The Insurance Basics

Understanding insurance basics is the first step to selecting an affordable, adequate plan that covers the services you need to live a healthy life with cystic fibrosis.

1 Common Insurance Terms

As a person living with cystic fibrosis, choosing the right insurance plan is an important decision to ensure you can receive the highly specialized care you need. Understanding insurance basics can help you with this decision. A good place to start is with some common terms, such as copay, deductible, and premium.

Understanding these terms can help you with the more complex parts of any insurance plan. A *Compass* case manager can also help walk you through the common terms so that you don't feel overwhelmed and can focus on choosing the plan that works best for you.

2 Types of Health Insurance

Depending on your employment status, household size, and income, there are several types of insurance that you can qualify for. The four primary types of insurance are employer-based plans, plans on the Health Insurance Marketplace (also known as the Health Insurance Exchange), private plans (also known as off-exchange plans), and public insurance such as Medicare and Medicaid. *Compass* can help you understand what options are available for your circumstances and walk you through a side-by-side comparison of options.

You can select or make changes to your health insurance coverage during annual open enrollment. Coverage begins at a specified date after open enrollment and usually applies for a full year.

Employer-Based (Group) Plans

In the United States, most people have health insurance coverage through their own or a family member's employer. Employer-based health insurance, also called a group plan, is selected and purchased by an employer and offered to eligible employees and their dependents. Any businesses with 50 or more full-time employees is required to provide health insurance to their employees. Your employer will typically share the cost of your premium with you. Some employers may offer insurance through a labor or trade union.

There are two types of employer-based coverage: fully funded group plans and self-funded group plans.

- **Fully funded group plans:** The employer purchases coverage from an insurance company and the insurance company processes and pays health care provider claims.
- **Self-funded group plans:** The employer sometimes assumes the role of the insurance company, and processes and pays health care provider claims. However, in some cases, there may be a third-party administrator that assists with health insurance claims. For self-funded plans, it is often up to the employer to decide whether to cover a service. In most cases, appeals are made directly to the employer's human resources (HR) department.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a form of employer-based coverage that gives employees and their families the option to extend their insurance if they lose job-based health coverage, such as by leaving their job or getting laid off. An employer is required to offer COBRA if it has 20 or more employees on more than 50 percent of its typical business days. Most qualified individuals are required to pay the full cost (which cannot exceed 102 percent of the premium, or the full cost of the coverage plus a two percent administration charge) of the plan. Because employers typically cover part of the premium while the employee is working, the cost of continuing coverage through COBRA can be significantly greater. COBRA coverage can continue for up to 18 months.

Once you opt into COBRA, you cannot drop it and switch to a Marketplace plan until the following year or until the open enrollment period, as voluntary loss of coverage is not considered to be a qualifying life event for the special enrollment period. You must have a qualifying life event or other unusual circumstance to buy a plan outside of the open enrollment period.

Those who do not take COBRA coverage can enroll in a Marketplace plan instead but will typically need to decide within 60 days of the loss of job-based coverage. The choice between COBRA and a Marketplace plan largely depends on your individual circumstances.

Health Insurance Marketplace Plans

The Health Insurance Marketplace, also known as the Health Insurance Exchange, provides people a way to buy a plan if they do not have access to group-based employer plans or do not qualify

for Medicare or Medicaid. To access your state's Marketplace, visit healthcare.gov.

Typically, Marketplace insurance plans are grouped by levels of coverage named after different types of metals:

- **Bronze plans** offer the least coverage but also have the least expensive monthly premiums. On average, you will pay 40 percent of your health care costs with a bronze plan.
- **Silver plans** will usually require you to pay 30 percent of your health care costs.
- **Gold plans** typically require you to pay 20 percent of your health care costs.
- **Platinum plans** offer the most coverage but also have the most expensive monthly premiums. On average, you will pay 10 percent of your health care costs with platinum plans.

You can buy a new plan or make changes to an existing Marketplace plan during the annual open enrollment period. You may qualify for a special enrollment period if you have a qualifying life event or other unusual circumstance.

Marketplace Subsidies

Based on your household size or income, you may be eligible for a subsidy in the form of a tax credit on your monthly premiums. You can qualify for a premium tax credit if your household income range is between 100 percent and 400 percent of the Federal Poverty Level (FPL). For more information on eligibility, visit the Saving Money on Health Insurance section on healthcare.gov.

