FLORIDA 2010

Got Insurance?

How to Get It,
Keep It and Use It!

Just the Facts: The 411 on Health Insurance for

Young Adults Ages 18-30 in Florida

Including Those with Chronic Health Conditions or Disabilities

Just the Facts:
The 411 on Health Insurance
for Young Adults
Ages 18-30 in Florida

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Florida Developmental Disabilities Council, Inc.

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FACTOID #1: Nearly half (45%) or approximately 20 million young adults between the ages of 19 and 29 were uninsured at some time during the past year. Young adults have the highest uninsurance rate of any age group! [1]

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About……

Just the Facts: The 411 on Health Insurance for Young Adults Ages 18-30 in Florida

Health insurance is a complicated subject. Many people - especially young adults just starting out - have difficulty getting, keeping and using their health insurance. We've written this publication to help you figure out what's available to help you pay for health care services, and what might be the best choice for your particular needs.

Let's be honest. When was the last time you read a health insurance guide, or saw your parents or other adults reading one? We've learned that people who are looking for information about health insurance want answers that are to-the-point and easy to understand.

So here's the scoop: This guide is designed to give you basic information, action steps and deadlines to help you stay focused and on track. Links to Web-based resources are included if you want to find out more about specific items. If you don't know what some terms mean, there's a glossary in the last section. And as more information becomes available about the new federal health care legislation – the Patient Protection and Affordable Care Act - we'll keep you updated on our Web site at www.FloridaHATS.org.

It's always a good idea to ask for help from a trusted adult, so share this guide with your family, providers, and friends. What's our goal? To make sure ***you*** and ***all young adults in Florida*** have the health insurance you need to be healthy, happy and productive!

Who should use the guide?

- Young adults between the ages of 18 and 30 living in Florida, including those with chronic health conditions or disabilities
- Parents, families, guardians, caregivers or other trusted adults who help them

Who else can use this information?

- Health Care Transition Coordinators
- Care Coordinators
- Benefit Navigators
- Community Providers
- Interfaith Community Leaders
- Post-Secondary High School Teachers
- Vocational Rehabilitation Counselors
- Transition Planners
- Cultural Brokers
- Medical Providers (Physicians, Nurses, Specialists and Therapists)

FACTOID #2: Young adults are at risk of losing health insurance coverage at major transitions in life: when they turn 19, when they graduate from high school or college or change jobs.[1]

Health Insurance: Why Do I Need It?

As a young adult who is making many important choices about your life, choosing a health care plan is probably not on the top of your "to do" list. Health insurance is a lot like car insurance: you don't appreciate it until you need it. Then you really want to have it!

I didn't know health insurance rules change at age 19.

I get confused about which services are paid for and which aren't.

Getting and *keeping* health insurance is important for all of us no matter how old or young we are. Everyone, regardless of their age, needs to be able to go to the doctor or hospital if they get sick or hurt, as well as for annual check-ups. And that costs money. If you don't have health care insurance, it can cost a LOT of money.

It might be tempting to think, "I'll figure this out tomorrow." Even though there is a lot of discussion about changes with national health care reform, it is important for you to have the most up-to-date information *now* so you can make informed decisions – decisions that can help you get or stay healthy, *and* save you money.

So, how do you get started? The following sections are designed to give you the information you need to make the best decision for ***you.***

I'm afraid about making a bad decision or picking the "wrong" plan that will cost more.

FACTOID #3: The average cost of an emergency room (ER) visit in Florida exceeded $2500 in 2009. One South Miami hospital reported $7056 per ER visit! [2]

Start Early!
Skills to Prepare for Adult Life

Skills, Questions to Ask, Information to Learn in High School and After

Health insurance is a lot like car insurance: you don't appreciate it until you need it. Plan ahead while you are still in high school to make sure you have a plan for health care coverage when you graduate.

Take it step-by-step!	Yes	No	Need Info
Grade 10 (ages 15-16) → Start asking questions about health care coverage after age 18.			
Student • Yes, you have health insurance now and carry your insurance card daily. ***Tip:*** Make a copy and keep it in your wallet. It's a form of identification and proves a payment source for medical services and medications, especially in an emergency.			
Family • Yes, you have insurance: Find out when your son/daughter will no longer be covered on your family plan – age 18, age 21, no longer a full-time student? Are there forms you need to submit to keep them on your coverage past this time? • No, you don't have insurance: Ask about options for getting coverage for your son/daughter after graduation.			
Grade 11 (ages 16-17) → Continue asking questions and learning about your options.			
Student: You still carry your health insurance card in your wallet.			
Family: You have a plan for how your child will have health insurance after they graduate or turn age of majority (18).			
Grade 12 (ages 17-18) → Notify insurance company that your minor child is turning 18.			
Student • Planning to attend college out-of-state? Ask if your current health insurance will pay for your medical visits (routine, specialists or emergency) near your new school. • Does your college require that you have health insurance? Check out free/low cost care through the College Student Health Services.			
Family • Fill out any necessary forms for adult dependent child over age 18 if your son/daughter is staying on your health care insurance. Teach them to review the EOB (Explanation of Benefits) that are sent after the plan pays for health services.			
College/Employment/ Community (18 and older) → Annually fill out forms to keep insurance.			
Student • You know how much your deductible and co-pays are before going to the doctor. • You pay at the time of service and KEEP RECIEPTS (bill paid by cash or charge). • If needed, you get referrals ahead of time to see a specialist or for medical tests.			
Family • You - with your son/daughter - annually provide the insurance company with evidence of college attendance or dependency. Acceptable proof may include college transcript, report cards, SSI benefit, etc.			

5 Tips to Become Insurance Smart!

1 Ask Others

Talk to friends, family members and other adults who have health issues similar to yours. Ask them what they like about their health insurance.

Qs> Does the plan pay for the services they use?
Are their out-of-pocket expenses or co-pays affordable?

You can also ask for help from doctors' office managers or billing clerks. They deal with different health plans every day and know which plans pay for certain health services and which plans do not.

Remember, there is no perfect plan that pays for everything, but there are plans that may be better for you and your health care needs.

2 List Your Health *Needs* versus *Wants*

- Which health issues and services do you need?
- Do you want to stay with your current doctors?
- Do you want to save on out-of-pocket costs? This may require higher premiums.
- Do you want a particular medical treatment to be covered?

3 Do You Qualify? Know Your Eligibilty

- All health insurance plans have their own rules about who is eligible.
- Some plans will ask about health issues, whether you are married or have children, etc.
- Is there a waiting period before your benefits will pay for your medical expenses?

4 What Services are Paid for and Which Ones are Not?

- Read your policy to understand the benefit packages that are available to you.
- Many employers and health insurance companies now have information on their Web sites about their health plans, including answers to frequently asked questions and phone numbers to call.

5 Be Willing to Compromise

- No health insurance plan is perfect, and no plan covers everything.
- Learn what you can from bills that are paid - and ones that aren't!
- Know your plan's renewal schedule. If your plan isn't paying for what you need, consider changing plans during the next open enrollment.

Words To Know

In-Network Providers:
Doctors who have a contract with the health plan, so you pay less out-of-pocket to see them.

Out-of-Network Providers:
Doctors who do not have a contract with the health plan, so you pay more out-of-pocket to see them.

Open Enrollment:
Time period when members of group health insurance plans can enroll or change their benefits program; generally held once a year.

The more you know and can learn, the better choices you can make to stay healthy!

Health Insurance Options at a Glance

Before we give you "Just the Facts" about each option, look over the choices. There are more than most people realize. In the next sections, we'll talk about how to qualify, out-of-pocket costs, monthly premiums, good points, potential downside to particular plans and resources to learn more. Remember, this guide offers just a few facts to give you an overall view and get you started. As you'll see, there are a lot of issues to think about before choosing or changing a health insurance plan or benefit package.

What are the good points 

What may be the downside 

Health Insurance After Age 19

PRIVATE

Group Insurance

Benefits offered through employer
- Family plan
- Adult dependent
- Student
- COBRA

Individual Insurance

- Self-employed
- Unemployed

PUBLIC
(aka Government Plans)

State Public Insurance

- Low income, not disabled
- Low income, disabled
- Waivers for disabled

Federal Public Insurance

- Low income, disabled

Local Safety Net Plans

NO INSURANCE

You Pay All the Bills

You pay full price
- Every medical visit
- All prescriptions
- Any hospitalizations

FACTOID #4: 67% of young adults have not made any plans for health insurance coverage after they leave school, even though the overwhelming majority acknowledge its importance. [3]

Private

Group plans are provided through work. Employers offer group plans to their employees. Employees generally work at least 32-40 hours per week to qualify for group coverage. An employee can buy coverage for just him/herself or buy a 'family' plan. Family members covered through a family plan are called **dependents,** no matter how old the person is.

