Questions and answers about individual, group and government health insurance options

This backgrounder helps answer many questions consumers may have about their health insurance options. It is designed to be used in conjunction with the three fact sheets (on individual health plans and government programs, employer-sponsored health plans, and Medicare) in our Health Insurance module (https://www.consumer-action.org/modules/module_health_insurance). The module also includes tools for consumer educators.

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Health Insurance Marketplace

I thought that the Affordable Care Act was repealed under the Trump Administration, no?

Although there have been changes made to the legislation (extending the length of "short-term" plans and removing the "individual mandate" penalty imposed on individuals who don't obtain coverage, for example), the ACA is still the law.

Read about the various changes (implemented or proposed) to health care under the Trump Administration at CNN.com (https://www.cnn.com/2019/01/19/politics/trump-two-years-changing-health-care/index.html). The Center on Budget and Policy Priorities "tracks Administration actions that would sabotage the ACA by destabilizing private insurance markets or reversing the law's historic gains in health coverage": https://www.cbpp.org/sabotage-watch-tracking-efforts-to-undermine-the-aca.

Do I have to go outside the exchange to get dental insurance?

You can, but there are standalone dental plans available on the exchanges, as well as health plans that include dental coverage.

What about psychiatric care—is that included in ACA health plans?

Yes. All ACA plans include psychotherapy, inpatient mental health services and substance abuse treatment.

What happens to my tax credits for insurance purchased through the Health Insurance Marketplace if my income changes?

If you qualify for "premium tax credits" for low- and moderate-income individuals through the Health Insurance Marketplace, you can apply some or all of the tax credit to your monthly insurance premium payment. The Marketplace will send that amount directly to your insurance company, resulting in a lower out-of-pocket premium for you. This is called taking an "advance payment of the premium tax credit." If you qualify for the tax credit but don't receive it throughout the year, you can claim it when you file your taxes, to either lower your tax bill or increase your tax refund.

If your income changes or household members change, your premium tax credit will most likely change too.

If your income increases or the number of covered household members decreases, your premium tax credit will probably go down. In this case, reducing the amount of tax credit you take in advance each month will allow you to avoid having to pay the overage back at tax time.

If your income decreases or you add a household member, you'll most likely qualify for a higher premium tax credit, which will result in lower monthly premiums.

Report income and household changes to the Marketplace as soon as possible. Get instructions at the HealthCare.gov website (https://www.healthcare.gov/reporting-changes/how-to-report-changes/).

What are cost-sharing reductions?

If your income qualifies you for "cost-sharing reductions" in addition to a premium tax credit, you will pay less out of pocket for the medical services you receive. This means a lower deductible, lower copayments or coinsurance, and a lower annual out-of-pocket maximum. (Cost-sharing reductions are available only on Silver category health plans.)

If I live in a state with an individual mandate, how do I prove I had health insurance when I file my taxes (to avoid a penalty)?

If you have health insurance, whether through the Marketplace (or state exchange), your employer or purchased through a broker or other source, you should receive a Form 1095 (A, B or C). You don't need to wait for the forms to file your taxes, and they don't have to be attached to your tax return. Still, you should keep any proof of coverage for your records.

What is the difference between an ACA high deductible health plan (HDHP) and a catastrophic health plan?

While both of these plans offered through the Health Insurance Marketplace have a high deductible, there are major differences.

A high deductible health plan is typically used in conjunction with a health savings account (HSA), which offers significant tax benefits on money saved in the account for future medical expenses. HDHPs that qualify for HSA contributions are not allowed to cover any *services* other than preventive care before the deductible is met.

A catastrophic plan does not qualify you to use an HSA. This type of plan does cover the minimum essential benefits required for ACA-compliant policies, including three primary care visits per year (though copays may apply to these) and free preventive services before your deductible is met. However, you must pay for all other health care costs (any type of medical care, including additional primary care visits over your three free ones) in full until you meet your yearly deductible. Premiums for this type of plan are lower than other options, though the deductible, copayments, coinsurance and out-of-pocket maximum are higher. Catastrophic plans are available only to a limited demographic (people under age 30, or those who qualify for a hardship exemption), and are not eligible for premium tax credits or cost-sharing subsidies. (This is *not* a short-term plan.)

