Health Insurance Literacy Training Module

It is important that Ryan White HIV/AIDS Program (RWHAP) staff who provide direct support to clients (e.g., case managers, front desk staff) understand the basics of health insurance literacy. Staff with strong health insurance literacy skills who are knowledgeable about key health insurance terms, forms, processes, and instructions will be able to work with clients more effectively and help them to enroll in health coverage, use their health coverage, and stay covered. Building health insurance literacy will also enable you to be more prepared to help your clients address health insurance-related challenges as they arise, minimize gaps in coverage, and manage potential health and financial challenges.

ENSURING CLIENTS MAINTAIN COVERAGE THROUGHOUT THE YEAR

RESOURCE ROUND-UP

Introduction

Purpose

The purpose of this course is to strengthen your understanding of the basics of health insurance, including key terms, forms, processes, and instructions. Building strong health insurance literacy skills will help prepare you to assist clients in enrolling in and using their health coverage and staying covered. You will also be more prepared to help your clients address health insurance-related challenges as they arise, minimize gaps in coverage, and manage potential health and financial challenges.

Throughout this interactive course, you will learn about:

- The connection between health insurance literacy and health literacy
- Types of health coverage
- How to help clients select, use, and keep their health insurance
- How to enable clients to access various sources of financial support to keep their coverage affordable

This course will be most useful to Ryan White HIV/AIDS Program (RWHAP) staff who provide direct support to clients, including:

- Case managers
- Front desk staff
- Benefits and enrollment staff
- Peer support specialists
- Community health workers

By the end of this course, you will be able to:

1. Define health insurance literacy
2. Correctly use key health insurance terms in conversation
3. Help clients understand their health coverage options
4. Help clients use and keep their health coverage
5. Understand how building your health insurance literacy can improve health care access for your clients

Plain Language Glossary of Terms

As we go through this course, we will define key terms. You may also find it helpful to download and reference the ACE TA Center's Plain Language Glossary of Health Care Enrollment Terms.

GO TO RESOURCE

Key Terms in this Section

- **Health insurance literacy:** The degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and use the plan once enrolled.
- **Personal health literacy:** The degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational health literacy:** The degree to which organizations equitably help people to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Teachback**: A technique that helps providers and staff understand whether they explained the information well enough to their client.

Health Insurance Literacy and Health Literacy

In this lesson, you will learn how building your health insurance literacy can help your clients to become more informed and engaged participants in their health care.

Health Insurance Literacy

Building *your* personal health insurance literacy builds your *organization's* health literacy, and enables you to help clients become more informed and engaged participants in their health care.

Health insurance literacy is the degree to which individuals have the knowledge, ability, and confidence to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and use the plan once enrolled.

Health Literacy

Health insurance literacy is a component of health literacy. There are two components to health literacy: personal health literacy and organizational health literacy. **Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Health literacy is key to ensuring that all clients are able to understand and fully engage with their care to help them have the best health outcomes possible.

Personal health literacy is dynamic. A person's health literacy at any moment is the result of both their skills and abilities and the demands placed on them by the health care system. Health literacy is not a reflection of a person's intelligence or desire to understand or engage with their care, nor is it necessarily related to the amount of formal education they received. In fact, most people will struggle with health literacy at some point.

A person's health literacy can change from moment to moment as a result of their environment and their emotional and physical state. These changes can affect what a person hears, how they interpret it, and how they act on it. Physical and emotional stress can make it difficult for people to receive and process information.

People who provide health information and services to others have a role in and responsibility to improve health literacy in order to build health equity. Therefore, the second component of health literacy is **organizational health literacy**, which is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

Attributes of health literate organizations

The white paper, "Ten Attributes of Health Literate Health Care Organizations" describes what healthcare organizations can do to lower barriers for people to access and use health information and services. Participants of the Institute of Medicine Roundtable on Health Literacy wrote the paper to inspire health care organizations to address health literacy issues. One of the ten attributes is, "**Communicate clearly what health plans cover and what individuals will have to pay for services**". This is an important but challenging attribute. Improving your health insurance literacy can help to overcome some of those challenges and strengthen clients' abilities to make choices about their health coverage and care.

The two components of health literacy are _____ and _____. *(Select all that apply.)*

- [ ] Personal health literacy
- [ ] Community health literacy
- [ ] Organizational health literacy
- [ ] Professional health literacy

A person's health literacy is dynamic, meaning that _____. *(Select all that apply.)*

- [ ] Health literacy is stable over time
- [ ] Health literacy is the result of both a person's skills and abilities and the demands placed on them by the health care system
- [ ] Health literacy can change from moment to moment
- [ ] If a person has limited health literacy, they will always have limited health literacy
- [ ] People with degrees do not experience limited health literacy

Health insurance literacy is the degree to which individuals have the_____, _____, and _____ to find and evaluate information about health plans, select the best plan for their own (or their family's) financial and health circumstances, and use the plan once enrolled.

- ◯ Intelligence, ability, and skills
- ◯ Knowledge, ability, and confidence
- ◯ Grade-level proficiency, desire, and time
- ◯ Desire, time, and skills

Centers for Disease Control and Prevention (CDC)
Learn more about health literacy.

GO TO RESOURCE

The Teachback Technique

Health insurance is complex and can be confusing for everyone. Your role is to support clients to understand their health coverage options and to make the best decisions for themselves. In this lesson, you will learn about the Teachback and Show Me techniques, which you can use to ensure that you are providing information to clients so that they understand.

The Teachback Technique

When you're working with clients, it's important to use the simplest language possible. Be sure to make a point to ask the clients if they have questions about the material that you are working through, and remind clients often that it's okay to ask questions at any time; you're there to support them. Asking questions can be intimidating though, and clients may be reluctant to let you know that they don't understand. Make sure that you leave enough time in your appointments to address any topics that may need to be clarified.

The **Teachback** is a technique that helps you to know whether you explained the information well enough to the client. Often used by medical providers, the Teachback technique can also help *you* ensure that your clients know and understand the information that you went over during your appointment.

The Teachback is **not a test or a quiz of the client**, it is an **opportunity for you** to check how well **you** explained information to the client.

Steps of the Teachback

Step 1

Explain

Explain the information to the client as simply and clearly as possible.

Step 2

Check

Check that you have explained the information to the client well. Make sure it's clear that it is not a test of their memory or skills. You want to make sure that **you've** explained the information clearly.

Some examples of ways to present the Teachback include:

- "I want to ensure that I explained everything well. Can you tell me what we just talked about?"
- "If you were to tell your partner about what we discussed at our appointment today, what would you tell them?"

