

Why the Affordable Care Act Matters for Women: A Consumer's Guide to Choosing and Using Health Insurance

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The Affordable Care Act (ACA) is the greatest advance for women's health in a generation. In the more than six years since its passage, it has made more affordable, comprehensive health insurance coverage available to millions of consumers. About 20 million people have gained health coverage under the law,¹ and roughly 12.7 million people signed up for marketplace plans during the third open enrollment period.²

Many women have questions about health insurance, the 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 you make the best possible choice when it comes to selecting a health plan in the marketplace and using that plan to access health care services.

Insurance Basics

Health insurance can be confusing, especially for people who have been uninsured or had inconsistent access to health care. Here are a few basic definitions about health insurance that can help you choose the plan that's right for you and your family:

Premium

The monthly payment you send to your health insurer to pay for your health insurance coverage.

Cost-Sharing

In addition to paying a monthly premium, insurance plans often require you to cover part of the cost of a covered health care service. Cost-sharing is the amount you pay for a covered health care service, such as visiting the doctor or filling a prescription. It is often called a [copay](#), [coinsurance](#) or [deductible](#).

Out-of-Pocket

The costs that you have to pay yourself, even though you have health insurance. These costs are often called [copays](#), [deductibles](#) and [coinsurance](#). Under the ACA, marketplace plans have limits on how much you must pay out-of-pocket. For 2017, the maximum out-of-pocket cost for marketplace plans is \$7,150 for individual plans and \$14,300 for family plans.³

Copay

A fixed amount of money that you must pay when you access a covered health care service, for example paying \$40 to see a specialist.

Coinsurance

The *percentage* of the cost of a covered health care service you have to pay. For example, if the plan requires you to pay 20 percent coinsurance 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. For example, if you have a \$300 deductible, you will have to pay \$300 for your covered health care services before your health insurance “kicks in” and starts paying for costs associated with your care. (Under the ACA, health plans cannot apply a deductible to preventive services, such as cervical cancer screenings.)

In-Network

Health insurance companies have contracts with specific health care providers to accept their enrollees as covered patients. Providers who have contracted with your health plan are considered “in-network.” Your insurer is responsible for providing you with a list of in-network providers; it can usually be found on your health insurance company's website.

Out-of-Network

Providers who do not have a contract with your health plan are likely to be considered “out-of-network.” If you access care outside of your plan's network, you may pay more than if you went to an in-network provider or hospital.

Allowed Amount

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](#).

Qualified Health Plans (QHPs)

Health plans offered through the health insurance marketplace are called “qualified health plans” or “QHPs.” Qualified health plans cover a wide range of important health care services, including annual well-woman visits, key preventive services and maternity care. To help make your care more affordable, QHPs also limit the amount of money you must pay [out-of-pocket](#) for health care services. If you signed up for health insurance through the health insurance marketplace (HealthCare.gov or your state's marketplace website), you are enrolled in a QHP.

Open Enrollment

The time period within which you can enroll in a new health plan. Private health insurance plans only accept new customers during open enrollment periods. If you are looking to buy a plan in the marketplace, the next open enrollment period is November 1, 2016 – January 31, 2017. Medicaid and the Children's Health Insurance Program (CHIP), which are administered by the government, accept new enrollees year-round.

Special Enrollment Period

An opportunity to enroll in a health plan outside of the [open enrollment period](#). An individual must qualify for a special enrollment period in order to enroll outside of the open enrollment period. Qualifying life events, such as getting married, having a baby or losing employer-sponsored coverage, generally allow you to enroll in private health plans during a special enrollment period.

Frequently Asked Questions About the Health Insurance Marketplace

Why should I shop for health coverage in the marketplace?

- ▶ All health plans offered in the marketplace cover essential health benefits, such as 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 also cover preventive services, such as 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.
- ▶ The marketplace provides access to financial help that can make health coverage much more affordable.

What type of financial help is available in the marketplace?

Many people shopping in the marketplace are eligible for premium tax credits, which help cover the cost of health insurance [premiums](#). They may also be eligible for [cost-sharing](#) assistance, which will help reduce how much they have to pay [out-of-pocket](#) for covered health care services.

What are premium tax credits?

Premium tax credits reduce your monthly payment for your health insurance premium, so you pay less for coverage. People with incomes between 100 and 400 percent of the federal poverty level (FPL) (up to \$47,520 for an individual and \$97,200 for a family of four⁴) may be eligible for premium tax credits. To receive these credits, in most cases you cannot be eligible for public health care programs such as Medicare, Medicaid or the Children's Health Insurance Program (CHIP), or have access to affordable, minimum value coverage through an employer.⁵

What is cost-sharing assistance?