Learn more at HealthInsurance.org (https://www.healthinsurance.org/faqs/what-is-the-acas-catastrophic-plan-and-who-is-eligible/) and HealthCare.gov (https://www.healthcare.gov/choose-a-plan/catastrophic-health-plans/).

I heard that the individual mandate penalty was eliminated. Does that mean I'm not required to have health insurance anymore?

While the mandate to have ACA-compliant health insurance technically still exists, the elimination of a penalty for noncompliance has taken the teeth out of the requirement (as of 2019). However, the elimination of penalties on the federal level doesn't mean that there aren't state penalties. New Jersey, Massachusetts, Vermont, Washington, D.C., and California have mandates already in effect or starting in 2020. Some other states are considering imposing them. And, if you want to purchase a catastrophic plan through the Marketplace, you'll still need a hardship exemption to access those plans.

I can save money by buying a short-term health plan? Are there any drawbacks?

Recent changes in the law allow plans that were supposed to last for only a few months—just long enough to fill short gaps during a transition in coverage—to last for up to 12 months (and, in some cases, be extended up to 36 months). A close look at these non-ACA-compliant plans show that they have a lot of shortcomings, including being able to discriminate based on your medical history, imposing annual coverage caps, imposing lifetime limits on your benefits, having higher deductibles, declining coverage for certain services if the insurer believes there were symptoms present before obtaining coverage, and omitting some crucial services (mental health, maternity, prescription drugs, etc.). (Read about one consumer's experience with a short-term plan that fell short: https://www.usatoday.com/story/news/health/2018/11/01/obamacare-enrollment-under-trump-short-term-health-insurance-cheaper-riskier/1830296002/.)

Before purchasing any coverage, verify that it is an ACA-compliant plan, which means it must meet certain important criteria (which all or most short-term plans do not).

I'm just out of college and not yet employed. If I get added to my parents' health insurance, will my health care activity be confidential?

No. The insurance company will send bills and statements to the policyholder(s), which means your parents will know what services have been provided to you.

Employer-sponsored plans

Can I opt out of my employer's health insurance?

Yes, you can choose to not enroll and sign a waiver of coverage form. While employer-sponsored insurance is usually a worker's best option, there are

reasons to opt out, including qualifying for Medicare or Medicaid or joining a spouse's plan because the cost or plan options are preferable.

While there is no longer a penalty for being uninsured, it is still unwise to go uncovered.

Is my share of the premiums for employer-sponsored health care tax deductible?

No, you can't deduct the cost of your employer-sponsored health care if your share of the premiums was paid with pre-tax dollars, which is generally the case when the money is deducted from your paycheck.

How much of my monthly health insurance premium should my employer pay?

While the Tax Cuts and Jobs Act of 2017 eliminated the individual mandate, it didn't have any impact on the employer mandate. According to Nolo (https://www.nolo.com/legal-encyclopedia/what-employers-healthcare-insurance-requirements-under-obamacare-2015.html), "large employers" (those with, on average, 50 or more full-time and "full-time equivalent" [FTE] employees) must provide employees with minimum essential healthcare insurance (i.e., it must pay for at least 60% of covered services). Employers can require that employees contribute toward their insurance coverage, but they can't require them to pay more than 9.86% of their household income toward it. ("Small employers" are not subject to the employer mandate.) Learn more about this calculation at HealthCare.gov (https://www.healthcare.gov/glossary/affordable-coverage/).

According to the Kaiser Family Foundation (https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/), in 2019, employers, on average, paid 82 percent of the health insurance premium for individual coverage, with employees paying the remaining 18 percent. For family coverage, employers contributed, on average, 70 percent, with employees paying the remaining 30 percent. Thirty-one percent of covered workers in small firms are in a plan where the employer pays the entire premium for single coverage, compared to only 5% of covered workers in large firms. In contrast, 35% of covered workers in small firms are in a plan where they must contribute more than one-half of the premium for family coverage (or the entirety of their dependents' coverage), compared to 6% of covered workers in large firms.

Why are many short-term policies for 364 days?