Individual plans are purchased by individuals directly from an insurance company.

The organization or individual who is issued the coverage is called the **subscriber or policyholder.**

- Young adults with or without disabilities (not married and have no children) can stay on their family's health care plan until age 25 and sometimes up to age 30
- Young adults who are disabled, don't work and are supported by their parent(s) can stay on their family plan indefinitely with annual review.
- Don't like your Group Plan? You can change plans during open enrollment. Contact your employer's Human Resources Department to find out when the next open enrollment occurs.

Group Plans

- Young adults who are single and have children can't remain on their parent's plan.
- HMO plans require a referal or authorization prior to routine doctor visits out-of-state.

Individual Plans

- Some plans won't accept "pre-existing conditions."
- This kind of coverage is generally very expensive to buy.

- Monthly premiums plus co-pays.
- By using in-network providers and services, the co-pays are cheaper than out-of-network providers.

How to Apply

- Employer: Check with Human Resources (HR) Department
- Dependent - Family Plan: Yearly Review
- Individual: Check with private insurance brokers and online websites.

Public

Medicaid is the state and federal partnership for people with low incomes, with or without a disability.

Medicaid Waivers cover children, youth and adults who have special needs and meet certain rules.

Medicare is a federal health insurance program for persons with disabilities [over 19], people who are age 65 or older, or those with end-stage kidney disease at any age.

- Florida Medicaid
  - is a managed health care plan
  - has several waiver plans
- Who qualifies? People who have low income, including
  - Young adults
  - Women who have children
  - Pregnant Women
  - Persons with disabilities
  - Those with high medical bills

- Trouble finding doctors and dentists, as some do not accept Medicaid.
- Co-pays can add up if you have a lot of medical visits.
- Some Florida Medicaid Waiver plans have long waiting lists.
- Florida does not have Medicaid Buy-in through Ticket to Work (yet).

- Monthly premiums plus co-pays.
- Sliding scale fee for co-pays.

How to Apply

- For Medicaid, visit www.myflorida.com/accessflorida.
  See Part 3 “Public Health Insurance” for more information.

Private

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Group Insurance							
N	19-up	Y	N	Y	Y	N	N
Student Status (Group Family Plan)							
N	19-25	N	N	N	Y	Y FS 627.6562	Y
Student Status (Post Secondary School)							
Y	Varies	N	N	Y	Y	Y FS 627.6562	N
Adult Disabled Dependent (Group Family Plan)							
N-Family Y-Child	19-up	N	Y	N	Y	Y FS 627.6041 FS 627.6615 FS 641.31(29)	Y
Individual Insurance							
N	19-up	N	N	Y	Y	N	N
Cover Florida							
N	19-up	N	N	Y	Y	Y FS 408.9091	Y

Public

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Medicaid (Child EPSDT)							
Y	up to 21	N	N Y-CMSN	N	N	Y - Title XIX	Y
KidCare (Title XXI)							
Y	up to 19	N	N Y-CMSN	N	Y	Y - Title XXI	Y
Full Pay Healthy Kids and MediKids							
Y	up to 19	N	N	N	Y	Y	Y
Medicaid (Adult)							
Y	18-up	N	N	N	N	Y	Y
Medicare							
Y	16-up	N	N	N	Y	Y	N
Medicaid & Medicare Dual Eligibility **Qualified Medicare Beneficiaries**							
Y < 100 FPL	18-65	N	Y	N	N	Y	Y
Specified Low-Income Medicare Beneficiaries							
Y 100% - 120% FPL	18-65	N	Y	N	N	Y	Y
Qualified Disabled Working Individuals							
Y < 200% - FPL	18-65	N	Y	N	N	Y	Y
Medicaid Home & Community-Based Service Waivers **Developmental Disabilities**							
Y	3-up	N	Y	N	N	Y	Y
Adults w/ Cystic Fibrosis							
Y	18-59	N	Y	N	N	Y	Y
Aged/Disabled Adult							
Y	18-up	N	Y	N	N	Y	Y
Familial Dysautonomia							
Y	3-up	N	Y	N	N	Y	Y
Model Waiver							
Y	0-20	N	Y	N	N	Y	Y
TBI/Spinal Cord Injury							
Y	18-64	N	Y	N	N	Y	Y
Indian Health Service							
N	0-death	N	N	N	N	Y	For each service unit
TriCare/ ECHO							
Y	17-up	Y	N	N	Y	Y	N
Local Safety Net Plans							
Y	19-up	varies	N	varies	varies	N	Y

Faces and Places of Young Adults in Florida

Here are some young adults who are in different situations. Are any of their situations similar to yours?

Heather, age 21, lives in Ocala

She lives with her divorced mom. She graduates from high school in June, and turns 22 in August. She's been on KidCare for years.

Does Heather have any health issues that need extra support and services?

Max, age 18, lives in Gainesville

He lives in Gainesville and goes to college. His parents are divorced. He has complex medical needs that require a lot of appointments and medical equipment. His father is retired.

What state insurance statute or law would protect his health insurance benefits?

Zach, age 25, lives in Cedar Key

He was recently laid off from his job and is looking for another one. His wife is 23 and pregnant, and they have a daughter who is 2 years old.

What options does he have for himself, his wife, and his child?

Juanita, age 19, lives in Gotha

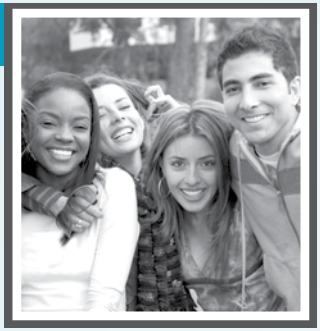
She plans on going to the local community college. She hasn't qualified for government benefits before because of her parents' income. Now, at age 19, she is considered "head of household" and her parent's income does not count against her when she applies for different government programs.

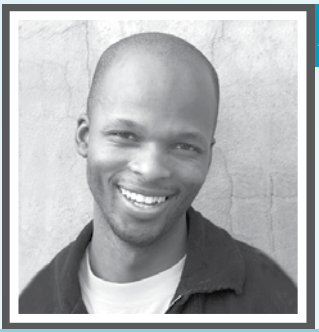
What plans might work for her?

Friends

These could be your high school buddies. Some are working, a few are going to college, some have insurance and some don't.

Who can they turn to for the information they need about insurance?





Agwe, age 27, lives in Jacksonville

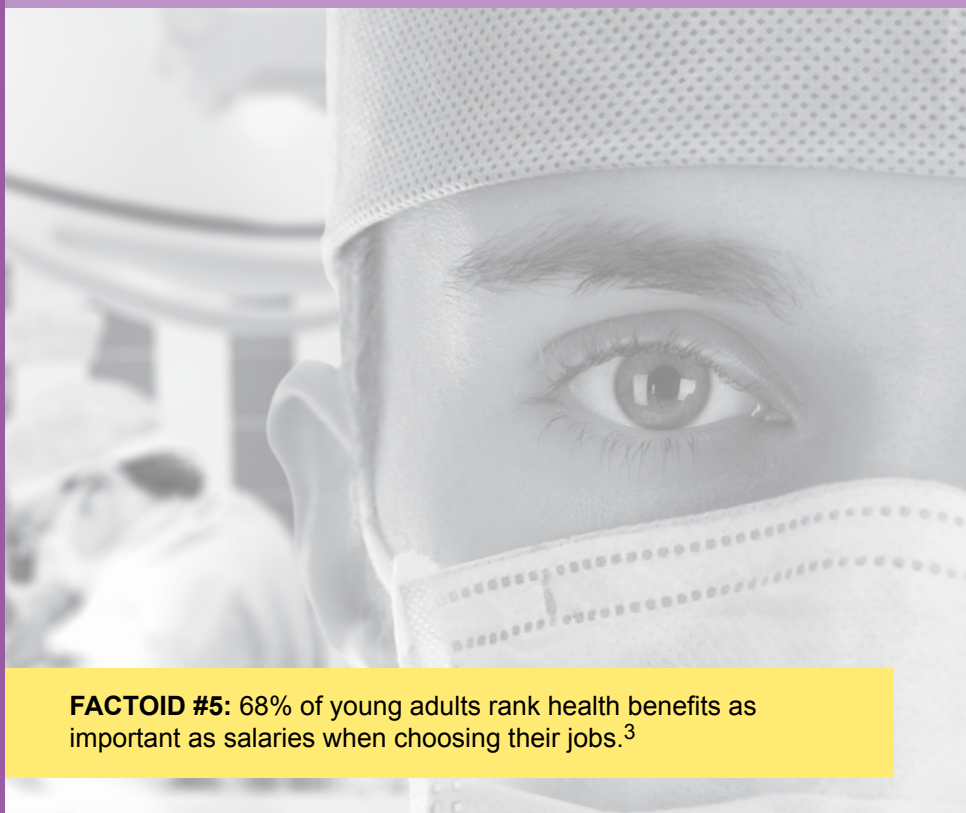
He's thinking about going to college but is working full-time right now. His health has been good all his life. However, his father has health problems that keep him from working. This may be a genetic issue for Agwe sometime in the future.

