Finding & Selecting Insurance

Look inside for information on enrollment options and key terms to know.

What is Insurance? Why do I need it?

Health insurance is an agreement made with an insurance company to jointly cover the costs of your care. Your plan is the specific **contract** that defines this relationship and identifies who pays what amount towards the expenses of your care. The plan language defines which doctors or providers are included in your network and what type of medical services are covered.

Insurance benefits are provided to you by the insurer in exchange for a monthly premium that is paid whether you seek treatment or not. In addition to this premium, you are responsible for paying a portion of the actual costs related to the services you receive.

FAST FACT

Every health insurance plan must include a Summary of Benefits and Coverage that outlines your plan in easy-to-understand language.

The Importance of Choosing the Right Plan

Choosing the right plan in the beginning can significantly impact your overall care options as well as your financial health during the plan year. Comparing coverage benefits with financial costs will help you understand differences in plan options and allow you to choose the best plan for your needs. **Sometimes the cheapest premium may ultimately mean you are paying significantly more during the year for your care.**

Consider factors beyond the premium amount when looking at cost. Out-of-pocket costs tend to impact the family's budget all at once rather than as a reoccurring bill that can be budgeted like premiums. For example, prescription out-of-pocket cost are required to be paid upfront and cannot be paid over time.

It's important to become familiar with the out-of-pocket co-payments and co-insurance amounts associated with potential services you may need, such as: routine care, specialty care, emergency care or prescription drug costs.

In addition to costs, when selecting a plan you should closely review and compare both the *basic benefits* offered and any *additional covered benefits* for each plan option. It is critical you are aware of the provider options offered within your plan network, including whether your current doctor is a member of the network. You'll also want to be familiar with medicines you are taking to know whether they are included in the plan's approved drug list or formulary.

Since each plan offers a different range of covered services, being familiar with the identified medical services that will **not** be paid by your insurance plan is also important. You'll find this under the plan's list of non-covered services or benefit exclusions. If you choose to receive medical services that are excluded, you will be required to pay the full cost.

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Patient Advocate Foundation
patientadvocate.org
(800) 532-5274

Vocabulary to Know

Provider:

Any healthcare professional or healthcare facility that is licensed or certified as required by law.

Network:

A combination of medical facilities, healthcare professionals and other suppliers your health plan has contracted with to deliver services. Providers are referred to as **in-network** or **out-of-network** as it relates to your insurance plan.

Cost Sharing:

The general term referring to the combined amount you are responsible for paying when you access care, including co-insurance, co-payments and deductibles.

Deductible:

The amount of money you must pay *before* the health insurance begins to pay its share.

Co-payment:

A fixed amount you pay for a health service or prescription due at the time you receive the service. These are not counted toward meeting your annual deductible.

Co-insurance:

A percentage of the total cost of service received, and applies after you have met your deductible.

Out-of-Pocket Maximum:

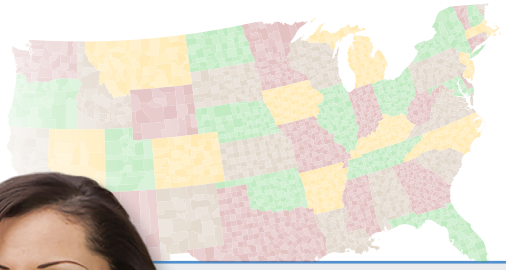
An annual limit on the total amount of money you are required to pay as part of your cost sharing for covered healthcare costs, not including the monthly premium.

Formulary:

A list of prescription drugs, both name-brand and generic, that are available through your health plan. Your health plan may only pay for medications listed on the formulary.

Will I Be Penalized For Not Buying Health Insurance?

The Affordable Care Act contains a provision for maintaining minimum essential health coverage referred to as an individual mandate. If you did not have qualifying insurance, you were subject to a financial penalty for the months you were without coverage. However, the tax penalty is no longer in effect. The individual mandate still applies, so there is still a rule that says you must have coverage, but there will no longer be a penalty enforced for people who do not comply with the mandate.



