UNDERSTANDING THE HEALTH INSURANCE SYSTEM: WHAT YOU & SPECIAL NEEDS FAMILIES SHOULD KNOW

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The health insurance system is complex. It is, therefore, critical that you have a complete understanding of your coverage in order to secure all the services you, your child or adult child needs. The more you know, the more you will maximize coverage and minimize your financial responsibility. Quite frequently, health insurance plans reduce, limit or deny coverage – often claiming the requested service is not medically necessary. When this occurs, it is important to know your appeal rights and exercise them in a timely manner.

Depending on the state in which you reside and what type of health insurance plan provides coverage, parents can continue coverage for adult disabled children. Typically, proof of disability is necessary to extend coverage for a dependent under private health insurance plans. Under Federal law, private insurance plans must cover dependents through their 26th year.

Types of Coverage

There are several types of health insurance coverage: private insurance (individual & group health plans); self-funded/self-insured plans; and public assistance (i.e., Medicaid and Medicare).

Because the coverage and appeal rights differ based on the type of plan and by state, it is important to read your member handbook to determine what type of coverage you have and to what appeal rights you are entitled.

Private Insurance is provided by your employer or obtained on your own. Plans are governed by state insurance laws. Services and procedures covered under private plans vary widely, requiring referrals for specialists or use of certain providers, such as labs, in order to receive coverage. Additional costs or co-payments may be required, particularly if you elect to use providers out-of-network. It is important to obtain a copy of your member handbook in order to be informed of the coverage offered and your financial responsibilities.

Self-Funded/Self-Insured Plans are health insurance plans offered by a private employer, which differ from typical employer-provided plans in that the employer (not an insurance company) assumes the risk of insuring its employees. As a result of this arrangement, these types of plans have greater latitude as to what they do and do not cover. Typically, these types of plans either eliminate coverage for skilled nursing or significantly limit the number of therapy services. Your Human Resources Department will be able to tell you whether you have this type of plan and provide you with your member handbook outlining what your plan covers.

Public Assistance Programs include Medicaid (Fee-for-service, EPSDT Program, Managed Care, and Waiver Programs) and Medicare coverage.

Medicaid (a.k.a., Medi-Cal) is a federal-state entitlement program for low-income Americans. There are three basic groups of low-income people parents and children, elderly, and the disabled. To be eligible for Medicaid, one must have limited financial resources. Each State's Medicaid State Plan provides the following Mandatory Services: in-patient and out-patient hospital treatment, lab tests, x-rays, EPSDT services, home healthcare, physician services, nurse midwife, family assistance, and nursing home for those over the age of 21. States can also elect to include additional Optional Services in their Medicaid State Plan. **Medicaid-funded Home and Community-Based Waiver Programs ("Waivers")** provide individuals with disabilities care in the home and community as an alternative to

institutional care. The programs "waive" some of the rules of Medicaid to serve children and adults otherwise requiring an institutional level of care who can; instead, be served at home or in the community. *For more information about your Medicaid State Plan or approved Waivers, visit cms.gov.*

Medicare is a partner program to Social Security, which provides a health and financial safety net to those 65 years and older and to those declared disabled for 24 months. Medicare is broken into several parts. Medicare Part A generally covers inpatient services – medical care when one is checked into a hospital or is recovering in a nursing facility. It also covers some short-term home health care, along with hospice care. Most people are enrolled automatically in Part A when they reach age 65 and get it for free. Together, Part A and Part B are called "Original Medicare." Medicare Part B covers outpatient services – like physician visits and treatment at a hospital where one does not check in – along with lab tests and other medical care. Although enrollment in Part B is often automatic, it is not free. One is required to pay a monthly fee; as well as, an annual deductible. Medicare Prescription Drug Plans (Medicare Part D) are optional plans that provide prescription drug coverage. The plans themselves are operated by private insurance companies; so, depending on one's plan, the costs and drugs covered vary. One must be careful when choosing a plan that makes the most sense for their individual circumstances.

Coordinating Coverage & Benefits

In addition to having a thorough understanding of your health care insurance coverage, you must also know who pays first for you or your child's health care and, then, communicate this information to your physicians and other providers. As a general rule, private insurance and self-funded/self-insured plans typically pay first. If both parents have private insurance, it is important to file for coverage for your child under the one that best meets your needs. When selecting the primary private insurer, you may want to consider whether the plan covers dental care, out-of-network coverage, eye care and eyeglasses, and adaptive equipment. If, however, you or your child is covered by Medicare in combination with other private insurance coverage, the first payer is not always clear. For example, if your child is also covered by private insurance, primary coverage is determined by the size of the group covered under the plan. For example, if the coverage is under a large group health plan with less than 100 employees, Medicare pays first. If there are more than 100 employees, Medicare pays second. If you are covered by Medicare and Medicaid, Medicare pays first. *For more information, visit www.cms.gov.*

Appeal Procedures

Most **private health insurance plans** provide three levels of appeal when a requested service is either denied, reduced, limited, or terminated or eligibility is terminated. The same is true for self-fund/self-insured plans, and Medicaid Managed Care HMOs. The three levels of appeal typically consist of two internal appeals – one informal, followed by a formal appeal – and an external appeal before a neutral arbiter outside of the health plan. Depending on the type of coverage, the external appeal could be heard by a medical review board, independent utilization review organization, state or federal agency, or an administrative law judge.

For **Medicaid Appeals**, you may file for a Medicaid Fair Hearing when a covered health benefit has been denied, terminated or reduced. By federal law, you must receive written notice (that is, 10 days before the proposed action) any time there is a proposed change to your Medicaid benefits or services. Your request for a Fair Hearing must be filed timely and in writing and should clearly state the reasons you are appealing the proposed action. Once a timely appeal is filed, all Medicaid services must stay "as is" (status quo) until the final disposition of the appeal.

Medicare Managed Care complaints are handled differently, depending on the nature of your complaint. A Medicare Grievance should be filed when you have a complaint relating to physician attitude, adequacy of facilities or time spent waiting for appointments. The Medicare Managed Care

Organization (MCO) must provide you with the procedure for filing a grievance in writing and must respond to your complaint in a timely manner. A Medicare Appeal can be filed when the MCO denies, reduces or terminates services or payment for health services. The appeal process may be comprised of as many as five steps, which largely relates to the value of the disputed service, including (1) reconsideration either by the MCO or local Social Security Office; (2) independent organization review; (3) administrative law review; (4) departmental appeals board review; and (5) filing of a civil suit in Federal District Court.

The Medicare Peer Review Organization (PRO) complaint process is for complaints regarding in-hospital stays. You may immediately request this review upon receiving written notice from the MCO or hospital that inpatient care is no longer necessary. Your request must be made either in writing or by telephone by noon of the first working day after receiving notice of discharge. The PRO has until the close of the business day on which it receives all necessary information from the hospital and MCO to issue a decision. You may stay in the hospital until noon after the day the PRO makes its final decision at no cost to you.

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