# Private Health Insurance

## Health Insurance for Ages 18-30

<table>
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<tr>
<th>PRIVATE</th>
<th>GOVERNMENT-FUNDED</th>
<th>NO INSURANCE</th>
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<td>Job-Based Group Plans</td>
<td>State Public Insurance</td>
<td>You Pay All the Bills</td>
</tr>
<tr>
<td>• Employee</td>
<td>Medicaid</td>
<td>• Every medical visit</td>
</tr>
<tr>
<td>• Family</td>
<td>• Low income, with and without disability</td>
<td>• All prescriptions</td>
</tr>
<tr>
<td>• Dependent adult child</td>
<td>• Waivers for special groups</td>
<td>• Any hospitalizations</td>
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<tr>
<td>• Dependent disabled adult</td>
<td>• Aged out of foster care</td>
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<td>• COBRA</td>
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<td>College/University</td>
<td>Federal Public Insurance</td>
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<tr>
<td>• Student Health Plan</td>
<td>Medicare</td>
<td>• Unless hardship exemption is approved</td>
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<td></td>
<td>• Low income, with disability</td>
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<td>Marketplace (ACA)</td>
<td>Indian Health Services</td>
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<td>• Individual</td>
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<tr>
<td>• Family</td>
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### TIP: If you are a resident of Florida but spend more time in a different state, you should pick a plan that has a national provider network (in-network providers in more than one state).
Words To Know

Subscriber/Policyholder is the organization or individual who the health care coverage is issued to. In job-based group plans, the employer is the policyholder and the employee is the certificateholder.
• Generally, the subscriber/certificateholder pays the monthly premiums.
• He/she can have insurance through a plan that covers just the person or includes dependent family members.
• Can also purchase insurance through the Marketplace or directly from an insurance broker

Dependent is the person who is covered under the subscriber’s health care plan.
• Can be a spouse, a minor child, an adult child (under certain conditions).
• In Florida, some dependent children up to age 30 can remain on their parents’ plan; coverage for dependent disabled adults may be for their lifetime.

Here are some of the major health insurance companies that offer job-based or Marketplace plans to Florida residents. Visit their Websites to learn more about each one.

Aetna www.aetna.com
Assurant Health www.assuranthealth.com
Blue Cross and Blue Shield (Florida Blue) www.bcbsfl.com
Cigna www.cigna.com
Coventry Health Care http://chcflorida.coventryhealthcare.com
Florida Health Care Plans www.fhcp.com
Health First www.health-first.org
Humana www.humana-one.com/florida-health-insurance/plans-available.asp
Molina Healthcare of Florida www.molinahealthcare.com/members/fl
Preferred Medical Plan www.pmpmarketplace.com
Sunshine Health www.sunshinehealth.com
UnitedHealthcare of Florida www.uhc.com/contact-us/florida
What to Know Before Choosing a Plan

There are several types of private insurance plans to choose from. Your first choice may be to decide between fee-for-service (or traditional) insurance and a managed care plan. Most individual and group policies sold today are managed care contracts, which typically include PPO, HMO, and POS options.

**Fee-For-Service** (also called Traditional or Indemnity Plan)

- You can see any doctor or go to any hospital you choose.
- You pay a percentage of the cost for the services you receive.
- Monthly premiums are usually higher than other types of plans.

**PPO: Preferred Provider Organization**

- Your portion of the cost is less expensive if you use the list of in-network providers.
- If you choose to see a doctor out-of-network, you’ll pay more.

**HMO: Health Maintenance Organization**

- Covers most of your health care needs - including checkups, immunizations and hospitalizations - for a small co-payment, typically between $5 and $40.
- No claim forms.
- Generally limited to in-network doctors and hospitals, though special circumstances may sometimes be treated as exceptions. In these cases you must obtain authorization to see Out-of-Network providers, and the copay is sometimes higher.
- Some services are not covered.

**POS: Point of Service** (typically 2 choices)

- A lower cost option is available for choosing in-network physicians and for obtaining service referrals from your primary care provider (PCP).
- A higher cost option allows your choice of doctors. You use your health plan just like a fee-for-service plan by choosing care from either a participating provider or a non-participating provider, without coordinating care through your PCP. You will pay a higher deductible and a percentage of your bill.
Second, consider what type of health care services you need and want:

- In the last year has your health status stayed the same, improved or gotten worse?
- Do you take prescription medications? Are they covered in your insurance plan?
- Do you get an annual physical? *If not, put it on your “To Do” list!*
- Do you want to select your own doctors, therapists, specialists and other providers?