State Penalties

Some states have enacted their own individual health insurance mandate. This will require you to have health insurance or pay a fee on your state taxes. Check with your state tax agency or your tax preparer to determine if there is a fee where you live for being uninsured.

Where Do I Find Insurance Options?

You can enroll or purchase insurance through many different outlets, including:

- A job-sponsored employer plan
- The individual marketplace or exchange for your state
- Through a spouse or family member's plan
- Through your parent's plan if you are under 26 years old
- Directly through an insurer or insurance broker
- A government-sponsored plan like Medicare or Medicaid, if eligible
- Military or Veterans Administration (VA) benefits, if eligible

Each state has an online marketplace for its commercial health insurance. Each state's marketplace must offer a range of plans designed to meet a variety of budget and healthcare needs, as well as provide coverage that meets defined minimums. You can find links to each state's marketplace website at *www.HealthCare.gov.*

Another option to consider is buying health insurance directly from a private insurance company, an online insurance seller, an agent or broker. Contact the insurers directly to discuss options.

If you're over 65, have been diagnosed with certain medical conditions, or deemed disabled by the Social Security Administration, you may be eligible for Medicare, a federal insurance program. Additional information can be found at *www.medicare.gov*.

You may be eligible for Medicaid, which is a federally mandated, state-run program for low income individuals, families and children, pregnant women, the elderly and people with disabilities. You must meet both a coverage category and income and asset requirements. Additional information can be found at *www.medicaid.gov*.

Is There Anything Else I Need?

Although new plans must have a minimum amount of coverage in each of the Essential Health Benefits, the exact amount of coverage may vary depending on the actual plan you choose. You have options for additional coverage and financial reimbursement through supplemental plans if desired.

Supplemental insurance policies can be used to cover gaps for out-of-pocket costs after insurance pays or for items that are not covered by your health insurance plan. Some policies offer cash benefits that can be applied toward practical expenses like transportation and lodging. These plans are usually named for specific situations or with a diagnosis in mind, and may be presented as "accident," "cancer" or "hospital indemnity" plans.

Dental and **vision** care are *not* essential benefits for adults, and therefore are not included in most insurance plans. You will need to purchase a separate policy specifically to cover this type of care.

Consider purchasing a supplemental plan if a financial hardship is likely when caused by paying your out-of-pocket medical bills or experiencing unpaid time off from work due to an illness. However, before choosing a supplemental policy, be sure you understand the benefits as well as the limitations of the plan, and weigh it against the premium amount.

Medicare Supplemental Insurance, Also known as Medigap help pay some of the health care cost that Original Medicare doesn't cover such as co-payments, coinsurance and deductibles. It is important to consider this open during your six-month open enrollment period that begins the month you are 65 or older and enrolled into Medicare Part B. The premium cost may be less then the overall medical cost without if you have a critical or chronic illness.

What are Essential Health Benefits?

The ACA requires **all** new insurance plans to offer basic coverage within each care category in order to be considered comprehensive. These benefits include:

- **Preventive and wellness services**
- **Chronic disease management**
- **Ambulatory or outpatient services**
- **Emergency services and hospitalization**
- **Laboratory services**
- **Pregnancy, maternity and newborn care**
- **Mental health and substance abuse treatment**
- **Pediatric services, including pediatric dental and vision**
- **Prescription drugs, including brand name and generic medications**
- **Rehabilitative, habilitative services and medical devices**

