NATIONAL WOMEN'S LAW CENTER

EXPANDING THE POSSIBILITIES

We've got you covered:

What Women Need to Know About Enrollment A Toolkit for Advocates

Introduction

STARTING ON NOVEMBER 15, millions of American women will be able to enroll in new, affordable insurance, with coverage effective as early as January 1st 2015. In each state, women will be able to choose a high quality plan that covers important health services like maternity care, prescription drugs, and preventive health services. This toolkit provides resources for advocates and community leaders to make sure women and their families find out about new health coverage options available through a Health Insurance Marketplace in their state.

For more information, including individual state enrollment information, please visit: **www.nwlc.org/enrollment**.

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Enrollment Talking Points for Advocates

November 2014

General

Starting on November 15, millions of Americans will be able to enroll, or re-enroll, in affordable insurance, with coverage effective as early as January 1 of next year. If you are currently enrolled in a Marketplace plan, this is an opportunity to go back to the Marketplace and see what new options are available. All insurance plans have to cover doctor visits, hospitalizations, maternity care, emergency room care, and prescription drugs. You can find a plan that fits your budget and get financial help with premiums and cost-sharing if you need it. All insurance plans have to show their costs and what services they cover in simple, easy-to-understand language. And, insurance plans can't refuse to cover you if you have a pre-existing condition.

Coverage in the Marketplace

In each state, you can choose a high quality plan that covers all of the basic care you need, including doctor visits, hospital visits, maternity care, emergency room care, and prescription drugs. All insurance plans will have to show their costs and what services they cover in simple, easy-to-understand language. But, if you need help understanding your options, you can call a designated phone number, or receive one-on-one help from groups in your community.

Security/Peace of mind

You will get the health care you need, when you need it. You no longer have to worry that your health plan could drop you (or your family members) when you get sick. Also, you will have greater access to the care you need, including preventive services with no out-of-pocket expenses like co-pays or deductibles.

Protection from Debt/Medical Bankruptcy

You can choose a quality plan that covers all the basic care you need and fits your budget – and that protects you from the financial risk of serious illness. If a family member gets sick, you don't have to worry about big medical bills or going into bankruptcy. Plus, your insurance would protect you from unexpected costs like a large bill from the emergency room for a broken bone.

Help Enrolling

You can get help in-person through a group in your community, over the phone, online at healthcare.gov, or directly from an insurance company. Trained staff at local organizations can answer questions about the financial help you may be eligible for, and walk you through the coverage details of your plan options.

Subsidies/Tax Credits

You may qualify for financial help with your insurance costs. The government will send these subsidies straight to your insurance plan every month to help cover the cost of your premium. You may also qualify for help with cost-sharing, such as deductibles, copayments, and coinsurance.

Fine/Penalty

Nearly everyone must have health insurance in 2015, or pay a fine. If you have very low income or cannot find an affordable plan, you may be exempted from paying this fine.

Targeted Messages for Moms

Pre-existing conditions

Being a woman no longer means being a pre-existing condition. Insurance companies can no longer deny women health coverage because they have a pre-existing health condition, or if they are a survivor of domestic violence or had a Caesarean section. Similarly, they can no longer charge women more than men for the same health plan, simply for being women.

Role of Mom

Most women would do anything for their loved ones, including making sure they get the care that they need when they need it and protecting them from financial catastrophe if they get sick. But too many young adults believe they don't need health insurance. But who do they listen when it comes to health care? Mom. Talk to your adult kids about why they need health coverage and the health insurance options they have to choose from

General

Starting on November 15, people who need insurance can sign up for insurance plans online at healthcare.gov, over the phone, or in-person through a community group. If your loved ones have been uninsured, have trouble affording their premiums or have a substandard insurance plan, they will be able to choose a quality plan in the Marketplace that works for them. If they already have a plan through the Marketplace, they should visit the Marketplace to update their information and understand any new options that are available this year.

Safety/Security

You will get the health care you need, when you need it. You will no longer have to worry that your family members could be dropped from their insurance coverage when they get sick. Also, you will have greater access to the care you need, including preventive services with no out-of-pocket expenses like co-pays or deductibles.

Messages for Young Women

Financial Help

Before the law, many young women couldn't afford health insurance. Now, millions of people receive financial help to buy a health insurance plan. If you have Marketplace coverage, you can shop for a new plan or choose to stay in your current plan beginning on November 15, with coverage beginning as soon as January 1 next year. Plans must cover important things like preventive services and screenings, birth control and maternity care. You may qualify for financial help with premiums and cost-sharing depending on your income. You may also qualify for free or low-cost health insurance through Medicaid.