** Individual names and descriptions are not real, and are for illustration purposes only.*

Private Health Insurance

Health Insurance After Age 19

PRIVATE	PUBLIC (aka Government Plans)	NO INSURANCE
Group Insurance Benefits offered through employer • Family plan • Adult dependent • Student • COBRA **Individual Insurance** • Self-employed • Unemployed	**State Public Insurance** • Low income, not disabled • Low income, disabled • Waivers for disabled **Federal Public Insurance** • Low income, disabled **Local Safety Net Plans**	**You Pay All the Bills** You pay full price • Every medical visit • All prescriptions • Any hospitalizations



FACTOID #5: 68% of young adults rank health benefits as important as salaries when choosing their jobs.[3]

Here are the major **health insurance companies** that offer employer group plans and individual plans to Florida residents. Visit their Web sites to learn more about each one.

Aetna	www.aetna.com
Assurant	www.assuranthealth.com
AvMed	www.avmed.org
Blue Cross Blue Shield Florida	www3.bcbsfl.com/wps/portal/bcbsfl
Cigna	www.cigna.com
Humana	www.humana-one.com/florida-health-insurance/plans-available.asp
UnitedHealthcare	www.uhc.com

Words To Know

Subscriber/Policyholder is the organization or individual who the health care coverage is issued to. In 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 group plan that covers just the person or includes dependent family members.
- Can also purchase a single or family plan directly from an insurance company.

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, an adult child who is not married and does not have children can remain on their parent's group plan up to age 25, and, for some plans, up to age 30.

What to Know Before Choosing a Plan

First, there are 4 types of private insurance plans to choose from:

Indemnity Insurance (also called Fee-For-Service)

- You can see any doctor or go to any hospital you choose.

- Pays a flat amount per day for health care services,which can range from $100 per day upward.
- Doesn't usually pay for preventive care like well visits and physical exams.
- Monthly premiums are usually higher than other types of plans

PPO: Preferred Provider Organization

- Covers many health care needs and your 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 allows you to use their doctors and get pre-authorization before receiving certain services. You have a lower co-payment when choosing in-network physicians and for obtaining authorizations for certain services and referrals to specialists from your primary care provider (PCP).

- A higher cost option allows your choice of doctors. You use your health plan just like an indemnity plan by choosing care from either a participating provider or a non-participating provider, without coordinating care through your primary care physician or health plan. 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 prescriptions 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!

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!

Group Insurance Through Employer

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.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Group Insurance							
N	19-up	Y	N	Y	Y	N	N

If possible, stay on your parent's group family plan! In Florida, private insurance plans must allow dependent children up to age 25 (sometimes up to age 30) to remain on their parents' insurance plan if the child lives with a parent, is a student, is unmarried and has no dependent children of his/her own. Beginning Fall 2010, new federal legislation will extend the age to 26 years.

Law: Florida Statute Chapter 627.6562 (see www.leg.state.fl.us)

- Young adults with or without disabilities (not married and have no children) can stay on their family's employer-provided group health care plan until age 25, and, in some cases, up to age 30.

- Young adults who are single and have children can't remain on their parent's plan
- 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.

Student Status

There are a couple of options for students in college or other types of post secondary schools.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Adult Dependent-Student Status through Group Family Plan							
N	19-25	N	N	N	Y	Y FS 627.6562	Y

In 2009, "Michelle's Law" was passed which allows students to reduce their class time or even take a medical leave from school without losing their health care coverage.

Tip: 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!

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Student Insurance through Post Secondary School							
N	varies	N	N	Y	Y	Y FS 627.6562 FS 627.659	N

- 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 can not stay on their family's employer- provided group plan (due to loss of job, etc.)

- Provides limited coverage; plan may not provide protections of Florida's health mandated benefits and services. Student who has a pre-existing condition may require a waiting period.

Adult Disabled Dependent

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
	Age						
Adult Disabled Dependent through Group Family Plan							
N-Family Y-Child	**19-up**	**N**	**Y**	**N**	**Y**	**N** **FS 627.6041 FS 627.6615 FS 641.31(29)**	**Y**

An Adult Disabled Dependent is:

- Incapable of self-sustaining employment by reason of mental retardation* or physical handicap;
- Chiefly dependent upon the policyholder or subscriber for financial support, care and maintenance.

Law: Florida Statute Chapter 627.6041 (see www.leg.state.fl.us)

- 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 without losing coverage for an adult child who is dependent and disabled.

* The term "mental retardation" appears in some legislation; however, "intellectual disability" is the term 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.

Law: Florida Statute Ann. § 743.07(2)
(see http://childsupportguidelines.com/articles/art200003.html)

Qualified Medical Child Support Order (QMCSO)

- QMSCO 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 QMSCO is no longer in effect.

Law: ERISA-covered health plan to provide health benefits coverage to children by issuing a medical child support order
(see www.dol.gov/ebsa/publications/qmcso.html)

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.

Loss of Group Insurance

What if you change jobs or your work situation? Don't be without health insurance coverage for more than 63 days or you lose some protections!

Q 1 > Did you have health care insurance coverage for at least 18 months before starting the new job?

Q 2 > Has there been less than 63 days between the time you were covered under the original job group health plan and to start of your next job's health insurance coverage?

If **NO** to both questions, the start date of your new insurance coverage may be delayed if you have a pre-existing health issue. Some waiting periods can be a year or more.

If **YES t**o both questions, as a new employee you are protected under a law called HIPAA (Health Insurance Portability and Accountability Act). Your health plan covers you without a waiting period whether you have or don't have a pre-existing condition. For more information on HIPAA, see www.hhs.gov/ocr/privacy.

Get your Certificate of Creditable Coverage or Certificate of Prior Coverage from your old plan.

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 used as a credit to reduce pre-existing condition limitations when you enroll in a new plan.

Remember, some plans have a waiting period for pre-existing conditions. However, there will not be a waiting period for that condition if you:

- Had at least 18 months of previous health care coverage from the last job,
- Have not been without insurance for more than 63 days, *and*
- Your medical condition was treated within 6-12 months prior to signing up for the new plan

What if you have been laid off or lost your job? COBRA may provide short-term coverage for you.

What is COBRA? Who is covered?

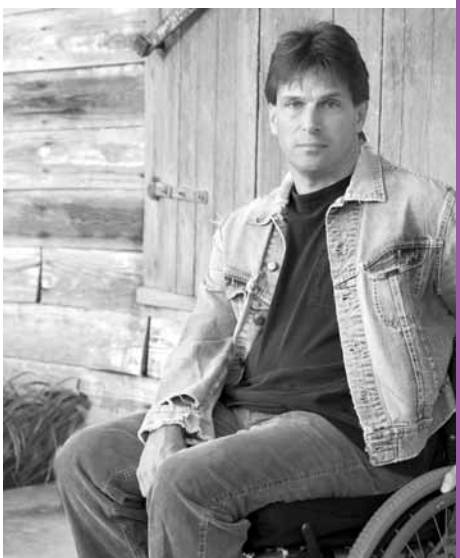
- The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to continue to offer their health insurance coverage to employees who have been laid off or terminated.
- COBRA is mandated for companies that employ 20 or more people, including part-timers.
- The employee pays for the entire 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.)