Help with Enrollment

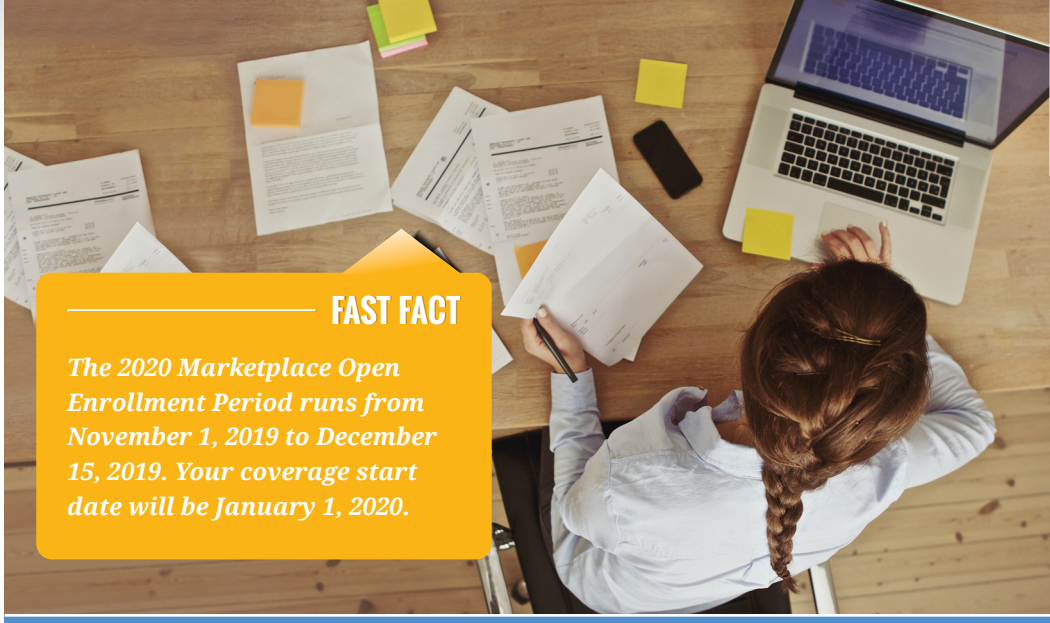
Much of the insurance enrollment process can be completed online or by phone, allowing for faster processing. Many state marketplaces offer complimentary phone assistance 24 hours a day. In addition, communities may also offer in-person marketplace enrollment assistance with a navigator or certified assister. To find a list of local organizations or phone numbers for those offering personal help in your area, go to www.*HealthCare.gov*.

What is Open Enrollment?

Open enrollment is when consumers can sign up or make changes to their coverage each year. **Once this period ends, you have to wait until the next annual enrollment period to make coverage changes**, unless you have a qualifying life event such as marriage, divorce, a new baby or moving to another state.

Many insurance companies are implementing open enrollment periods that match state marketplace periods, generally occurring in the fall. Employer-based plans can choose their open enrollment period at any point during the year.

However, if you or your family meets the eligibility requirements for your state's Medicaid program or the Children's Health Insurance Program (CHIP) you can enroll at any time of the year through the state marketplace or directly with your state's Medicaid office.



FAST FACT

The 2020 Marketplace Open Enrollment Period runs from November 1, 2019 to December 15, 2019. Your coverage start date will be January 1, 2020.

Oops, I Missed Open Enrollment

If you miss the deadline for the open enrollment period, you can *only* buy or choose a different plan if you qualify for a special enrollment period. Otherwise, you must wait until the next enrollment period.

FAST FACT

Your Marketplace application will ask you about each person in your household, even those who are not applying for coverage. Your household includes the tax filers and their tax dependents, but sometimes the Marketplace includes people you live with who aren't in your tax household.

I Cannot Afford Monthly Premiums

You may qualify for financial assistance for a marketplace plan if you meet either of these two conditions:

1. If you make between 100% and 400% of the Federal Poverty Level (FPL) guidelines and enroll in a marketplace plan in your state, you may qualify for assistance in a **Premium Tax Credit**. If you qualify, the government pays an amount toward your premium directly to the insurer on your behalf. This can help you afford health insurance and can be used right away to lower your monthly premiums. You can also choose to have the amount credited to you when you file your federal income taxes.

FAST FACT

You can get quick premium estimates before you complete an application on the HealthCare.gov website. Go to www.HealthCare.gov.

2. If your annual income is at or below 250 percent of the FPL guidelines, you may qualify for a reduction in your out-of-pocket costs associated with your insurance plan including your deductible, co-payments and co-insurance. This assistance, called **Reduced Cost Sharing**, is meant to ensure that it is affordable to use your plan benefits when you need care.

