

Why the Affordable Care Act Matters For Women: **Choosing a Health Plan 101**

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Women are the health care decision makers in our country – they make approximately 80 percent of the health care decisions in their families. Women take the lead role in choosing health plans, scheduling doctor's appointments, and making sure their loved ones are getting the care they need. Women need the right tools and information to make the best health care choices for their families and for themselves.

Many women have questions about health insurance, the new insurance marketplace, and how to choose the best health plan for themselves and their families. While every family will have unique health care needs, the following information can help women make the best choices.

Insurance Basics

Health insurance can be confusing, particularly for individuals who are uninsured or have had inconsistent access to health care. Knowing a few basics about health insurance can help you choose the plan that's right for you:

Premium

- ▶ A premium is the monthly payment you send to your health insurance company to pay for your health insurance coverage.

Cost-Sharing

- ▶ In addition to paying a monthly premium, an insurance company often requires you to cover part of the cost of a health care service. Cost-sharing is the amount you pay for a health care service, such as visiting the doctor or filling a prescription. Cost-sharing takes the form of copays, co-insurance, and deductibles.

Copay

- ▶ A copay is a fixed amount of money that you must pay when you access care. Ex: A \$40 copay for a visit to a specialist.

Co-Insurance

- ▶ Co-insurance is the *percentage* of the cost of a health care service that you must pay. Example: If a plan requires you to pay 20 percent co-insurance for a \$400 doctor's visit, you will pay \$80.

Deductible

- ▶ The amount of money that you must spend out-of-pocket on covered health care services before your plan covers the cost of care. (Under the Affordable Care Act, health plans cannot apply a deductible to essential preventive services, such as mammograms or cervical cancer screenings.)

In-Network

- ▶ Insurance companies contract with specific providers to accept their enrollees as covered patients. Providers who have contracted with your health plan are considered “in-network.” Your insurance company is responsible for providing you with a list of in-network providers.

Out-of-Network

- ▶ Providers who do not have a contract with your health plan are likely to be considered “out-of-network.” Unless it’s an emergency, if you access care outside of your plan’s network, you likely will pay more than if you had accessed the same care in-network.

Allowed Amount

- ▶ “Allowed amount” refers to the amount of money that your plan will pay for a health care service. If your provider charges more than your plan’s allowed amount for a service, you may be required to pay the difference out-of-pocket.

Out-of-Pocket

- ▶ “Out-of-pocket” refers to the type of costs that insured consumers must pay themselves – often through copays, deductibles, and co-insurance, or to cover the amount of an out-of-network service. Under the ACA, marketplace plans have limits on how much you must pay out-of-pocket. By 2015, the maximum out-of-pocket costs for all marketplace plans will be \$6,350 for an individual plan and \$12,700 for a family plan.

Frequently Asked Questions about the Health Insurance Marketplace

Who is eligible to shop for health insurance in the marketplaces?

- ▶ You may be eligible to shop for health coverage in the new marketplaces, accessible through HealthCare.gov, if:
 - ▶ You do not get affordable, adequate insurance through your employer.
(To be considered adequate and affordable, employer-provided coverage must cover 60 percent of the cost of covered benefits; the equivalent of a bronze

plan sold in the marketplace, and the monthly premium must not exceed 9.5 percent of an employee's income. If you have questions about your employer-provided insurance, check with your employer or ask a Navigator.)

- ▶ You do not qualify for full Medicaid coverage or for other types of public insurance coverage, such as Medicare or TRICARE.

Why should I shop for health coverage in the new marketplaces?

- ▶ Health plans offered in the marketplace are guaranteed to cover the health care you need. All health plans offered in the marketplace cover essential health care services, including **ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.**
- ▶ All health plans offered in the marketplace cover essential preventive services like birth control, cervical cancer screenings, mammograms and breastfeeding support **without cost-sharing.**
- ▶ You're guaranteed access to coverage. You can't be denied coverage because of a pre-existing condition.
- ▶ **You may be eligible for financial help** to make health coverage more affordable.

What type of financial help is available in the marketplace?

- ▶ Many individuals shopping in the marketplace are eligible for premium tax credits, which help cover the cost of health insurance. They may also be eligible for cost-sharing assistance, which will help reduce how much they have to pay out-of-pocket for healthcare services.

What are premium tax credits?

- ▶ Premium tax credits reduce your monthly payment for your health insurance, so that you pay less for coverage. Individuals and families with incomes between 100 percent and 400 percent of the federal poverty line (up to \$45,960 for an individual and up to \$94,200 for a family of four) are eligible for premium tax credits.

What is cost-sharing assistance?