Who qualifies and for how long?

- **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, enrolls in Medicare, or your parents divorce or are legally separated.

What does it cost?

- More than what you paid as an employee, but it's better than not having insurance coverage and a pile of unpaid medical bills.
- COBRA participants must pay the full premiums out of their own pocket, plus up to a 2% administrative fee.



Individual Insurance

You can purchase a single policy for yourself through one of the health insurance companies listed at the beginning of this section. Or, if you meet certain criteria, you may qualify for a special lower cost program for Florida residents called Cover Florida.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Individual Plan (single policy purchase)							
N	19-up	N	N	Y	Y	N	N

- Insurers are required to offer a basic health plan and a high deductible plan.
- If you had prior coverage for a pre-existing condition and have less than 63 days break in coverage, you can get insurance.
- If you are self-employed and buy your own health insurance, you may be eligible to deduct 100 % of the cost of your premium from your federal income tax. Check with a tax attorney or tax service for details.

- If you had no prior coverage, the health plan can count as pre-existing any condition for which you received – or, in your insurer's judgment, for which you should have sought– diagnosis, treatment or medical advice during the 2 years prior to enrolling in the plan.

FACTOID #6: 87% of young adults polled in the summer of 2009 said that the nation's educators and educational institutions could do more to communicate the basics of health insurance to students to prepare them for graduation.[3]

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Cover Florida							
N	19-up	N	N	Y	Y	Y FS 408.9091	Y

Cover Florida is primarily for Floridians who have been without insurance for at least 6 months. Exceptions to avoid the 6 month wait include:

- Loss of a job that provided an employer-sponsored health benefit plan
- Death of or divorce from a spouse who provided an employer-sponsored health plan
- End of COBRA coverage

Visit www.coverfloridahealthcare.com for more information about this option.

- Young adults with pre-existing health conditions will not be denied enrollment.
- Plans are generally lower cost than other single policy options.

- The plan can exclude payment for treatment of a specific pre-existing condition for one year.

Coming Soon

One immediate result of the new Patient Protection and Affordable Care Act is the creation of state-run "High Risk Pools." This option is for individuals who have been unable to purchase insurance because of their health status. Starting this fall, you will be able to purchase insurance that will cap your personal out-of-pocket expenses for health care.

- Individuals will pay no more than $5,950 per year ($495.84 per month) for medical expenses.
- Families will pay no more than $11,900 per year ($991.67 per month).

Visit www.FloridaHATS.org to get the latest information.

Public Health Insurance

Health Insurance After Age 19

PRIVATE	PUBLIC (aka Government Plans)	NO INSURANCE
Group Insurance Benefits offered through employer • Family plan • Adult dependent • Student • COBRA **Individual Insurance** • Self-employed • Unemployed	**State Public Insurance** • Low income, not disabled • Low income, disabled • Waivers for disabled **Federal Public Insurance** • Low income, disabled **Local Safety Net Plans**	**You Pay All the Bills** You pay full price • Every medical visit • All prescriptions • Any hospitalizations

Medicaid and Medicare, the 2 major publicly-funded health insurance programs, can be confusing to many people. It takes patience to try to understand how these programs can be helpful to young adults. Let's discuss where these programs can potentially benefit young adults who are low income, may have a disability and/or high medical expenses.

What is Medicaid?

Medicaid provides coverage for health care and health-related services to low income children and adults, in addition to some people with disabilities. Medicaid is a federal-state partnership; it is overseen by the federal government but is administered by the individual states. That is why different states have different eligibility rules and offer different kinds of benefits. The federal and state governments share the cost of covering people through Medicaid.

To **qualify,** you must meet certain program criteria, including:

- Financially eligible (usually low income)
- "Categorically eligible," which includes:
  - Low-income children and sometimes their parents
  - Pregnant women
  - People with disabilities, or
  - The elderly (age 65 and older), or
- Enrolled in a Home and Community Based Services (HCBS) waiver program.

You can **apply** for Medicaid through the Florida Department of Children and Families (DCF). Call (866) 762-2237, visit www.myflorida.com/accessflorida and apply through ACCESS Florida (**A**utomated **C**ommunity **C**onnection to **E**conomic **S**elf-**S**ufficiency), or visit a Service Center near you. Once your application is approved, you can choose the type of plan you want by visiting http://mymedicaid-florida.com.

What is Medicare?

Medicare is a federal health insurance program for people who are age 65 or older, certain persons with disabilities, or those with end-stage kidney disease. Unlike Medicaid, Medicare is run by the federal government alone, so the eligibility rules and benefits are the same in every state.

Those who **qualify** include:

- Persons with disabilities who have received SSA disability benefits for a period of 2 years (SSA disability benefits, not SSI or early retirement)
- Persons who have end-stage renal disease, are receiving kidney dialysis or have had a kidney transplant
- Persons age 65 and over and a resident of the U.S. for 5 years
- Persons with Lou Gehrig's disease

For more information, visit www.medicare.gov

What Else Is Important To Know?

There are several different types of programs in Medicaid and Medicare, and the financial criteria to qualify for them vary. Most public benefit programs are needs-based; that is, you have to make less than a specific income to qualify. Generally speaking, public programs use a percentage of the Federal Poverty Guidelines to determine income eligibility. The Federal Poverty Level or "FPL" is based not only on income but family size – families with more people in them can make more money. See www.coalitionclinics.org/fpl.html

Tip: In deciding whether you qualify for a program, certain expenses may be subtracted from your total or 'gross' income, so don't just look at a chart and decide you shouldn't apply because you make a little too much – there is no cost in applying and you might actually qualify! You can use the online pre-screening tool through ACCESS Florida to see if you might qualify for a variety of programs, including Medicaid, cash assistance and help buying food (www.myflorida.com/accessflorida)

Medicaid and other Public Options Up to Age 21

Publicly-funded programs for young people up to age 21 include Medicaid, KidCare (Title XXI), MediKids and Full Pay Healthy Kids.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Medicaid (Child EPSDT)							
Y	**Up to 21**	**N**	**N Y-CMSN***	**N**	**N**	**Y Title XIX**	**Y**

* Children and youth with specific medical conditions or a disability may qualify for Children's Medical Services Network (CMSN), MEDS-AD (for Aged and Disabled) and/or one of several Home and Community Based Services (HCBS) waiver programs.

The **Child Health Check-Up,** or **Early Periodic Screening, Diagnosis, and Treatment (EPSDT),** is a service available to all Medicaid-eligible children up to age 21. Under Federal EPSDT rules, the Florida Child Health Check-Up program for young adults ages 18-21 consists of:

- Comprehensive health and developmental history
- Assessment of behavioral health status
- Thorough physical exam
- Vision, hearing and dental screenings
- Appropriate immunizations
- Laboratory tests
- Health education/anticipatory guidance
- Diagnosis and treatment; and referral and follow-up, as needed
- A referral to a dentist, examinations every 6 months, or more frequently as prescribed by a dentist or other authorized provider
- Health check-up once every year

List of Child Health Check-up Coordinators by region/city: www.fdhc.state.fl.us/medicaid/childhealthservices/chc-up/pdfs/chcup_area_map.pdf

Law: Title XIX (see www.ssa.gov/OP_Home/ssact/title19/1900.htm)

Do you meet Medicaid eligibility requirements for low-income families? Here are current guidelines for up to a family of 4.

Household Size	Income Limit Per Month
1	$180
2	$241
3	$303
4	$364

Remember, if you're not sure whether you qualify, it's always better to apply at www.myflorida.com/accessflorida

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
KidCare (Title XXI)							
Y	**Up to 19**	**N**	**N Y-CMSN***	**N**	**Y**	**Y Title XXI**	**Y**

* Children and youth with specific medical conditions may qualify for services up to age 21 through Children's Medical Services Network (CMSN).

Eligibility requirements for **KidCare (Title XXI),** Florida's Children's Health Insurance program, are:

- Be under age 19
- Be uninsured
- Meet income eligibility requirements
- Be a U.S. citizen or qualified non-citizen
- Not be eligible for Medicaid
- Not be the dependent of a state employee eligible for health insurance
- Not be in a public institution
- Monthly premiums depend on your household's size and income. Most families pay $15 or $20 per month.
- A child who is a member of a federally recognized American Indian or Alaskan Native tribe may qualify for no-cost KidCare coverage

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Full Pay Healthy Kids and MediKids							
Y	Up to 19	N	N	N	Y	Y	Y

For more information about KidCare and all publicly-funded children's health care plans, call (888) 540-5437 or visit www.doh.state.fl.us/AlternateSites/KidCare for online application.

