How to Select a Health Plan

Time: 10:00am – 11:30am
Dial-In Number: 1-855-897-5763
Conference ID: 7935185

Today's Webinar

- Dial in to listen to the audio portion of the webinar using the audio instructions on your Webex control panel.
- All participants will remain muted for the duration of the program.
- Questions can be submitted using the Q&A function on your Webex control panel; we will pause periodically to take questions.
- A recording of the webinar and any related materials will be available online and emailed to all registrants.

Understanding the Uninsured

Here's what you said:

- More than 96% said it "increased my knowledge of the topic(s).
- More than 96% said "the information will allow me to better assist consumers who are uninsured.

"Keep up the good work."

"I mostly enjoyed the real life scenarios. This makes the information much more tangible."

"I really wish there were statistics on the uninsured by New York counties. I imagine the uninsured populations look different in the Bronx vs. Albany."

"Still need the presenters to read the slide number each and every time they move to the next slide."

Presenters

- **Welcome**

  Donna Frescatore, NY State of Health

- **Today's Panelist**

  Lynn Quincy, Consumers Union

Presenter

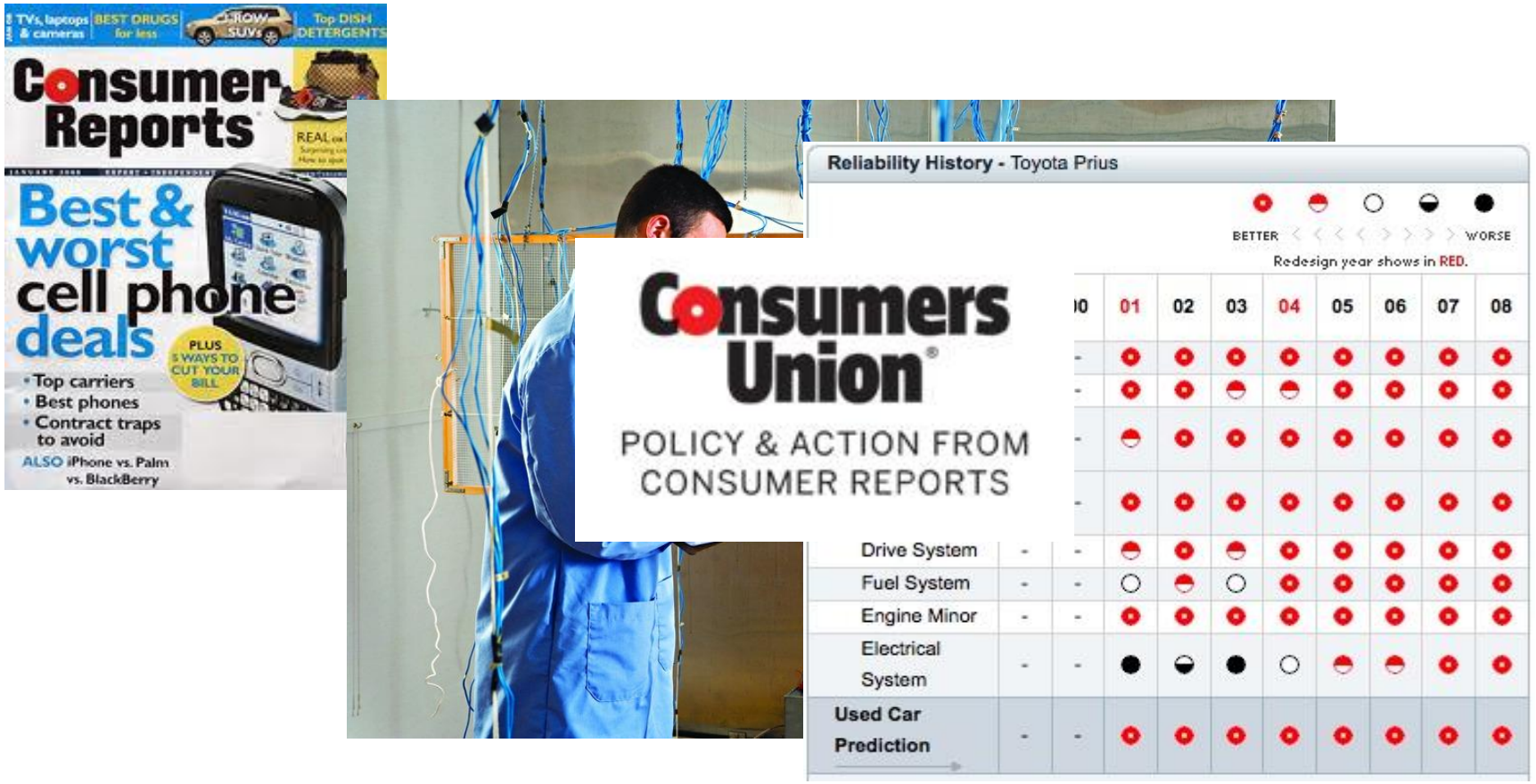
Lynn Quincy
Associate Director
Health Reform Policy
Consumers Union

Picking the Best Health Plan - What Consumers Need to Know

Lynn Quincy
Associate Director, Health Policy
Sept 16, 2015

Consumers Union®
POLICY & ACTION FROM CONSUMER REPORTS

Yes, THAT *Consumer Reports*



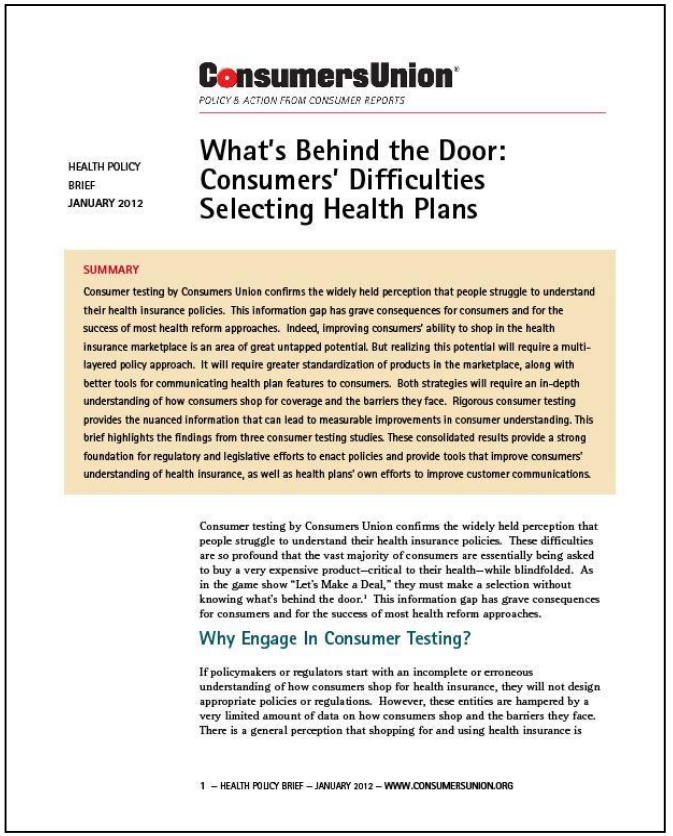
Learning Objectives

- The value of in-person assistance for plan selection
- Helping consumers compare QHPs:
  - Cost
  - Benefits
  - Provider Networks
  - Formularies
  - Quality Ratings
- Become familiar with plan selection tools

In-Person Enrollment Assistance is Critical and Preferred

Consumers Hate Health Insurance Shopping

That makes your job very difficult!



ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

HEALTH POLICY BRIEF
JANUARY 2012

What's Behind the Door: Consumers' Difficulties Selecting Health Plans

SUMMARY

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. This information gap has grave consequences for consumers and for the success of most health reform approaches. Indeed, improving consumers' ability to shop in the health insurance marketplace is an area of great untapped potential. But realizing this potential will require a multi-layered policy approach. It will require greater standardization of products in the marketplace, along with better tools for communicating health plan features to consumers. Both strategies will require an in-depth understanding of how consumers shop for coverage and the barriers they face. Rigorous consumer testing provides the nuanced information that can lead to measurable improvements in consumer understanding. This brief highlights the findings from three consumer testing studies. These consolidated results provide a strong foundation for regulatory and legislative efforts to enact policies and provide tools that improve consumers' understanding of health insurance, as well as health plans' own efforts to improve customer communications.

Consumer testing by Consumers Union confirms the widely held perception that people struggle to understand their health insurance policies. These difficulties are so profound that the vast majority of consumers are essentially being asked to buy a very expensive product—critical to their health—while blindfolded. As in the game show "Let's Make a Deal," they must make a selection without knowing what's behind the door.[1] This information gap has grave consequences for consumers and for the success of most health reform approaches.

Why Engage In Consumer Testing?

If policymakers or regulators start with an incomplete or erroneous understanding of how consumers shop for health insurance, they will not design appropriate policies or regulations. However, these entities are hampered by a very limited amount of data on how consumers shop and the barriers they face. There is a general perception that shopping for and using health insurance is

1 – HEALTH POLICY BRIEF – JANUARY 2012 – WWW.CONSUMERSUNION.ORG

What is Health Insurance Literacy?

Health insurance literacy measures the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their financial and health circumstances, and use the plan once enrolled.

Source: *Measuring Health Insurance Literacy: A Call to Action*, Consumers Union and partners, February 2012

Most Consumers Have Low Health Insurance Literacy

That means:

- less likely to enroll in coverage
- less likely to pick the best plan for them
- not confident in their selection
- not sure how to use coverage once enrolled

In-Person Assistance…

… provides consumers with

- Knowledge of how to select a plan
- Confidence in their choice
- Help with using coverage once enrolled.

Helping Consumers Compare Health Plans

Don’t Forget…

Navigators, CACs, and In-Person Assisters may not favor one plan over another, but should help a consumer compare plans to find the right plan for them.

"Best" is in the eye of the beholder

Shoppers should take into account:

- Ability to afford premiums and cost-sharing
- Health status
- Existing relationships with doctors
  - Transportation/language considerations if no current doctor
- Drugs currently being taken

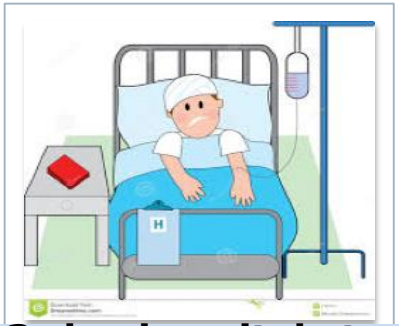
Comparing QHPs

- Cost
- Benefits
- Networks
- Formularies
- Quality Ratings

Underlying Cost of Care and Why We Need Health Insurance

- Some consumers lack a basic understanding of why we need health insurance: it protects them from large medical bills.
- Many consumers have little idea of what medical care costs when you have to pay the whole thing out-of-pocket.

Cost of Care Without Insurance



3-day hospital stay
Without insurance:
$30,000

Broken leg
Without insurance:
$7,500

12-month prescription
Without insurance:
$500

Source: https://www.healthcare.gov/why-should-i-have-health-coverage/

With Insurance..

You pay a fixed premium each month…

BUT the cost of most medical care is shared between you and the insurance company. And many preventive care services are free.

If you get an really expensive illness, insurance will pay the majority of those bills. The most you have to pay in a year is capped.

And even when you pay your share, you benefit from lower payment rates with doctors negotiated by the insurer.

Buying Coverage Involves Two Kinds of Costs

Premiums	Out of Pocket Costs When You See the Doctor:
(Pay these every month whether or not you use care)	Deductible
	Co-payments
	Co-insurance
	Out-of-pocket maximum
	Benefit limits

There's typically a trade-off between premium costs and Out-of-Pocket costs (also known as cost-sharing).

Metal Tiers provide an overall indication of patient cost sharing in-network

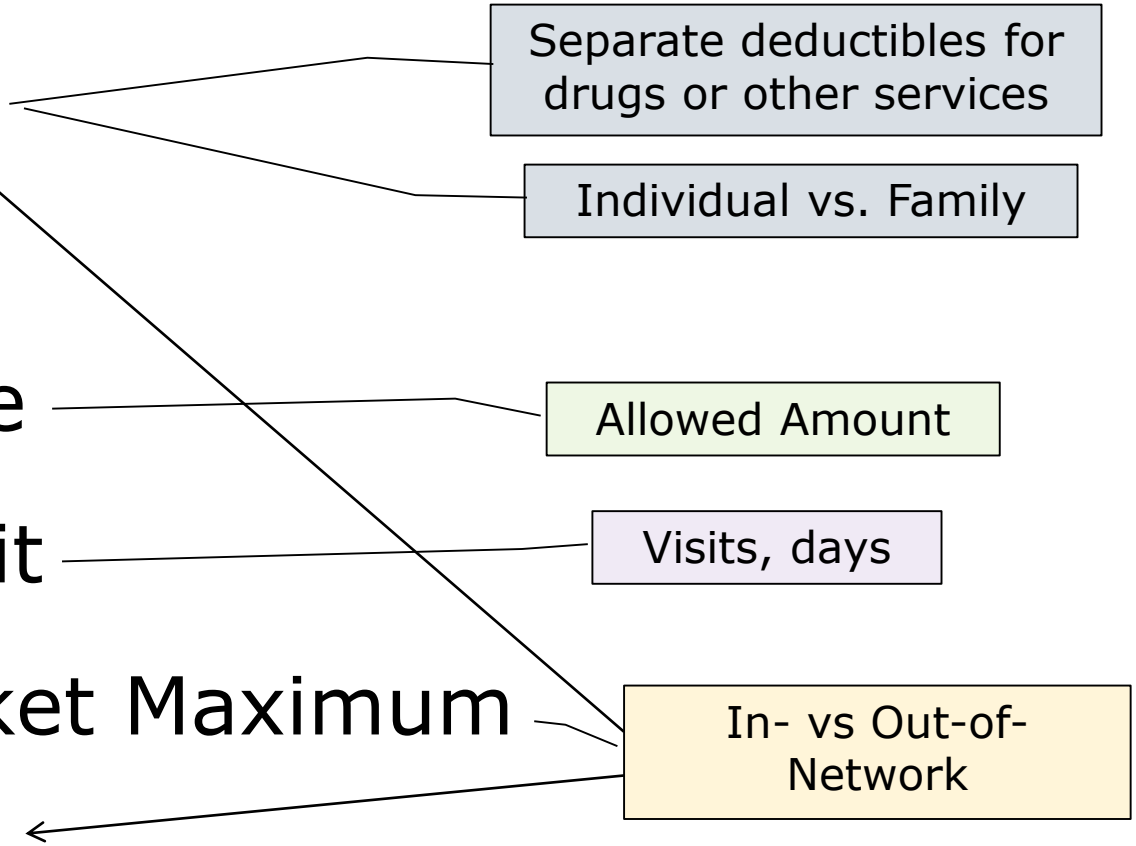
	Premiums	Out-of-Pocket Costs
Platinum Plans	Highest	Lowest
Gold Plans	Higher	Lower
Silver Plans	Moderate	Moderate
Bronze Plans	Lower	Higher
Catastrophic Plans	Lowest	Highest

Remember:

Consumers eligible for Cost-Sharing Reductions (CSR) can only use that benefit with Silver plans

Cost-sharing terms are very difficult for consumers

- Deductible
- Copay
- Coinsurance
- Benefit Limit
- Out-of-Pocket Maximum
- Balance Bill



Remember:
NY has Standard Plans

Standard Plans	Non-standard Plans
Feature standardized cost-sharing within a metal tier	Cost-sharing varies, even within a metal tier
Cover "essential" benefits and offer preventive services for free.	Cover "essential" benefits and offer preventive services for free. Some offer additional benefits.
Provider network and premium vary across carriers.	Provider network and premiums vary across carriers. Some carriers offer a different provider network than in their standard plan.