So, before choosing a plan, ask about...

**Costs**

- How much are monthly premiums and co-pays? Do they fit in your budget?
- Is there a yearly maximum deductible? How much?
- If you have lots of medical services one year, will the plan pay for additional needed services or prescriptions?

**Doctors**

- Are your current doctors approved by the plan as in-network?
- Think about services you need now and may need in the future—will these be covered by the plan?

**Tests / Services**

- Do the benefits offered in the plan provide basic coverage for well visits?
- What kinds of preventative tests or other alternative services are covered by the plan?

**Prescriptions**

- Are your medications covered under the plan? If so, how much will co-pays cost?

**Paperwork / Paying for Services**

- Are health claims filed by the doctor’s office?
- If not, who can teach you how to fill in the insurance claim forms? Forms need to include the billing codes (CPT) and diagnosis codes (ICD-9). If the paperwork isn’t filled out right, the bill doesn’t get paid!

**TIP:** Remember, there is no such thing as a perfect health insurance plan, but some plans will meet your needs better than others. Only YOU can decide which!
Job-Based Group Plans

Group insurance through an employer is usually the most cost effective private insurance option, so try to take advantage of this benefit if it’s available to you. In addition to covering the employee, most job-based plans offer provisions to cover family members (spouse and dependent children) if needed. Always check with your insurance company to learn the specifics of your policy.

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Job-Based/Employee and Family Plans

|              | N | N | Y | N | Y | N |

Dependent Adult Child

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Dependent Adult Child/Family Plan

|              | N | 19-26 | N | N | Y | Y |

If possible, stay on your parent’s group family plan! Under the ACA, private insurance plans must allow adult children up to age 26 who do not have their own job-based insurance coverage to remain on their parents’ plan – even if the child is not a student, is married, lives in a different state, and/or files taxes as an independent. In Florida, some dependent children up to age 30 can remain on their parents’ plan (check with employer plan administrator).

- Young adults with or without disabilities can stay on their family’s employer-sponsored group health plan until age 26, and in some cases, to age 30.
- HMO plans limit routine well visits to in-network doctors that are in-state. This could be a problem for students who go to college out-of-state.
## Dependent Disabled Adult

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### Dependent Adult Child/Family Plan

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### An Adult Disabled Dependent is:

- Incapable of self-sustaining employment due to intellectual,* mental or physical impairment;
- Chiefly dependent upon the policyholder or subscriber for financial support, care and maintenance.

- Provides parents with a way to pay for medical services for their disabled adult child over an extended period of time.
- Family may be “job locked,” that is, unable to change jobs or a work situation without losing coverage for an adult child who is dependent and disabled.

* The term “mental retardation” is being phased out of legislative language; “intellectual disability” or “cognitive impairment” are terms commonly used today.
Courts have the power to order divorcing parents to maintain their child’s health insurance, including coverage for adult children with disabilities.

**Support for Adult Children with Disabilities**

- A divorce decree can mandate financial support to take care of the adult child who is disabled.

**Qualified Medical Child Support Order (QMCSO)**

- QMCSO orders the non-custodial parent to pay for their child’s health insurance regardless of the cost.
- No age limitation if dependency is due to a mental or physical disability which started before age 18.
- May not drop coverage for the child without proof that the QMCSO is no longer in effect.

Things to think about when purchasing a plan for someone who is medically complex:

- If the parent who is legally mandated to provide health insurance lives in one state and the adult dependent child lives in another state, he/she needs to make sure the plan will pay for all services. How will billing be coordinated? Who pays the premiums and co-pays?
- Can an adult disabled dependent also be covered by a step-parent’s employer-provided group plan, especially if it offers better coverage?
- Should a non-custodial parent buy a group health insurance policy as a back-up?
- Who is analyzing the plan to make sure needed services are covered and co-pays are affordable?
- Who is watching to see if a different plan should be selected during open enrollment?
- What happens if the subscriber retires and does not have an employer-provided group plan? Has the decree specified a plan to continue paying for coverage?
- Remember, some chronic health issues get worse over time.

**Make sure you have a copy of the court decree mandating who pays for health insurance and medical bills. Share this with your providers and file in the electronic health record.**

Ask if your group plan will pay for out-of-state health services that are non-emergency care. Some plans will not pay for well visits or preventative care that is not coordinated through their in-network provider without a preauthorized form. Some plans allow a sign-off from the in-state primary care provider. Find out more before leaving for school!
COBRA

What if you change jobs or lose job-based insurance? COBRA may provide a short-term coverage option for you.

