Shield and Cigna.

WHAT IS MANAGED CARE?

Some private insurance plans work with certain health care providers that are part of the health plan's network to provide care at lower costs. This is called managed care. There are different kinds of managed care plans:

HEALTH MAINTENANCE ORGANIZATIONS (HMOS): With an HMO plan, you pick one primary care physician, called a PCP. All your health care services go through that doctor. That means that you need a referral before you can see any other health care professional (except in an emergency). Visits to health care professionals outside of your network typically aren't covered by your insurance.

PREFERRED PROVIDER ORGANIZATIONS (PPOS): PPO plans give you flexibility. You don't need a primary care physician (PCP). You can go to any health care professional you want without a referral—inside or outside of your network. Staying inside your network means smaller copays and more coverage. If you choose to go outside your network, you'll have higher out-of-pocket costs, and not all services may be covered.

POINT-OF-SERVICE PLAN (POS): A point-of-service plan (POS) is a type of managed care plan that is a mix of an HMO and PPO plan. Like an HMO, you must choose a doctor in your insurance network to be your primary care physician (PCP). But like a PPO, you may go outside of your insurance network for health care services. If you go out of the network, you'll have to pay most of the cost, unless your PCP has made a referral to the out-of-network provider. Then the medical plan may cover the cost.

WHAT IS PUBLIC INSURANCE?

You might qualify for government-supported programs like Medicaid or Medicare.

MEDICAID is a government-run insurance program that helps some people with lower incomes pay for health care. Medicaid is available only to certain people who have low- to medium - income and are eligible. Learn more about Medicaid at ***www.cms.gov***

MEDICARE is a health insurance program run by the Social Security Administration that pays some insurance costs for people 65 and older and who have certain disabilities or health problems. Read about government-supported options on the government's website: ***healthcare.gov***

MASSACHUSETTS OFFERS SEVERAL PUBLIC AND PRIVATE PLANS THROUGH MASSHEALTH AND COMMONWEALTH CARE. These can be free or low cost. Take a look at the "What is MassHealth?" section below or ***mahealthconnector.org*** for more information.

WHAT IS MASSHEALTH? MassHealth is a public health insurance program for people who have low- to medium-income and live in Massachusetts. The national health insurance program called Medicaid and the Children's Health Insurance Program (CHIP) are combined into MassHealth. If your child is covered by a MassHealth family plan, she must apply for her own MassHealth coverage when she turns 19. See ***mass.gov/eohhs/gov/departments/masshealth***

MASSHEALTH ENROLLMENT CENTERS: To speed up the process of enrolling in MassHealth, visit a Financial Counseling Office at your neighborhood health center, community hospital or here at Boston Children's Hospital. To reach Boston Children's Financial Counselors, call 617-355-7201.

WHAT ARE STUDENT HEALTH PROGRAMS?

Massachusetts college students are required by law to have health insurance, and colleges must offer health insurance to their students. These health plans are called Student Health Programs (SHPs). Students who enroll in a Massachusetts college must pay for the school's SHP plan or prove that they have other health insurance that is at least as good (comparable coverage).

KEEP IN MIND that coverage from SHPs may not be enough coverage if your child has a chronic health condition and/or takes many medications.

CONTACT your child's Student Health Services Department or the Office of Disability Services at your child's college before your child starts care at Boston Children's Hospital.

HOW LONG CAN MY CHILD STAY ON MY HEALTH INSURANCE?

The law requires insurance companies to allow you to be able to keep your child on your current family health plans until she is **26 YEARS OLD.** If your child has a job, it's a good idea to compare the costs and benefits of that plan with your current plan.

WHAT SHOULD I CONSIDER WHEN CHOOSING A HEALTH PLAN?

- **COMPARE EACH PLAN'S COSTS:** Monthly costs, deductibles, coinsurance and co-pays.
- **ESTIMATE HOW MANY VISITS** your child has with a primary care doctor and a specialist every year.
- **CONSIDER WHAT PRESCRIPTION DRUGS YOUR CHILD TAKES** on a regular basis. Add up the copays and out-of-pocket costs to fill these prescriptions.
- **INCLUDE COSTS FOR MEDICAL SUPPORTS:** For example, medical equipment or procedures.
- **MAKE SURE THAT YOUR CHILD'S CURRENT DOCTORS ARE CONSIDERED "IN NETWORK"** for the plans you are considering.
- **ASK WHETHER YOUR EMPLOYER/INSURANCE PROVIDER OFFERS A FLEXIBLE SPENDING ACCOUNT (FSA)** or Health Savings Account (HSA) to further lower your costs.

I HAVE A DISABLED CHILD. WHAT ARE MY OPTIONS?

If you have an adult disabled child who can't gain employment due to a disability (intellectual and/or physical), she is allowed to stay on your private health insurance past the age of 26. You may need to fill out additional paperwork to keep your child on your plan.

