Health Care Plan Selection Worksheet

Use this worksheet to help your client choose the best health care plan. The ACE TA Center's Plain Language Glossary of Health Care Enrollment Terms also provides easy to understand explanations of the health care terms in this worksheet.

Step 1: Get client's current information.

Current prescription medications			HIV-related medication?
1	Drug name		_____ Yes _____ No
2	Drug name		_____ Yes _____ No
3	Drug name		_____ Yes _____ No
4	Drug name		_____ Yes _____ No
5	Drug name		_____ Yes _____ No
6	Drug name		_____ Yes _____ No
7	Drug name		_____ Yes _____ No

Current sources of care

Primary care provider (PCP) _____

Clinic or hospital where PCP is seen _____

Is PCP also an HIV specialist? _____ Yes _____ No

Is PCP certified in specialty infectious disease? _____ Yes (If yes, specialty?) _____   _____ No

HIV specialist (if different than PCP) _____ Clinic or hospital where seen _____

Facility (clinic/hospital) where client goes when sick _____

Mental health provider _____ Clinic or office where seen _____

Substance use provider _____ Clinic or office where seen _____

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Other specialist(s)

1. Provider name _____ Clinic or hospital where seen _____

2. Provider name _____ Clinic or hospital where seen _____

Income information

Client household income as a percentage of Federal Poverty Level (FPL)		
$	Percentage (%) FPL	Number of people in household
Note: Federal poverty guidelines change each year. To determine the percent FPL for your client's income, go to https://aspe.hhs.gov/poverty-guidelines		
With this income, can client get ADAP premium/cost-sharing assistance in your area? *Note: Eligibility guidelines and availability of assistance vary in different areas and may only be offered for certain health plans. Use the extra space to write any specific guidelines about the ADAP assistance.*		
Premium assistance	_____ Yes _____ No	Notes:
Co-pay assistance	_____ Yes _____ No	Notes:
Deductible assistance	_____ Yes _____ No	Notes:
Assistance purchasing medications	_____ Yes _____ No	Notes:
With this income, does client qualify for financial help with health insurance costs through the Marketplace? *Note: See Appendix A.*		
Premium tax credits to help lower monthly premium costs		_____ Yes _____ No
Cost-sharing reductions to lower out-of-pocket costs for deductibles, copays, and coinsurance		_____ Yes _____ No

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Step 2: Compare plans.

	Plan 1 **Name:**				Plan 2 **Name:**				Plan 3 **Name:**			
	Company offering plan:				**Company offering plan:**				**Company offering plan:**			

Plan general information & cost												
Circle plan "metal" *To receive cost-sharing reductions through the Marketplace, eligible clients must select a Silver level plan.*	Bronze	Silver	Gold	Platinum	Bronze	Silver	Gold	Platinum	Bronze	Silver	Gold	Platinum
Is plan eligible for ADAP premium or co-pay assistance in your area?	_____ Yes _____ No				_____ Yes _____ No				_____ Yes _____ No			
Premium client will pay Full premium minus advance premium tax credit or other premium assistance, including ADAP assistance *Note the amount of premium assistance provided by ADAP and the premium tax credit.*	Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount				Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount				Monthly Premium (minus tax credit or other premium assistance) x 12 = Annual Premium Amount			
Annual deductible The client may have a lower annual deductible if s/he qualifies for financial help through the Marketplace.	_____In-network _____Out-of-network				_____In-network _____Out-of-network				_____In-network _____Out-of-network			

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	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
Does the plan have a separate annual prescription drug deductible? **If yes, what is the amount?**	_____No _____Yes $_____	_____No _____Yes $_____	_____No _____Yes $_____
What coinsurance is the client responsible for? The plan may have different coinsurance percentages for different services. If so, note the percentage for each service. *Note the amount of cost-sharing assistance provided.*			
Out-of-pocket maximum for plan The client may have a lower out-of-pocket maximum if s/he qualifies for financial help through the Marketplace (cost-sharing reductions).			
What is the co-pay for each health service? *If your client is receiving cost-sharing assistance, note the reduced co-pay.*	Primary care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Primary care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
How many times does the client estimate they will use each health service in the next year? *Specialty care could include routine HIV care if client's HIV provider is a specialist.*	Specialty care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Specialty care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

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	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
How much will the client pay in co-pays? *This is only an estimation of co-pays for the client.*	Urgent care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Urgent care visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	Emergency room visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Emergency room visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Inpatient care (hospitalization) $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	Lab work $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Lab work $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Lab work $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	Mental health visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Mental health visits $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____ *estimated client cost*	Substance use disorder visit $_____ co-pay x _____ number of visits = $_____ *estimated client cost*
	TOTAL ESTIMATED CO-PAYS/CO-INSURANCE *Add up total estimate client cost in each column.*		
	Plan 1 total co-pay costs:$_____	Plan 2 total co-pay costs:_____	Plan 3 total co-pay costs:_____

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	Plan 1 **Name:**	Plan 2 **Name:**	Plan 3 **Name:**
What is the co-pay for each medication? *If your client is receiving cost-sharing assistance, note the reduced co-pay.*	Medication 1 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 1 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*
How many refills does the client estimate in the next year?	Medication 2 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 2 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*
How much will the client pay for medication? *If client has more than five medications use a blank page to calculate additional costs.*	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*
	Medication 4 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 4 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*
	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*	Medication 5 $_____ co-pay x _____ number of refills = $_____ *estimated client cost*
	TOTAL ANNUAL ESTIMATED MEDICATION COSTS *Add up total estimate client cost in each column.*		
	Plan 1 total medication costs:$_____	Plan 2 total medication costs:$_____	Plan 3 total medication costs:$_____