The reality is that everyone will change jobs at one time or another, Sometimes, it is not our choice when it happens. The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides some protections and coverage for a limited period of time.

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<tr>
<td>COBRA</td>
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What is COBRA? Who is covered?

- COBRA may cover employees who have been laid off or terminated; dependents who lose coverage because of divorce, legal separation or death, or who lose dependent status due to age; retiring employees and those qualifying for Medicare.

- COBRA is mandated for companies that employ 20 or more people, including part-timers. Florida also has a “mini-COBRA” law for employees who work for companies with 2 to 19 employees.

- The employee pays for the entire premium; the employer does not pay for any portion of it.

- You have only 60 days to sign up for this coverage after the qualifying event (job loss, reduced hours, family change, etc.).
How long does coverage last?

- **18 months** coverage if you lost your job or have fewer hours (for reasons other than misconduct).

- **29 months** if you or another beneficiary of the plan are disabled at enrollment, using SSA (Social Security Administration) disability criteria. However, the plan can increase the cost of the premium for the last 11 months of this period.

- **36 months** if your parent who had the insurance plan dies or enrolls in Medicare; your parents divorce or are legally separated; or you lose “dependent child” status under the plan due to aging out.

What does it cost?

- COBRA participants must pay the full premiums out of their own pocket, plus up to a 2% administrative fee.

  - More than what you paid as an employee, but it’s better than not having insurance coverage and a pile of unpaid medical bills.

  - If premiums are paid on time, this plan can last 18 to 36 months.

  - Payment and paperwork must be received within 60 days; there is no grace period.

  - If payments are late, coverage ends.

  - Monthly premiums are high, and paid 100% by the participant.

When your group plan coverage ends, you will receive a written certificate of the time period that was covered, called a **Certificate of Prior Coverage**. This may be required when you enroll in a new plan.
College/University Student Health Plans

In addition to their parents’ group family plan, students in college or other types of post secondary schools may have the option to purchase insurance through their school.

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College/University Student Health Plans

- Covers full-time or part-time students (undergraduate and graduate).
- Health coverage usually has a deductible, co-insurance provisions and co-payments for physician and hospital charges.
- Access to student health center (ask about after-hours care!)
- This kind of coverage is a good option if the student cannot stay on their family’s employer-provided group plan (due to loss of job, etc.).
- Provides limited coverage; may not meet the ACA’s “essential health benefits” requirements, or, if you attend college out of state, may not cover medical services in your home state.

FACTOID #5: Among young people aged 18- to 25, 77% said having health insurance was personally important to them and 76% said it was something they needed.²
The Marketplace can be accessed at www.healthcare.gov or call (800) 318-2596, or TTYTDD at (855) 889-4325. The web site is updated regularly and includes FAQs about many topics, including coverage for young adults. You can also view a guide for Florida consumers at www.myfloridacfo.com/division/Consumers/understandingCoverage/Guides/documents/healthguide.pdf, or call the Florida Department of Financial Services Consumer Helpline toll-free at (877) 693-5236.

## Marketplace Plans

If you can’t get coverage through your parents, your job or your school, you may need to buy health insurance through the ACA Marketplace, also called the Exchange. The Marketplace was established to provide an easy means of shopping and purchasing individual and small group health coverage. It allows you to compare private health insurance options on the basis of price, benefits, quality and other factors. States choose whether to develop and manage their own exchange or have the federal government do it. In Florida, the federal government developed and runs the Marketplace.

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### Marketplace/Individual and Family Plans

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Here are 3 important things to know about the Marketplace:

1. It’s an easy way to shop for health insurance - you can see all your options in one place, and with one application, you can explore every qualified option in your area.
2. Most people will be able to get a break on cost through tax credits that are based on income.
3. It offers clear options with apples-to-apples comparisons.

The ACA doesn’t require you to purchase private health insurance through the Marketplace, though tax credits are only available for plans sold through the Marketplace. You can purchase this coverage through the Marketplace web site or through an agent if he or she is approved to sell Marketplace plans. If you would rather buy coverage directly through an insurance company or broker off of the exchange, you are free to do so.
These are some key topic areas to consider as you explore your options.