- Mandated services include inpatient and outpatient hospital services; prenatal care; vaccines for children; physician services.
- KidCare and Full Pay Healthy Kids end at age 19 (MediKids ends at age 5)

- Not all providers accept Medicaid. Make sure your doctor or dentist accepts Medicaid or a payment plan is agreed upon before treatment begins.

- KidCare has comprehensive benefits; families pay monthly premium
- Full Pay Healthy Kids and MediKids has cost-share option; full cost of coverage
- Co-pays range from $1-$3 per provider per visit

How to Apply

- For family-related Medicaid, apply at www.myflorida.com/accessflorida
- If applying for children only, a single application will identify whether the child qualifies for any publicly funded program. Documentation required includes financial information and the child's social security number. Apply at www.doh.state.fl.us/AlternateSites/KidCare

Medicaid for Adults Ages 18 and Over

There are several ways to qualify for Medicaid adult benefits starting at age 18. Outlined below are 3 programs that provide access to Medicaid: SSI, SSI-Related Medicaid, and the Medically Needy Program.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Medicaid (Adult)							
Y	18-up	N	N/Y*	N	N	Y	Y

* Individuals under age 65 must be disabled to receive SSI or SSI Related Medicaid.

SSI Recipients

In Florida, **Supplemental Security Income (SSI)** recipients automatically qualify for Medicaid. Young adults who receive SSI benefits must be both significantly disabled and have low income and low assets. The SSI Program is administered by the Social Security Administration (SSA).

There are work incentives that allow SSI recipients to work, receive reduced SSI cash benefits and still maintain Medicaid. **The more you work, the lower your SSI cash benefits will be but you will still get Medicaid for your health care needs.** To view SSI's Substantial Gainful Activity (SGA) monthly gross amounts for 2010, see www.ssa.gov/OACT/COLA/sga.html.

For more information about Medicaid and all SSI-related programs, see www.dcf.state.fl.us/programs/access/docs/ssifactsheet.pdf and www.ssa.gov/ssi/text-resources-ussi.htm You may also visit www.socialsecurity.gov or call toll free (800) 772-1213

To **apply** for SSI, schedule an appointment at your local SSA office. Find an office near you by entering your zip code at this site, http://www.ssa.gov/atlanta/southeast/fl/florida.htm. In addition, Work Incentives Planning and Assistance (WIPA) projects work with SSA beneficiaries with disabilities on job placement, benefits planning, and career development. A description of this program and list of offices throughout Florida can be found at www.fmqai.com/library/attachment-library/WIPA1.pdf.

Law: Title XVI

Tip: SGA for the blind does not apply to SSI benefits, while SGA for the non-blind disabled applies to both Social Security and SSI benefits.

SSI-Related Medicaid

Medicaid for low income individuals who are either aged (65 or older) or disabled is called SSI-Related Medicaid. The MEDS for Aged and Disabled (MEDS-AD) Program provides Medicaid to individuals who are disabled or age 65 and older who meet technical requirements and have income and assets within program standards.

Law: Florida Statute Chapter 409.904 (see www.leg.state.fl.us)

Medically Needy Program

The Medically Needy program helps families, pregnant women, individuals with disabilities or individuals aged 65 and over who would qualify for Medicaid except for having income and/or assets that are too high.

- Individuals enrolled in the Medically Needy program have a "share of cost" (which is like an insurance deductible) and the amount varies depending on the family's size and income.
- There is no income limit to qualify for the Medically Needy program; however, gross income after medical expenses must be below Medicaid limits.
- There is an asset limit, which varies based upon the family's size.

For **more information** and to **apply** online, visit ACCESS Florida, www.myflorida.com/accessflorida

Law: Florida Statute 409.904 (see www.leg.state.fl.us)

Do you qualify for the Medically Needy Program?
Here are current guidelines for up to a household of 4.

Household Size	Asset Limit
1	$5,000
2	$6,000
3	$6,000
4	$6,500

Remember, if you're not sure, it's always better to apply! Apply online, visit a Service Center near you, or call DCF toll-free at (866) 762-2237 for more information.

- SSI, SSI-Related Medicaid, and the Medically Needy program all provide access to Medicaid health care coverage (vision, hearing, dental, mental health and family planning).

- Not all providers accept Medicaid. Make sure your doctor or dentist accepts Medicaid or a payment plan is agreed upon before treatment begins.
- Medicaid benefits for adults are more limited than they are for children.

Medicare

Medicare is the second major publicly funded health insurance program for adults.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Medicare							
Y	**16-up***	**N**	**N**	**N**	**Y**	**Y**	**N**

* No age limit if child has End Stage Renal Disease (ESRD)

Generally, Medicare has "richer" benefits than Medicaid; that is, more services are covered and more doctors serve Medicare patients. As with Medicaid, there are several ways to qualify for the program. One way is through the Social Security Disability Insurance (SSDI) Program. ***Eligibility criteria for SSDI can be complex, so read the information below carefully!***

SSI/SSDI Beneficiaries

Young adults who are SSI beneficiaries become SSDI beneficiaries when:

1. The young adult has worked enough "qualifying quarters." The amount of earnings required for a quarter of coverage in 2010 is $1,120.
   - If an individual became disabled before age 24, he/she needs 6 work credits within the past 3 years to be eligible for SSDI.
   - If an individual became disabled between the ages of 24 and 31, he/she needs 12 credits within the past 6 years to be eligible for SSDI.
2. The young adult is considered a Disabled Adult Child (DAC):
   - The young adult must
     - have become disabled before age 22 and the disability is continuing
     - be at least 19 years old
     - never have been married
   - There must be proof that the parent of the young adult on SSDI
     - worked enough quarters under the Social Security System AND
     - has retired OR has become disabled OR has died

For more information, see the following Web sources:

- www.ssda.us/index_files/types_of_benefits.htm
- www.disabled-world.com/disability/social-security/usa/ssi-ssdi.php
- www.medicare.gov

To **apply** for SSDI, apply on line at www.ssa.gov or schedule an appointment at your local SSA office. Find an office near you by entering your zip code at this site, http://www.ssa.gov/atlanta/southeast/fl/florida.htm.

In addition, Work Incentives Planning and Assistance (WIPA) projects work with SSA beneficiaries with disabilities on job placement, benefits planning, and career development. A description of this program and list of offices throughout Florida can be found at www.fmqai.com/library/attachment-library/WIPA1.pdf

- Young adults with a Medicare Card have access to more physicians and medical services.
- Since Medicare is a federal program, eligibility and coverage criteria is the same no matter where you live in the U.S.

Medicaid & Medicare Dual Eligibility

In some cases, individuals may qualify for both Medicaid and Medicare benefits, which is called **Dual Eligibility.** This can be particularly tricky for young adults who are working, are staying under SGA income limits ($1,000 for non-blind individuals or $1640 for blind individuals per month in 2010), or who are able to defer earned income through work incentive off-sets. It can be an advantage for someone whose health issues are progressive and whose work income is not stable. Having both benefits will reduce out-of-pocket expenses. Listed below are different levels of dual eligibility coverage.

Limits		Eligibility Based on Employment Status	Eligibility Based on Medicare Entitlement	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
				N	N	Y	Y
Qualified Medicare Beneficiaries (QMB)							
Y < 100 FPL	18-up	N	Y	QMB Only: Medicaid pays their Medicare Part A premiums, deductibles, and co-payments(except for Part D). Resources/ assets do not exceed $6,600 for individual or $9,510 for couple.			
Specified Low-Income Medicare Beneficiaries (SLMB)							
Y 100%-120% FPL	18-up	N	N	SLMB Only: Individual who is entitled to Medicare Part A. Medicaid pays the Medicare Part B premiums only. Resources/assets do not exceed $6,600 for individual or $9,510 for couple.			
Qualified Disabled Working Individuals (QDWI)							
Y <200% FPL	18-up	N	N	QDWI: Working people with disabilities who receive Medicare and whose incomes after disregards are less than 200% of FPL. Medicaid pays the Medicare Part A premiums only. Resources/assets do not exceed $ 5,000 for individual or $6,000 for couple.			