	Plan 1 Name:		Plan 2 Name:		Plan 3 Name:	
Provider network						
Are the client's current providers included in-network, out-of-network or both? (Circle)	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Does the plan consider the client's current HIV provider to be a primary care provider or a specialist?	_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist		_____ Primary care provider _____ Specialist	
If a specialist, would the client need a referral from a primary care provider to see his/her HIV specialist?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Are the client's preferred medical facilities, such as a specific hospital, included in the plan?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	
Is the client allowed to see out-of-network providers? If yes, what does the client have to do to get approval?	_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*		_____ Yes _____ No *If yes, note approval process:*	
Do out-of-network visits cost more? **Is yes, what is the additional cost?** Clients who plan to use out-of-network providers and/or facilities should note any additional costs in the estimated co-pay cost above.	_____ Yes _____ No $_____		_____ Yes _____ No $_____		_____ Yes _____ No $_____	
Are plan providers located conveniently for client?	_____ Yes _____ No		_____ Yes _____ No		_____ Yes _____ No	

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	Plan 1 Name:	Plan 2 Name:	Plan 3 Name:
Pharmacy			
Does the plan allow use of ADAP pharmacy/ pharmacies?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Does the plan's drug formulary include the client's current HIV-related drugs? Plans must include at least one drug in each class of core ART medications for ADAP to help with costs.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are the client's current non-HIV drugs covered by the plan?	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No
Are there restrictions on drug coverage? For example: Required use of specialty or mail-order pharmacy, prior authorization, step therapy.	_____ Yes _____ No	_____ Yes _____ No	_____ Yes _____ No

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	Plan 1 Name:			Plan 2 Name:			Plan 3 Name:		
Access to additional services									
		Covered Service	Referral Required		Covered Service	Referral Required		Covered Service	Referral Required
What other needed services are covered by the plan? *Check all that apply.* **Would the client require a referral to access these services?** *Check all that apply.*	Mental/behavioral health			Mental/behavioral health			Mental/behavioral health		
	Substance use disorder			Substance use disorder			Substance use disorder		
	Vision			Vision			Vision		
	Oral health/dental			Oral health/dental			Oral health/dental		
	Chiropractic care			Chiropractic care			Chiropractic care		
	Laboratory services			Laboratory services			Laboratory services		
	X-ray/imaging services			X-ray/imaging services			X-ray/imaging services		
	Durable medical equipment			Durable medical equipment			Durable medical equipment		
	Home health services			Home health services			Home health services		
	Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy			Nutritional counseling/medical nutrition therapy		
	Case management			Case management			Case management		
	Other_____			Other_____			Other_____		
Does the plan limit the number of visits for specific services?	Mental health	Yes	No	Mental health	Yes	No	Mental health	Yes	No
	Substance use disorder	Yes	No	Substance use disorder	Yes	No	Substance use disorder	Yes	No
	Dental	Yes	No	Dental	Yes	No	Dental	Yes	No
	Other	Yes	No	Other	Yes	No	Other	Yes	No

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Adapted from:

- Colorado Consumer Health Initiative CoveredU.org
  http://coveredu.org/shop/intro
- National Health Council Putting Patients First Estimate My Costs Calculator
  http://www.puttingpatientsfirst.net/calc
- Harvard Law School Center for Health Law & Policy Innovation's Marketplace Health Plans Assessment Workbook
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/HLP-Market-Place-Health-Plan-Assesment-Tool-updated-10.23.pdf
- HIV Health Reform's Passport to Health Care
  http://www.hivhealthreform.org/wp-content/uploads/2013/10/ACA-Passport-how-I-get-my-care.pdf
- NASTAD's Health Reform Issue Brief: Plan Assessment Tools for Insurance
  http://www.nastad.org/Docs/045101_HCA-Brief-Plan%20Assessment-10.25.13.pdf

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Quick check chart: Do I qualify to save on health insurance coverage?

To learn if you qualify for lower costs on health coverage, find your estimated household income and household size on the chart below.

Choose the column for your household size.* The column on the left shows income levels that qualify for lower costs on premiums and out-of-pocket costs for private health insurance, and for low-cost health care through Medicaid. Remember to update your income and/or household size information if there are any changes throughout the year so that any financial assistance with premium and out-of-pocket costs is accurately calculated.

		Number of people in your household					
		1	**2**	**3**	**4**	**5**	**6**
Private Marketplace Health Plans	You may qualify for **lower premiums on a Marketplace insurance plan** (Premium Tax Credits) if your yearly income is between… *See next row if your income is at the lower end of this range*	$12,880 - $51,520	$17,420 - $69,680	$21,960 - $87,840	$26,500 - $106,000	$31,040 - $124,160	$35,580 - $142,320
	You may qualify **for lower premiums AND out-of-pocket costs for Marketplace insurance** (Premium Tax Credits and cost-sharing reductions) if your yearly income is between…	$12,880 - $32,200	$17,420 - $43,550	$21,960 - $54,900	$26,500 - $66,250	$31,040 - $77,600	$35,580 - $88,950
Medicaid Coverage	If your state has expanded Medicaid: You may qualify for **Medicaid coverage** if your yearly income is below…	$17,775	$24,040	$30,305	$36,570	$42,836	$49,101
	If your state isn't expanding Medicaid: **You may not qualify for any Marketplace savings programs** if your yearly income is below…	$12,880	$17,420	$21,960	$26,500	$31,040	$35,580

*Include in your household everyone you will claim as a dependent on your tax return and any children who live with you. To view instructions on calculating income, see: https://www.healthcare.gov/how-can-i-save-money-on-marketplace-coverage-chart/. Adapted from HealthCare.gov

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