Marketplace plans also offer access to cost-sharing reduction plans, which are specially designed silver plans featuring lower copays and deductibles. These plans are only available to people with incomes between 100 percent and 250 percent of the FPL. Individuals who fall within this category can take advantage of the premium subsidy at the same time.

Private Insurance Plan

Private or off-exchange insurance is provided by nongovernmental sources, such as private insurance companies. Individuals can purchase these plans through a broker or directly from an insurance company outside the marketplace. These plans vary greatly in what services are covered, premiums, and other out-of-pocket expenses. You can buy a new plan or make changes to an existing private plan during the annual open enrollment period. You must have a qualifying life event or other unusual circumstance to buy a plan outside of the open enrollment period.

Public Insurance Programs

Public health insurance programs are government-funded and provide health care assistance to qualifying individuals and their families. These programs include:

- Medicare
- Medicaid

- U.S. Department of Veterans Affairs
- Children's Health Insurance Program (CHIP)
- Department of Defense TRICARE and TRICARE for Life programs
- Indian Health Service (IHS)

Many states also have CF-specific programs such as programs for children with special health care needs (sometimes called CSHCN programs). In most states, families that do not qualify for Medicaid may be eligible for this program, although some states require enrollment in Medicaid to qualify. Some states may also offer this program to adults who have a qualifying diagnosis.

Primary Versus Secondary Insurance

Many people with cystic fibrosis report having more than one form of health insurance coverage. In these cases, you will have both a primary and a secondary insurance provider and your benefits must be coordinated to ensure you receive maximum coverage.

Your primary health insurance plan is the first to pay for services or treatments you receive. If the primary plan does not cover a service or treatment completely or at all, then your secondary health plan or program may cover it. It is important to notify both plans, so that coordination of benefit can be set up correctly. If the claim gets billed in an incorrect order, it may result in you receiving a bill in the amount higher than your actual responsibility.

---

3 Types of Health Insurance Networks

Learning more about the makeup of various plan types can help you make the most of your coverage and evaluate your options. There are five main types of insurance networks:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- Point of Service (POS)
- High-Deductible Plans With a Health Savings Account (HSA)

Provider Networks

A provider network is a set of doctors, hospitals, clinics, and other health care providers that are contracted with your health insurance plan to provide care at a reduced cost. Most health plans use a network. Because CF care teams are important for people with CF, knowing whether your CF care center is included in a plan's health insurance network is a key factor when you are selecting

the right plan. Not all health care providers are contracted under a plan's provider network, so it is important to know what is considered in-network and the policies regarding out-of-network coverage before enrolling in a plan.

Health Maintenance Organization

A health maintenance organization (HMO) plan limits coverage to health care providers who are contracted with the HMO network. The plan covers care only from providers in the network and does not pay for care from the providers outside of the HMO network, except in an emergency. HMOs require you to choose a primary care physician (PCP) who must then give you a referral to see any specialist. Without a referral, HMO plans do not cover care from a specialist and you will be responsible for most, if not all, of the associated costs.

HMOs have contracts with a network of doctors, hospitals, and other health care providers who have agreed to accept payment at a certain level for any provided services. The primary benefit of HMOs is that they have lower premiums and may have low or no deductible. In addition, copayments for doctor or emergency-department visits will likely be minimal.

Although HMO plans may feature lower health insurance costs up front, they can be more restrictive in covered services and how they are accessed. When you are considering an HMO, it’s important to make sure your CF care is covered.

Preferred Provider Organization

A preferred provider organization (PPO) plan provides coverage for the services obtained from providers outside of a plan's network. With PPO plans, you pay less for care from in-network providers but can still receive coverage for out-of-network care without a referral at an additional cost.

PPO plans generally provide more flexibility than HMO plans. However, they often cost more. If you enroll in a PPO plan, you will pay higher monthly premiums and out-of-pocket costs in exchange for the flexibility to choose providers both in and out of network.

Exclusive Provider Organization

Exclusive provider organization (EPO) plans combine the flexibility of a PPO plan with the cost-saving benefits of an HMO plan by giving you the freedom to choose any provider within an EPO network without selecting a PCP. In addition, EPO plans do not require referrals from a PCP to see a specialist.

It is important to note that EPOs do not cover the services obtained from providers outside of the plan’s network. When selecting this plan, it is important for you to confirm that your CF providers are in-network before enrolling. If you do go to a doctor or hospital that does not accept your plan, you will be responsible for paying all care-associated costs.

