Healthcare

Frequently Asked Questions

This self-advocacy guide is designed to provide families, advocates and people with disabilities more information about New Jersey's health care system.

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Advocating and advancing the human, civil and legal rights of people with disabilities

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- Se Habla Español

Introduction

Health care continues to be a major issue impacting the residents of New Jersey. More than one million New Jersey citizens are uninsured; many more are underinsured. Large numbers of people, with and without insurance, do not understand how the health care system works. The health care system is complex with different types of private and public insurance coverage available to individuals and families.

This booklet is intended to assist in understanding the different types of health care programs available to residents of New Jersey and familiarize people with the major health care laws. It is not intended to discuss the merits of health care reform or the many proposals to achieve health care reform. However, it may provide a foundation by which people can understand the discussions taking place now.

What are the different types of health insurance available in New Jersey?

There are three basic types of insurance. First, there are government funded health insurance programs. Medicaid and Medicare, both funded through the Social Security Administration, are the best known of this type of insurance. Second, there is commercial insurance, which is purchased by an individual or an employer from a commercial insurance company. Third, there is self-funded insurance. An employer who is self-funded does not purchase insurance from an insurance company, but instead covers costs and benefits from its own funds. The New Jersey State Health Benefits Program for State employees is an example of a self-funded insurance plan.

What is Medicare?

Medicare is a federal government subsidized health coverage program. Unlike Medicaid, there are no income and resource limits for Medicare. Individuals that are eligible for Social Security benefits may enroll in Medicare upon turning age 65. The initial enrollment period is up to seven months after turning 65. If someone wishes to enroll after the initial enrollment period, the individual may be subject to fees and penalties. Additionally, individuals with disabilities who receive Social Security Disability Insurance (SSDI) payments are eligible to enroll in Medicare. Most people with disabilities must wait two years after receiving Social Security disability benefits to receive Medicare benefits, except for people with serious kidney disease or amyotrophic lateral sclerosis (Lou Gehrig's disease). Medicare is a fee-for-service program, however, individuals may enroll in an optional managed care program called Medicare Advantage.

What is Medicaid?

Medicaid is a government subsidized health coverage program for low-income individuals as well as some people with disabilities. Although Medicaid has strict income and resource limits, some individuals with disabilities may "buy in" to Medicaid and still earn income. Each state sets eligibility criteria and benefits package. In New Jersey, Medicaid has moved to a managed care system.

What is commercial health insurance?

Commercial health insurance is an insurance policy not paid for by the government. It is private insurance paid for

by an employer and/or individual. Commercial health insurance policies vary widely in cost and covered benefits.

What is a self-funded insurance plan?

A self-funded health insurance plan is a plan that is not purchased through commercial companies such as Blue Cross Blue Shield and Aetna. Instead the employer bears the financial risk associated with the health of its employees. Self-funded plans are governed under ERISA, the federal Employee Retirement Income Security Act, and are not subject to state regulation.

What is Fee-for-Service?

Fee-for-service is a method of bill payment whereby a physician or medical provider is paid for each individual service provided. The patient may pay the bill at the time services are rendered or the medical provider may submit a claim directly to the insurance carrier for payment.

What is Managed Care?

Managed care is the combining of service delivery and the financing of health care services. It includes a network of providers who agree to participate in the insurance plan and accept a negotiated rate for medical services rendered. The insurance carrier provides greater coverage to this in-network group of medical providers than to out-of-network medical providers.

What is an HMO?

HMO stands for Health Maintenance Organization, which is one form of managed care. Individuals who receive

services through HMOs generally must select doctors, hospitals, and other health care providers who are part of the HMO's network. Some HMOs require that all services be provided within their network, while others charge additional fees or co-payments for using non-network providers. In many instances, an employee must select a primary care physician who is responsible for coordinating all care for the member and making referrals before the employee may see a specialist.

What is a PPO?

A PPO (Preferred Provider Organization) is a form of managed care where insurance companies negotiate with health care providers to provide medical services at pre-negotiated rates. Individuals who are members of a PPO generally are not required to select a primary care physician, but are required to use the health care providers who participate in the PPO network.

What is a POS?

An individual in a POS (Point of Service) plan may obtain services from in-network or out-of-network providers. However, the deductibles and co-pays will be higher for out-of-network services.

What is major medical insurance coverage?

Major medical insurance coverage is a type of insurance coverage that provides comprehensive coverage for most medical expenses with generally higher individual benefits and policy limits. Comprehensive major medical insurance combines traditional basic coverage and more extensive coverage into a single comprehensive policy. Supplemental major medical insurance, supplements the

traditional basic policy that pays first, with the supplemental coverage paying expenses left uncovered by the initial basic policy.

What is a High Deductible Health Plan?

A High Deductible Health Plan is defined in federal law as a health insurance plan that contains at minimum an $1,350 annual deductible for individuals and/or a $2,700 family annual deductible for calendar year 2018. The deductible amount is adjusted each year. Health savings accounts (see below) are available only in conjunction with High Deductible Health Plans.

What is a health savings account?

A health savings account is an account where pre-tax dollars can be placed to pay for medical expenses. It must be used in conjunction with a high deductible health insurance plan. The account is completely portable, so individuals can take the account with them when changing jobs. There are strict limits on how much money can be placed in the account each year, and on what items the money can be used. Individuals are not required to spend all the money in the account each year. If there is an unused portion it rolls over to the next year.