The cut-off for having to comply with ACA minimum essential coverage requirements is 12 months—in other words, policies of a year or longer must be ACA-compliant. A short-term policy (364 days or less, under new rules) does not have to comply.

Under what circumstances can I extend COBRA?

While COBRA coverage typically lasts for up to 18 months, you can extend it up to 29 months if you become disabled within the first 60 days of coverage. (You might, however, be required to pay up to 150% of the premium cost for the additional 11 months.) A spouse or dependent can extend COBRA for up to 18 additional months (up to 36 months total) in the case of a divorce or separation from the covered employee, the employee's death, a child's loss of dependent status, or if the employee becomes eligible for Medicare.

How can I avoid surprise medical bills?

Surprise medical bills typically are the result of (unwittingly) receiving care from an out-of-network provider. For example, you could go to an in-network hospital for a surgery performed by an in-network surgeon, but the anesthesiologist might be from outside the network. This would result in a higher bill and less covered by the insurer (i.e., more out of your own pocket). It would also likely result in "balance billing," where the provider bills you directly for any of the bill not covered by your insurer.

The issue of unexpected—and, often, unaffordable medical bills—has become so big that some states have enacted laws to protect patients. As of the end of 2019, California, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New York and Oregon had implemented such laws, while New Mexico, Washington, Colorado and Texas had laws on the books that had not taken effect yet. There is no federal law protecting patients from surprise medical bills, though Congress is working on three measures that would protect consumers nationwide. In the meantime, the federal Employee Retirement Income Security Act of 1974 (ERISA) preempts state regulation of employer-provided health benefit plans, thereby preventing state laws from reaching the vast majority of consumers with private coverage through employer-based plans.

Aetna offers some tips (https://www.aetna.com/health-guide/tips-to-avoid-surprise-medical-bills.html) for avoiding surprise medical bills, including finding out ahead of time which ambulance service would respond if you needed emergency transport and knowing your rights around balance billing.

Medicare

What are IRMAA surcharges?

IRMAA stands for "income-related monthly adjustment amount"—the additional premium you must pay for Medicare Part B and Part D if your income exceeds a certain level. The Social Security Administration uses your recent tax returns to determine if you must pay the IRMAA surcharge.

In 2019, the Part B surcharge for higher-income beneficiaries ranged from $54.10 to $325 (this is the amount in addition to your regular Part B premium). For Part D (prescription drug coverage), the surcharge ranged from $12.40 to $77.40).

The SSA says that IRMAA affects less than five percent of Medicare enrollees, so the vast majority of people don't have to pay extra.

Some life events, including divorce, death of a spouse, and loss of employment or rental income, may allow you to appeal a surcharge. Use this form for your appeal: https://www.ssa.gov/forms/ssa-44-ext.pdf.

Learn more, including the 2019 income brackets, in the publication *Medicare Premiums: Rules For Higher-Income Beneficiaries* (https://www.ssa.gov/pubs/EN-05-10536.pdf). Income thresholds and surcharge amounts are adjusted occasionally.

What is the Medicare "hold harmless" provision?

The Medicare "hold harmless" provision prohibits Medicare from raising most enrollees' Part B premiums by more than the cost-of-living adjustment (COLA) they received from Social Security. In years when the COLA is zero, Medicare charges proportionally higher premiums to those ineligible for the provision's protection (high-net-worth households). Learn more from Investopedia: https://www.investopedia.com/terms/m/medicare-hold-harmless-provision.asp.

Will Medicare pay for my long-term care?

While Medicare will pay for a period in a skilled nursing facility or home health care—usually following a hospitalization—it does not cover "custodial" care, which includes assistance with daily activities such as bathing and dressing. For this type of long-term care, your options generally are to pay the costs out of your pocket, rely on long-term care insurance, or receive long-term care benefits under Medicaid (if you qualify).

What if I haven't worked long enough to qualify for medicare?

AARP explains the rules around work history and Medicare eligibility (https://www.aarp.org/health/medicare-insurance/info-04-2008/ask_ms__medicare_9.html). In a nutshell, not having worked long enough to "qualify" means you can't get Medicare Part A (hospital insurance) without paying premiums, but you will most likely qualify for Medicare Part B and for Part D, because these have nothing to do with how long you've worked. If you're 65 or older, you can buy into Medicare by paying monthly premiums for Part A. You can also join Part B and pay the same premiums as other people. If you buy Part A, you must also enroll in Part B. But you can enroll in Part B without having Part A.