Well-Woman Visits

When you sign-up for a new health plan, your plan must cover women's preventive services without any cost-sharing. This includes your well-woman visits, which are an opportunity to receive all your recommended preventive services and talk with your health care professional about how to manage your health. Your plan will cover multiple well-woman visits each year, if you need them. And, if you are pregnant, many of your prenatal visits will be covered without any cost-sharing as part of your well-woman visits.Well-Woman Visits

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We've Got You Covered: Frequently Asked Questions on Health Care Enrollment

November 2014

BACKGROUND ON INSURANCE

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. Health insurance also covers basic medical costs related to seeing your doctor or health care provider for preventive services such as birth control, annual check-ups, or health screenings.

2. 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 owe tens of thousands of dollars for medical care you needed to save your life or manage your condition. If you don't have health insurance, you will probably have to pay a fine of $325 (per adult without insurance in your household) — or 2 percent of your family income, whichever is more.

3. What is a premium? What is cost-sharing? What is a deductible?

You pay a monthly premium to the insurance company for your health coverage. You pay a premium whether you use health services or not.

When you get medical services that are covered by your plan, you will likely pay cost-sharing. This might be a set dollar amount, called a co-pay or co-payment, such as $20 or $30 a visit. Or you might pay a percentage of the allowed 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.

A deductible is the amount you pay for covered health care services before your health plan begins to pay your health care bills. For example, if your deductible is $1,000, your plan won't pay for your health services until you've paid $1,000 yourself. However, any payments you make for services your plan does not cover—perhaps acupuncture or message therapy—will not count towards your deductible. The deductible does not apply to preventive services—including well-woman visits, birth control, and breastfeeding support and supplies—which are covered without any patient cost-sharing and any other services your plan excludes from the deductible.

GETTING COVERAGE

4. What if I already have insurance?

If you already have insurance either through your job, your spouse or partner's job, your school, or your parents, you don't need to make any changes. If you purchased insurance on your own or through the Marketplace, you should review your options for 2015 on healthcare.gov or your state Marketplace's website. If you buy your insurance through the Marketplace, you should also update your account with any new information about your family size and income to make sure that your monthly premium for 2015 is as accurate as possible.

5. How do I get insurance?

The Health Insurance Marketplace is a one stop shop where you can compare health insurance plans. There is a Marketplace operating in every state. Some states run their own Marketplace, and in other states, the federal government operates the Marketplace. Starting November 15, you can fill out an 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. You can find out where to get in-person assistance at localhelp.healthcare.gov. Or, to apply on your own, go to www.healthcare.gov or call 1-800-318-25966.

RENEWING A MARKETPLACE PLAN

6. When can I enroll?

People can shop for health insurance coverage from November 15 through February 15, 2015. 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 1, 2015 for people who enroll and pay by December 15, 2014.

7. When does health coverage take effect?

You can shop for insurance options starting November 15. The date your coverage takes effect depends on when you enroll or renew your coverage.

- If you enroll or renew your coverage between November 15, 2014-December 15, 2014→Your coverage will take effect January 1, 2015.
- If you enroll or renew your coverage between December 16, 2014-January 15, 2014→Your coverage will take effect February 1, 2015.
- If you enroll or renew your coverage between January 16, 2014-February 15, 2014→Your coverage will take effect March 1, 2015.

While the health care law makes sure you can get health insurance even if you are sick, you can only start your 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.

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

You can only enroll during open enrollment periods. This means that, if you don't enroll before February 15 then you will have to wait until next fall and your coverage won't begin until January 1, 2016. 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 after February 15.

9. What happens if I bought insurance through the Marketplace last year?

If you bought insurance through the Marketplace last year, you will receive notices from your health insurance company and from the Marketplace. These letters will indicate whether the plan you are currently enrolled in will continue, changes to your monthly premium, and information about how your income is calculated for the financial help you may receive.

Even if you bought a plan through the Marketplace last year, you should visit healthcare.gov to update your information and consider whether you want to purchase a different plan this year. If you do not visit healthcare.gov, you will be automatically enrolled in the same plan or another plan offered by the same insurance company you have now. However, a new plan could have a different premium, cost-sharing responsibilities, or network of participating doctors and hospitals than your current plan. In addition, changes in your family size or income, for example, could influence which plan best fits your needs and budget.

If you choose to enroll in a new plan, you should let your insurance company know you are dis-enrolling from your previous plan. This will ensure you are only charged a monthly premium for the new plan.

10. What if I bought insurance from an insurance company or through a broker last year?

If you bought a Marketplace plan directly from an insurance company or through a broker last year, you will receive notices from the health insurance company and the Marketplace. These letters will indicate whether the plan you are currently enrolled in will continue, changes to your monthly premium, and information about how your income is calculated for the financial help you may receive. You should visit healthcare.gov to update your information and consider whether you want to purchase a different plan this year. If you do not visit healthcare.gov, you will be automatically enrolled in the same plan or another plan offered by the same insurance company you have now.

If you have a continuation of an old plan through an insurance company or broker, you should visit healthcare.gov to see what options are available through the Marketplace. Old plans don't always provide comprehensive benefits and there is no financial help to pay for your premiums, so you can probably find a better plan for your needs and budget at healthcare.gov. To understand your options, you can find in-person assistance through localhelp.healthcare.gov.