Step 3

Re-Explain, If Necessary

If the client cannot teach the information back to you, take the time to explain the information to the client again. Try explaining the information a different way, and be sure to use the simplest language possible. Continue to work with the client until they can explain it back to you clearly in their own words.

Show me technique

If you want to check that the client understands how to do something, you can still use the Teachback, but instead of asking the client to explain it to you, ask them to show you. For example:

- "Show me which sections of this form you will complete when you get home."
- "Show me how to navigate to the “find a provider” page on your health insurance’s website.”

Watch the 1-minute video below to learn more about Teachback.

View this video: https://www.youtube.com/embed/bzpJJYF_tKY

Which of the following accurately describes the Teachback technique? *(Select all that apply.)*

- [ ] The Teachback is a technique that helps you to know whether you explained the information well enough to the client.
- [ ] The Teachback technique can help you ensure that your clients know and understand the information that you went over during your appointment.
- [ ] The Teachback allows you to test the clients on the information they should have learned during your appointment.
- [ ] You can have the clients demonstrate skills to you as a part of the Teachback.

Agency for Healthcare Research and Quality (AHRQ)

Learn more about the Teachback technique and find tools to support adoption.

GO TO RESOURCE

Key Terms in this Section

- **Health insurance coverage:** An agreement a person makes with a payer to help pay for medical care, such as doctors' visits and medication. The insurer pays part of the person's health care costs because the individual has been making regular payments (premiums) to the insurance company. Someone else, like ADAP, may make these payments for the person.
- **Ryan White HIV/AIDS Program (RWHAP):** The government program that helps people with low-income who have HIV to get HIV-related health care. The program fills gaps in HIV care not covered by other options.
- **AIDS Drug Assistance Program (ADAP):** A government program, part of the RWHAP, that is administered at the state level and provides free HIV medications to people with low-incomes. In many states, the program also helps pay for insurance for people living with HIV.
- **Health Insurance Marketplace:** A service that helps people shop for and enroll in health insurance. The federal government operates the Health Insurance Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces.
- **Premium**: The amount a person pays for a health insurance plan. A premium may be paid every month, every three months, or every year. Part or all of a person's premium may be paid by their employer, ADAP, or someone else.
- **Premium tax credits:** A tax credit to lower the cost of insurance premiums for health coverage purchased through the Health Insurance Marketplace.
- **Cost-sharing**: The amount of out-of-pocket costs that a person must pay for services covered by health insurance. Some examples of out-of-pocket costs include deductibles, co-payments, and coinsurance.
    - **Deductible**: The amount that a person may have to pay for health care services before the health insurance plan begins to pay.
    - **Co-payment (co-pay)**: A fixed amount a person pays for some health care services. People usually pay a co-pay when they get the service. The amount may change for different types of care.
    - **Coinsurance**: Coinsurance is a fixed percentage of a health care service that a person is responsible for paying for after they have reached their deductible.
- **Cost-sharing reductions:** A reduction in the amount of out-of-pocket costs that a person has to pay.

Types of Health Coverage

While the Ryan White HIV/AIDS Program (RWHAP), including the AIDS Drug Assistance Program (ADAP), provides HIV primary medical care, essential support services, and medications, and fills gaps in HIV care, coverage, and affordability, RWHAP is not health insurance. In this lesson, you will learn about the types of health coverage. This lesson will overview public coverage options, including Medicaid, Medicare, The Children's Health Insurance Program (CHIP), and Tricare, and will cover private health insurance options, including employer-sponsored insurance, Marketplace plans, and off-Marketplace plans.

Health Coverage

Health coverage offers comprehensive care for all of a person's health needs. In addition to their HIV care and medications, a person with health insurance can receive other health services, such as:

- Preventive care, like flu shots and cancer screenings
- Care and medications for other health conditions a person may have, like heart disease or diabetes
- Hospitalizations
- Substance use treatment and mental health services
- Prenatal, postpartum, and newborn care

Health coverage can also help protect a person's finances in the case of an unexpected medical emergency.

There are two different types of health coverage: **public** and **private**. Both public and private coverage help to make health care affordable and ensure that clients have access to the comprehensive medical care that they need to be healthy.

Public Coverage

Public coverage refers to health coverage programs that are funded and administered by the state and/or federal government. Public coverage includes programs such as Medicaid, Medicare, TRICARE, and the Children's Health Insurance Program (CHIP). A person may be eligible for these programs if their income and/or age qualifies them to participate. If a person becomes eligible for one of these public coverage programs, they are immediately eligible to enroll; there is no need to wait for an open enrollment period.

Types of Public Coverage

MEDICAID	MEDICARE	CHIP	TRICARE

Medicaid: Medicaid provides health coverage to eligible low-income adults, children, pregnant people, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. This means that although each state follows a general standard set by the federal government, each state's program may differ depending on the needs and goals of that state. The eligibility criteria vary by state, so it is important to understand who is eligible for Medicaid in your state or service area.

MEDICAID	MEDICARE	CHIP	TRICARE

Medicare: Medicare is the federal health coverage program for people who are 65 or older and certain people under 65 who have a qualifying disability. HIV status alone does not usually qualify someone for Medicare, and it is important to be familiar with Medicare eligibility requirements. Medicare is broken up into different Parts, and each Part covers a different aspect of a person's care (hospital, medical, and prescription drug). When a person enrolls in Medicare, they will choose whether they want to enroll in:

- *Original Medicare*: Includes Part A (hospital) and Part B (medical) coverage. Medicare Part D (prescription drug coverage) is optional and is purchased separately.
- *Medicare Advantage*: Medicare Advantage plans, also called Medicare Part C, are bundled plans that include Part A (hospital) and Part B (medical) coverage. It usually also includes Part D (prescription drug coverage).

MEDICAID | MEDICARE | CHIP | TRICARE

The Children's Health Insurance Program (CHIP) is a health insurance program that provides low-cost health coverage to children in families whose income is too high to qualify for Medicaid but too low to afford private insurance. In some states, CHIP covers pregnant people. CHIP goes by different names in different states. Each state offers CHIP coverage and works closely with its state Medicaid program. A person can apply for CHIP at any time, and if they qualify, coverage can begin immediately. If a person applies for Medicaid coverage from their state agency, they will also find out if their children qualify for CHIP.

MEDICAID | MEDICARE | CHIP | TRICARE

TRICARE is the health care program for uniformed service members, retirees, and their families. There are two beneficiary categories:

1. Sponsors, which include active duty, retired and Guard/Reserve members
2. Family members, which include spouses and children who are registered in DEERS

A person's benefits and plan eligibility will vary depending on their beneficiary category. If you think your client may qualify for TRICARE, review their eligibility on the TRICARE website.