What if I don't agree with a decision made by Medicare?

You can appeal if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal denials of coverage, changes in coverage, your costs, or, if you have a Medicare Medical Savings Account (MSA) Plan, issues related to what counts toward your deductible.

The appeals process has 5 levels. If you disagree with the decision made at any level of the process, you can generally go to the next level. Learn more about appeals at the Medicare website: https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal.

What is an MSA Plan?

A Medicare Medical Savings Account (MSA) Plan is similar to a Health Savings Account (HSA)—both are used in conjunction with a high-deductible health plan (HDHP). Medicare enrollees who choose an Advantage Plan (Part C) rather than Original Medicare may have the option of a high-deductible plan. If you choose a Medicare MSA Plan, money will be deposited by Medicare into your account to be used to pay your health care costs before you meet your deductible.

There are some advantages to a high-deductible/MSA Plan, including being able to use funds in the account for some expenses not covered under Original Medicare (vision and long-term care, for example) and being able to roll unused funds over for use in future years. But these plans aren't right for everyone. Learn about MSAs in a CNBC article on the topic: https://www.cnbc.com/2018/02/20/a-tax-free-account-for-medicare-that-very-few-people-use.html. Get plan details at the Medicare website: https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/medicare-medical-savings-account-msa-plans/10-steps-to-use-a-medicare-msa-plan.

What are "senior supplement" plans?

"Senior supplemental plans" may include coverage for things like dental and vision care, but they also cover some very specific types of costs, like critical illness/cancer and long-term care. They typically pay out a cash benefit directly to you for covered claims. These plans are not part of Medicare—do not confuse them with Medigap (Medicare supplement) plans, which do not cover vision or dental care, but do pay all or part of the coinsurance, copayments and deductibles for Original Medicare (Parts A and B).

Can I switch Medigap plans at any time?

You can apply for a different Medicare Supplement plan at any time (perhaps because you want additional benefits, or the same benefits for a lower premium), but the plan can reject your application or charge you a higher premium unless

you have guaranteed-issue rights. You have guaranteed issue rights if you're enrolled in Medicare Part A and Part B **and** you're either within your six-month Medicare Supplement Open Enrollment Period (the period between the month you're both age 65 or older **and** enrolled in Part B) or you qualify for a different reason, such as you signed up for an Advantage plan for the first time and have decided (within 12 months) that you want to switch to a Medigap plan instead, or you are moving outside of your plan network (generally only applicable for SELECT plans).

Learn more at https://www.ehealthinsurance.com/medicare/supplement-all/can-i-change-medicare-supplement-plans-anytime.

What is SilverSneakers?

SilverSneakers is a benefit available in some Medigap plans and many Advantage plans that allow covered seniors to access thousands of gyms and fitness classes nationwide at no charge. Learn more at BoomerBenefits.com (https://boomerbenefits.com/silver-sneakers-medicare/) and SilverSneakers.com (https://www.silversneakers.com).

I have a low income. Is there any help with the cost of Medicare?

There are a few programs that might be able to help you afford Medicare and associated health care costs.

Medicare Savings Programs (MSPs) are state government programs that can pay for premiums, deductibles, copayments and coinsurance for Medicare enrollees with limited income and assets. These programs fall into three categories:

- Qualified Medicare Beneficiary (QMB) program helps with Part B premiums and copays, and Part A and Part B deductibles and coinsurance.
- Specified Low-Income Medicare Beneficiary (SLMB) program helps with Part B premiums.
- Qualified Individual (QI) program helps with Part B premiums, but at a lower level of assistance than the SLMB program provides.
- Qualified Disabled and Working Individuals (QDWI) program helps with Part A premiums for people who are under 65, have a disabling impairment, continue to work, and are not otherwise eligible for Medicaid.

If you qualify for the QMB, SLMB or QI program, you automatically qualify for Medicare's Extra Help (https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d). Also known as the Part D Low-Income Subsidy, this program can reduce or eliminate your prescription drug coverage (Part D) premiums and deductible, and lower the cost of prescriptions covered under your plan.