Point of Service Plan

A point-of-service (POS) plan combines different elements of HMO and PPO plans. Like an HMO plan, you must choose a PCP, but you can also go outside of the provider network for health care services with greater out-of-pocket costs, like a PPO plan. Services provided by the PCP are typically not subject to a deductible, and a wide range of preventive care benefits are also included.

The primary benefit of a POS plan is that it offers a “middle of the road” option in which you have more choices than what an HMO plan typically offers while you pay less than with a PPO plan.

	PPO Preferred Provider Organization	EPO Exclusive Provider Organization	POS Point-of-service	HMO Health Maintenance Organization
Primary Care Physician (PCP) required?	No	Sometimes	Yes	Yes
Referral required to see a specialist?	No	No	Sometimes	Yes
"In-network" benefits	Yes	Yes	Yes	Yes
Non-emergency "out-of-network" benefits	Yes	No	Yes	No
Emergency coverage	Yes	Yes	Yes	Yes

High-Deductible Health Plans

A health savings account (HSA) is a tax-exempt medical savings account that is paired with a high-deductible health plan. It’s a personal bank account to help you save and pay for covered health care services and qualified medical expenses. You must sign up for a high-deductible health plan that meets a deductible amount set by the Internal Revenue Service (IRS). The IRS sets a limit on how much you can put into it each year. For more information, visit the Health Savings Accounts section on irs.gov.

You may also be eligible for a flexible spending account (FSA) or a health reimbursement account (HRA), if it is offered by your employer. An FSA is a tax-exempt account to set aside funds to cover eligible medical expenses that are not covered by your employer-sponsored plan. Employers may make contributions to your FSA but are not required to do so. An HRA is another health savings account that supplements a high-deductible plan that is fully owned and funded by the employer.

Both FSAs and HRAs are owned by your employer, so they are not transferable when you switch jobs.

---

4 The Medical Benefit v. the Pharmacy Benefit

Almost every insurance plan has a set of defined pharmacy and medical benefits. Understanding how your plan's pharmacy and medical benefits will be handled by your health insurance provider is an important aspect of choosing the right plan.

Understanding Medical Benefits

A plan's medical benefits are primarily for services such as care center visits, hospitalizations, in-home intravenous (IV) services, medical devices, therapies, respiratory therapies, procedures, and lab work. Any service that falls under the medical side of your plan's benefits is subject to the medical deductible and the out-of-pocket maximum. Copays or coinsurance may vary depending on the category of service. For example, you may have a set copay for office visits but have coinsurance for a medical device. Every plan is structured differently. Your plan's medical and pharmacy benefits may or may not have a combined deductible or out-of-pocket maximum.

Understanding Pharmacy Benefits

A plan's pharmacy benefits determine the level of coverage for prescription medications. Most health insurance plans have a tiered structure for pharmacy benefits, offering different copay amounts that increase in price as you move through each tier. Most plans have three to five tiers for prescription medications. For example:

- **Tier 1**: Generic medications (least expensive)
- **Tier 2**: Preferred brand-name medications
- **Tier 3**: Non-preferred brand-name medications
- **Tier 4**: Specialty medications (most expensive)

Because each tier has different associated costs, it is important to know which tier your medication is in before selecting a plan. Even though a plan's Summary of Benefits may list a certain copay amount for prescription medications, this rate will likely not apply if your medication falls under a higher tier.

Specialty Pharmacies

A specialty pharmacy typically fills prescriptions for many CF medications that are often unavailable at local retail pharmacies. They also provide:

- High-cost drugs
- Services such as refill reminders, overnight deliveries, and online prescription tracking
- Therapy management to ensure safety and compliance

Medications from specialty pharmacies typically need to be handled and stored in a particular way to maintain effectiveness. Your insurance plan may require you to use a certain specialty pharmacy.

To learn more about your insurance options and coverage, contact CF Foundation *Compass* by calling **844-COMPASS** (844-266-7277) Monday through Thursday, 9 a.m. until 7 p.m. ET and Friday, 9 a.m. until 3 p.m. ET, or emailing compass@cff.org.

Cystic Fibrosis Foundation
4550 Montgomery Ave.
Suite 1100 N
Bethesda, MD 20814

301-951-4422
800-344-4823 (toll free)