The Ryan White HIV/AIDS Program (RWHAP) is not health coverage

RWHAP, including ADAP, provides HIV primary medical care, essential support services, and medications, and fills gaps in HIV care, coverage, and affordability for eligible people with HIV. RWHAP-eligible individuals will benefit greatly from health coverage to address all of their health needs.

Private Insurance

Private health insurance refers to coverage by a health plan that is provided through an employer or union, purchased through a state or federal Marketplace, or purchased off-market from a private health insurance company.

Ways to Access Private Insurance

EMPLOYER-SPONSORED INSURANCE | MARKETPLACE PLANS | OFF-MARKETPLACE PLANS

This is private insurance offered by a person's employer. The employer typically pays a portion of the overall cost to insure the employee. The employee may have the opportunity to select between plan types from a given list of options, or there may be only one option available. The list of covered services and medications is determined by the employer and the insurer. A person becomes eligible for employer-sponsored health insurance when they start a job that offers insurance. The employee will lose this coverage if they leave the job, except in the case of employers that offer post-retirement health benefits.

EMPLOYER-SPONSORED INSURANCE | MARKETPLACE PLANS | OFF-MARKETPLACE PLANS

Individuals can purchase private health insurance through a federally- or state-operated Health Insurance Marketplace (sometimes called **Exchanges**). These plans are designated as **Qualified Health Plans (QHPs)** because they provide comprehensive health coverage. Many people enrolled in Marketplace coverage qualify to receive financial assistance to help pay for their premium. They may also receive tax credits to help make their coverage more affordable. The amount of assistance depends on a person's income and family size.

To be eligible to enroll in health coverage through the Marketplace, a person must live in the U.S., be a U.S. citizen or national (or otherwise lawfully present), and cannot be currently incarcerated. Marketplace plans will be covered in more detail in the next section.

EMPLOYER-SPONSORED INSURANCE | MARKETPLACE PLANS | OFF-MARKETPLACE PLANS

Off-Marketplace plans are private health insurance plans that are purchased directly from private insurers. Purchasing directly from the insurance company is an alternative to enrolling into a plan through the Marketplace. People who purchase these plans are not able to take advantage of premium assistance or tax credits to help them pay for their insurance. There are a number of different types of Off-Marketplace plans. Not all Off-Marketplace plans are considered to be Qualified Health Plans.

> *Short Term Limited Duration (STLD) plans* are a particular type of Off-Marketplace plan that provides limited benefits and coverage for a defined and often short amount of time. While STLD plans may seem more affordable than Marketplace plans, enrollees may experience unexpected high costs. STLDs often exclude coverage for pre-existing conditions, including HIV, and are not recommended for RWHAP clients.

Clients who are eligible for RWHAP services do not need health coverage.

- ◯ True
- ◯ False

Match each type of health coverage to its description.

Provides health coverage to eligible low-income adults, children, pregnant people, elderly adults, and people with disabilities	Medicaid
Federal health coverage program for people who are 65 or older and certain people under 65 who have a qualifying disability	Medicare
Health insurance program that provides low-cost health coverage to children in families whose income is too high to qualify for Medicaid but too low to afford private insurance	CHIP
Health care program for uniformed service members, retirees, and their families	TRICARE
Coverage by a health plan that is provided through an employer or union, purchased from a health insurance company on one's own, or through a state or federal Marketplace	Private Insurance

Health Insurance Purchased through State or Federal Marketplaces

One way in which people can gain health coverage is to purchase health insurance through State or Federal Marketplaces. In this lesson, you will learn about the ten essential health benefits that Affordable Care Act (ACA)-compliant plans must cover and the protections that these plans must include in order to be considered Qualified Health Plans.

Qualified Health Plans

All health insurance plans offered through state or federal Marketplaces are considered **Qualified Health Plans (QHPs)**. A Qualified Health Plan is a plan that is approved by the Marketplace and provides 10 essential health benefits (see list below) that must be covered by Affordable Care Act (ACA)-compliant health insurance plans, including QHPs. QHPs limit how much of their own money individuals pay for covered services. This may include limits on deductibles, co-payments, and out-of-pocket maximum amounts. QHPs must also meet other requirements, such as being offered by a licensed insurer and must include patients' rights and protections.

Health insurance Marketplaces approve each plan they sell to ensure only QHPs are available for purchase. This includes HealthCare.gov as well as state-based Marketplaces.

QHPs on the Marketplace are available in four "metal" categories: Bronze, Silver, Gold, and Platinum. These metal categories are based on how the consumer and the plan split the costs of health care. They have nothing to do with the quality of care. In general, Bronze plans have the lowest monthly premiums and highest deductibles, while Platinum plans have the highest monthly premiums and lowest deductibles.

Ten Essential Health Benefits of Qualified Health Plans

1. Ambulatory patient services (outpatient care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization (like surgery and overnight stays)
4. Pregnancy, maternity, and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment (including counseling and psychotherapy)
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (note that adult dental and vision coverage are not essential health benefits)

You should encourage your eligible clients to select a Qualified Health Plan (QHP) because QHPs provide coverage for essential services and have other patient protections.

- ◯ True
- ◯ False

Financial Support Available for People with Marketplace Coverage

Premium tax credits (PTCs) are tax credits that can lower the cost of insurance premiums for health coverage purchased through the Health Insurance Marketplace. PTCs are available to clients with annual household incomes between 100-400% of the Federal Poverty Level (FPL). People with lower incomes pay a lower percentage of their income for their premiums. In other words, people who have lower incomes will receive a larger premium tax credit.

When a person takes their PTC in advance of (before) filing taxes to lower their monthly premium payment, it is called an **advance premium tax credit (APTC)**. Though both PTCs and APTCs reduce the cost of health insurance premiums, APTCs effectively lower the premium amount that a person has to pay each month because they are paid directly to the insurer. It is recommended that Ryan White HIV/AIDS Program (RWHAP) clients take the APTC in order to decrease the amount they have to pay each month.

The other type of financial support available to people with Marketplace plans is **cost-sharing reductions (CSRs)**. Cost-sharing reductions (CSRs) reduce the amount of out-of-pocket costs that a person has to pay. The discount will be applied automatically to the plan the client enrolls in, and their out-of-pocket costs will be lower. The exact amount of CSR that a person is eligible for is based on their income and household size. Only Silver metal-level plans are eligible for CSRs. People in households with incomes 100%-250% of the FPL may be able to receive CSRs. We will learn more about cost-sharing in the next section.

_____ are tax credits intended to lower the cost of insurance premiums for health coverage purchased through the Health Insurance Marketplace.