For more information on Medicaid & Medicare Dual Eligibility, visit:

- www.cms.hhs.gov/IntegratedCareInt/Downloads/Cost_Sharing Chart.pdf
- www.statehealthfacts.org/comparereport.jsp?rep=61&cat=6

Few out-of-pocket expenses for people who qualify for both Medicare and Medicaid.

Home and Community Based Waivers

Home and Community Based Services (HCBS) Waivers are Medicaid programs that provide services in the home for persons who would otherwise require institutional care in a hospital or nursing facility. Without waiver services being delivered in the community, some young adults might not be able to live at home or receive needed supports in the workplace. There are currently 15 HCBS waivers in Florida. A few of them are described below.

Waivers provide specific services over and above those in the general Medicaid adult benefits package and are targeted to persons who demonstrate the need for a high level of care. **Enrollment is typically capped; once enrollment reaches a specified number or dollar threshold, waiting lists are created.**

The waiting lists for Florida Medicaid Waivers can be quite long, sometimes years. But don't be discouraged from applying because of the waiting lists; remember, you can't get on the waiver if you don't apply! To apply for a waiver program, you must contact the operating agency. Each of those agencies is listed in the chart on the next page.

For full list of waiver programs and descriptions, see Florida Medicaid Summary of Services Fiscal 09/10 at http://ahca.myflorida.com/Medicaid/pdffiles/SS_10_100105_SOS.pdf

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
		N	Y	N	N	Y	Y

Developmental Disabilities

3-up Services for persons with mental retardation/developmental disabilities who meet level of care requirements to remain living at home and in the community. Services offered under this waiver include: support coordination, adult day training, consumable medical supplies, residential habilitation therapy, transportation, and personal care assistance. Apply online to the Agency for Persons with Disabilities (APD), http://apd.myflorida.com/customers/application.htm

Adults with Cystic Fibrosis

18-59 This program provides services for individuals who are diagnosed with Cystic Fibrosis (CF) and are at risk of hospitalization (as determined by the Department of Elder Affairs) but could remain at home if provided special services. The program may serve up to 150 adults with CF per year. Contact the Department of Health to apply, or visit www.dcf.state.fl.us/programs/access/

Aged/Disabled Adult

18-up Allows physically disabled persons ages 18 and over who meet nursing facility level of care to remain living at home and in the community. Services include adult day health care, attendant care, case management, homemaker, personal care services and home-delivered meals. Contact the Department of Elder Affairs to apply, or visit www.dcf.state.fl.us/programs/access/

Familial Dysautonomia

3-up Services for individuals who are diagnosed with familial and are at risk of hospitalization (as determined by the Department of Elder Affairs) but could remain at home if provided special services. All waiver services are limited to an annual total amount of $20,900; this amount is provided per family. For additional information, visit www.familialdysautonomia.org/Florida-Waiver.htm Contact the Agency of Healthcare Administration (AHCA) to apply, or visit www.dcf.state.fl.us/programs/access/

Model Waiver

0-20 Services for persons with degenerative spinocerebellar disease who otherwise, as determined by Children's Medical Services, require the level of care provided in an acute care hospital. Florida can only serve 5 children at any one time under this program. Contact AHCA to apply, or visit www.dcf.state.fl.us/programs/access/

TBI/Spinal Cord Injury

18-64 Services for individuals who have traumatic brain injury or spinal cord injury, meet nursing facility level of care (as determined by the Department of Elder Affairs) but could remain at home if provided special services. Services offered under this waiver include case management, specialized medical equipment and supplies and personal care. Contact the Department of Health to apply, or visit www.dcf.state.fl.us/programs/access/

Indian Health Service (IHS)

The Indian Health Service (HIS) is a federal agency within the Department of Health and Human Services.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Indian Health Service (IHS)							
N	**0-death**	**N**	**N**	**N**	**N**	**Y**	**For each service unit**

IHS provides clinical and public health services such as doctors visits, check-ups, screenings, diabetes prevention and treatment, mental health and substance abuse services, and many more services - and often in remote locations. The individual must provide proof of enrollment as a member of a federally recognized tribe. Some tribes provide supplemental private insurance.

There are two federally recognized Indian tribes in Florida today: the Miccosukee and Seminole Tribes. For more information about the Miccosukee Tribe, visit www.miccosukeetribe.com; for the Seminole Tribe, visit www.seminoletribe.com. Florida contacts are listed below:

- Miccosukee Reservation, (305) 223-8380

  Miccosukee Tribe of Indians of Florida, (305) 894-2389

- Seminole Reservation, (305) 966-6300

  Seminole Tribe of Florida, (954) 962-2009

  Seminole Tribe of Florida - Big Cypress HC, (954)962-2009

  Seminole Tribe of Florida- Brighton HC, (954) 962-2009

For more information about IHS, see:

- IHIS Directory at www.ihs.gov/AdminMngrResources/EmployeeServInfo/StaffDirectories/index.cfm

- IHS Contract Health Services (CHS) at www.ihs.gov/NonMedicalPrograms/chs/index.cfm?module=chs_program_directory_list

- Tribal contract health care facilities serve only their tribal members, with other qualified Indians/Alaska Natives being offered care on a space available basis.

- This policy makes it difficult or impossible for tribal members who leave the reservation for education or employment to receive the IHS services to which they are legally entitled.

TriCare and ECHO (Extended Care Health Option for Military)

TriCare is a regionally managed health care program for Active Duty, Activated Guard and Reserves, retired members of the uniformed services, their families, and survivors.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
TriCare and ECHO							
Y	17-up	Y	N Y-ECHO	N	Y	Y	N

TriCare uses both military health care resources and networks of civilian health care professionals to provide services to their beneficiaries. For more information about TriCare, see www.military.com/benefits/tricare.

In addition to primary coverage, TriCare's **Extended Care Health Option (ECHO)** provides financial assistance to family members of active duty military who have **moderate or severe mental retardation, or a serious physical disability.** Children of sponsors who reach the usual TriCare eligibility age limit (21 or age 23 if enrolled in college fulltime) can retain their eligibility for ECHO services, as long as the sponsor remains on active duty, the child is incapable of self-support because of a mental or physical incapacity that occurs prior to the loss of their eligibility, and the sponsor is responsible for more than one-half the child's support. ECHO benefits may cover a wide range of services, including:

- Medical and rehabilitative services
- Training to use assistive technology devices
- Special education
- Institutional care when a residential environment is required
- Transportation under certain circumstances
- Assistive services (interpreter or translator)
- Durable equipment
- In-home medical services and respite

For more information about ECHO, see www.military.com/benefits/tricare/tricare-extended-care-health-option

- Plan provides financial assistance to active duty family members who have a qualifying condition as defined by law. Pays for equipment that does not qualify as Durable Medical Equipment.

- Coverage limited to active duty family members only.

Local Safety Net Plans

Several counties in Florida have explored ways to provide cost-effective, accessible health care for low-income, uninsured residents in their respective areas. Among counties with local "safety net" health care plans are Hillsborough, Dade, Palm Beach, Pinellas and Polk counties.

Limits		Eligibility Based on Employment Status	Eligibility Based on Disability/ Health Condition	Pre-Existing Condition Exclusion/ Other Circumstances	Monthly Premiums	Legislative Mandate	Requires Annual Certification
Income	Age						
Local Safety Net Plans							
Y	**19-up**	**varies**	**N**	**varies**	**varies**	**N**	**Y**

Local safety net programs vary in the way they're organized and funded: some are entirely publicly funded by county governments and some are public-private partnerships with commercial insurance companies. Each plan has its own eligibility requirements and benefits package. While we have provided a few Web links below, you should contact the county government office where you live and ask whether a local health care program is available and how to apply.

- Hillsborough County: www.hillsboroughcounty.org/hss/healthcare
- Dade County: http://echealthinsurance.com/dadeblue
- Palm Beach County: www.hcdpbc.org
- Pinellas County: www.pinellascounty.org/humanservices/medical-home.htm
- Polk County: http://apps.polk-county.net/php/site/about

- Provides important primary and preventive care services for those who don't qualify for Medicaid or Medicare, and don't have any other coverage options.

- Program limitations may not provide adequate, on-going coverage for people with chronic health conditions; not available in every county.