What is a flexible spending account?

A flexible spending account for health care is an account where pre-tax dollars are set aside to pay for medical expenses not covered by insurance such as deductibles and co-payments. It may also be used to cover dental and vision expenses. The maximum amount that can be set aside is determined by the employer's plan. The money in the account cannot be carried over past March 15 of the

following year. Any expenses paid through the flexible spending account may not be used as a medical expense tax deduction.

What are health reimbursement arrangements?

Only employers can make contributions to health reimbursement arrangements. The employer's contributions are tax-free to the employee and funds may carry forward to later years. In addition to medical expenses, the money can be used for health insurance premiums and long term care premiums. The health reimbursement arrangements are not tied to health insurance plans.

What is meant by medical necessity?

Medical necessity is a term unique to the United States healthcare system. It means healthcare services that are essential to the treatment of symptoms or a diagnosis under standard medical care practices.

What is meant by habilitation services?

Habilitation services are services necessary to assist an individual in gaining a skill such as speaking or walking.

What is meant by rehabilitation services?

Rehabilitation services are services necessary to assist an individual in recovering a skill lost due to a medical condition or accident.

What is COBRA?

COBRA stands for Consolidated Omnibus Budget Reconciliation Act. This law requires employers to offer workers who are separated from employment, or who lose employer-provided health insurance coverage, the opportunity to purchase continued health coverage. Individuals can purchase COBRA coverage for up to 18 months, or up to 29 months if the worker is disabled as determined under the Social Security Act. COBRA does not apply to small businesses that employ fewer than 20 individuals. However, under the New Jersey Small Group Continuation Right, a New Jersey law, small business employers must provide the option of continued coverage when employees are terminated for reasons other than cause or when work hours are reduced to less than 25 hours a week.

What is HIPAA?

HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA is a federal law that serves several different purposes. The most widely known purpose is the privacy provision that establishes national standards for the protection of medical records and personal health information. In addition, HIPAA limits the ability of insurance companies to exclude pre-existing conditions from coverage. HIPAA also prevents insurance companies from charging a higher premium for similarly situated individuals based upon health status. New Jersey law also provides additional protections for individuals.

What is the Affordable Care Act?

The Patient Protection and Affordable Care Act (PPACA) is often referred to as the Affordable Care Act or

“Obamacare.” It is a federal law that overhauls the U.S. healthcare system. Its goal is to expand coverage to more Americans and reduce the overall costs of health care. It requires insurance companies to cover all applicants and offer the same rates, regardless of pre-existing conditions.

It also allows children of policy holders to be covered under their parents’ policies until the age of 26, prohibits lifetime dollar limits on plans and prohibits annual limits for policies that begin in 2014. It will require that most people have insurance, but there are exceptions to this mandate. It will also provide for subsidies for some people who cannot afford to purchase health insurance and don’t have Medicaid or Medicare.

What are the legal rights within New Jersey governing commercial managed care insurance coverage?

There are numerous rights that an individual has with respect to health insurance coverage. The rights include but are not limited to the following:

- The right to call 911 or seek treatment from an emergency room in a potentially life-threatening situation without prior approval as well as the right to have the insurance company cover a medical exam in the emergency room to determine whether a medical emergency exists.
- The right to know how the insurance plan pays its doctors, in order to permit the patient to determine the financial incentives and disincentives tied to medical decisions.
- The right to know covered treatments and services, and to receive notification of changes in covered benefits.

- The right to know before receiving services the financial responsibility, including co-pays and deductibles.
- The right to know promptly if your doctor is no longer part of the insurance company's network and receive up to four months of continued coverage, if medically necessary.
- The right to appeal a medical necessity decision that results in a denial, limitation, or termination of covered benefits.

What are the legal rights within New Jersey governing Medicaid coverage?

There are numerous rights that individuals have with respect to Medicaid coverage. These rights include but are not limited to the following:

- The right to choose your own doctor.
- The right to access medical care 24-hours-a-day, seven-days-a-week. Medical care must be available after hours and on holidays.
- The right to prior written notice of a decision to deny or terminate health benefits.
- The right to file for a fair hearing when medical services are limited, denied or terminated.

What can be done to increase chances of successfully appealing a medical coverage denial?

The most important things individuals can do to increase their chances of successfully appealing denials is to become knowledgeable about what is covered by the policy and keep detailed organized records. This includes but is not limited to:

- Read and keep the member handbook so you know what services are covered, the benefits of your plan, and your cost-sharing obligations, if any.
- Keep a journal of all telephone calls that includes the date of the call, the name and title of the individual spoken to, and the substance of the discussion.
- File by date all correspondence and Explanation of Benefits (EOBs).
- Research the health condition and treatment options.

What options are available if an appeal of a denial is unsuccessful?

There are several options that may be available if an appeal is not successful. These options may include:

- An individual may choose to switch health plans if more than one plan is available.
- An individual may choose to pay for the treatment out of pocket.
- An individual may choose to use out-of-network benefits, if available.

What advocacy organizations are available to assist individuals in understanding their rights or filing appeals?

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Disability Rights New Jersey (DRNJ), the State's federally funded designated protection and advocacy system for people with disabilities, is a statewide non-profit organization that advocates and advances the human, civil and legal rights of persons with disabilities. DRNJ's mission includes the empowerment of people with disabilities through information to assist them in self-advocacy.