- ◯ Cost-sharing reductions
- ◯ Premium tax credits
- ◯ Personal tax credits
- ◯ Cost-sharing exemptions

_____ reduce the amount of out-of-pocket costs that a person has to pay.

- ◯ Cost-sharing reductions
- ◯ Premium tax credits
- ◯ Personal tax credits
- ◯ Cost-sharing exemptions

Premium tax credits and cost-sharing reductions are only available to people whose insurance is purchased through HealthCare.gov or a state-based health insurance Marketplace.

- ◯ True
- ◯ False

Healthcare.gov

Find out what Marketplace health insurance plans cover.

GO TO RESOURCE

Understanding Premium Tax Credits and Cost-Sharing Reductions

The ACE TA Center's self-paced, interactive course helps RWHAP program staff understand the basics of premium tax credits and cost-sharing reductions as well as how they can help RWHAP clients pay for their Marketplace insurance and reduce out-of-pocket costs.

GO TO RESOURCE

HRSA Policy Clarification Notice (PCN) #14-01

Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act

GO TO RESOURCE

Premiums

In this lesson, you will learn what a premium is and the importance of helping your clients understand the need to make sure their premium is paid in order to stay covered. This lesson will also provide information about the types of financial support available to people who purchase insurance through State or Federal Marketplaces.

Paying Premiums

Clients need to ensure that their premiums are paid each month. Late or missed payments can impact whether the client stays covered. Help clients to understand what their premium is and when it needs to be paid each month.

If the client receives financial assistance from the Ryan White HIV/AIDS Program (RWHAP), the program may be able to work directly with the insurance company to make sure the financial help goes directly to the client's bill. This will decrease the amount that the client has to pay each month. Encourage the client to bring a copy of their most recent bill when they meet with you to help you understand their premium. Their bill will also include contact information you can use to connect the RWHAP with the insurance company for assistance with the premium.

Non-Payment of Premiums Can Result in Canceled Coverage

Clients are required to make sure their premium is paid each month in order to keep their coverage. RWHAP may be able to provide assistance with premiums for eligible RWHAP clients. If a person does not pay their premium, they may risk losing their coverage.

If a premium is not paid on time, the client will receive a notice from their insurance company, and their insurer can end their coverage. The client may be eligible for a grace period (see below) in which they can pay their premium and retain their coverage. If the client's coverage ends, the insurance company must send them a letter to inform them of the termination of coverage. If the client loses coverage because they did not pay their premium, they will not be able to re-enroll until the next Open Enrollment Period. If a client wants to re-enroll into a plan with the same insurance company during the next Open Enrollment Period, they may have to back-pay any missed premiums.

Grace Periods

If you become aware that a client has missed or is behind on their monthly premium payments, encourage them to make a payment right away. Many health insurers offer a grace period on payments, which is a short period of time after the premium is due when a person can make a payment without losing coverage. Each state has different rules about grace periods. Help the client to contact their insurance company as soon as possible to learn about their grace period and make a payment.

How often do clients need to pay their premiums?

- ◯ Once per year, at re-enrollment
- ◯ Monthly
- ◯ Each time they visit a provider

- ◯ Each time they add a dependent to their plan

HRSA Policy Clarification Notice (PCN) #14-01
Clarifications Regarding the Ryan White HIV/AIDS Program and Reconciliation of Premium Tax Credits under the Affordable Care Act Policy Clarification Notice

GO TO RESOURCE

Cost-Sharing

Though the amount and types of cost-sharing your clients will be responsible for will vary by their plan, most people will have to pay for a portion of their care. In this lesson, you will learn about the types of cost-sharing that clients may be responsible for, including deductibles, coinsurance, and co-payments.

Cost-sharing

Even though health insurance pays for much of a person's care, people with health insurance may still have to pay for a portion of their health care services themselves. This is called **cost-sharing**.

The amount and types of cost-sharing a person is responsible for will vary by their plan. Three types of cost-sharing are described below.

DEDUCTIBLES | COINSURANCE | CO-PAYMENTS

The **deductible** is the amount a person may have to pay for health care services before their health insurance plan begins to pay. For example, if a person's deductible is $500, the plan won't pay anything until the person has paid $500 for health care services covered by their health plan. After that, their health insurance plan will begin paying for eligible services. Some plans have lower deductibles but include other costs that the client must pay. **Premium payments do not count towards a person's deductible.**

DEDUCTIBLES | COINSURANCE | CO-PAYMENTS

Coinsurance is a fixed percentage of a health care service that the client is responsible for paying after they've reached their deductible. For example, a person may be responsible for paying 20% of the overall cost of a service.

DEDUCTIBLES | COINSURANCE | CO-PAYMENTS

Co-payments (co-pays) are a fixed amount a person pays for some health care services. A person usually pays a co-pay at the time they get the service. The amount may change for different types of care. For example, a person might pay $15 when they go in for a doctor's visit and $30 when they go to the emergency room.

Remember: coinsurance and co-payments are different. Co-payments are flat fees usually paid at the time of service, and coinsurance is paid after the insurance company pays their percentage of the cost.

Out-of-Pocket Maximum

The most a person will pay with their own money (out-of-pocket), for covered services, during a health insurance policy period (usually a year) is called the **out-of-pocket limit** or **out-of-pocket maximum**. After a person reaches their deductible and their out-of-pocket limit, their health insurance plan will pay 100% of the allowed costs for services covered by their health plan for the rest of the coverage year.

Premiums, costs for health services that the plan doesn't cover, out-of-network care and services, and certain other costs don't count toward the out-of-pocket limit. Different health insurance plans count different things toward the out-of-pocket limit, so help the client understand the rules of their plan.

For example, if the plan's out-of-pocket limit is $3,000, once the client has paid $3,000 of their own money in deductibles, co-pays, and coinsurance (all added together), they won't have to pay any more health insurance costs in the year.

Your client Sam goes to the doctor and pays a $10 fee when he checks in for the care he received during the appointment. What is that $10 fee called?

- ◯ Coinsurance
- ◯ Co-payment
- ◯ Co-sponsorship
- ◯ Coordinated care fee

What should clients consider when comparing different kinds of plans? *(Select all that apply.)*

- ☐ Premium cost
- ☐ Cost-sharing requirements (e.g. co-pay, coinsurance)
- ☐ Provider network
- ☐ Whether they have a pre-existing condition

Key Terms in this Section

- **Claim**: A request for payment that a person or their health care provider submits to their health insurer to be paid or reimbursed for items or services they have received. Most often, individuals are not responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on an insured individual's behalf.
- **Appeal**: A request for the health insurance company or the Marketplace to review a decision that denies a benefit or payment.
- **In-network**: The clinical providers, clinics, health centers, hospitals, and pharmacies whose services are covered by a health insurance plan.
- **Out-of-network**: The clinical providers, clinics, health centers, hospitals, and pharmacies whose services may cost more, or not be covered at all, by the health plan.