No Health Insurance

Health Insurance After Age 19

PRIVATE	PUBLIC (aka Government Plans)	NO INSURANCE
Group Insurance Benefits offered through employer • Family plan • Adult dependent • Student • COBRA **Individual Insurance** • Self-employed • Unemployed	**State Public Insurance** • Low income, not disabled • Low income, disabled • Waivers for disabled **Federal Public Insurance** • Low income, disabled **Local Safety Net Plans**	**You Pay All the Bills** You pay full price • Every medical visit • All prescriptions • Any hospitalizations

None!

Not having health insurance means you "pay as you go." Many young adults who don't have a chronic health issue and currently feel healthy believe getting sick won't happen to them. WRONG. People get sick, are in accidents, get hurt. Urgent medical care costs money. Being sick costs time away from school or work. And people often don't seek help until their medical symptoms get worse – which can be life threatening.

FACTOID #7: 83% of 18- 21 year-olds said they had no idea about the kinds of policies that exist for young adults between jobs and without coverage.[3]

What Are My Options?

1. Do some homework. Compare costs of what you need and what various health plans offer.

- **Health Plans by County.** Check out health plans that are available in your county at www.floridahealthfinder.gov/healthplans. This list doesn't include local safety net plans, so find out whether your community offers one (see Part 3 "Public Health Insurance").

  If you live in Broward, Hillsborough, Polk, Palm Beach or Miami-Dade county, you may be able to get health coverage through a Health Flex Plan. These plans provide basic and preventive health care coverage to low-income uninsured people in Florida. See http://ahca.myflorida.com/MCHQ/Managed_Health_Care/Health_Flex/index.shtml.

- **Short-Term Policies.** New short-term health care plans offered by UnitedHealthcare are designed to bridge gaps in health insurance coverage for workers between jobs who find COBRA too costly or who aren't eligible for COBRA, new graduates looking for work, students dropping off their parents' plans, new employees not yet covered by employer plans, early retirees awaiting Medicare eligibility and others whose lives are in time of transition. See www.uhc.com/individuals_families/health_insurance_plans/short_term_medical.htm

- **Discount Cards.** Individuals under age 60 may qualify for the Florida Discount Drug Card if they have a total family income under 300% FPL. See www.floridadiscountdrugcard.com.

  In addition, Selectcare Benefits Network (SCBN) works closely with hundreds of Patient Assistance Programs (PAP) sponsored by pharmaceutical companies that offer free prescription drugs for patients needing medication assistance. While there are different guidelines for each PAP, you will generally qualify for assistance if:

  - You are a U.S. resident
  - You lack insurance coverage for outpatient prescription medication
  - Your income is low enough to cause a hardship when paying retail prices for outpatient prescription medication (generally, under 200% FPL)

  For more information, see www.scbn.org/pap.html

Tip: There are other discount drug, dental, and eye plans offered by private companies. These are not insurance plans; rather, they are memberships in discount health care savings programs (sometimes called "discount medical plans") that will help reduce the expense of obtaining care and treatment. Check the prices and terms to make sure they offer the discount on services you need!

2. Can't afford health care exams? Stay well through medical check-ups, immunizations at state health clinics, and free volunteer clinics.

   • At **Federally Qualified Health Centers (**also know as **community health centers**), you pay what you can afford based on your income. Community health centers provide:

   - Checkups when you're well
   - Treatment when you're sick
   - Complete care when you're pregnant
   - Immunizations and checkups for your children
   - Dental care and prescription drugs for your family
   - Mental health and substance abuse care

   To find a community health center, see http://findahealthcenter.hrsa.gov

   • In addition, free clinics, mobile clinics, We Care programs (run by volunteer physicians), and county health departments can help with primary care and, in some cases, limited specialty care. For a full listing of clinics and health centers in Florida, see www.floridahats.org/wp-content/uploads/2010/03/Florida-Health-Clinics1.pdf

3. Know what medical tests you need after age 18. Here are some online resources to learn about prevention guidelines and important screening tests for young adults:

   • Prevention Guidelines for Women Ages 18-39
   - www.womenshealth.gov/whw/health-resources/screening-tool/index.cfm
   - http://meriter.staywellsolutionsonline.com/Library/preventionguidelines/43,women1839

   • Prevention Guidelines for Men Ages 18-39
   - www.womenshealth.gov/prevention/men
   - http://meriter.staywellsolutionsonline.com/Library/preventionguidelines/43,Men1839

   • Dental
   - www.simplestepsdental.com/SS/ihtss/r.WSIHW000/st.31819/t.31819/pr.3

Need More Information?

Glossary of Health Care Financing Terms

Benefit	The amount payable by the insurance company to an individual (or a provider) for a health care service that is part of the insured's coverage.
Certification Of Prior Coverage	A certificate of prior coverage is issued when a person who was insured under employer-sponsored coverage leaves their job. It provides information on the amount of time a person held insurance coverage. This can be important as it can be used as a credit to reduce pre-existing condition limitations when you enroll in a new plan.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) is jointly financed by the federal and state governments and is administered by the states. It provides health care coverage to uninsured children whose families meet state-specific income eligibility limits. Within broad federal guidelines, each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures.
Claim	A request to the insurance company by an individual (or his or her provider) to pay for services obtained from a provider.
COBRA	Most people get their health care coverage through plans offered by their employer. A COBRA plan allows an employee who leaves a job or whose company stops offering health insurance to continue to be covered under the company's health plan for up to 18 months. The Consolidated Omnibus Reconciliation Act of 1985 (or COBRA) is the federal legislation that established this option for health insurance coverage.

Co-Insurance	When you have co-insurance, instead of paying one set amount for a particular health care expense like you do with a co-pay, you pay a percentage of the total cost for your care, usually after paying a deductible. Co-insurance is common in indemnity and PPO plans.
Co-Pay	Most HMOs and some other plans provide full coverage for certain expenses with the insured paying only small, set co-pay to the provider at the time of service.
Deductible	The amount you must pay before your health insurance plan begins paying your health care expenses. HMO and POS plans may eliminate deductibles when you remain in-network for your care.
Dependents	Spouse and/or unmarried children (whether natural, adopted or step) of a subscriber.
Explanation Of Benefits (EOB)	The insurance company's written explanation for a claim, showing what they paid and what the subscriber must pay.
Exclusions And Limitations	Depending on your policy, some services may not be included in your health plan benefits, like cosmetic dentistry or mental health care. And some items are limited, such as the length of time you can stay in the hospital. You are responsible for the cost of services excluded or limited by your plan.
Group Insurance	Coverage through an employer or other entity that covers all individuals in the group. The premiums for group insurance are generally less expensive than for individual insurance. In Florida, both a single, self-employed individual and an employer with employees are eligible to buy group insurance. Proof of self-employment or business existence through income tax records is usually required.

HMO- Health Maintenance Organization	Available to groups and individuals, HMO plans offer payment of benefits with co-pays required. These plans usually do well in providing coverage for preventative care and routine health care needs like those in an uncomplicated pregnancy. Members must use doctors and other providers who are contracted with the HMO or obtain a referral or authorization to see an out-of-network provider. The co-pay is sometimes higher for such providers.
Indemnity Plan	Insurance that allows the policyholder to use any doctor or other provider they want or need. Unlike PPO or HMO plans, there is no list of contracted providers or a network to be concerned about.
Individual Health Insurance	Plans obtained by individuals and families who pay premiums directly to the insurer, instead of through an employer (see group insurance). The insurance company or HMO may decline to issue coverage for individuals with pre-existing medical conditions.
In-Network	Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.
Managed Care	A medical delivery system that attempts to manage the quality and cost of medical services that individuals receive. Most managed care systems offer HMOs and PPOs that individuals are encouraged to use for their health care services. Some managed care plans attempt to improve health quality, by emphasizing preventative care and covering wellness activities (like smoking cessation, weight control, etc.)