Standard Plans always have the same cost-sharing within a tier

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (4-15-2015)

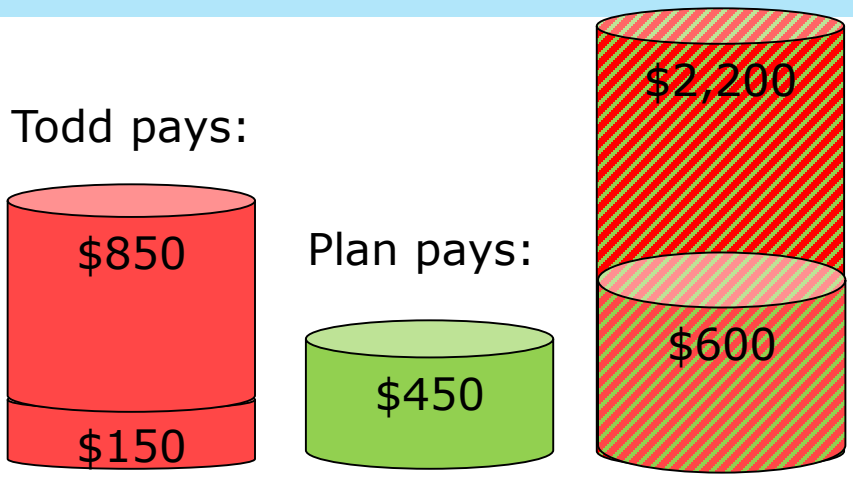
NOTE: The standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2016) and NYS Laws/Regulations. The Catastrophic plan design was revised to reflect the official OOP maximum of $6,850 (single) for calendar year 2016.

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver CSR 200 - 250 % FPL (AV = 0.72 to 0.74)
DEDUCTIBLE (single)	$0	$600	$2,000	$1,500
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,000	$5,500	$5,450
COST SHARING - MEDICAL SERVICES				
Inpatient Facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission
Outpatient Facility-Surgery, including freestanding surgicenters	$100	$100	$100	$100
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$100
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".			

Deductibles

Deductible is what you pay first

Todd's plan has a $1,000 deductible:



Visit Doc for Flu:
$150
Todd pays: $150

Colonoscopy
$450
Todd pays: $0 (an exception to the deductible)

Broken arm (waterskiing)
$3,850
Todd pays: $850 (deductible) then coinsurance.
(If coinsurance is 20%, Todd would pay $600 and his plan would pay $2,200.)

Jan Mar Jul Dec

Exceptions to Deductible

- Free Preventive Health Services
  - Includes some vaccinations, mammograms and other cancer screenings, contraception, including birth control pills, and periodic physicals. But prevention services do not include treatment for an illness, such as the flu.
  - See: https://www.healthcare.gov/what-are-my-preventive-care-benefits/
- For all Standard Platinum, Gold and Silver plans, prescription drugs are not subject to the deductible
- Some nonstandard plans offer 1-3 primary care visits before the deductible – you have to look.

If the price for a doctor visit is followed by the phrase "after the deductible is met" the consumer must pay the full deductible before getting doctor visits for indicated copayment or coinsurance amount.

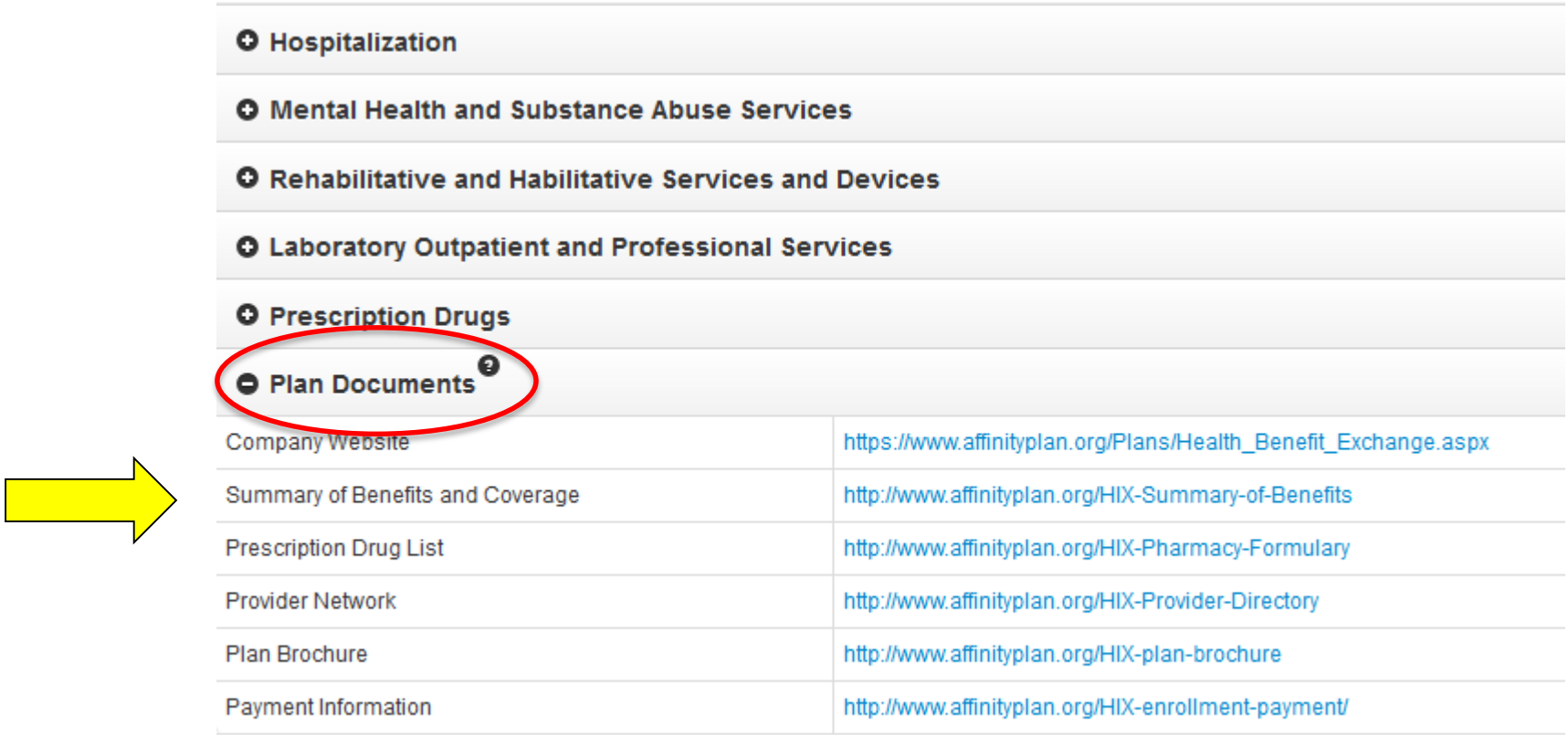
Types of Deductible

- Individual vs. Family
- Separate Medical and Prescription Drug vs. Combined

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

Where can I find deductible information?