Visit the Medicare website for details on these programs, including qualifying income limits: https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/medicare-savings-programs. Income and asset limits may increase each year so, if your income and resources are slightly higher than the current cut-off levels, you should still apply.

Another program that can help is Medicaid. It's possible to qualify for both Medicare and Medicaid. If you are eligible for both programs, you could, under Medicaid, receive some types of home-based care (such as getting in and out of bed or getting dressed), nursing home care and prescription drugs not covered under Medicare Part D.

To make it easier to find out what benefits you're eligible for, the National Council on Aging offers a BenefitsCheckUp tool: https://www.benefitscheckup.org.

I'm a 70-year-old recent immigrant. Do I qualify for Medicare?

While most Americans become eligible for Medicare at age 65, immigrants of that age or older must be lawfully present in the U.S. for five years before they can buy into the Medicare program. In the meantime, you can purchase coverage through the Marketplace, and can even receive subsidies if you qualify. Under the ACA, premiums for older enrollees are limited to three times the premiums for younger enrollees, which provides a cap that could make individual Marketplace insurance more affordable for elderly recent immigrants even if their income is too high to qualify for subsidies. But, here too, you must be in the country legally.

Where do I find my plan's contact information?

Your plan's contact information should appear on your plan membership card and/or on a recent statement. You can also find it by searching for the plan name on the Medicare website: https://www.medicare.gov/find-a-plan/questions/search-by-plan-name-or-plan-id.aspx.

How do I find a Medicare Part D, Advantage and/or Medigap plan?

A good place to start the search is with Medicare's Plan Finder tool: https://www.medicare.gov/plan-compare.

How do I find out if there are changes to my Medicare coverage?

Each September, every Medicare Advantage and Part D plan has to send enrollees an Annual Notice of Change (ANOC). This document shows any changes in coverage, costs or service area that will become effective the following January. Some of the changes that appear in an ANOC include whether the plan is being eliminated (and you have to choose a new one), any benefits that are being added or eliminated, changes in premiums, deductibles, coinsurance, copays and out-of-pocket caps, and changes to the drug formulary

(which drugs are covered under the plan). These and other changes can be significant, so it's important to review the notice to understand any upcoming changes and to decide whether the plan will still meet your needs. If you don't receive the notice by the first week of October, contact your plan.

How can my Advantage plan have a $0 premium?

Although one of your options might be a Medicare Advantage $0-premium plan, that doesn't mean your health care will be cost-free. Plans with no premiums receive a flat fee from Medicare for paying enrollees' medical claims. But you, the patient, will also have out-of-pocket costs in the form of an annual deductible, copayments and coinsurance, in addition to your Part B premium.

While a $0 premium is attractive, consider what services and providers are covered and how much you might have to pay out of your own pocket.

When can I enroll in or switch Medicare-related plans?

The enrollment period that applies to you depends on what plan you're enrolling in or switching to/from and, in some cases, what your reason for enrolling/switching is (for example, you lost employer-sponsored health insurance). To see what the various enrollment periods are, visit the MyMedicareMatters.org "When Are Medicare Enrollment Periods" webpage (https://www.mymedicarematters.org/enrollment/when-can-i-enroll/) and Aetna's "Unpacking Medicare: What you need to know about Medicare enrollment periods (and when you can change your plan)" (https://www.aetnamedicare.com/en/understanding-medicare/medicare-enrollment-periods-what-to-know.html).

Does Medicare pay for cancer treatment?

Medicare generally covers cancer-related expenses, including chemotherapy and radiation. However, neither Original Medicare nor Part D has an out-of-pocket maximum, which means that even the copayments or coinsurance for cancer treatments could be financially devastating. However, most Medigap plans will pay the portion not covered by Medicare, something to consider when determining what coverage you need.

Are there any free services I qualify for as a Medicare enrollee?

Medicare beneficiaries can receive a number of free services, including annual "wellness" visits, annual mammograms, biannual diabetes screenings, colorectal cancer screenings, alcohol and obesity counseling, flu shots and more. See Motley Fool's "10 Medicare Services You Can Get for Free" (https://www.fool.com/retirement/2019/07/06/10-medicare-services-you-can-get-for-free.aspx).