Identifying Important Health Insurance Documents

Once the client is enrolled in health insurance, it's important that they understand how to use their health insurance to access and pay for their care. In this lesson, you will learn about the documents that clients receive once they enroll in health insurance and how to ensure they're prepared with the documents they will need for each visit.

Identifying Important Documents

Your clients will receive a number of documents after they enroll in health insurance. It's important that you know what the client should expect to receive, and encourage them to be on the lookout for these materials. Explain to the client what each of the materials is, and whether or not any follow-up is expected of them.

Welcome packet

A welcome packet typically contains key phone numbers, instructions for finding a provider, procedures for filing claims, and how to handle a medical emergency. The client might also find lists of what prescription drugs are covered, or provider and pharmacy directories.

Insurance cards

Insurance cards typically contain the client's name (and/or the name of the primary policyholder), policy number, group number, insurance company contact information, coinsurance or copay information, and prescription coverage information.

Summary of Benefits and Coverage (SBC)

The Summary of Benefits and Coverage uses clear, plain language to summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations.

See an example.

First bill

The first bill a client receives for their health insurance. Clients will need to take action and make sure this first bill is paid in full.

Once clients receive these documents, help them to develop an organizational system so that they do not lose these important coverage documents. This can be as simple as a folder, envelope, or drawer in their home. You may also encourage clients to carry their insurance card

in their wallets so that they're always prepared to provide their insurance information (e.g. at the pharmacy, at their provider office, or in a medical emergency).

What Clients Should Bring to Every Visit

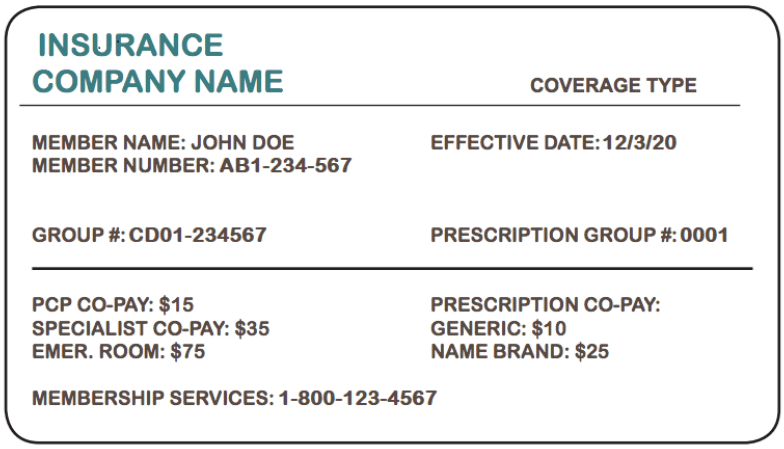
Help the client prepare for the visit and know what to expect when they get there.

Advise the client that they should bring the following items to every health care visit:

- Current insurance card
- Photo identification (ID)
- A list of medications the client is currently taking
- Information about any other health care providers the client has seen since their last visit (e.g., mental health/substance use, dental, specialists)
- Information about any ongoing health conditions or symptoms
- A list of any questions the client would like to ask the provider
- Recent mail from their insurer, the Marketplace, or the Ryan White HIV/AIDS Program (RWHAP), if they have found the information confusing.

Using the image of the health insurance card below, locate the client's member number and enter it into the box below.

Sample Insurance Card. Your actual card may look slightly different.



Type your answer here

Types of Providers and Relative Cost

Different types of coverage plans will have implications for where clients can receive care and how much that care will cost. In this lesson, you will learn about provider networks and where to go for care. This lesson will also cover the cost implications of receiving care from different provider types.

In-Network and Out-of-Network

Insurance helps cover unexpected costs, such as emergency care, hospital stays, ongoing medications, or therapies. While a person's insurance can help to cover the cost of many health-related services, it may not cover all services or providers.

In-network providers are the doctors, clinics, health centers, and hospitals whose services are covered by the health insurance plan. It is important to get health services from in-network providers, when possible, to keep costs down.

If a provider is not in-network, they are said to be **out-of-network**, which refers to the doctors, clinics, health centers, and hospitals whose services may cost more or not be covered at all by the health plan. Out-of-network services can get expensive because insurers generally will not cover the same percentage as they would if the service were performed by an in-network provider. The client will often be responsible for paying more money.

Health insurance plans vary in the degree to which they require or encourage enrollees to visit in-network providers. Common types of health insurance plans include:

Exclusive Provider Organization (EPO)

A managed care plan where services are covered only if the enrollee uses doctors, specialists, or hospitals in the plan's network (except in an emergency).

Health Maintenance Organization (HMO)

A plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. HMO plans often require the enrollee to get a referral from their primary care doctor in order to see a specialist.

Point of Service (POS)

A plan where the enrollee pays less if they use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans require the enrollee to get a referral from their primary care doctor in order to see a specialist.

Preferred Provider Organization (PPO)

A plan where the enrollee pays less if they use providers in the plan's network. Enrollees can use doctors, hospitals, and providers outside of the network without a referral for an additional cost.

Finding covered services

Insurers offer online member portals that their enrollees can access to determine if a service is covered. Enrollees can also consult the plan's summary of benefits and coverage document for this information. Case managers can support clients to consult these resources or call the client's insurance company before they make choices about their care in order to help to prevent unexpected bills.

Most clients will want to try to find an _____ provider for their care in order to keep their costs low.

- ◯ In-network
- ◯ Out-of-network
- ◯ Social network
- ◯ Independent network

Where to Go for Care

Help clients to understand which types of providers are appropriate for which types of services.

PRIMARY CARE PROVIDER | SPECIALIST | URGENT CARE CLINIC | EMERGENCY DEPARTMENT

Clients should visit their primary care provider when they need a regular checkup and when they feel sick. The primary care provider may also be the client's HIV provider.

PRIMARY CARE PROVIDER | SPECIALIST | URGENT CARE CLINIC | EMERGENCY DEPARTMENT

Clients should visit a specialist when they have specific symptoms or conditions that their primary care provider doesn't treat. There are many kinds of specialists, and a client's HIV provider may be considered a specialist. Clients should check with their insurance company to see if a pre-authorization is required before they make an appointment with a specialist.

PRIMARY CARE PROVIDER | SPECIALIST | URGENT CARE CLINIC | EMERGENCY DEPARTMENT

Clients should go to an urgent care clinic when they have an illness or injury that is not life-threatening and when their regular doctor isn't available. This is a good option at night and during the weekend. Before going to an urgent care clinic, the client should call ahead or check their insurance provider's website to ensure the clinic accepts their insurance.