Gathering Your Information

You will be required to provide the following information when completing an application:

1. Social Security Numbers (or document numbers for legal immigrants)
2. Birthdates for you and family members
3. Employer contact information and wage information, if any, for **each** household member
4. Information about any additional sources of income, if any
5. Information about any current health insurance policies, including this information for children or other family members who will be covered

It is important that you carefully read the information about eligibility and financial assistance presented at this stage.

Making a Selection

When Choosing a Plan:

Evaluate your current medical needs and family medical history, taking a close look at frequency of doctor visits, specialty care and prescriptions, along with the following questions:

- How much would you spend on medications you are currently taking?
- What is your current household income and any anticipated changes?
- How much can you afford to pay for out-of-pocket medical expenses considering other budgeted obligations?
- What are the deductible amounts that would need to be paid before insurance kicks in?

Keep in mind that paying a slightly higher premium for a plan that provides lower out-of-pocket costs and a higher percentage of coverage throughout the year may prove to be more cost effective in the long run. *Consider making a sample budget or using a comparison chart to evaluate your plan options.*

Marketplace Plan Coverage Options:

Marketplace plans are categorized by metal levels to help easily distinguish coverage levels. Each plan is designed to pay a percentage of the total medical bills up to its defined out-of-pocket maximum.

After you reach your plan's established out-of-pocket maximum, every plan will pay 100% of the **plan's negotiated amount** for *covered* medical care.

60% BRONZE	Will cover a minimum of **60%** of the medical bills
70% SILVER	Will cover a minimum of **70%** of medical bills
80% GOLD	Will cover a minimum of **80%** of the medical bills
90% PLATINUM	Will cover a minimum of **90%** of the medical bills

FAST FACT

There are no family policies sold through the marketplace. Each consumer receives insurance coverage as an individual and has his or her own policy, even if plans are purchased at the same time. The only exception is for newborn care, which will be covered temporarily under the mother's policy.

Why Would I Get Catastrophic Only Insurance?

If you are under 30 or if you have what is defined as a "hardship exemption," you may be eligible to buy a plan that provides coverage for sudden, serious accidents or illnesses, but has *very minimal coverage* for everyday health needs or treatment of chronic conditions.

This kind of plan has a lower premium but has a high deductible of several thousand dollars which you need to meet before your insurer begins to pay its share of the cost.

If you have the option of a catastrophic plan from the marketplace, you will **not** be eligible for a tax credit or financial assistance based on your income. **Catastrophic plans provide services at a level below the Bronze plan and should be carefully considered before selection.**

Helpful Resources

These tools can help you evaluate your insurance options.

Cancer Insurance Checklist

www.cancerinsurancechecklist.com

This useful guide helps find a plan that will meet your health needs and budget in easy-to-understand worksheets, *even if you do not have a cancer diagnosis*.

Health Insurance Marketplace – Tips for Choosing a Plan

www.HealthCare.gov/choose-a-plan

With video and text information, this resource highlights the important areas to consider when choosing a plan, including amount of coverage, monthly premiums, provider network and out-of-pocket costs.

Calculators

These calculators will tell you if your income is in range to save on Marketplace premiums and how much.

healthcare.gov/lower-costs

kff.org/interactive/subsidy-calculator

Need More?

Insurance is a big decision and can impact your physical and financial health in the coming year. If you have any questions along the way, seek help from a trusted advisor or advocate, such as Patient Advocate Foundation.

Now What?

Your insurance will not go into effect until you have submitted both your application *and* first month's premium payment. Once both of those occur, expect to receive your insurance card and other documentation related to your plan. Once enrolled, it's very important that you pay each of the monthly premium payments **on time** to maintain coverage.

Get Started Using Your Insurance Benefits!

Don't be afraid to use your plan benefits. Early detection and regular healthcare are especially important to keep you healthy throughout the year.

Take advantage of annual check-ups, including preventive care to help prevent illness.

Always take your insurance card with you when you make visits to your medical provider, hospital or pharmacist. Be sure to update your information so your patient file is accurate.

Always confirm your insurance is accepted and in-network for both the medical provider being seen and for the office location at which you are being treated.

If your health insurance company doesn't pay for a specific healthcare service, you have the right to appeal the insurance company's decision.