



Catastrophic Health Plans and other Health FAQs

As of October 25, 2022

What is a catastrophic health plan under the Affordable Care Act?

Under the Affordable Care Act, a catastrophic health plan is a specific type of health insurance policy that has low monthly premiums and very high deductibles. They can be an affordable way for some people to protect themselves in a worst case scenario situation, like a serious injury or illness, protecting them from very high medical costs.

Is a catastrophic health plan expensive?

Catastrophic health plans typically have low monthly premiums and a very high deductible. Preventive services and at least three primary care visits per year are covered without cost sharing, but after that, you will likely have to pay all your medical costs up to your deductible. After you have incurred the cost of your deductible, the costs for essential health benefits above that amount are covered without additional expense to you.

You cannot use a tax credit to help pay your premium with a catastrophic health plan. If you qualify for a tax credit to reduce your premium, another plan may be cheaper.

What is the deductible for 2023 under a catastrophic health plan?

For 2023, the deductible for all catastrophic health plans is \$9,100 for a single individual.

How do I qualify for a catastrophic health plan?

Catastrophic health plans are only available to Marylanders under 30 or people of any age with a hardship exemption or affordability exemption from the Maryland Health Benefit Exchange through the Maryland Health Connection website, www.marylandhealthconnection.gov.

Where can I purchase a catastrophic health plan in Maryland?

You can purchase a plan from the Maryland Health Benefit Exchange through the Maryland Health Connection website directly or through a licensed insurance broker. You can find a list of authorized brokers at: www.marylandhealthconnection.gov.

I was recently diagnosed with COVID-19. Would a catastrophic health plan cover this diagnosis and treatment?

Generally, essential health benefits are subject to the cost sharing requirements of the plan. However, cost sharing barriers may be removed by your plan as a result of certain COVID-19 related services. Some plans may require prior authorization before these services are covered.

Is coverage for dental services required to be included under the Affordable Care Act?

The Affordable Care Act treats dental coverage differently for adults and children. For children, dental coverage is an essential health benefit so it must be included in Maryland as part of a qualified medical plan. Insurance companies do not need to offer dental services to adults. If you are an adult enrolling in Medicaid, your Managed Care Organization (MCO) may offer limited adult dental services.

Can I purchase dental insurance from the Maryland Health Connection?

The Maryland Health Connection does offer stand-alone dental insurance plans, but the plans are not eligible for federal subsidy tax credits.

Does the Affordable Care Act cover vision as well?

Vision care coverage is not mandated for adults by the Affordable Care Act. Health plans can opt to include adult vision coverage in their benefit design, such as an eye exam or glasses, but they are not required to do so.

How does my health plan deductible work?

Your deductible is a dollar amount you pay out-of-pocket for qualified health care services before your health insurance begins to pay. When the insurance company processes your claims, the allowed amount for services is applied to your deductible. When the total of claims applied to your deductible equals your deductible, the insurance company starts to pay. You share the cost with your plan by paying co-pays or coinsurance until you reach your out-of-pocket maximum.

What are co-pays and coinsurance?

A co-pay is a fixed amount you pay for a covered service, such as \$15 for a doctor visit. Coinsurance is a share of the allowed amount that you are responsible for and is a percentage of the amount determined by your health benefit plan for a health care service.

What do I do if I cannot find an in-network specialist?

Sometimes, you may not be able to get the health care that you need from a specialist who is in your insurance company's network. The in-network specialist may be unreasonably far away, or might not have an appointment for an unreasonably long time, or may not be able to treat your condition. When that happens, and you have to go to a specialist that is out-of-network, your insurance company may have to cover the out-of-network specialist the same as they would an in-network specialist. Your health insurance company has to have a process that you can use to find out how to get in-network coverage for care by an out-of-network specialist. And when you make your request, they have to respond quickly. You can contact your health plan using the number on the back of your card, or use the link: <https://bit.ly/miaccp> to find out the process to use for your insurance company:

IMPORTANT: *You must use the company process.* If you do not and you choose to see an out-of-network specialist, and in-network specialists were available, the services will be covered only if you have out-of-network benefits and only for the amount allowed for out-of-network coverage.

Additionally, beginning on January 1, 2023, if you are approved to see an out-of-network specialist for mental health or substance use disorder services, your health plan must pay the costs of the out-of-network specialist's services other than your cost-sharing amount (deductible, copay, coinsurance), which you must pay.

If approved, your claims will be paid based on your in-network deductible, coinsurance, or copayment. Your specialist may agree to a fee with the health plan, but may balance bill you if there is no agreement, unless you are in an HMO. Ask your health plan for information concerning your financial liability.

How does the Maryland Insurance Administration decide whether to approve or deny a requested rate change?

Carriers must demonstrate that requested rates comply with Maryland law. Specifically, Section 11-603(c) (2) of the Insurance Article, Annotated Code of Maryland requires that

rates be based on reasonable assumptions and that rates are not inadequate, unfairly discriminatory or excessive in relation to benefits. An excessive rate reduces access and affordability for Marylanders. An inadequate rate means the insurer may not be able to pay claims in the long run. A rate is unfairly discriminatory if, for example, it is not applied consistently to members of the same demographic or benefit rating profile. The Maryland Insurance Administration considers all of these factors when it reviews a rate filing.

What are habilitative services?

Habilitative services are therapeutic services provided to help a child keep, learn, or improve skills and functioning for daily living. Habilitative services include, but are not limited to, physical therapy, occupational therapy, speech therapy, and the treatment for autism or autism spectrum disorder.

Is there any age limit to receiving covered benefits for habilitative services?

Under Maryland law, insurers and HMOs are required to pay benefits for habilitative services until the end of the month in which your child turns age 19. Check your policy to see if it provides benefits beyond this age.

My child receives services through an early intervention program or school, but I think my child needs more services. What should I do?

Contact your health plan to see if you need a referral to get the names and contact information for potential health care providers and to understand your financial benefit and liability. Your child's pediatrician, family practitioner, or other primary health care provider may examine your child and assess your child's needs or refer your child to an appropriate specialist for further assessment. You may also have out-of-network benefits. Check with your health plan to understand your financial responsibility for their services if they are not part of your health plan's network or their services have not been approved by your health plan.