PRIMARY CARE PROVIDER | SPECIALIST | URGENT CARE CLINIC | EMERGENCY DEPARTMENT

Clients should go when they are very sick, seriously injured, in a life-threatening situation, or are experiencing any other medical emergency. The client should inform their primary care provider that they visited the Emergency Department so they can assist with any necessary follow-up care.

Match (drag and drop) each scenario to the provider most appropriate for each situation.

Primary Care Provider	A person is experiencing mild nasal congestion and a sore throat.
Specialist	A person finds out they are pregnant and needs prenatal care.
Urgent Care Clinic	A person has an urgent health need and their regular provider's office is closed.
Emergency Department	A person thinks that they are having a heart attack.

Assistance with Paying for Prescription Drugs

The cost of prescription drugs can be a challenge for many clients, and understanding the way in which insurers classify prescriptions and how that affects costs. In this lesson, you will learn about prescription drug formularies and how the Ryan White HIV/AIDS Program (RWHAP) and the AIDS Drug Assistance Program (ADAP) can support clients to pay for their HIV medications.

Prescription Drug Formularies

A **formulary** is a list of prescription drugs covered by a health plan. This includes both generic and specialty medications.

A formulary is divided into categories, often called **tiers**, and medications are placed into these categories based on the type of drug they are: generic, preferred brand, non-preferred brand, or specialty. The cost of a prescription drug is related to what category, or tier, it is placed in by the health plan. Typically, generic medications are the least expensive. Brand names are more expensive, and specialty medications may cost even more.

The formulary also contains important information about requirements or restrictions a health plan may have for certain medications. Medications will note if any of the following apply:

- **Prior authorization**: The health plan must approve a medication before it can be covered.
- **Step therapy**: The health plan requires that a patient try a lower-cost medication for a period of time before gaining coverage for a higher-cost medication.
- **Quantity limits**: A limit on the quantity of a prescription drug that can be dispensed at one time. For example, plans may limit patients to a 30-day supply of a particular medication per month.

Financial Help to Cover the Cost of Prescription Drugs

Financial help is available to clients to help cover the cost of prescription drugs. The AIDS Drug Assistance Program (ADAP) provides medications to people with HIV who have low incomes and limited or no health coverage from private insurance, Medicaid, or Medicare.

In many places, ADAP funds may also be used to purchase health insurance for eligible clients. This means that eligible individuals can get help covering the cost of medications for HIV and for other health conditions.

If for some reason a client is not eligible for health insurance, or an aspect of their HIV care is not covered, they can still get their HIV care and medications through RWHAP.

HIV.gov HIV Testing Sites & Care Services Locator
Find an RWHAP service provider near you.

View this webpage: https://locator.hiv.gov/

How to Read an Explanation of Benefits

After a person visits a provider and receives services, they will receive an Explanation of Benefits (EOB) in the mail. In this lesson, you will learn how to read and review an EOB for accuracy and to help the client prepare for any bills from their provider.

Explanation of Benefits

An **Explanation of Benefits (EOB)** shows a person the costs associated with the services they received and what insurance will pay.

The EOB includes the following information:

- What was billed by the provider
- Any discounts applied
- What the insurer pays
- The total amount covered by insurance
- The amount that the client is responsible for paying

An Explanation of Benefits is not a bill. The EOB is typically clearly marked as "not a bill" and is sent by the insurer. The provider will send the bill to the patient.

The information presented within the EOB can make it easier to match bills from providers and ensure accuracy. When the client receives their EOB, you can help the client to:

- Verify that the name of the patient and provider seen is accurate.
- Verify the date for the service performed.
- Review the procedure code and brief description of the service performed.
- Review the billed amount as well as the allowed amount for the service.
- Review the amount the insurance company paid as well as the amount the patient is responsible for paying. Help the client to understand if the Ryan White HIV/AIDS Program (RWHAP) can help pay for a portion of their remaining costs.
- Understand their right to **appeal** a charge and how to do so.

The Explanation of Benefits received from the insurance company is a bill and the client should send money to the insurer right away to avoid late fees.

- ◯ True
- ◯ False

Main Street Insurance Company

EXPLANATION OF BENEFITS – This is not a bill.

Patient name: John Doe
Member number: AB1-234-567
Group: CD01-234567

This is your Explanation of Health Care Benefits. This statement shows how we applied your coverage to claim(s) submitted to us. This is NOT a bill and there is no payment due for these services at this time.

Date of service	Type of service	Amount Charged	Network Savings	Amount paid by health plan	Deductible	Copay	Coinsurance	Amount not covered
1/27/2021	Office medical care	$150.00	$20.00	$82.00	$0.00	$15.00	$0.00	$0.00
	Office laboratory	$36.00	$15.00	$21.00	$0.00	$0.00	$0.00	$0.00
	Office laboratory	$30.00	$20.00	$10.00	$0.00	$0.00	$0.00	$0.00
	Claim total:	**$168.00**	**$40.00**	**$113.00**	**$0.00**	**$15.00**	**$0.00**	**$0.00**
								Patient is responsible for $15.00

Customer

Use the Sample Explanation of Benefits above to answer the questions below.

Which services did the client receive?

- ☐ Diagnostic screening
- ☐ Office laboratory
- ☐ Office medical care

Main Street Insurance Company

EXPLANATION OF BENEFITS – This is not a bill.

Patient name: John Doe
Member number: AB1-234-567
Group: CD01-234567

This is your Explanation of Health Care Benefits. This statement shows how we applied your coverage to claim(s) submitted to us. This is NOT a bill and there is no payment due for these services at this time.

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	Office laboratory	$36.00	$15.00	$21.00	$0.00	$0.00	$0.00	$0.00
	Office laboratory	$30.00	$20.00	$10.00	$0.00	$0.00	$0.00	$0.00
	Claim total:	**$168.00**	**$40.00**	**$113.00**	**$0.00**	**$15.00**	**$0.00**	**$0.00**
Patient is responsible for $15.00								

Customer

Use the Sample Explanation of Benefits above to answer the questions below.

Which services did the client receive?

- [ ] Diagnostic screening
- [ ] Office laboratory
- [ ] Office medical care
- [ ] Office dental care

On what date did the patient receive services?

Type your answer here

How much does the insurer say the patient owes?

Type your answer here

How to Help Clients Deal with an Unexpected Bill

Sometimes, clients receive bills that they do not expect. In this lesson, you will learn how to review the client's bill and help them to find a way to pay the bill.

Reviewing Unexpected Bills

If a client receives a bill that they did not expect, carefully review the bill together.

