FAIRHEALTH® Consumer ACCESS

SUMMER 2015

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Cool as a Consumer

Welcome to the Summer 2015 issue of *Consumer Access*! We hope that, with summer in full swing, you're keeping cool with some rest, relaxation and quality time with friends and family. But, we also hope that you're open to one other summer pastime: keeping your understanding of health insurance fresh! If you find our idea to be a bit unseasonable, and more effort than it's worth, don't sweat it! Simply follow these tips:

- **Know Before You Go!** If you are insured, know what your plan covers. For example, does it cover out-of-network care? If so, how does your plan reimburse for that care? Are your healthcare providers (such as doctors and hospitals) in your plan's network? And, did you know that you can get certain preventive services, like annual checkups, at no cost to you? Know your out-of-pocket costs in advance! Use fairhealthconsumer.org (or download the app from iTunes or Google play) to estimate your costs for out-of-network care. If you are uninsured you also can use our tools to estimate how much you may pay for care. What's more, you may be able to negotiate your provider's fee using this cost information.
- **Gear Up for Open Enrollment Season!** Starting November 1, 2015 and ending January 31, 2016, you can buy or renew coverage from your marketplace, whether state or federal. If you are insured, be aware of your options for renewing your coverage—whether from the marketplace, employer or spouse's employer. Keep in mind that employers' enrollment periods differ slightly, so check with your employer if you're not sure. If you still need coverage for 2015, you may be able to enroll at any time if you have had certain life events (like having a baby) and/or if you qualify for Medicaid or the Children's Health Insurance Program (CHIP). Learn more.
- **Read *Consumer Access*!** We explain two models of care that can help you coordinate and manage your health. We also offer some mind over matter when it comes to taking charge of your behavioral health needs. Finally, our summer reads offer more than meets the eye in a refreshing take on our FH Health Insurance 101 series.

No matter the season, rely on FAIR Health to keep you cool as a consumer—summer and year-round.

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Home, Sweet Home: Coordinated Care with Medical Homes and Accountable Care Organizations

Getting the care you need may involve getting different tests and services and seeing more than one healthcare provider, like hospitals and doctors. Ideally, to give you the best care, your doctors need to know about other care you receive from healthcare professionals, such as what tests and treatments you've had. That way, you won't get the same screening twice, or have a bad reaction to a drug because they didn't know your medical history. They will also know if you've been getting the preventive care you need, like regular blood tests if you have diabetes.

Some medical practices are improving the way they care for patients by "coordinating" their care. What is coordinated care? It means that everyone in the medical practice knows your medical history and treatment plan. In some cases, your medical information will be stored in a personal electronic health record that you, your doctors and other healthcare professionals can share. This lets everyone have a complete picture of your health.

Accountable care organizations (ACOs) and medical homes are two kinds of healthcare models that coordinate care for their patients. Though they are similar in many ways, ACOs and medical homes are slightly different. ACOs are much bigger, somewhat like a network of many different medical homes—which is why an ACO is sometimes called a "medical neighborhood." While both a medical home and ACO focus on your primary care, an ACO will have more providers other than your primary care doctor, such as specialists and hospitals.

So how can ACOs and medical homes help you manage your care? Here's how:

- Be informed! If you are not sure whether you are getting care from an ACO or medical home, ask your doctor or insurer.
- If you would like to get care from an ACO or medical home—for example, if you have a chronic condition—ask your insurer or doctor about options open to you.
- If you are receiving care from an ACO, know whether you can see providers outside of the ACO, as well as your level of coverage for "out-of-ACO" and "out-of-network care."
- In the market for a medical home? Find providers in your state that meet medical home standards by the National Committee for Quality Assurance here.

Learn more by reading our new 101 guides on ACOs and medical homes.