[Cost-sharing](#) assistance reduces the amount of money you need to pay [out-of-pocket](#) for covered health care services. People with incomes between 100 and 250 percent FPL (up to \$29,700 for an individual and \$60,750 for a family of four⁶) may be eligible for cost-sharing subsidies. Eligible individuals and families must enroll in a Silver-level plan to receive cost-sharing subsidies.

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 information into the [Kaiser Family Foundation's Health Insurance Marketplace Calculator](#).) If you're looking for information outside of an open enrollment period, you can find out if you might be eligible for financial help by visiting [HealthCare.gov](#).

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

Plans sold in the marketplace are categorized as bronze, silver, gold or platinum based on the percentage of covered health care services the plan will pay for.

- ▶ A bronze plan will generally pay 60 percent of expenses; if you choose a bronze plan, you'll generally pay 40 percent of your health care costs through copays, coinsurance and deductibles.
- ▶ A silver plan will pay 70 percent; if you choose a silver plan, you'll generally pay 30 percent of your health care costs through copays, coinsurance and deductibles.
- ▶ A gold plan will pay 80 percent; if you choose a gold plan, you'll generally pay 20 percent of your health care costs through copays, coinsurance and deductibles.
- ▶ A platinum plan will pay 90 percent; if you choose a platinum plan, you'll generally pay 10 percent of your health care costs through copays, coinsurance and deductibles.⁷

No matter which plan level you choose, your plan is guaranteed to cover essential health benefits, such as maternity care, and will cover important preventive services like birth control, cervical cancer screenings and mammograms – without [cost-sharing](#).

When can individuals sign up for health care coverage?

- ▶ The next open enrollment period for marketplace coverage is between **November 1, 2016 and January 31, 2017**. You may also qualify to sign up for coverage outside of open enrollment through a special enrollment period if you experience certain qualifying life events. You can find out what counts as a qualifying life event at [HealthCare.gov](#).
- ▶ Medicaid and 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.
- ▶ December 15 is the last day to sign up for coverage that will start on January 1, 2017.

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

- ▶ Plans offered in the marketplace are guaranteed to cover a wide array of health services and are required to limit [cost-sharing](#). Plans sold outside the marketplace may not be required to follow these same rules. It's important to know that

comparing costs between plans offered inside and outside the marketplace can be misleading.

- ▶ 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 to look at your options in the marketplace. While a marketplace plan may look more expensive than another plan, it may end up being much cheaper if you are eligible for financial help.

What Should I Consider When Choosing a Plan?

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](#) (this means you'll pay more each month, but less at each doctor's visit). 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 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 usual. For example, a woman who anticipates getting pregnant may want to choose a more robust health plan that covers a greater portion of 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](#).

If I am pregnant or planning to become pregnant, what type of coverage is available?

The ACA provides many coverage options for pregnant women. Depending on her income and family size, a pregnant woman may be eligible for Medicaid coverage, a qualified health plan in the marketplace with financial assistance, or both. She may also be able to get coverage through her employer. Women who are planning to become pregnant and are seeking private coverage through the health insurance marketplace need to enroll in coverage during an [open enrollment](#) period because becoming pregnant is *not* considered a qualifying life event and therefore won't allow a woman to enroll in the marketplace outside of open enrollment. (Medicaid and CHIP accept new enrollees year round.)

Are my preferred providers in the plan's network?

- ▶ If visiting a particular doctor is important to you, check that a plan lists your doctor as [in-network](#). Health plans offered in the marketplace are responsible for providing a list of in-network providers. In addition, some marketplaces, including Healthcare.gov, now offer integrated provider directories on their websites to help determine if a provider is in-network. (Since provider networks can change over time, though, it's also a good idea to call the health insurance company to confirm that a preferred provider is in-network before enrolling in coverage.)
- ▶ Keep in mind that insurance companies change their networks often. They can add and remove providers at any time, so if you're thinking about renewing your plan, make sure to check to see if your provider is still in-network.

Frequently Asked Questions About Using Health Insurance

Now that I'm enrolled in a health plan, how do I access care?

- ▶ Start by finding an [in-network](#) primary care doctor. Your health plan's website has a provider directory. Use this directory to search for a primary care doctor near you.
- ▶ If you need to visit a specialist, like an endocrinologist or cardiologist, check with your plan to see if there are any requirements you need to meet before you access specialty care. For example, some plans will require you to get a referral from a primary care doctor before you visit a specialist. (Some plans will not cover your specialty care if you did not first get a referral from a primary care doctor.)
- ▶ There is an important exception: Women do NOT need a referral from a primary care doctor to visit an OB/GYN, even though an OB/GYN is a specialist.