https://nystateofhealth.ny.gov/



- Hospitalization
- Mental Health and Substance Abuse Services
- Rehabilitative and Habilitative Services and Devices
- Laboratory Outpatient and Professional Services
- Prescription Drugs
- Plan Documents

Company Website	https://www.affinityplan.org/Plans/Health_Benefit_Exchange.aspx
Summary of Benefits and Coverage	http://www.affinityplan.org/HIX-Summary-of-Benefits
Prescription Drug List	http://www.affinityplan.org/HIX-Pharmacy-Formulary
Provider Network	http://www.affinityplan.org/HIX-Provider-Directory
Plan Brochure	http://www.affinityplan.org/HIX-plan-brochure
Payment Information	http://www.affinityplan.org/HIX-enrollment-payment/

Summary of Benefits and Coverage

Insurance Company 1: Plan Option 1

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2014 – 12/31/2014

Coverage for: Individual + Spouse | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Doesn't apply to preventive care	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$300** for prescription drug coverage. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$2,500** person / **$5,000** family For non-participating providers **$4,000** person / **$8,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.[insert].com** or call **1-800-[insert]** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-[insert] or visit us at www.[insert].
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

Where can I find deductible information?

Fidelis Care Silver

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015-12/31/2015
Coverage for: Individual/Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.fideliscare.org or by calling 1-888-FIDELIS.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers $2,000 individual / $4,000 family. Doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers
Is there an out–of–pocket limit on my expenses?	$5,500 individual / $11,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.fideliscare.org or call 1-888-FIDELIS	If you use an in-network doctor or other health care **provider**, this plan will pay come or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-FIDELIS or visit us at www.fideliscare.org.
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Released on April 23, 2013 (corrected)

1 of 8

Polling Question: How many of these deductible terms have you encountered when helping New York consumers?

1. Family Deductibles
2. Out-of-network deductibles
3. Exceptions to deductibles
4. Separate deductibles for Medical/Pharmacy
5. Some but not all of these
6. All of these

A Break for Questions

Copays and Coinsurance

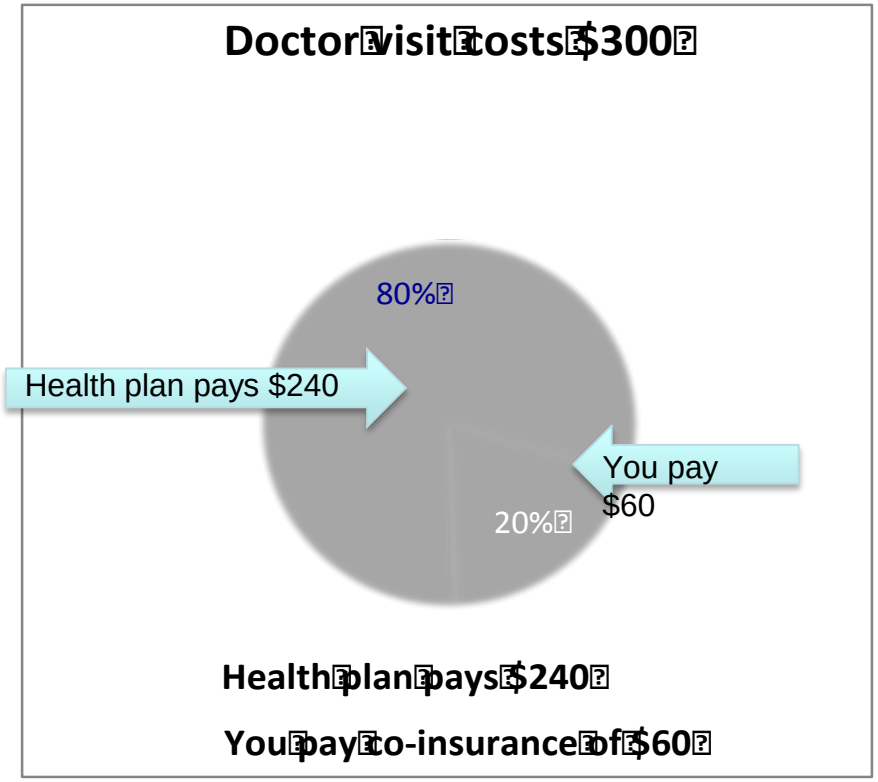
Copays vs Coinsurance

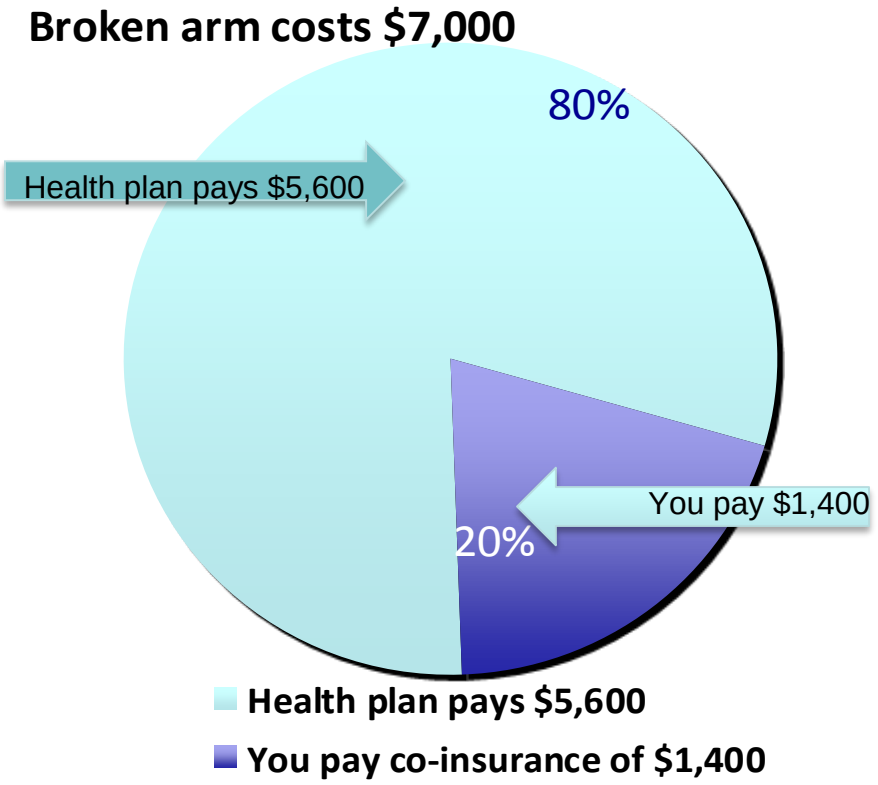
What the consumer pays once insurance starts paying part of the bill

	Co Pays	**Co Insurance**
Definition	Fixed cost for each service	A fixed percentage of the bill
Example	$25 for each PCP visit	50% of the bill for each PCP visit
Predictability	OOP is clear at the time of plan selection	Don’t know how much you have to pay until you get the bill

Co-insurance Example

Cost is shared between enrollee and plan





Co-insurance percentages apply to the “allowed amount”

Most times, you don’t learn what the allowed or contracted amount is until you get your bill.

Where can I find coinsurance information?