Check the date of service and service description to see if the client has been charged in error for a service they did not receive. If there is an error, work with the client to contact the provider and rectify the error. If the client enrolled in insurance after the date of service, help the client check with their insurance company to see if they are able to receive coverage retroactively. If so, help the client contact their provider and ask the provider to file a claim with the client's insurance provider.

If all of the information on the bill is accurate and the client is unable to pay the full amount, help them contact their provider to ask about any financial assistance programs they may have. Most major hospitals have some sort of payment program that can help the client to manage and pay down their amount owed.

If you and the client review the bill and feel it was sent in error, help them understand their rights to appeal the charge.

A client receives a bigger bill than they expected from their provider and shows it to you. You review the bill together and decide that there are no errors. Your next step is to work with the client to contact the provider to inquire about any financial assistance programs that may be available to them.

- ◯ True
- ◯ False

Key Terms in this Section

- **Qualifying life event**: A change in a person's life that can make them eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in income, and changes in family size (for example, if a client marries, divorces, or has a baby)

- **Special Enrollment Period (SEP)**: The time outside the Open Enrollment Period when a person can sign up for job-based health coverage (health insurance paid in part or fully by the employer) or Marketplace health coverage.
Note: There are also Special Enrollment Periods and Open Enrollment Periods for Medicare. Eligible individuals are allowed to enroll in Medicaid and CHIP at any time.

Open Enrollment and Special Enrollment Periods

People are only eligible to enroll in health insurance during certain periods of time or when they meet certain criteria. In this lesson, you will learn about the open enrollment period for Marketplace plans, employer-sponsored, and Medicare. You will also learn about events in a person's life that may make them eligible for a special enrollment period in which they can enroll in health insurance.

Open Enrollment

Open Enrollment is a period of time each year when people can enroll in a health insurance plan. Many types of plans, including Marketplace, employer-sponsored insurance, and Medicare, have open enrollment periods. Help your client identify their open enrollment period.

In general, a person can only enroll in a health insurance plan outside the Open Enrollment Period if they qualify for a Special Enrollment Period. (A person can apply and enroll in Medicaid or the Children's Health Insurance Program (CHIP) any time of year.)

Marketplace Open Enrollment

The **Marketplace Open Enrollment Period** is when people who are eligible to enroll in a Qualified Health Plan can sign up for a plan through the Marketplace. Clients must re-enroll each year during Open Enrollment. Ryan White HIV/AIDS Program (RWHAP) clients should be encouraged to review and compare plan options each year to make sure they enroll in the best plan for their needs.

For example, for coverage starting on January 1, 2021, the HealthCare.gov Open Enrollment Period was from November 1 to December 15, 2020. If the client did not act by December 15, they could not get 2021 Marketplace coverage through HealthCare.gov unless they qualified for a Special Enrollment Period (see below for more detail).

Enrollment for Medicaid, CHIP, and Medicare

A person can apply for Medicaid or CHIP at any time of the year, so long as they qualify.

A person becomes eligible for Medicare for the first time on their 65th birthday, or if they qualify based on disability. If a person misses the open enrollment window, they must wait to enroll until the next Medicare Open Enrollment period.

Open enrollment is _____.

- ◯ A time when everyone's health care is free.
- ◯ Not available for RWHAP clients.
- ◯ A period of time each year when people can enroll in a health insurance plan.
- ◯ Not something clients need to pay attention to if they already have health coverage.

Preparing for 2021 Open Enrollment
This ACE TA Center resource is a self-paced, interactive course designed to help RWHAP program staff and enrollment assisters prepare for an efficient and successful Open Enrollment Period.

View this resource: https://targethiv.org/library/preparing-2019-open-enrollment

Account Tune-Ups: Getting Ready for Marketplace Open Enrollment
This resource provides guidance on conducting Account Tune-Ups to help make sure eligible clients are ready to enroll in health coverage in the months leading up to Open Enrollment.

View this resource: https://targethiv.org/library/account-tune-ups-getting-ready-marketplace-open-enrollment

Medicare Coverage for People with HIV
ACE TA Center tools and resources intended to provide RWHAP managers, staff, and enrollment assisters with an overview of Medicare eligibility and coverage, including prescription drugs, for RWHAP clients and people with HIV.

View this resource: https://targethiv.org/ace/medicare

State Health Insurance Assistance Program (SHIP) TA Center
SHIPs provide local, in-depth, and objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers.

View this webpage: https://www.shiptacenter.org/

Special Enrollment Periods

A **Special Enrollment Period** is a time outside the Open Enrollment Period when a person can sign up for job-based health coverage (health insurance paid in part or fully by the employer) or Marketplace health coverage. A person becomes eligible for a SEP if they experience a **qualifying life event** which is simply a change in a person's life.

Examples of qualifying life events that might create a special enrollment period include:

- Household changes (e.g., marriage, birth, adoption)
- Loss of health coverage
- Change in immigration status
- The client moves to a new area where new health plans are available
- Change in income or household size
- Something kept them from enrolling during Open Enrollment (e.g., serious medical condition, serious natural disaster, incarceration, or experience of domestic abuse)

Which of the following could be considered a qualifying life event? *(Select all that apply.)*

- [ ] Birth of a child
- [ ] Adoption of a child
- [ ] Loss of employment
- [ ] Death of a spouse
- [ ] A move from one state to another
- [ ] Expensive medical bills

Stay Covered All Year Long
This ACE TA Center consumer resource helps consumers understand what they can do to maintain their health coverage, including paying premiums on time, reporting income and household changes, and what to do if they lose their coverage.

View this resource: https://targethiv.org/library/stay-covered-all-year-long

Special Enrollment Periods
This ACE TA Center fact sheet provides consumers with an overview of the life events and special circumstances that may qualify them for a Special Enrollment Period, as well as what to do if they think they are eligible.

View this resource: https://targethiv.org/ace/special-enrollment-periods-consumer-fact-sheet

Avoiding Gaps in Coverage

Throughout the year, your clients may transition between health insurance plans or types of coverage. In this lesson, you will learn common reasons why clients may transition between plans or types of coverage, what you can do to ensure that the client maintains continuous coverage, and how you can help make sure that the client will not run out of their HIV medications.

Transitioning Between Coverage Types

Clients may transition between health insurance plans (including Marketplace, off-Marketplace, and employer plans) to Medicaid, Medicare, or other types of health coverage during the year. Clients can move between coverage types for any number of reasons. They may become eligible or ineligible for coverage as their income or age changes, or as their employment or immigration status changes. Ask clients to report any changes in income to you so that you can help them enroll in the appropriate coverage and make sure they know what providers and services are covered under their new plan. If a client is enrolled in a Marketplace plan or Medicaid coverage, they will receive a letter from the Marketplace and/or Medicaid if their eligibility changes.

