A Guide to Purchasing Insurance for Children with Special Health Care Needs

1. My child has special health care needs and has been previously denied insurance coverage due to his pre-existing conditions. Are there any health care coverage options for him?

Yes! The Patient Protection and Affordable Care Act (ACA) eliminated the ability of insurers to deny coverage to individuals on the basis of pre-existing conditions, age, or gender. Therefore, you will now be able to purchase coverage for your child. Additionally, you may wish to access supplemental programs outlined in question 12.

2. I do not receive employer-sponsored insurance. How do I purchase insurance?

You may access available insurance plans by visiting www.healthcare.gov. Beginning October 1, 2013, all qualifying health insurance plans will be available for review and purchase on the Health Insurance Marketplace (also known as the Exchange). By submitting your application to the Marketplace, the application will automatically be reviewed for eligibility for tax credits, cost-sharing reductions, and state and federally sponsored coverage, such as Medicaid. Additionally, you'll be able to compare like plans in an easy to read format. For more information about choosing and comparing plans, please skip to question 7.

3. My family is currently insured by my employer, do I need to register with the Health Insurance Marketplace?

No. If your employer currently offers adequate and affordable coverage for you and your family, you may continue to take advantage of this benefit. No additional applications or registrations must be filed. For more information about whether a plan is affordable and adequate, please see questions 4 and 0, respectively. If you are interested in programs and services to supplement your current insurance, please see question 12.

4. My employer offers health insurance, however, the coverage is not affordable. What options do I have?

Your options may be limited by what you define as "affordable." While you are always able to purchase individual coverage via the Marketplace, there is no guarantee this coverage will be more affordable for your family, as tax credits and cost sharing reductions are dependent upon family income (100%-400% FPL) and the "affordability" of employer-sponsored insurance. Individuals who have employer-sponsored insurance options may not qualify for tax credits and cost-sharing reductions if the cost of the employer-sponsored health insurance for the employee *only* is less than 9.5% of the family income. In cases where an employer offers "affordable" coverage for the employee and family, it may be possible for the spouse to qualify for tax credits and cost sharing reductions for her own coverage if the spouse is not offered employer-sponsored coverage, such as in the case of self-employed individuals.

5. My employer offers health insurance, however, I do not believe the coverage is adequate. What options do I have?

Once again, your options may be limited depending on what you and your employer deem "adequate." The Affordable Care Act states that employer-sponsored insurance is "adequate" if it has a minimum value of 60%. That is to say, the insurance plan will cover 60% or more of costs incurred to cover the essential health benefits for a typical population and after cost sharing requirements are factored in. The legislation outlined essential health benefits as: 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; and pediatric services, including oral and vision care.

6. I do not believe that my employer-sponsored coverage is affordable or adequate, but how can I know for sure?

Determining whether a plan is affordable and adequate can be difficult. You may want to first ask your benefits coordinator whether these standards have been met. If you need further verification or are still unsure whether the plan meets these requirements, you may wish to submit an application on the Marketplace for benefits. The application will have an appendix that asks about employer-sponsored coverage to determine whether it meets the requirements. You may need to ask your employer for assistance completing the application.

7. I need to purchase coverage on the Marketplace. What should I look for in a plan?

First, review question 2. Once you have registered with the Marketplace, you will have a better idea of the subsidies available to you and your family. The subsidies may somewhat dictate which plan(s) make the most since for you to purchase. Here is a list of considerations that may guide your purchase:

*The ACA was designed to ensure consumer accessibility during the purchase of plans. That means all plans will have an easy-to-understand benefits summary and must be categorized by actuarial value, which is discussed further in question 9.

*Determine the benefits and coverage you need. Individuals with special health care needs undoubtedly have insurance needs above and beyond those of the typical population. Therefore, it is important to find the most comprehensive plan for your needs. For example, determine whether it makes more sense to purchase a plan with a higher premium and deductible but more comprehensive coverage. Take into account the number of allowed therapy visits per year, copayments, and ancillary services that will be utilized. Generally speaking, plans with higher premiums are often (but not always) more comprehensive in coverage, and out of pocket limits ($6,250 per individual/year; $12,500 per family/year) will also cap after-premium expenses. For more information about what premiums cover, please see question 8.

*Determine whether you would like to continue to receive care from current providers. If so, check with the insurer of the plans you are considering as well as providers to ensure the providers are part of the "network" contracted with the insurer. If you are not interested in staying with current providers, research the providers from whom you wish to receive care to ensure they are contracted "network" providers and are accepting new patients.

*Consider the tax credits and subsidies you will be receiving. Individuals and families who are eligible for cost-sharing reductions will be required to purchase a plan with an actuarial value of silver or greater. To fully benefit from all subsidies it is important to factor those into your decision making process.