Table of "Common Medical Events" in the Summary of Benefits and Coverage

If you need help recovering or have other special health needs	Home health care	$30	Not covered	Coverage for up to 40 home health care visits per condition, per lifetime.
	Rehabilitation services	$30	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Habilitation services	$30	Not covered	Covered for up to 60 visits per condition, per lifetime.
	Skilled nursing care	$1,500	N…vered	Coverage for up to 200 days. Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility
	Durable medical equipment	30% coinsurance	Not covered	Repairs and replacements are covered when necessary due to normal wear and tear. Repairs and replacements that result from misuse or abuse are not covered.
	Hospice service	$30	Not covered	Precertification is required
If your child needs dental or eye care	Eye exam	$30	Not covered	
	Glasses	30% coinsurance	Not covered	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames; also applies to contact lenses
	Dental check-up	Not Cover…	Not covered	See stand-alone dental provider

Sorting out Out-of-pocket maximum and Benefits Limits

Out-of-Pocket Maximum

Protects Consumers

- This is the total you have to pay each year for most of your covered services.
- It does not include premiums or balance bill charges from Out-of-network providers.

Where can I find out-of-pocket Maximum information?

Fidelis Care Silver

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015-12/31/2015
Coverage for: Individual/Family | **Plan Type:** HMO

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers $2,000 individual / $4,000 family. Doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
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Is there an out–of–pocket limit on my expenses?	$5,500 individual / $11,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Released on April 23, 2013 (corrected)

1 of 8

Benefit Limits
(less coverage for consumers)

- Not allowed by law:
  - Dollar lifetime limits
  - Dollar annual limits
- Allowed under law:
  - Visit limits
  - Day limits
  - Script limits (i.e., number of days)

Once a limit is reached, patient pays all costs for services over the limit.

Where can I find Benefit Limit information?

You guessed it: table of "Common Medical Events" in the Summary of Benefits and Coverage

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30	Not covered	----------none----------
	Specialist visit	$50	Not covered	----------none----------
	Other practitioner office visit	$30	Not covered	----------none----------
	Preventive care/screening/immunization	$0	Not covered	For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise, PCP/Specialist copay per visit applies to all services in this benefit service category.
If you have a test	Diagnostic test (x-ray, blood work)	$50	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	$50	Not covered	----------none----------
If you need drugs to treat your illness or condition More information	Generic drugs	$10	Not covered	Rx through Caremark. For questions, please call: 1-888-FIDELIS Retail: 30-day supply Mail Order: 90-day supply
	Preferred brand drugs	$35	Not covered	
	Non-preferred brand drugs	$70	Not covered	

What Services Are Covered?

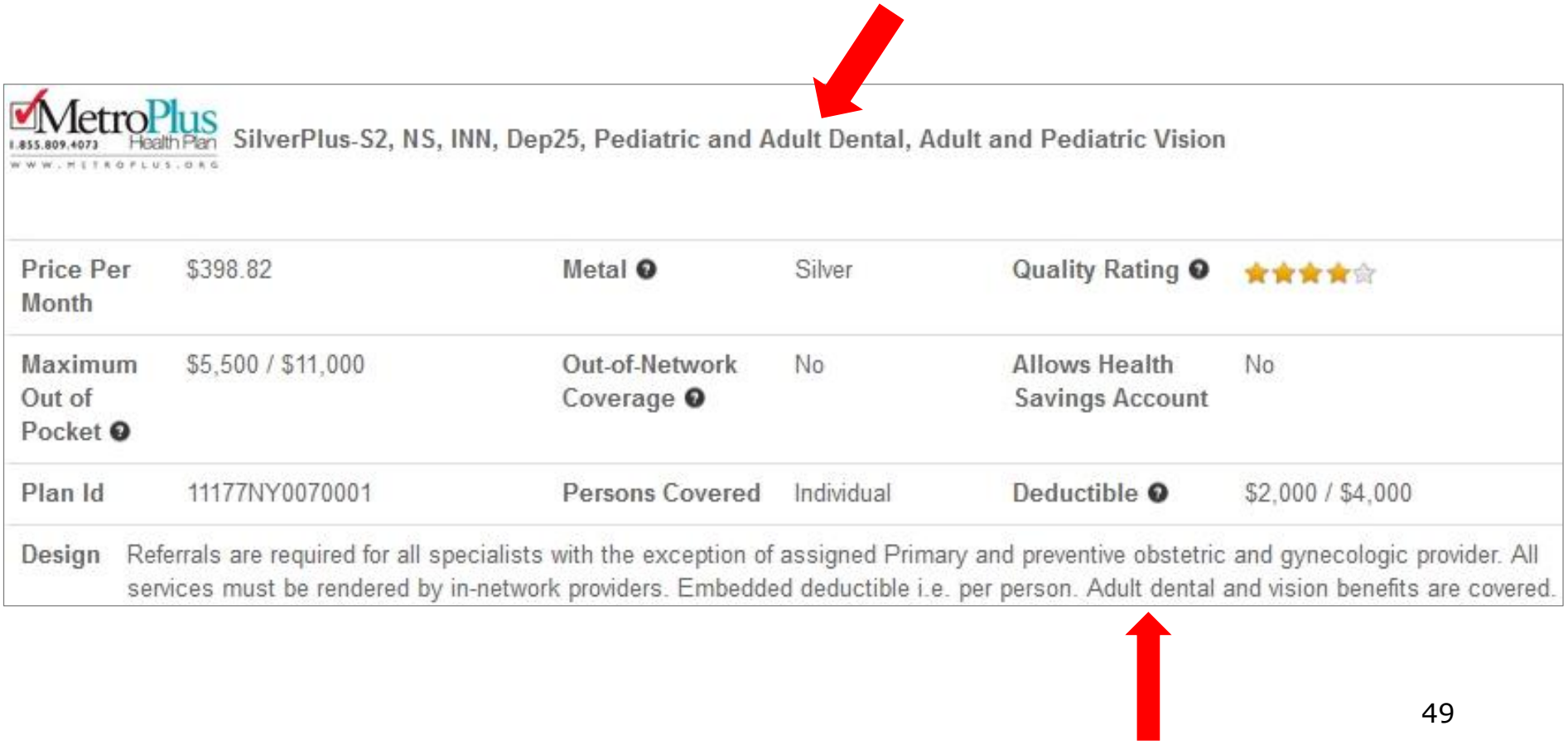
What's Covered?

- All market place plans cover a comprehensive, standard set of "essential" benefits:
  - Doctor, hospital, maternity, prescription drugs, mental health and more.
- Non-standard plans may include additional benefits – you have to check:
  - Adult vision
  - Adult dental
  - Acupuncture
  - Primary Care Physician visits before the deductible

The Summary of Benefits and Coverage lists non-essential benefits that are covered or not covered

Plan Name may provide information

Naming rules mean that plan name signals what additional benefits are offered



MetroPlus Health Plan
1.855.809.4073
WWW.METROPLUS.ORG

SilverPlus-S2, NS, INN, Dep25, Pediatric and Adult Dental, Adult and Pediatric Vision

Price Per Month	$398.82	**Metal**	Silver	**Quality Rating**	★★★★☆
Maximum Out of Pocket	$5,500 / $11,000	**Out-of-Network Coverage**	No	**Allows Health Savings Account**	No
Plan Id	11177NY0070001	**Persons Covered**	Individual	**Deductible**	$2,000 / $4,000
Design	Referrals are required for all specialists with the exception of assigned Primary and preventive obstetric and gynecologic provider. All services must be rendered by in-network providers. Embedded deductible i.e. per person. Adult dental and vision benefits are covered.				