What is a drug "tier"?

According to the Medicare.gov "What Medicare Part D drug plans cover" page (https://www.medicare.gov/drug-coverage-part-d/what-medicare-part-d-drug-plans-cover), plans can vary the list of prescription drugs they cover (called a formulary) and how they place drugs into different "tiers" on their formularies. Each tier costs a different amount. Generally, a drug in a lower tier will cost you less than a drug in a higher tier. Typically, the drugs in Tier 1, with the lowest copay, are most generic drugs, and those in Tier 3 or a specialty tier, with the higher/highest copay, are brand-name and/or very high-cost drugs. Experimental drugs are rarely, if ever, covered, however you might be able to join "drug trials" of new treatments. See ClinicalTrials.gov.

If your drug is in a higher (more expensive) tier and your doctor thinks you need that particular drug instead of a similar one in a lower tier, you can file an exception and ask your plan for a lower copayment. (Neither Original Medicare nor Part D has an out-of-pocket annual maximum.)

Who regulates Medigap, Advantage and Part D premiums?

Medigap health insurance premiums are filed with and regulated by each state's Department of Insurance (https://content.naic.org/state_web_map.htm). Medicare Advantage plan and prescription drug plan premiums are filed with and regulated by the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov).

Should I enroll in Medicare or stick with my employer-sponsored health plan?

Since there is no charge for Part A, you should enroll in that as soon as you're eligible. Whether you enroll in Part B while you're still working depends on the size of your employer and the costs and benefits of Medicare versus your job-based insurance.

If your employer has 20 or more employees, your employer-sponsored coverage is primary and Medicare is secondary, which means you can keep your work coverage and enroll in Part B later, without any penalties.

If there are fewer than 20 employees where you work, Medicare is considered the primary coverage when you turn 65, which means your employer-sponsored coverage will only pay claims after Medicare has paid. If you don't enroll in Medicare when you become eligible, your job-based insurance might not pay claims, and you'll go uncovered.

Because Medicare Part B premiums may be cheaper than your employer-sponsored insurance premiums, your employer might be amenable to reimbursing you for your Medicare premiums. (However, make sure you understand how your income will impact your Medicare premiums.) Learn more

at MedicareFAQ.com (https://www.medicarefaq.com/faqs/can-my-employer-pay-my-medicare-premiums/).

Can my employer pay my Medicare premiums?

Technically, no—at least not directly. However, you could get a reimbursement for premiums if the employer agrees, which it might do if the cost of Medicare is lower than the cost of insuring you under the company's health plan. Learn more about this arrangement, which could be done through a Section 105 Medical Reimbursement Plan or an Health Reimbursement Arrangement (HRA): https://www.medicarefaq.com/faqs/can-my-employer-pay-my-medicare-premiums/.

Other health care options (Medicaid, CHIP, etc.)

I'm a new U.S. citizen (or have recently gained lawfully present status). Can I get Medicaid?

On the federal level, Medicaid and Medicare both require five years of lawful residency to be eligible for coverage. However, some states have more lenient rules, and you may qualify for Medicaid regardless of your immigration status. Purchasing coverage through the Health Insurance Marketplace is another option. You have 60 days from the time your citizenship or residency status changes to enroll in a plan through the exchange, and receive subsidies if you qualify for them.

If you can't provide proof of lawfully present status, you can't get insurance through the exchange, even if you're willing to pay the full cost of coverage. However, there's no federal rule against buying insurance outside the exchange.

Learn more in HealthInsurance.org's "How immigrants are getting health coverage" (https://www.healthinsurance.org/obamacare/how-immigrants-are-getting-health-coverage/#recentimmigrant).

What is Medicaid expansion?

The Affordable Care Act (ACA) called for the expansion of Medicaid eligibility in order to cover more low-income Americans and, thereby, reduce the number of individuals without any health insurance. Under the expansion, Medicaid eligibility was extended to include individuals with incomes up to 138% of the federal poverty level. Prior to the ACA, Medicaid only required coverage for low-income children and some of their parents; poor pregnant women; some low-income seniors; and some disabled people under the age of 65.