DISABLED ADULT CHILDREN WHO ARE COVERED BY THEIR PARENT'S MASSHEALTH PLAN MUST SWITCH TO THEIR OWN MASSHEALTH PLAN AT AGE 19.

In order for you to continue to communicate with MassHealth about your child's plan, your child must sign a "release of information" form after she turns 18. This is required even if you are the legal guardian. Also, MassHealth can serve as a secondary insurance or a primary insurance.

I HAVE A DISABLED CHILD. WHAT ARE MY OPTIONS? (CONTINUED)

Disabled adults might be eligible for Supplemental Security Insurance (SSI) benefits from the Social Security Administration. SSI is a government program that provides stipends to low-income people who are either aged (65 or older), blind or disabled. Although administered by the Social Security Administration, SSI is funded from the U.S. Treasury general funds, not the Social Security trust fund.

GLOSSARY OF TERMS

CARVE-OUT: An arrangement in which some benefit (for example, mental health) is removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers.

COINSURANCE: Money that an individual is required to pay for services, after a deductible has been paid. Coinsurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

COPAYS: Some plans charge copays for certain type of medical appointments. For example, $10 for a doctor's visit or $75 for an emergency room visit.

DEDUCTIBLE: The amount an individual must pay for health care expenses before insurance covers the costs. Often, insurance plans are based on yearly deductible amounts.

EXCLUSIONS: Conditions or treatments and other services that a health plan will not cover. These must be clearly spelled out in materials given to you about your plan.

FLEXIBLE SPENDING ACCOUNT (FSA): Account you set up through your employer to pay for most medical expenses not covered by your insurance. Your employer automatically deducts pre-tax dollars from your paycheck so you save money. However, if you do not use all the money at the end of the year, you lose it.

HEALTH SAVINGS ACCOUNT (HSA): Similar to a flexible spending account, except that if you do not use all the money at the end of the year it rolls over to the next year.

IN-NETWORK PROVIDERS: Doctors who have a contract with a health insurance plan, so you pay less out of pocket to see them.

OPEN ENROLLMENT: A set period, usually at the end of the year, when you can enroll in a group health plan or change from one plan to another. Outside of open enrollment, only certain life-changing events (marriage, birth, divorce, etc.) may permit you to join or change plans.

OUT-OF-POCKET MAXIMUM: This limits the total amount of money you pay each calendar year for health care, including co-pays and deductibles. For example, if your policy carries a $1,000 out-of-pocket maximum and you get sick and require a lot of health care services, the most you will pay in a year is $1,000. After that, your insurance picks up the costs.

OUT-OF-NETWORK PROVIDERS: Doctors who do not have a contract with a health insurance plan, so you may be responsible for the entire bill.

REFERRAL: This is a written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, your plan may not pay for the services.

COMPARE YOUR OPTIONS

PLAN	EXAMPLE	OPTION A	OPTION B
PREMIUM (amount you pay to belong to a health plan; usually due on a monthly basis)	$58 x 12 months = $696		
DEDUCTIBLE (amount you pay out-of-pocket before insurance coverage kicks in)	$500		
PRIMARY CARE VISITS (usually a family practice doctor, internist, gynecologist, or pediatrician; this doctor is your first point of contact with the health care system)	$25 copayment*/visit (2 visits/year) **A copayment is a set fee you pay each time you see the doctor; your insurance plan pays the rest.*		
SPECIALTY VISITS (this is a visit with a provider other than a primary care provider, or PCP; usually requires a referral from your PCP)	$35 copayment/visit (1 visit/month)		
EMERGENCY ROOM VISITS (many insurance plans waive this fee if admitted inpatient)	$125 copayment/visit		
INPATIENT ADMISSIONS	$1200 copayment/inpatient stay		
PHYSICAL THERAPY/OCCUPATIONAL THERAPY/OTHER THERAPIES	$35 copayment/visit		
PRESCRIPTIONS (medications are separated into different levels—or tiers—depending on their cost; if you are prescribed a tier 3 medication, ask your doctor if there is a less expensive equivalent)	$10 = tier 1 (2 meds/month) $20 = tier 2 $30 = tier 3 *Tier 1 = least expensive, generic* *Tier 2 = mid-range* *Tier 3 = most expensive*		
OUT-OF-POCKET MAXIMUM (a yearly cap on out-of-pocket costs; excluding premiums)	$2500/year		
ANNUAL LIMIT (a yearly cap on the dollar amount or types of benefits; once you've reached your cap, you must pay the full cost of the health care for the rest of that year)	$1.25 million		
OTHER DETAILS (mental health coverage, vision coverage, maternity benefits, travel expenses for getting to appointments and inpatient stays, reimbursements for gym membership, weight loss programs, other programs, additional medical expenses)			
ESTIMATE OF ANNUAL EXPENSES	$696 (premium) + $500 (deductible) + $50 (PCP visits) + $420 (specialty visits) + $840 (mental health visits) + $240 (prescriptions) = $2746		