**Essential Health Benefits**

All plans in the Marketplace are required to provide a package of essential health benefits so that comparisons are “apples-to-apples.” These benefits fall into 10 categories:

- Hospitalization
- Emergency services
- Ambulatory (outpatient) services
- Prescription drugs
- Rehabilitative (regaining skills that have been lost or preventing a further loss of skills) and habilitative (learning skills) services and devices
- Mental health and substance abuse services
- Preventive and wellness services, including chronic disease management
- Laboratory services
- Pediatric services, including oral and vision care
- Maternity and newborn care

The ACA also guarantees that you can’t be turned down for coverage due to your health history or a pre-existing condition, and cannot charge men and women different rates.

**Coverage Levels**

There are 4 categories of plans, or “metal tiers,” plus a separate catastrophic plan for certain qualifying individuals. The plans in these categories have different benefits, premium prices, doctors that can be used, and out-of-pocket expenses. However, all plans have the same quality of care and include the 10 essential health benefits. The levels of coverage are:

- **Bronze:** The plan must cover 60% of expected costs.
- **Silver:** The plan must cover 70% of expected costs.
- **Gold:** The plan must cover 80% of expected costs.
- **Platinum:** The plan must cover 90% of expected costs.
- **Catastrophic:** The plan is available to people under age 30, or those who can’t afford other health coverage and are approved for a hardship exemption. These plans carry very high deductibles; that is, you pay a large out-of-pocket cost before the plan begins to pay for covered services.

HealthPocket offers a useful tool to compare all of the plans available in a particular area, [www.healthpocket.com/individual-health-insurance](http://www.healthpocket.com/individual-health-insurance).
You can purchase an **individual plan** for yourself or, in some situations, be included in your **family’s plan**. Just as with job-based family plans, adult children up to age 26 can be added to or kept on a parent’s policy that is purchased inside or outside the Marketplace. The maximum out-of-pocket cost limit for any individual Marketplace plan for 2015 can be no more than $6,600 for an individual plan and $13,200 for a family plan.

**Tax Credit**

The **Advanced Premium Tax Credit**, also known as a **premium subsidy**, is intended to make health coverage more affordable. When you apply for coverage through the Marketplace, you will be asked for income and family information as part of the application process. You will be advised of the available tax credit amount, if eligible, after the application has been completed.

Eligibility is for individuals and families whose income is between 100% and 400% of the poverty level and who are not eligible for other affordable coverage. The tax credit is based on a sliding scale, with people with lower incomes receiving a higher credit. You have a choice to claim the tax credit at the time you file your annual tax return, or have the Internal Revenue Service apply the tax credit directly to your monthly cost for the plan (to reduce your monthly out-of-pocket cost). It can be applied to any Bronze, Silver, Gold or Platinum plan, but can’t be applied to a Catastrophic plan.

You may also qualify for reduced cost-sharing (co-payments, co-insurance and deductibles) if your income is at or below 250% of the poverty level. You must purchase a Silver plan through the Marketplace in order to be eligible for cost-sharing reduction assistance.

For an easy-to-understand, interactive subsidy tool, visit the Kaiser Family Foundation at [http://kff.org/interative/subsidy-calculator](http://kff.org/interative/subsidy-calculator). With this calculator, you can enter your income, age, and family size to estimate your eligibility for subsidies and how much you could spend on health insurance.
Enrollment Period

Just as with other types of insurance policies and subscriptions, there is a period of time during which you can sign up or change your health insurance plan more easily and with fewer restrictions. This is called the **open enrollment** period. Beginning in 2015, the annual open enrollment period will be October 15 through December 7 with a January 1 effective date.

You’ll be able to sign up or change your plan during this period each year (only) unless you have a **qualifying life event** such as birth, divorce, marriage, adoption, change in residence, income or other life circumstance. If you do, you can request a **special enrollment period**. Individuals have 60 days from the date of the change to request special enrollment.

Enrollment Assistance

If you choose to enroll for private coverage through the Marketplace, you can use **Navigators** or **Certified Application Counselors (CAC)** to assist you in the process. These individuals are trained and certified to help consumers prepare electronic or paper applications to establish eligibility and enroll in coverage. They can help you identify potential qualification for tax credits, reduced cost-sharing, or other coverage through a government-funded program. Visit [https://localhelp.healthcare.gov](https://localhelp.healthcare.gov) to locate a Navigator or CAC near you.

**TIP:** If you are not getting a driver’s license, get a state-issued identification card (ID) before age 18 from the Florida Department of Highway Safety and Motor Vehicles. When you apply for health care insurance through the Marketplace, you will need to show official ID and proof of your income. Getting this information together ahead of time makes the process less stressful.