While the Medicaid expansion was intended to be national, a June 2012 Supreme Court ruling essentially made it optional for states. As a result, as of September 2019, there are 14 states that have not expanded coverage

(not counting Utah, Idaho and Nebraska, which are expected to have expanded coverage available by 2020): Alabama, Florida, Georgia, Kansas, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming.

If your state hasn't expanded Medicaid, your income is below the federal poverty level, and you don't qualify for Medicaid under your state's current rules, you fall into a gap where you can't get Medicaid coverage and you can't get savings on a private health plan bought through the Marketplace. (However, lawfully present immigrants who are Medicaid-eligible based on their low incomes, but are barred from the program because of their status as *recent* immigrants, are eligible to enroll in plans through the exchange and receive subsidies during the five years when Medicaid is not available to them. And in some states, lawful presence doesn't have a bearing on Medicaid eligibility.)

Use HealthCare.gov's online tool to see if you qualify for Medicaid in your state based on your income: https://www.healthcare.gov/lower-costs/.

Learn more at HealthInsurance.org (https://www.healthinsurance.org/glossary/medicaid-expansion/) and HealthCare.gov (https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/).

What is a Medicaid waiver?

A Medicaid waiver allows individual states to adopt policies for their Medicaid programs that achieve their particular health care and budgetary goals. One type of Medicaid waiver is widely used to provide in-home care for people who would otherwise have to go into an institution (nursing home, etc.). The exact services available through a Medicaid waiver depend on the state. Learn more about Medicaid waivers, including how to apply, at AssistedLivingToday.com (https://assistedlivingtoday.com/blog/what-is-a-medicaid-waiver/).

Can I use both Medicare and Medicaid?

Yes, it's possible to qualify for both Medicare and Medicaid. If you are eligible for both programs, you could, under Medicaid, receive some types of services that are not covered under Medicare.

Does applying for Medicaid make me subject to the new "public charge" rule?

If you are a legal immigrant but not a U.S. citizen, be aware that the use of certain public benefits could have an impact on future immigration/citizenship proceedings under new "public charge" rules. ("Public charge" refers to individuals considered financially dependent on the government.) The main change from the previous rule is the inclusion of non-cash benefits, such as Medicare. Under previous policy, Medicaid only counted as evidence of public-

charge status if it was used to pay for nursing home or other long-term institutional care. Now, almost any use of Medicaid by non-citizens could have a negative bearing on a newcomer's visa or citizenship application. Getting coverage under the Children's Health Insurance Program (CHIP) or receiving a subsidy for Affordable Care Act marketplace plans does not make someone a "public charge." *(Note: As of November 2019, the proposed new public charge rules were facing legal challenges that could prevent implementation.)*

Learn more at the CommonWealthFund.org (https://www.commonwealthfund.org/blog/2019/new-public-charge-rule-affecting-immigrants-has-major-implications-medicaid-and-entire and SpectrumNews.org (https://www.spectrumnews.org/news/how-the-new-public-charge-rule-affects-immigrants-healthcare-benefits/).

Is it possible to get free care from a hospital if I can't afford to pay?

Most hospitals have financial assistance (sometimes called "charity care") programs that provide "medically necessary" treatment (such as inpatient hospitalization or ER visits) for free or at reduced cost to low-income patients. In fact, non-profit hospitals are required by federal and state law to provide "community benefits" as a condition of their tax-exempt status, and this usually includes some amount of charity care. The amount they provide is not mandated by the government, though some states might have standards.

If a hospital offers financial assistance, it must post a notice of its availability in conspicuous areas of the hospital. If you don't see a posted notice, ask the hospital directly if financial assistance is available and how to apply.

If you have private insurance, Medicare or Medicaid, you must use those benefits first. If you are uninsured, or if you can't afford your insurance deductible or other out-of-pocket expenses, you can apply for financial assistance. Every hospital has a different policy, but most are dependent on income (relative to the federal poverty level). You could qualify to have your entire bill waived or to have the amount you owe reduced.

Where can I go for immediate care that's less expensive than the ER?