- ▶ Cost-sharing assistance reduces the amount of money you need to pay out-of-pocket when you go to the doctor or fill your prescription. Individuals and families with incomes up to 250 percent of the federal poverty line (\$28,725 for an individual and \$58,875 for a family of four) are eligible for cost-sharing assistance.

How do I find out if I'm eligible for financial help?

- ▶ To find out if you're eligible for financial help during an open enrollment period, go to HealthCare.gov and fill out an application. During the application process, you'll

be asked to enter some basic income information. Have your W-2 form or a recent paystub handy so you have the right information. (Prior to starting the application process, you can find out if you're likely to be eligible for financial help by entering your income into the [Kaiser Family Foundation's subsidy calculator](#).

- ▶ If you're looking for more information outside of open enrollment, you can still find out if you might be eligible for financial help by visiting [HealthCare.gov](#).

On HealthCare.gov, does “financial help” refer both to Medicaid and to premium and cost-sharing assistance?

- ▶ Yes. If you think that you might be eligible for either Medicaid or premium tax credits, then make sure you apply for financial help on HealthCare.gov.

What's the difference between the plan colors in the marketplace?

- ▶ The difference between plan colors is the amount of health care costs that they cover. A bronze plan covers 60 percent of your health care costs, a silver plan covers 70 percent, a gold plan covers 80 percent, and platinum plan covers 90 percent. If you choose a bronze plan, you'll pay 40 percent of your health care costs through copays, co-insurance, and deductibles. If you choose a silver plan, you'll pay 30 percent of your health care costs through copays, co-insurance and deductibles, and so on. No matter which plan level you choose, your plan is guaranteed to cover essential health benefits, such as maternity care, and will cover key preventive services, like birth control, cervical cancer screenings, and mammograms, without cost-sharing.

What is the deadline to sign up for coverage?

- ▶ For coverage beginning January 1, 2015, the next open enrollment period is between **November 15, 2014 and February 15, 2015**. (Individuals may also qualify to sign up for coverage outside of open enrollment if they experience certain qualifying life events. You can find out what counts as qualifying life event at [HealthCare.gov](#).)
- ▶ Medicaid and the Children's Health Insurance Plan (CHIP), which are administered by the government, accept new enrollees year-round. Contact your state's Medicaid office to find out if you or your children are eligible to enroll.
- ▶ Generally, if you sign up and pay your first premium before the 15th of the month, your coverage will start on the 1st of the following month. (For example, if you sign up and pay your premium by December 15th, your coverage will go into effect on January 1st.)

What if I find a more affordable plan outside of the marketplace?

- ▶ Plans offered in the marketplace are guaranteed to cover the health services you need. Plans offered outside the marketplace are not. It's important that consumers know that comparing costs between plans offered in the marketplace and plans offered outside of the marketplace can be misleading because these are not apples-to-apples comparisons. Plans offered in the health insurance marketplace offer a

guaranteed set of benefits and cost-sharing protections. Plans offered outside of the marketplace do not offer that same guarantee.

- ▶ **You are only eligible for financial help if you purchase a plan in the marketplace.** If you think you're eligible for financial assistance (e.g., premium tax credits and cost-sharing reductions), make sure you apply at HealthCare.gov. While a marketplace plan may look more expensive than a plan offered outside the marketplace, the marketplace plan may end up being much cheaper if you are eligible for a premium tax credit.

Choosing a Plan: What to Consider?

How much health care do I need? How much health care does my family need?

- ▶ Deciding what plan to buy depends on how much health care you think you need. If you visit the doctor a lot (or a member of your family does), you may want to consider a plan with lower cost-sharing but a higher premium. While gold and platinum plans require a higher monthly premium payment, they cover a larger percentage of your health care costs, leaving you with fewer out-of-pocket expenses. On the other hand, if you only go to the doctor once a year and don't require much health care, a lower-premium bronze or silver plan may be a better fit.

Do I anticipate any major life events in the coming year?

- ▶ Life-changing events, like having a baby, may cause you to need more care than you usually do. For example, a woman who anticipates getting pregnant may want to choose a more robust health plan, which would cover a greater portion of the cost-sharing for covered maternity care services. She may also want to look at the obstetricians in a plan's network and see if her preferred doctor and facility for labor and delivery are considered "in-network."

Are my preferred providers in the plan's network?

- ▶ If visiting a particular doctor is important to you, make sure to check if a plan considers that doctor to be "in-network." Health plans offered in the marketplace are responsible for providing a list of participating in-network providers. If you can't find the provider list on-line, call the HealthCare.gov call center at 1-800-318-2596 or the insurance company for help.
- ▶ Keep in mind that insurance companies change their networks from year to year. They are allowed to add new providers and to end their relationships with providers who had been part of their networks. If you're thinking about renewing your plan, make sure to check to see if your provider is still "in-network."

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.NationalPartnership.org.

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