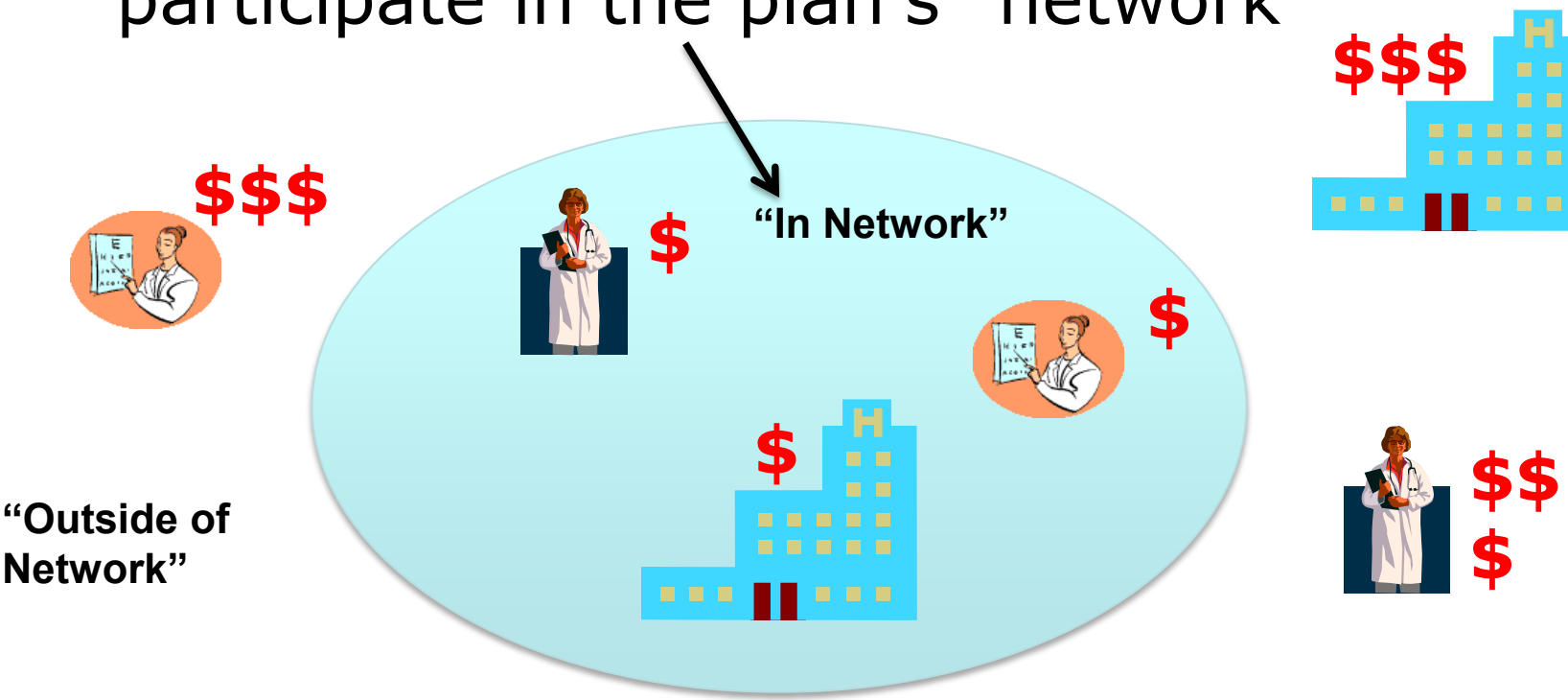
Break for Questions

Comparing QHPs

- Cost
- Benefits
- Provider Networks
- Formularies
- Quality Ratings

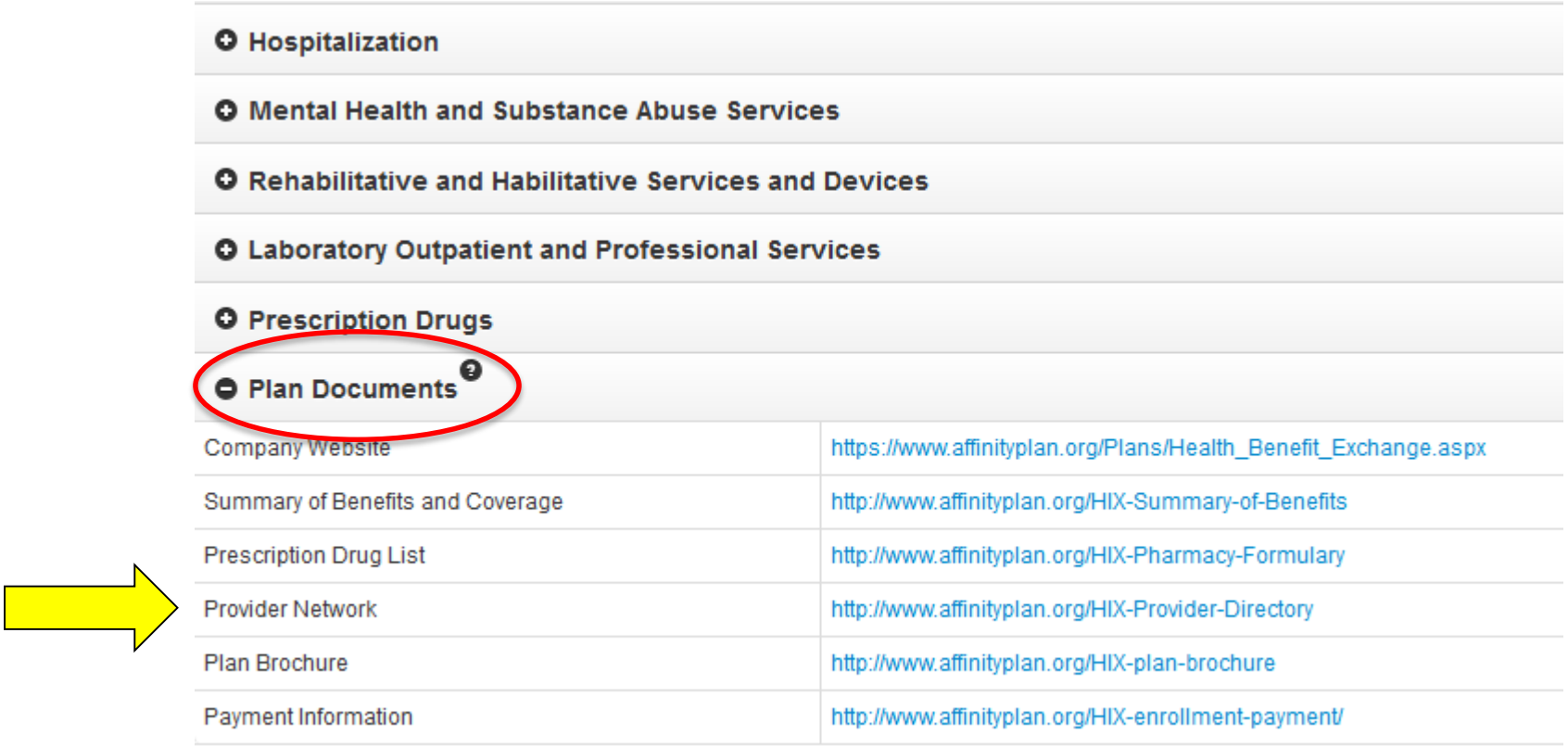
Provider Networks

- To minimize costs, patients must use doctors and hospitals that participate in the plan's "network"



Where can I find Provider Network information?

https://nystateofhealth.ny.gov/



- Hospitalization
- Mental Health and Substance Abuse Services
- Rehabilitative and Habilitative Services and Devices
- Laboratory Outpatient and Professional Services
- Prescription Drugs
- Plan Documents

Company Website	https://www.affinityplan.org/Plans/Health_Benefit_Exchange.aspx
Summary of Benefits and Coverage	http://www.affinityplan.org/HIX-Summary-of-Benefits
Prescription Drug List	http://www.affinityplan.org/HIX-Pharmacy-Formulary
Provider Network	http://www.affinityplan.org/HIX-Provider-Directory
Plan Brochure	http://www.affinityplan.org/HIX-plan-brochure
Payment Information	http://www.affinityplan.org/HIX-enrollment-payment/

What about the SBC?

