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Health Insurance: Your Rights and Responsibilities

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April 2012

Your basic rights and responsibilities including:

Your rights:

- To health coverage
- To stay covered
- To certain benefits
- To appeal denials or limits on benefits

Your responsibilities:

- To stay covered (electing or enrolling on time, recertifying)
- To follow plan rules
- To pay your share

Resource Information

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Source(s) of coverage for people with MS

- 60 65% in employer plans
- 20 – 25% in Medicare
- 10 – 15% in Medicaid or other state program
- 5 – 10% uninsured
- Not unusual to have multiple sources of coverage, but transitions can be tricky
- *Nearly* everyone to be covered as healthcare reform is implemented in 2014
- Tax credits applied in advance make coverage affordable for those with lower and moderate income (to 400% of FPL), no one denied due to pre-existing condition

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Do you have a *right* to health coverage? Now vs. 2014?

Job-related coverage – employers decide:

- *If* they will offer health benefits to employees
- *If* they will cover dependents
- *If* they will cover part time workers
- NOTE: Healthcare reform will *not* require employers to cover employees, but tax incentives, other help will encourage it.

Medicare – FEDERAL LAW guarantees eligibility:

- To individuals age 65 and above
- To 'disabled' (receiving SSDI for at least 24 months)
- Diagnosed with end stage renal disease or ALS
- NOTE: Healthcare reform will *not* change eligibility for Medicare

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Do you have a right to health coverage? Now vs. 2014?

Medicaid eligibility *until* year 2014

STATE LAWMAKERS decide eligibility based on:

- Your household income, assets *AND*
- Categories of eligibility such as if you have dependent children at home, who is the head of the household, if you are pregnant, and more
- States vary – a lot! For quick check on your eligibility now: www.healthcare.gov

- In year 2014, healthcare reform to be based only on:
  - Household income
  - Legal residency status

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Are you eligible for OTHER insurance or savings programs?

- BOTH employer coverage AND Medicare?
- BOTH Medicare AND Medicaid?
- A Medicare Savings Program?
- A high risk pool?
- State Child Health Insurance Program?
- A Medicaid ‘buy-in’ or other state program for lower income?
- State Pharmacy Assistance Program (in some states only)
- A Drug Manufacturer’s Patient Assistance Program **(www.needymeds.org)**

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Your eligibility for coverage with a pre-existing condition - Now and until 2014

If joining a job-based GROUP plan

- Anti-discrimination: You cannot be denied enrollment, charged more, given fewer benefits than anyone else in the GROUP even with a 'pre-existing condition'
- Pre-ex condition defined: ANY condition for which advice, diagnosis, care or treatment was recommended or received within past six months
- Pre-ex condition *exclusion* limited: no more than 12 months
- Portability: you can reduce your pre-ex exclusion period by the number of months you were previously covered by another group plan.

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Your eligibility for coverage with a pre-existing condition - Now and until 2014

If *not* eligible for group plan

- Few guarantees of coverage for those seeking individual coverage, but 2014 guarantees now phasing in
- Children with pre-existing conditions cannot be denied coverage now
- Adults over age 19 may be eligible for a high-risk pool. Check www.healthcare.gov

Tip! Always enroll in coverage when first eligible to avoid premium penalty – Medicare, Disability, Long term care insurance too!

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Your COBRA Rights Examined – keeping coverage during changes

Consolidated Omnibus Budget Reconciliation Act – federal law affecting ALL group health plans of 20 or more.

Allows group plan enrollee the right to stay in the group after 'qualifying event':

- The job ends for any reason (other than bankruptcy/dissolution or gross misconduct)
- Working family member goes on Medicare, retires, dies
- Divorce or separation
- Child 'ages out' of dependent status

Other important facts about COBRA:

- 18 to 36 months depending on the 'qualifying event'
- Enrollee must 'elect COBRA' within 60 days of offer
- Must pay 102% of premium - on time!
- State laws guarantee COBRA- Like benefits to people in smaller groups

- Your responsibility re: COBRA
  - duty to inform health of qualifying event occurs
  - Pay full premium, plus 2% admin fee

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Do you have a right to certain benefits?

ALL plans set limits on benefits for cost and quality reasons

- See your plan materials for list of benefits-- these are GENERAL descriptions
- Also check for 'excluded' benefits
- Customer service personnel and websites give general information only
- Health plan can *always* deny or limit a benefit for various reasons:
  - 'not medically necessary'
  - 'not approved use' (aka 'off-label' or 'unlabeled')
  - drug, dosage or method not on their formulary
  - prior authorization requirements
  - not 'preferred' drug or item (step therapy)

- Medicare and Medicaid may limit 'amount, scope or duration' of covered service or item

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Your expanded appeal rights

- ***ALL*** health plans must have right to appeal *adverse determinations*
- *Adverse determinations* may include the plan's judgment over covered benefits, the amount covered or reimbursed, provider network determinations and more
- Exclusions based on law or regulation, or clearly stated in plan materials as 'not covered' are not worth appealing
- Over 50% of appeals done correctly are overturned – but watch deadlines!
- Everyone entitled to at least 3 levels of appeal, including new 'external review' rights for all
- Each level of appeal must be reviewed by a different and higher authority than earlier appeal
- Call the National MS Society for help with your appeal (1-800-344-4867), or type 'appeals' into search bar at www.nationalmssociety.org

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Understand your financial obligations

- Doctors and other health care providers routinely ask patients to sign statement of financial responsibility – good time to ask questions or negotiate
- Examine and understand your 'explanation of benefits' (EOB)
  - *Deductible(s)* – amount you must pay each year before coverage begins
  - *Allowed Charge*: Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges.
  - *Amount you owe* is percent of the allowed charge
  - *Cost-sharing* terms
    - Usual, customary and reasonable
    - Co-insurance
    - Copay

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Other tips for minimizing your *out-of-pocket* costs and managing medical debt

- Ask to pay over time if necessary, but show good faith
- Avoid paying for care with credit cards
- Use in-network providers as much as possible
- Use generic and preferred brand drugs as much as possible
- Maximize Rx patient assistance programs (www.needymeds.org), ask for free samples and coupons
- Check your eligibility for programs to reduce other living expenses (www.benefitscheck-up.org)
- Maximize tax deductions, Flexible Spending Accounts, budgeting and financial counseling services
- Speak with a National MS Society Navigator 1-800-FIGHTMS (344-4867)

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Helpful resources

For general information see www.nationalmssociety.org>Living with MS>Insurance and Money Matters, or call 1-800-344-4867

For state-by-state information about your insurance options and protections in English or Spanish www.healthcare.gov

For Medicare help:

- Center for Medicare & Medicaid Services **www.medicare.gov** or 1-800-MEDICARE
- The Medicare Rights Center 1-800-333-4114

For Medicaid help:

- Center for Medicare and Medicaid Services 1-800-MEDICARE, and your state Medicaid office or Dept. of Social Services, National MS Society

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