NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

We've Got You Covered: Frequently Asked Questions on Health Care Enrollment (In-Depth Answers)

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1. What is health insurance?

Health insurance helps you pay for medical costs such as doctor visits, prescription drugs, and visits to the emergency room or a hospital stay. Health insurance is there to protect you from unmanageable medical bills in case of a medical emergency or a serious health problem. But, health insurance often also covers the basic medical costs you might face when going to the doctor to get preventive services such as birth control, annual check-ups, or health screenings.

2. What is a premium? What is cost-sharing?

The monthly premium is what you pay to the insurance company each month for your coverage. You pay this whether you use health services or not. When you get medical services that are covered by the plan, you will likely pay "cost-sharing." This can be either a set dollar amount, called a co-pay or co-payment, or a percentage of the cost of the service, called co-insurance. Your insurance may cover a different proportion of the cost depending on whether you see a provider that is in or out of the insurance company's network of providers.

3. Why do I need insurance?

You never know when you will need medical services. If something happens to you—if you are in a car accident, need to have your appendix out or find out you have diabetes—then how will you pay for your medical care? Without insurance you could find yourself owing tens of thousands of dollars for medical care you needed to save your life or manage your condition.

4. How do I go about getting insurance?

The new health insurance Marketplace is a one stop shop where you can compare and shop for health insurance. There is a Marketplace operating in every state. Some states will run their own Marketplace, and in other states, the federal government will operate the Marketplace. Starting October 1st, you can fill out a simple application to find out if you are eligible for financial assistance or other programs that provide low cost insurance. Even if you are not eligible for this help, you can still buy insurance through the new Marketplace. Go to www.healthcare.gov or call 1-800-318-2596.

5. When does health coverage take effect?

You can shop for insurance options starting October 1st and coverage will be effective starting January 1st 2014. While the new health law makes sure you can get health insurance even if you are sick, you can only start the coverage during specific periods. So if you don't have insurance and get sick, you may have to wait months before your insurance starts. Once your insurance starts, it won't pay for services you have already used.

6. What if I already have insurance?

If you already have insurance either through your job, your school, your parents, or another family member, you don't need to make any changes—but you may be able to get coverage that costs less or covers more benefits. You can contact the new insurance Marketplace (www.healthcare.gov) to find out more about your options.

7. What will it cover?

All insurance plans available through the new Marketplace will cover a core set of essential health benefits including maternity and newborn care, doctor visits, preventive care, hospitalization, prescriptions, and more.

8. Will plans cover preventive services?

Many preventive services will be covered without cost-sharing, which means you can get these services with no cost to you. These services include mammograms, cervical cancer screenings, diabetes and blood pressure screenings, depression screenings, and vaccinations. Plans also have to cover additional preventive services to women including birth control, well woman visits, lactation counseling and supplies, and screening for gestational diabetes.

9. Can I stay with the same doctor or clinic?

Each insurance plan will contract with a network of health care providers. They are sometimes called "participating providers" or "in network providers." You can compare insurance plans through the Marketplace to find out which plans your doctor, hospital or clinic has joined. Some plans only pay for services provided by doctors or other providers that are in their network. Other plans will cover some of the cost if you go out of their network. However, you may need to pay the provider up-front and ask the plan to pay you back. In addition, the plan will often pay much less than if you went to a doctor in the network and it can be difficult to find out the exact amount you will have to pay for an out-of-network doctor.

10. How much will the insurance cost and what do I have to pay?

You may have to pay a monthly premium for your health insurance. If your income is low enough, you may qualify for enough financial help that you do not have to pay a monthly premium. Otherwise, your premium will depend on which plan you choose, the number of people covered by your plan, where you live, your age and your income. You may also get help with cost-sharing, including deductibles, co-pays and co-insurance.

The Marketplace will categorize plans four tier levels—from Bronze plans, which will have the highest cost-sharing, to Platinum plans, which will have the lowest cost-sharing. The tier levels will let you easily compare plans that have similar financial protections. There are limits on the maximum amount you will ever have to pay for covered services to protect you and your family. Go to www.healthcare.gov or call 1-800-318-2596 to find out more.

11. How does financial assistance work?

Financial assistance will help make health insurance more affordable so more people can buy coverage. If you are eligible for this help, the money will go directly to the insurance company and your will pay less each month for your health insurance. Financial assistance is available for many middle class families— families with annual incomes up to about $78,000 for a family of three and $94,000 for a family of four will qualify for help. Families with somewhat lower incomes will also qualify for help with cost-sharing, including co-payments, co-insurance and deductibles. Your eligibility for financial assistance will depend on your income and family size.

12. When can I enroll?

People can shop for health insurance coverage from October 1st, 2013 through March 31st 2014. This is called the "open enrollment period." During this period you can shop for insurance, compare plans, and purchase a plan. Coverage begins as early as January 1st 2014 for people who enroll and pay by December 15th 2013. Those enrolling the end of March may not have coverage begin until May 1st 2014.

13. What happens if I don't enroll on time?

You can only enroll during enrollment periods. This means that, if you don't enroll before March 31st 2014 then you will have to wait until next October and your coverage won't begin until January 1st 2015. The exception would be if you qualify for a "special enrollment period" because you lose other health coverage, get married, divorced, give birth or adopt a child, or become newly eligible for financial assistance. You could then enroll between April 1st 2014 and September 30th 2014.

14. What if I don't pay on time?

You need to pay your premium each month to keep your health insurance. However, if you are receiving financial assistance, you will have a grace period of 90 days if you have problems paying. If you do not receive financial assistance, then you need to check with the Marketplace to find out whether or not you have a grace period. If you do not pay within your grace period, your health insurance benefits will be cancelled as of the last month that was paid. You will be responsible the full cost of any health services you used during the grace period. You will not be able to enroll again until the next enrollment period.

15. What if I don't get insurance?

The law says that almost everyone needs to have health insurance or pay a fine as of 2014. The fine is $95 in the first year, but increases over the next few years. There are a few exceptions to the requirement to have health insurance. Native Americans and certain religious communities, like the Amish, are exempt from the requirement. Other people can apply for a "hardship exemption" if they cannot afford health insurance. Check with www.healthcare.gov to see if you would qualify for any exemption. But remember, most people will have to have insurance.

16. What if my income or family size changes during the plan year?

You may need to change your insurance coverage in some circumstances. If you become pregnant, you may be eligible for your state's Medicaid program (depending on your income). If you have changes in your family size, income, or if you lose or gain a job, you should check back with Navigators and other community assistance, or at www.healthcare.gov to see if you are eligible for more financial assistance, or a different type of insurance coverage.

Things to think about:

- If you get pregnant, you may be eligible for other types of insurance. Check in with a Navigator or www.healthcare.gov to find out other options.
- If you give birth or adopt a child, you may be eligible for additional financial help to pay for insurance because your family sized changed. Check in with www.healthcare.gov.
- If you change jobs or have an increase or decrease in salary, your eligibility for financial assistance may change. Check in with www.healthcare.gov.
- If you get married, divorced or legally separated your eligibility may change. Check in with www.healthcare.gov.