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Mind Over Matter: Getting the Behavioral Healthcare You Need

Our mental health is a vital part of our overall well-being. It affects how we think, how we feel, and how we act. That's why it's important to take our mental and emotional health as seriously as our physical well-being. The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires most plans that cover mental health to offer the same level of coverage for these conditions that they do for medical conditions. That includes costs like co-pays, deductibles, and co-insurance and treatment limits (like the number of visits and inpatient days of coverage). If a plan includes mental health services and covers out-of-network medical care, it must also cover out-of-network mental healthcare. However, you may still need to follow plan rules like authorizing services in advance, or getting a referral from your primary care doctor to avoid high out-of-pocket costs. Here are a few tips to help you put mind over matter:

- **Insured? Start with Your Health Plan:** Before you get care, find out if your plan covers the services you'll need. Read your plan documents carefully. For example, are there any limits on the number of visits or inpatient days? Review your plan documents and ask your health plan any questions you may have. If you have any questions, contact a member services representative using the number on the back of your insurance ID card. Once you start treatment, keep track of your visits and inpatient days so you know when you are close to reaching your plan's limits and you don't get surprised by a bill.
- **Not Insured for Behavioral Healthcare?** You will have to pay the full cost yourself. Let your provider know up front, and ask if you can negotiate the cost. You may also want to ask whether you can pay for your treatment in installments. Of course, your providers don't have to accept a lower price or installment payments for their services, but it doesn't hurt to ask. Certain organizations and agencies may be able to help you get the care you need at a lower cost, or even for free. Learn more from the Action Plan in our 101 guide. If your plan does not cover behavioral health services, or if you are seeking care out-of-network, use our FH Medical Cost Lookup to estimate how much you might have to pay.
- **Know Where to Get Care:** To find behavioral healthcare services near you, ask your primary care provider for recommendations or a referral, or any one of the other mental health services near you. In an emergency dial 911, contact your provider and/or go to the emergency room. You also may contact the National Suicide Prevention Lifeline (800 273-TALK), a free 24-hour service and the Lifeline website.

Learn more from our FH Health Insurance 101 guide.

Word to the Wise Consumer: Refreshing Summer Reads

Refresh your understanding of health insurance and costs with a few short summer reads. Based on the FH Health Insurance 101 series, these snippets are sure to energize even the wisest consumers. For more detail, click on the links.

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- **Explanation of Benefits (EOB) Form**
  After you receive care, your provider sends a bill, or "claim" to your insurance company. Your insurance company processes the claim and sends you an Explanation of Benefits, or EOB. The EOB is just what it sounds like - a summary of how much your provider charged your insurer, and how much your insurer paid. The EOB may also include the amount you have paid toward your deductible. An EOB is not a bill, so you shouldn't make any payments based on this information. You will receive a bill from your provider or hospital if you owe a balance.
- **Understanding Your Medical Bill**
  After a visit to a healthcare provider, a patient usually receives a bill showing how much is owed. The bill amount will depend on factors such as whether the patient has a health plan, the plan's features and whether the care was in-network or out-of-network. Before a visit, patients should find out the cost of care and how much will be paid by the insurer. This will help prevent surprise bills. To make sure a bill is correct, patients should review it for errors and make sure it matches the insurer's Explanation of Benefits (EOB) form. If unable to pay the bill, patients should contact the provider immediately to discuss other forms of payment; consumer assistance and patient advocate programs may also be able to assist.
- **Orthodontics**
  Orthodontics is the field of dentistry that fixes misaligned teeth and jaws with braces and other corrective procedures. Many dental plans cover orthodontics, but the coverage often differs from other dental services. You will usually pay a higher share of the cost, coverage is generally limited to children and there is often a lifetime maximum. Because orthodontic services continue for a long time, most orthodontists offer payment options like installment plans, financing, or discounts for paying the full cost up front. If you have a flexible spending account (FSA) or health savings account (HSA) through your employer, you may be able to use it to pay for orthodontic costs.

Read the full *FH Health Insurance 101* series.

We Want to Hear From You!
E-mail Us at consumer@fairhealth.org with future topics to feature in *FAIR Health Consumer Access.*
Take Our Survey and let us know how we can improve the *FH Consumer Cost Lookup*.

Tell Us
How have our consumer tools and resources helped you? E-mail us at consumer@fairhealth.org.