Fidelis Care Silver

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015-12/31/

Coverage for: Individual/Family | **Plan Type:** H

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or pla document at www.fideliscare.org or by calling 1-888-FIDELIS.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers $2,000 individual / $4,000 family. Doesn't apply to in-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay covered services you use. Check your policy or plan document to see when the **deduct** starts over (usually, but not always, January 1st). See the chart starting on page 2 for hov much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on 2 for other costs for services this plan covers
Is there an out–of–pocket limit on my expenses?	$5,500 individual / $11,000 family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually o year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limi**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.fideliscare.org or call 1-888-FIDELIS	If you use an in-network doctor or other health care **provider**, this plan will pay come all of the costs of covered services. Be aware, your in-network doctor or hospital may u an out-of-network **provider** for some services. Plans use the term in-network, preferre participating for **providers** in their **network**. See the chart starting on page 2 for how t plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this		Some of the services this plan doesn't cover are listed on page 5. See your policy or pla

Confirm Provider Participation

Enrollee should call health plan and doctor to confirm in network

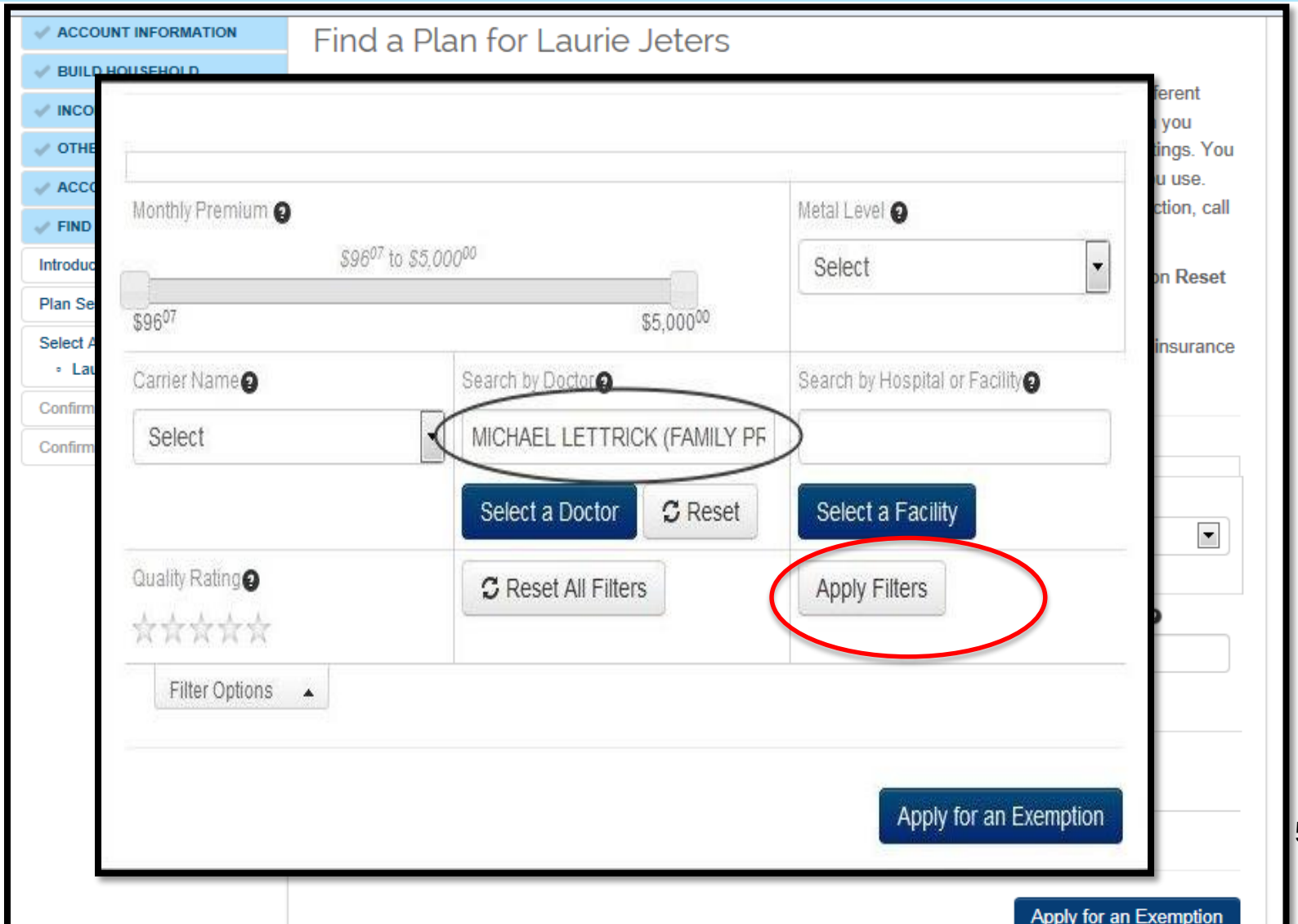
Balance Billing

Charges from Out-of-Network Providers

- In-network providers are capped on what they can bill you:
  - They can only bill patients the amount of their copayment or cost sharing under their insurance policy
- These billing limits do not apply to out-of-network doctors
- Bill might look like this:

	Provider Charge	Plan Allowed Amount	Balance
Total	$500	$300	$200
Plan Pays		$150 (50%)	$0
Patient Pays		$150	$200

Bottom line: use provider directories to ensure YOUR doctors and hospitals are in-network



Comparing QHPs

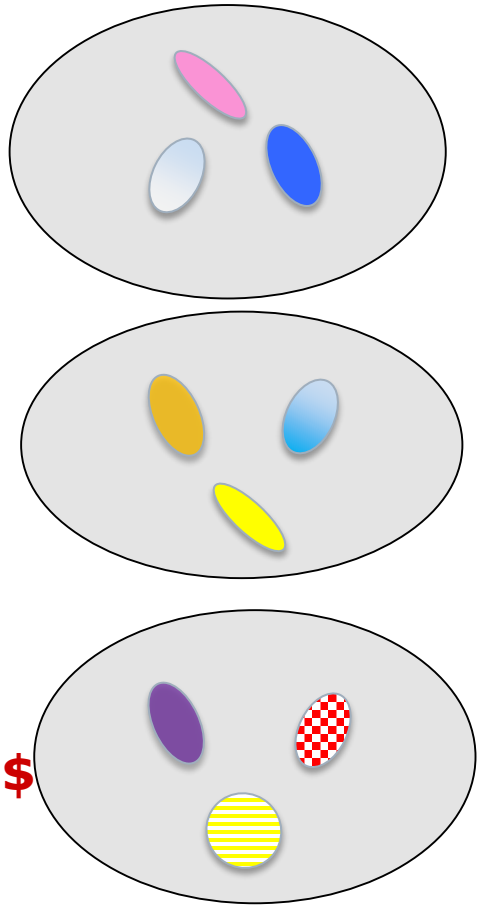
- Cost
- Benefits
- Provider Networks
- Formularies
- Quality Ratings

