NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

FACT SHEET

# New For You: Answers to Frequently Asked Questions about the Individual Market

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*The many changes coming to the individual health insurance market on January 1, 2014 will improve health insurance for millions of Americans. These changes include important protections for you if you buy coverage in this market—when you shop for coverage and when you need that coverage. If you received a notice informing you that your insurance plan does not meet the standards of the health care law, these frequently asked questions can help you understand your new protections and health plan options.*

## 1. Why are people receiving notices that their insurance plans are being discontinued?

These notices, inform plan subscribers that their individual-market health insurance plan does not meet the standards of the Affordable Care Act (ACA), and they will need to choose a new plan that does meet these requirements. When corporations take advantage of people and sell them something that does more harm than good, we expect the government to step in. That is why con-artists can't call themselves "doctor" and sell snake oil to cure all your ailments. The ACA prevents insurance carriers from selling substandard plans that do not provide coverage people need. The health care law added important improvements to the individual health insurance market so individuals and families will have insurance that works for their budget and that covers the services they need. These improvements include coverage of preventive services without cost sharing, coverage of essential health benefits and limits on cost sharing (See questions 5 and 7) as well as banning insurance practices such as excluding pre-existing conditions and canceling your insurance policy when you get sick (See questions 11 and 12).

Insurance carriers have created new health plans that are available for coverage beginning January 1, while they are discontinuing plans that do not include these improvements. Enrollees are receiving these notices now so that they have time to compare their options and purchase a new health plan with all the benefits and consumer protections guaranteed under the health care law.

## 2. Does this affect me?

This could affect you if you buy coverage through the individual market, rather than receiving health insurance through your employer or other group coverage. If it does affect you, then you will receive a notice from your insurance carrier before your coverage is discontinued. As always, employers have the flexibility to make changes to their health plans, including changing carriers, covered benefits or cost sharing. Many of these changes employers make will bring with them new benefits such as coverage of preventive services without cost sharing.

## 3. If my coverage is discontinued, where can I get new coverage?

The new health insurance Marketplace is a one-stop shop where you can compare plans and buy health insurance. There is a Marketplace operating in every state. Some states are running their own Marketplace, and in other states, the federal government is operating the Marketplace. You can access your state Marketplace at www.healthcare.gov or by calling 1-800-318-2596. You can also find local assistance to help you enroll by visiting https://localhelp.healthcare.gov/.

## 4. What if I want to remain with my insurance carrier?

You can contact your insurance carrier to find information on the new plans they are offering, or you can look to see what plans your carrier is offering through the new Marketplace. Be aware that if you enroll in a plan outside of the Marketplace[1], you will not be eligible for financial assistance (See Question 9 for more information on financial assistance). Your insurance carrier may be able to help you enroll in a plan through the Marketplace so you can receive the financial assistance. You may also wish to compare the plans offered by your carrier to other plans in the Marketplace.

## 5. Can my insurance carrier enroll me in a new plan without my permission?

Some insurance carriers are automatically enrolling people in health plans that are comparable to the plan that will no longer be offered. If you do not want the plan you were automatically enrolled in, you have other options. You can shop and compare plans through the health insurance Marketplace to see if there are plans offered by other carriers and if you are eligible for financial assistance. These carriers should be providing notice before the new plan starts so you can make a decision to enroll in a plan that best meets your needs.

## 6. What will be covered in the new health plans?

All new health insurance plans offered on the individual market will cover a core set of essential health benefits including maternity and newborn care, doctor visits, preventive care, hospitalization, prescriptions, and more. Many preventive services will be covered without cost-sharing, which means you can get these services without paying a deductible or copayment. These services include mammograms, cervical cancer screenings, diabetes and blood pressure screenings, depression screenings, and vaccinations. Plans must also cover additional women's preventive services including birth control, well woman visits, lactation counseling and supplies, and screening for gestational diabetes.

## 7. Didn't health plans already cover all these services?

No. Many health insurance plans in the individual market currently do not cover all of the essential health benefits, leaving many policy holders without coverage they need. For example, only 12 percent of plans offered on the individual market include maternity coverage, leaving many women without insurance to pay for their pregnancy and delivery.[2] Plans in this market also fail to cover other essential services—18 percent of individuals enrolled in the individual market do not have coverage for mental health services and 9 percent do not have coverage for prescription drugs.[3] Many people had health insurance that didn't really provide coverage when they needed it.