If a client loses coverage or is at risk of losing their coverage, it's very important to make sure the client will not run out of their HIV medications. Help the client to talk to their doctor to get a few months of medications, if possible. The Ryan White HIV/AIDS Program (RWHAP) may be able to help fill gaps in HIV care, including medication access, until they can get new coverage that meets their health care needs. The AIDS Drug Assistance Program (ADAP) is a part of RWHAP and can help cover the cost of HIV medication for eligible individuals. If the client isn't enrolled in ADAP, help them to enroll as soon as possible.

Which of the following is **not** a reason that a person might transition from one health coverage option to another?

- ◯ Change in income
- ◯ Change in family size
- ◯ Change in age
- ◯ Change in employment
- ◯ Change in name

If Your Client Loses Coverage

Despite your efforts to ensure that your client has health coverage, some clients may still lose coverage. In this lesson, you will learn how you can help a client to get covered again, and how the Ryan White HIV/AIDS Program (RWHAP) can help fill gaps in HIV care while the client is uninsured.

Non-Payment of Premiums Can Result in Canceled Coverage

Clients are required to make sure their premium is paid each month in order to keep their coverage. RWHAP may be able to provide assistance with premiums for eligible RWHAP clients. If a person does not pay their premium, they may risk losing their coverage.

If a premium is not paid on time, the client will receive a notice from their insurance company, and their insurer can end their coverage. The client may be eligible for a grace period in which they can pay their premium and retain their coverage. If the client's coverage ends, the insurance company must send them a letter to inform them of the termination of coverage. If the client loses coverage because they did not pay their premium, they will not be able to re-enroll until the next Open Enrollment Period. If a client wants to re-enroll into a plan with the same insurance company during the next Open Enrollment Period, they may have to back-pay any missed premiums.

Remember, though RWHAP can help fill the gaps in HIV care, RWHAP is not health insurance. Support clients to get new coverage as soon as possible.

Make a Plan for Getting Health Coverage Again

Help the client to determine whether they are eligible for a Special Enrollment Period or if they have to wait to enroll until the next Open Enrollment Period. When clients re-enroll, they may have to pay back the premiums they missed. This could result in an expensive bill. Help clients to prepare for this, and to find a way to manage the potential burden that this could bill could bring.

Learn about Special Enrollment Periods on page 37, lesson 17: Open Enrollment and SEPs

Be sure to explore all of your client's health coverage options. Changes in life circumstances (e.g., income or age) can make a person newly eligible for public coverage, such as Medicaid or Medicare.

If a client misses a premium payment, their insurance will be immediately canceled.

- ◯ True
- ◯ False

If a person loses their insurance coverage because they did not pay their premium, when will they be eligible to re-enroll? *(Select all that apply.)*

- [ ] The next month
- [ ] During the next Open Enrollment Period
- [ ] When their health status worsens
- [ ] After a life event that creates a Special Enrollment Period
- [ ] January of the next year

Which of the following statements is true?

- ○ RWHAP clients do not need health coverage so long as they are continuously enrolled in RWHAP and the AIDS Drug Assistance Program (ADAP).
- ○ Health coverage is not important for RWHAP clients.
- ○ RWHAP is comprehensive health coverage that meets the requirements to be considered a qualified health plan.
- ○ RWHAP can help fill gaps in HIV care, but RWHAP is not health coverage.

Resources

This course is intended as a starting point for you to build your health insurance literacy. By improving your health insurance literacy, you'll be better able to better support your clients to access, understand, and use their health coverage.

The resources below reinforce the content of this course and will help you to learn more and build your health insurance literacy skills.

ACE TA Center Resources

Plain Language Glossary of Health Care Enrollment Terms
Quick reference glossary with plain language explanations of health care enrollment terms and phrases for HIV providers.

View this resource: https://targethiv.org/library/plain-language-glossary-health-care-enrollment-terms

Making the Most of Your Coverage
Guide to help newly enrolled clients get started using their health insurance benefits

View this resource: https://targethiv.org/library/making-most-your-coverage-consumer-guide

Account Tune-Ups: Getting Ready for Marketplace Open Enrollment
This resource provides guidance on conducting Account Tune-Ups to help make sure eligible clients are ready to enroll in health coverage in the months leading up to Open Enrollment.

View this resource: https://targethiv.org/library/account-tune-ups-getting-ready-marketplace-open-enrollment

Special Enrollment Periods
This fact sheet provides consumers with an overview of the life events and special circumstances that may qualify them for a Marketplace Special Enrollment Period, as well as what to do if they think they are eligible.

View this resource: https://targethiv.org/sites/default/files/file-upload/resources/Special%20Enrollment%20Periods%20Fact%20Sheet%20for%20Consumers_March2019.pdf

Stay Covered All Year Long
This consumer resource is designed to help consumers understand what they can do to maintain their health coverage, including paying premiums on time, reporting income and household changes, and what to do if they lose their coverage.

View this resource: https://targethiv.org/library/stay-covered-all-year-long

Marketplace Plan Renewal Flowchart
This tool provides a basic timeline for Marketplace enrollment and plan renewals, with an emphasis on avoiding gaps in coverage and ensuring that financial assistance is up-to-date.

View this resource: https://targethiv.org/library/marketplace-plan-renewal-flowchart

How Enrollment Assisters Can Help People with HIV
This video provides essential tips to enrollment assisters, navigators, and certified application counselors who may be new to supporting people with HIV.

View this resource: https://targethiv.org/library/video-enrollment-assisters

Understanding Premium Tax Credits and Cost-Sharing Reductions
This eLearning module is a self-paced, interactive tool designed to help RWHAP program staff understand the basics of premium tax credits (PTCs) and cost-sharing reductions (CSRs) as well as how they can help RWHAP clients pay for their Marketplace insurance and reduce out-of-pocket costs.

View this resource: https://targethiv.org/library/understanding-premium-tax-credits-and-cost-sharing-reductions-elearning-module

The Basics of Medicare for Ryan White HIV/AIDS Program (RWHAP) Clients
Learn about the common Medicare eligibility pathways for people with HIV; the different parts of Medicare, including their coverage and costs; how you can support RWHAP clients to enroll in Medicare; and how the RWHAP helps clients with Medicare costs.

View this resource: https://targethiv.org/library/basics-medicare-ryan-white-hivaids-program-clients

The ABCDs of Medicare Coverage
This resource helps clients understand the different parts of Medicare (Parts A, B, C, and D) and the difference between Original Medicare and Medicare Advantage plans as they consider enrolling in Medicare.

View this resource: https://targethiv.org/library/abcds-medicare-coverage

External Resources

HIV Testing Sites & Care Services
Find HIV services near you.

View this resource: https://locator.hiv.gov/