Check the Drug Formulary for drugs you take

Tier 1: Generic **$**

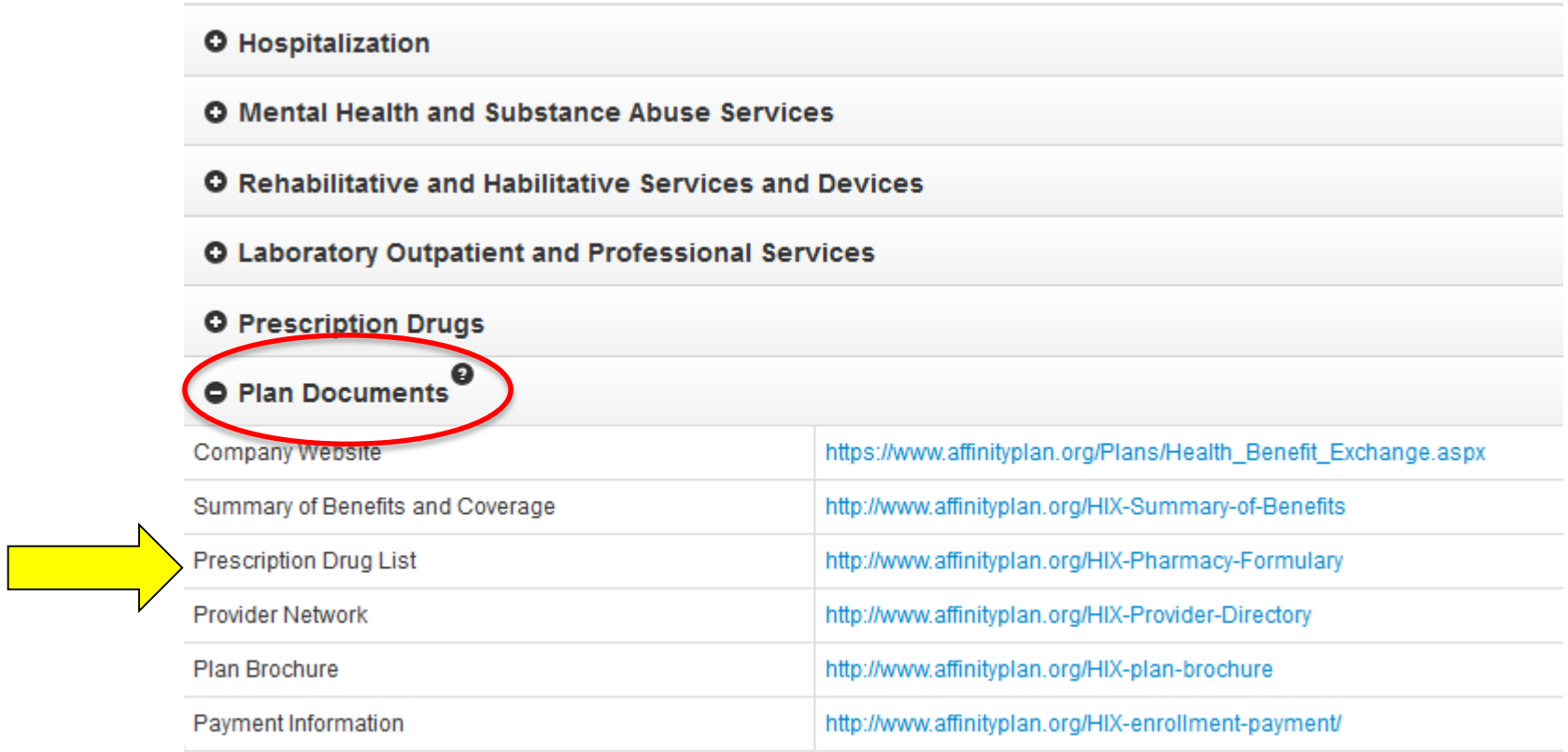
Tier 2: Formulary Brand **$$**

Tier 3: Non-Formulary Brand **$$$$**



Where can I find Drug Forumulary information?

https://nystateofhealth.ny.gov/



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Comparing QHPs

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Quality Rating

- QHPs have a quality rating
  - Some plans are too new to have a quality rating, but they will have one in the future
- 5 star rating system combines quality measures and consumer satisfaction

Quality Rating

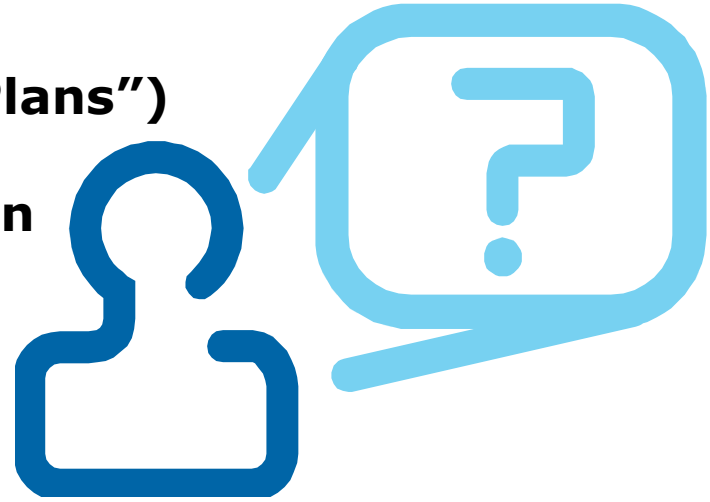
Polling Question: Which Aspects of Plan Selection are Hardest for Your Clients?

1. **Premiums**
2. **Which services are covered?**
3. **Cost-sharing (deductibles, coinsurance, etc)**
4. **Provider networks**
5. **I'm not sure**

Break for Questions

Polling: Which NY State of Health Plan Selection Tools Do You Find Most Helpful When Assisting Consumers?

1. Anonymous Shopping ("Search for Plans")
2. "Compare Plans" (feature within Plan Selection)
3. Plan Details
4. Summary of Benefits and Coverage
5. Something else



Any Final Questions?

Thank you!

Please email
with questions:

lquincy “at” consumer.org
www.consumersunion.org

We're here to help!

CACMail@health.ny.gov

- Eligibility Assistance
- Application Errors
- Technical/System Issues with an Application
- Document Review Assistance

Assistor.Admin@health.ny.gov

- Staff Changes
- Assistor Account Issues
- Training/Recertification

Reminder: Recertification Process

- Assistors must attend or view each NY State of Health Recertification Webinar in order to be recertified on NY State of Health.
- Please use the following link to report that you have viewed this webinar:
  https://www.surveymonkey.com/r/Assistor_Reporting_How_to_Select_a_Health_Plan
- If you are unable to access Survey Monkey, please have your supervisor contact Assistor.Admin@health.ny.gov and NYSDOH will send your supervisor the manual process for recertification reporting.

Previous NY State of Health Assistor Recertification Reporting Surveys

https://www.surveymonkey.com/r/Assistor_Reporting_Special_Populations_1

https://www.surveymonkey.com/r/Assistor_Reporting_Special_Populations_2

https://www.surveymonkey.com/r/Assistor_Reporting_Household_Composition

https://www.surveymonkey.com/r/Assistor_Reporting_Immigration

https://www.surveymonkey.com/r/Assistor_Reporting_Understanding_the_Uninsured

https://www.surveymonkey.com/r/Assistor_Reporting_How_to_Select_a_Health_Plan

nystateofhealth
The Official Health Plan Marketplace

Thank you for joining us!

- Watch for surveys
  - Recertification Evaluation of Webinar: How to Select a Health Plan
  - NY State of Health Assistor Recertification Reporting – How to Select a Health Plan
- Watch for the video to be posted to http://info.nystateofhealth.ny.gov/SpringTraining

Next Recertification Training:

Title: Self-Employment

Date: September 30, 2015