What does my plan cover?

- ▶ All qualified health plans (QHPs) must cover essential health benefits. If you signed up for a QHP in the marketplace, your plan covers the [essential health benefits](#) discussed above.
- ▶ All qualified health plans cover key [preventive services](#), discussed above.
- ▶ For more detailed information about covered services and [cost-sharing](#) requirements, refer to your plan's benefit guide; this is available on your insurance company's website.

Which prescription drugs are covered?

- ▶ Your plan's pharmacy benefit guide – often referred to as a “prescription drug formulary” – lists which prescription drugs are covered by your plan; it is available on your insurance company's website.
- ▶ If your doctor prescribes a drug that your health plan does not cover, you can apply for an exception. Each plan's process for an exception is different but, generally, in order to be granted an exception your doctor will need to explain to your insurance company the reason she/he has prescribed the specific drug. If your insurance company denies your request for an exception, you can file an appeal.⁸

How much will I have to pay out-of-pocket for a specific prescription drug?

- ▶ Cost-sharing requirements for prescription drugs vary, depending on the drug's “tier.” For example, generic drugs are often categorized as Tier 1, whereas specialty drugs are often categorized as Tier 4. Tier 1 drugs require the lowest [cost-sharing](#) and higher tier drugs may require greater cost-sharing.
- ▶ Refer to your plan's pharmacy benefit guide for specific cost-sharing requirements.
- ▶ You should not hesitate to ask your doctor about the cost of a prescription drug. Ask your doctor if she/he is prescribing a generic drug and/or if a generic version of a drug is available. Your doctor can explain the benefits or risks associated with taking a generic drug rather than the name-brand version. It's important to know how much your medication costs so that you can make an informed health care decision.

I know health insurance doesn't cover all of my health care costs. How do I know what my total out-of-pocket expenses will be?

- ▶ To estimate how much you should expect to spend [out-of-pocket](#) for your care, look at the “color” of your qualified health plan: bronze, silver, gold or platinum. The difference between plan colors is the amount of covered health care costs that the plan covers. This is discussed in more detail [above](#).
- ▶ No matter which plan level you have, a qualified health plan is guaranteed to cover key preventive services like birth control, cervical cancer screenings and mammograms, without [cost-sharing](#).
- ▶ Many health plans offer online tools to help consumers calculate their [out-of-pocket costs](#). To access these tools, you may need to go to your health plan's website and log into your account.
- ▶ If you are eligible for cost-sharing assistance, you will pay less out-of-pocket for covered health care services.
- ▶ Do not hesitate to ask your doctor about the cost of a test or procedure. It's important to know how much your care will cost so that you can make informed decisions about your care and your coverage.

What if my insurance company denies a claim for my care?

Under most plans, if your insurance company denies a claim for your care, you have the right to challenge the decision. Your insurance company should tell you why it denied the claim and how to appeal the decision.⁹

1 U.S. Dept. of Health and Human Services. (2016, March). *Health Insurance Coverage and the Affordable Care Act, 2010-2016*. Retrieved 18 October 2016, from <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>

2 U.S. Dept. of Health and Human Services. (2016, March). *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*. Retrieved 18 October 2016, from <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>

3 U.S. Dept. of Health and Human Services. (2016, February). *Final HHS Notice of Benefit and Payment Parameters for 2017*. Retrieved 18 October 2016, from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-fact-Sheets-items/2016-02-29.html>

4 Families USA. (2016, February). *Federal Poverty Guidelines*. Retrieved 2 September 2016, from <http://familiesusa.org/product/federal-poverty-guidelines>

5 Internal Revenue Service. (2016, October). *Questions and Answers on the Premium Tax Credit*. Retrieved 18 October 2016, from <https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit>

6 Families USA. (2016, February). *Federal Poverty Guidelines*. Retrieved 2 September 2016, from <http://familiesusa.org/product/federal-poverty-guidelines>

7 U.S. Centers for Medicare & Medicaid Services. *The 'metal' categories: Bronze, Silver, Gold & Platinum*. Retrieved 18 October 2016, from <https://www.healthcare.gov/choose-a-plan/plans-categories/>

8 U.S. Centers for Medicare & Medicaid Services. *Getting prescription medications*. Retrieved 18 October 2016, from <https://www.healthcare.gov/using-marketplace-coverage/prescription-medications/>

9 U.S. Dept. of Health and Human Services. (2014, September). *Appealing Health Plan Decisions*. Retrieved 18 October 2016, from <http://www.hhs.gov/healthcare/rights/appeal/appealing-health-plan-decisions.html>