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8. What does the premium cover?

Previously, paying a premium did not guarantee consumers any uniform or regulated protection or services. The coverage varied widely by plan and individual. Now, premiums will guarantee consumers:

*Insurance coverage. Many families have had to cope with the unbelievable costs of health care without adequate or any health insurance simply because of pre-existing conditions. Now, no one will be excluded from coverage. Additionally, annual and lifetime coverage limits will be eliminated, and there will be limits on out of pocket expenses ($6,250 for an individual and $12,500 per family per plan year).

*Preventative care, without cost-sharing. Now premiums are applied to the costs of preventative care and recommended screenings, including immunizations, well-woman visits, contraceptives, cancer screenings, tobacco screenings and cessation services, mental health and domestic violence screenings and interventions, and many others. For a complete list, please visit: https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1. Preventative care coverage will no longer require co-pays or be contingent upon meeting a deductible.

*Coverage of essential health benefits. Previously, many insurers on the individual market failed to cover or adequately cover many of the newly established essential health benefits, including maternity and newborn care, rehabilitative and habilitative services, mental health and substance abuse disorders, and others.

*Better coverage. While the ACA has left a lot to interpretation, it does require insurers to provide a certain level of coverage. This is accomplished by requiring out of pocket limits and establishing the actuarial value of plans (platinum, gold, silver, and bronze), all of which must cover a certain percentage of total health care costs after premiums have been paid. Actuarial value is discussed in greater detail in question 9.

If you would like more details about premium pricing for your family, try the Kaiser Family Foundation's subsidy calculator, which will calculate whether your family qualifies for tax credits and/or subsidies and how both may affect your premiums.

Kaiser Family Foundation Subsidy Calculator: http://kff.org/interactive/subsidy-calculator/

In Spanish: http://kff.org/cuidado-de-salud-recursos-para-los-consumidores/

Health Sherpa: http://www.thehealthsherpa.com/

9. What is actuarial value and how may those values affect my plan selection and coverage?

Actuarial value is a value assigned to a plan based upon the coverage of the plan and cost-sharing responsibility of the consumer after the premium and deductible have been paid. Four levels of actuarial value have been assigned to plans. Those levels are represented by the metals platinum, gold, silver, and bronze. Platinum plans have the highest actuarial value whereas bronze plans have the lowest actuarial value (excluding catastrophic plans). The values correspond to the percentage paid by the insurer for essential health benefits. So, a platinum plan is designed to cover 90% of expenses, after the premium and deductible have been paid, for the covered services, among which essential health benefits are mandated. As the metal value decreases, the insurer responsibility decreases in 10% increments.

It is important to note that tax credits and other subsidies may essentially raise the actuarial value of the plan for individual consumers in that those subsidies will result in decreased consumer cost-sharing responsibilities.

10. Do I qualify for tax credits?

Individuals and families whose income is between 100% and 400% federal poverty levels ($11,490-45,960 for an individual, $23,550-94,200 for a family of four) and who will be shopping for insurance on the Marketplace will be eligible for premium tax credits. The consumer can decide whether to reap the tax credit when income taxes are filed or as a credit directly issued to the insurer. Those nearest federal poverty levels will have 94% of covered health care expenses paid for by their insurance plan, tax credits and cost-sharing reductions, which results not only in savings with regard to premiums but also extended protections in the event of more complex illnesses. The Center on Budget and Policy Priorities outlines the cost-sharing reductions and premium tax credits in greater detail here.

11. Do I qualify for cost-sharing subsidies?

Individuals and families whose income falls at or below 250% FPL ($28,725 for an individual, $58,875 for a family of four) will be eligible for cost-sharing reductions. Those eligible for this subsidy can take advantage of it by purchasing a silver-rated (or higher) plan. Those nearest federal poverty levels will have 94% of covered health care expenses paid for by their insurance plan, tax credits and cost-sharing reductions, which results not only in savings with regard to premiums but also extended protections in the event of more complex illnesses. The Center on Budget and Policy Priorities outlines the cost-sharing reductions and premium tax credits in greater detail here

12. We have health insurance but still find we need access to additional coverage and services. What other options do we have to cover our child's special health care needs?

There are many programs designed to provide services to individuals with special health care needs. The eligibility for those programs and services varies and may be dependent upon diagnosis, family income, and level of care needs. We often encourage families to apply for programs such as Medicaid Waivers (Aged and Disabled, Traumatic Brain Injury, Community Integration and Habilitation, and Family Supports waivers), Medicaid disability coverage (Traditional Medicaid and Care Select), Children's Special Health Care Services, Early Intervention (First Steps), Social Security programs, and others.

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