If your situation isn't extremely serious (unbearably painful, life-threatening, etc.), you may get quicker and less expensive care by visiting an independent urgent care facility, or one inside your regular hospital. Learn more in this CNET article: https://www.cnet.com/news/how-to-find-urgent-care-and-avoid-a-hefty-hospital-bill/. It would be wise to research in-network urgent care facilities associated with your insurance plan that are located near your home, work and/or school(s) in advance to avoid surprise medical bills; some patients have reported high, uncovered charges at urgent care centers. (See https://www.consumerreports.org/fees-billing/surprise-hospital-fee-just-for-seeing-a-doctor-facility-fee/ and https://www.bostonglobe.com/metro/2018/11/27/patients-surprise-visit-urgent-

care-brings-steep-hospital-bill/oGjlaiSoytJ7Z45sGI55TI/story.html for cautionary information.)

Prescription assistance

Can I apply for prescription assistance even if I have insurance?

According to RxAssist (https://www.rxassist.org/faqs), Some Patient Assistance Programs will help those who have insurance if they meet program hardship requirements or their medication is not covered by their insurance. It may help to have a letter from your insurance company stating that the medication is not covered.

Also, there are several foundations which offer to help with co-pays for specific medications or diseases. Visit this link for the website's list of copay assistance organizations: http://learning.rxassist.org/sites/default/files/Copayfound%203-11.pdf.

What is the process for getting assistance from the drug companies?

Typically, you need to submit an application that will include information about your insurance status, financial situation, etc. Your doctor will most likely need to contribute information about your prescriptions. If your application is approved, many companies will send a supply of the drug to your home or your doctor's office.

Are there other prescription assistance programs?

Some states run their own programs, typically to help the elderly, disabled or low-income patients. Find out if your state has such a program by visiting https://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx.

What is a prescription drug discount card?

Drug discount cards qualify you for discounts on your prescriptions. The cards are available from some government agencies, non-profits, retail pharmacies, membership organizations (AARP, for example) and drugmakers. Some restrict eligibility to certain groups, such as seniors, families with young children, or people without insurance. Others can be used by anyone. The cards may be free or low-cost.

While these cards can save some people money, there's no guarantee; sometimes they don't, or they end up costing you even more than without the card (https://www.pharmacytimes.com/news/the-truth-about-pharmacy-discount-cards). You need to do some research to make sure the card is accepted where you purchase your prescriptions, and that it is valid for the prescriptions you take. You

also should compare the cost of the card, if any, with the cost of your prescriptions without the card to make sure that any fee is recouped through discounts.

Visit VerywellHealth.com (https://www.verywellhealth.com/discount-prescription-drug-cards-2615039) for more information, including where to obtain prescription drug discount cards.

Beware of scammers who try to steal your money and/or your personal information (Social Security number, credit card number, etc.) by selling phony discount drug cards.

Are there any other ways to save money on prescription drugs?

Yes, your medical insurance might offer deep discounts if you order your drugs through the mail from companies the plan partners with. In addition, some big box pharmacy or retail chains might have flat pricing on generic drugs.

Avoiding fraud and scams

I received an unexpected call asking me for my Medicare/Social Security information. Is this a legitimate request?

Generally speaking, it is illegal for anyone to contact you regarding your coverage without your permission or prior request.

Furthermore, Medicare plans aren't allowed to ask for your Social Security number, bank account number or credit card information over the phone, and Medicare Part D prescription drug plans aren’t allowed to call and ask you to enroll in their plan.

Scammers commonly pose as Medicare representatives, employees of a medical supply company, or someone else with a justification—issuing you a new Medicare card, selling a medical device or supplies, processing a health care claim, etc.—for contacting you and asking for your Medicare, Social Security or credit card number.

If you are not certain that a call, email or other communication claiming to be from Medicare or Social Security is legitimate, call the agency to verify: 800-633-4227 for Medicare and 800-772-1213 for Social Security.

About Consumer Action and this publication

Consumer Action
www.consumer-action.org

Through multilingual consumer education materials, community outreach and issue-focused advocacy, Consumer Action empowers underrepresented consumers nationwide to assert their rights in the marketplace and financially prosper.

Consumer advice and assistance:
Submit consumer complaints to our advice and referral hotline: www.consumer-action.org/hotline/complaint_form/ or 415-777-9635. Chinese, English and Spanish are spoken.

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