## 8. Will there be cost sharing protections?

Health plans offered on the individual market are categorized into four tiers—from Bronze plans, which will have the highest cost-sharing, to Platinum plans, which will have the lowest cost-sharing. If you compare plans within

a single tier, you will look at plans that have similar cost-sharing responsibilities, although the plan designs may differ. In addition, plans must have limits on the maximum amount you will have to pay each year for covered services to protect you and your family. Over a third of current plans in the individual market have maximums on out of pocket costs that are higher than the new limits.[4] The new limits will provide important protection against medical bankruptcy from an unexpected hospitalization or illness.

## 9. How much will a new health plan cost?

Your premium will depend on which plan you choose, the number of people covered by your plan, where you live, and your age. Depending on your income and family size, you may receive financial assistance that will reduce your monthly premium and possibly even reduce your cost-sharing, including deductibles, co-payments and co-insurance. If you are eligible for this help, the money will go directly to your insurance carrier, who will reduce the amount you pay each month for your health insurance. Many middle class families will qualify for financial assistance—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. Financial assistance for premiums and cost-sharing is only available for plans offered through the Marketplace.

## 10. How will I know the cost of my plan?

The health insurance Marketplace will provide information on pricing before you choose and enroll in a health plan. When you used to shop online for health insurance, you would see a base price, but once you applied for coverage, your price was actually higher. That won't happen when you shop through the Marketplace. You can compare plans and see prices based on the limited rating factors—your age, tobacco use and area of residence. After your application is processed, you may discover your cost is actually lower because you qualify for financial assistance.

## 11. Won't I be paying for services I don't need?

Insurance works because we all pay into a pool and then get coverage for services we use. If we could pick and choose coverage for the services we expect to use each year, then it would not be insurance. It would be more like a payment plan—the insurance companies would charge each person for the cost of the expected services plus enough to make a profit. Individuals would have no protection for unexpected costs that could cause financial ruin. Nobody knows exactly what health services they will need in a given year, so we pool our premiums together to provide comprehensive coverage that is there when we need it.

## 12. Can a plan refuse to cover me because of a pre-existing condition? Or can a plan not cover my condition because it is pre-existing?

No. An insurance carrier can no longer reject your application or charge you more because you have a pre-existing condition, such as having had a C-section, asthma, or having had medical treatment following a sexual assault. Insurance carriers are also no longer allowed to refuse to cover treatment for a pre-existing condition – such as refusing to cover your cancer treatment or a medication you were taking before you enrolled in coverage. If you felt that you were stuck in your insurance plan because other plans would not cover your pre-existing condition, you now have new options.

## 13. Doesn't the law prevent insurance carriers from kicking people off?

There are protections in the health care law that prevent insurance plans from terminating somebody's coverage because they got sick or are costing too much. Health plans must give notice before terminating coverage and

they can only kick somebody off an existing plan if the individual has committed fraud or lied about something that impacts their coverage. Health plans also have to let all enrollees reenroll in existing health plans at the end of the contract year. However, insurance carriers have always been allowed to stop offering a specific health plan. If you received a termination notice, it is because the insurance carrier is no longer offering that product.

## 14. What if I had my insurance plan before the health care law passed?

If you were enrolled in an individual market health insurance plan before the law passed on March 23, 2010 and you have not changed plans, then your plan may be grandfathered. Grandfathered plans can continue to provide coverage without having to comply with certain parts of the law—such as the requirement to provide preventive services and the essential health benefits. If you are enrolled in a grandfathered plan, the law does not prevent you from remaining enrolled in the same plan. If you are enrolled in a grandfathered plan and receive a notice that your plan is discontinued, it is because the insurance carrier chose to no longer offer your health plan.

1 The District of Columbia and Vermont have chosen to close their insurance markets so all individual market plans are sold through the health insurance Marketplace.

2 Danielle Garrett, National Women's Law Center, *Turning to Fairness: Insurance Discrimination Today and the Affordable Care Act*, (March 2012), *available at* http://www.nwlc.org/resource/report-turning-fairness-insurance-discrimination-against-women-today-and-affordable-care-ac

3 U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Issue Brief, *Essential Health Benefits: Individual Market Coverage*, (December 2011) *available at* http://aspe.hhs.gov/health/reports/2011/individualmarket/ib.shtml

4 Kev Colemean, Health Pocket, *1 in 3 Health Plans' Out-of-Pocket Costs Fail ACA Standards*, (February 2013) *available at* http://www.healthpocket.com/healthcare-research/infostat/1-3-health-plans-out-of-pocket-costs-fail-aca-standards/#.UnEVRlMwIcg