Medicaid	Medicaid provides coverage for health care and health-related services to low income children and adults, in addition to some people with disabilities. Medicaid is a federal-state partnership; it is overseen by the federal government, but is administered by the individual states. That is why different states have different eligibility rules and offer different kinds of benefits. The federal and state governments share the cost of covering people through Medicaid.
Medicare	Medicare is a federal health insurance program for people who are age 65 or older, certain persons with disabilities, or those with end-stage kidney disease. Unlike Medicaid, Medicare is run by the federal government alone, so the eligibility rules and benefits are the same in every state.
Open Enrollment	Time period when members of group health insurance plans can enroll or change their benefits program; generally held once a year.
Out-of-Network	This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred through out-of-network health professionals may not be covered, or covered only in part by an individual's insurance company.
Out-of-Pocket Limit	If you have an out-of-pocket limit as part of your plan, once you spend a certain dollar amount on covered medical services (including your co-pays and deductibles) your insurance company will pay the rest of your medical expenses for the remainder of the year.
POS- Point of Service Plans	An insurance plan that allows the insured to obtain health care services out-of-network. This option usually requires the subscriber to pay a deductible and co-insurance, and provides less coverage than within the network.

PPO- Preferred Provider Organization	An insurance plan, usually with a deductible and co-insurance, which offers full benefits when using in-network providers. Benefits are available out-of-network, but at a lower level and /or higher cost. Some PPO plans have Primary Care Provider referral requirements (see referral) and some PPO plans offer benefits with a co-pay and no deductible for certain services.
Pre-Existing Condition	A medical condition that is excluded from coverage by an insurance company because the condition was believed to exist prior to the individual obtaining a policy from the particular insurance company. Currently, insurance companies can deny or drop coverage to individuals they determine to have 'pre-existing' conditions. Beginning in September, 2010, the Patient Protection and Affordable Care Act ensures that insurance companies will no longer be able to deny coverage due to pre-existing conditions to children under age 19. Beginning January, 2014, insurers will no longer be allowed to deny adults with pre-existing conditions.
Premiums	Total monthly or annual payment to the insurance company in return for providing coverage.
Primary Care Physician (PCP)	Most HMO's and some PPOs require the insured to select a primary care physician (PCP) who is usually a general practitioner, pediatrician, family physician, internist or other non specialist. The PCP is responsible for being 'in charge' of a patient's overall health care. Some plans require the insured obtain a referral from the PCP before seeing a specialist.
Prior Authorization	Some health insurance plans require that before any hospitalization or certain other procedures or treatments, the insurance company be contacted and told of the "course of treatment" which is planned. Authorization (or permission) for the hospitalization or treatment must be given first. If it is not, the plan may not cover the hospitalization or treatment or may cover less of the cost.

Private Health Insurance	Insurance plans marketed by the private health insurance industry. The majority of the non-elderly population in the U.S. are covered through private health insurance. Coverage includes policies obtained through employer-sponsored insurance, with approximately 62% of non-elderly Americans receiving insurance provided as a benefit of employment. Another 5% of the non-elderly group bought coverage outside of the workplace on the individual health insurance market.
Provider	Provider is a term used for health professionals who provide health care services. Sometimes, the term refers only to physicians. Often, however, the term also refers to other health care professionals such as hospitals, nurse practitioners, chiropractors, physical therapists, and others offering specialized health care services.
Provider Network	A list of doctors, hospitals, and other providers that an HMO or PPO has a contract with to provide health care services to its members. Many provider networks have contracts with more than one insurance company and some are established and maintained by the insurance company or HMO themselves.
Public Health Insurance	Health insurance coverage that is funded by public (tax) dollars, usually through the state or federal government. Publically funded programs in include Medicare, Medicaid and the Children's Health Insurance Program (CHIP).
Referral	Most HMO and PPO plans require the insured to obtain a referral from a primary care provider (PCP) before seeing any specialist. Depending on the PCP, this can be done with a simple telephone call or may require a visit to the PCP. The purpose of referrals is to avoid unnecessary specialist visits and the resulting cost to the insurer.

Self Insured Plans	Coverage offered by a company, typically a large employer, that chooses to pay employees' health care costs directly, instead of purchasing health insurance coverage through a private insurance company. Benefits are usually administered through a health plan.
State Mandated Benefits	A specific benefit that must be covered by private insurers as a matter of state law. Companies that self-insure are exempt from such mandates.
Student Health Coverage	In recent years, many colleges have begun requiring proof of health insurance for students. Coverage options include insurance through family policies and coverage through school-sponsored student health plans, now offered by more than 80 percent of public four-year colleges. Students may also seek coverage through an employer's plan if they're employed full time, or they can purchase their own individual health insurance plan from a licensed health insurance provider. And, depending on the state in which a student resides, the student may also be eligible for coverage by a state-sponsored risk pool, a program that provides coverage for individuals denied insurance by private insurers because of their health condition.
Subscriber/ Policyholder/ Insured	The subscriber/policyholder/insured is the individual or organization to whom the health care coverage is issued. In group plans the employee is the "certificateholder." • Generally, the subscriber/certificateholder pays the monthly premiums. • The subscriber/policyholder can have insurance through a group plan that covers just that person or their dependent family members. • A subscriber can also purchase a single or family plan directly from an insurance company.

* Resources: *A Consumer's Glossary of Health Insurance Terms* and The Catalyst Center

Additional Resources

National

healthinsuranceinfo.net.
Developed by Georgetown University Health Policy Institute, this site provides consumer guides for each state. See Consumer Guide for Getting and Keeping Health Insurance in Florida (2009)
http://healthinsuranceinfo.net/getinsured/florida/

Healthcare 411
http://healthcare411.ahrq.gov
Healthcare 411 is an audio podcast series produced by the U.S. Department of Health and Human Services. It shares news and information in the form of 60-second programs that feature current research on important health care topics. Healthcare 411 gives consumers information they can use in their health care decision making.

healthfinder.gov
www.healthfinder.gov
An encyclopedia of over 1,600 health topics from trusted sources.

Questions are the Answer
www.ahrq.gov/questionsaretheanswer
You can improve your care and the care of your loved ones by taking an active role in your health care. Ask questions. Understand your condition. Evaluate your options.

Health Insurance Resource Center
www.healthinsurance.org
A wealth of general and state-specific information, including a glossary of health care terms.

Social Security Online
www.ssa.gov/disability
Eligibility information and application for SSDI and SSDI disability benefits.

GovBenefits.gov
Easy-to-use confidential online screening tool allows individuals and families to find out which federal and state government benefits they may be eligible to receive.
Kaiser Family Foundation
http://www.kff.org/medicare/disabilities.cfm
A comprehensive guide to navigating Medicaid and Medicare for people with disabilities.

Alliance For Health Reform
www.allhealth.org/
Medicaid fact sheet, related policy resources and links.

American Association For Retired People (AARP)
www.aarpmagazine.org/family/Articles/a2003 -01-21-understandingmed.html
Information to better understand Medicare, Medigap and Medicaid.

State

Health Insurance: A Guide for Consumers
http://www.myfloridacfo.com/Consumers/Guides/Health/index.htm
Several comprehensive guides about health insurance in Florida from the Florida Department of Financial Services.

Florida Medicaid Information
www.fdhc.state.fl.us/Medicaid/index.shtml
Florida's Medicaid program covers prescription drugs and medical services for low-income individuals.

Articles

Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2009 Update
http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/Aug/Rite-of-Passage-Why-Young-Adults-Become-Uninsured-and-How-New-Policies-Can-Help-2009-Update.aspx
This is the seventh edition of Rite of Passage, first published by The Commonwealth Fund in 2003.

Uninsured young people face tough decisions amidst healthcare debate (from Yes! Weekly)
www.yesweekly.com/article-8454-uninsured-young-people-face-tough-decisions-amidst-healthcare-debate.html

Income Trumps Health Status in Young Adults' Coverage
www.gallup.com/poll/126203/income-trumps-health-status-young-adults-coverage.aspx
Young adults who are in good health are significantly more likely to have health insurance than those who have some health issue, according to an analysis of Gallup Healthways Well-Being Index data from 2009.

Uninsured Young Adults: Who They Are and How They Might Fare Under Health Reform
www.kff.org/healthreform/7785.cfm
This issue brief highlights the current health coverage status of young adults, current approaches to expand coverage to this population, and how they might be affected by national health reform.

References

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3. *Young Adults No Longer Feel Invincible* (2009). An online poll of 1,000 18-21 year olds conducted by the Polling Company™, Inc., for UnitedHealthcare.

4. A *Consumer's Glossary of Health Insurance Terms.* Available at www.healthinsurance.org/insterms.html

5. The Catalyst Center: *Improving Financing of Care for Children and Youth with Special Health Care Needs.* Available at http://hdwg.org/catalyst/glossary/1#letters

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FloridaHATS

Graduating from pediatric to adult health care