11. What if the plan I have is no longer available?

If the plan you have now is no longer available, you should visit healthcare.gov to explore your options.

12. 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 or 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.

13. What will insurance cover?

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

14. Will plans cover preventive services?

Many preventive services are 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 for women including birth control, well woman visits, lactation counseling and supplies, and screening for gestational diabetes.

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

Each insurance plan contracts 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 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, you may end up paying more than you would to see an in-network provider because the plan will often pay much less than an out-of-network doctor's charges. It can be difficult to find out the exact amount you will have to pay for an out-of-network doctor.

PAYING FOR INSURANCE

16. How much will the insurance cost and when 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. You will need to pay your first month's premium before your coverage will be effective.

The Marketplace categorizes plans into four tiers—from Bronze plans, which have the highest cost-sharing, to Platinum plans, which have the lowest cost-sharing. The tiers 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.

17. How does financial assistance work?

Financial assistance helps 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 you 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 $79,000 for a family of three and $95,000 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.

18. 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.

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.

- If you don't get insurance, you will probably have to pay a fine. The fine for 2015 will be $325 (per adult without insurance in your household) or 2 percent of your family income, whichever is more. There are a few exceptions to this requirement. 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 pay a fine if they don't have insurance.

A Checklist

KEY TIPS FOR OPEN ENROLLMENT

NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

A Checklist for Women: Key Tips for Open Enrollment

November 2014

The health care law makes health coverage more affordable and easier to obtain for millions of American women. Beginning November 15, women and their families will again have the opportunity to enroll in health insurance through Health Insurance Marketplaces, which operate in every state. The Marketplace will allow individuals to comparison shop to find the insurance plan that best meets their needs and budget. Women who are currently uninsured and women who already purchase insurance on their own can buy coverage through the Marketplace.

Enrollment in health insurance through the Marketplace begins November 15, and coverage will be effective as early as January 1, 2015. As you and your family prepare for enrollment in, or renewal of health coverage, here are some important questions to consider and tips for evaluating your options.

If you already have insurance through the Marketplace:

If you purchased insurance through the Marketplace last year, you will receive letters from your health insurance company and from the Marketplace. These letters will include information about changes to your monthly premium, whether the plan you are currently enrolled in will continue, and information about how your income is calculated for the financial help you may receive.

If you make no updates to your personal information or do not actively choose a new plan, you will be automatically enrolled in the same plan or another plan offered by the same insurance company you have now. However, a new plan could have different premium, cost-sharing responsibilities, or networks than the plan you are currently enrolled in.

Whether you like you current plan or not, you should visit the Marketplace (www.healthcare.gov) to update your personal information and browse the other health plans offered this year. As you decide whether to renew your plan or enroll in a new plan, here are a few things to consider:

- ✓ Do you like your current plan?
  - o Have the healthcare services you needed been covered by your plan?
  - o Has the cost-sharing been manageable this year?
  - o Were the specific doctors, clinics, or other providers you needed included in your plan network?

✓ Are you expecting any changes to your health care needs, such as getting pregnant?

If you expect to see a doctor more frequently in the future because of a new medical condition or if you are expecting to become pregnant, you may want think more about how you pay for insurance and medical costs. For example, would you prefer to pay more each month in premiums and have a lower deductible?

✓ Have you updated the Marketplace about any life changes, including changes in income, changes in family size, or a new address?

Changes in income, family size, location, and immigration status can all effect how much financial help you are eligible for. You and your family might qualify for more help to afford insurance. Be sure to update the Marketplace about these changes so you have an accurate assessment of how much you will have to pay for health insurance.

✓ Have you or your spouse been offered health insurance coverage?

If you or your spouse has an offer of health coverage through an employer, you may no longer be eligible for financial help to purchase coverage on the Marketplace.

✓ How does your plan compare to others offered on Marketplace this year?

In many places, there are more plans offered on the Marketplace this year; it's important to compare the new plan options with the plan you're enrolled in. Some of the new plans may better fit your needs and budget.

- o Is there a more affordable option this year?
- o Is there a plan that provides better coverage for your health care needs, including prescription drugs?

If this is your first time enrolling through the Marketplace:

If you are currently uninsured or purchase insurance on your own, outside of the Marketplace, you can enroll in an affordable, comprehensive health plan starting on November 15 with coverage effective as early as January 1, 2015. As you prepare for your first open enrollment, here are some key questions and tips to consider:

✓ What are your healthcare needs?

Thinking about your health care needs should help you understand what health plan will be best for you. Depending on how often you go to the doctor or how many medications your need covered, you may want to pay higher or lower premiums, or have higher or lower cost sharing when you need care. And, if you know in advance any providers you want to continue to see or the names of medications you're on, then you can check to see if the provider or medication is covered by a particular plan.

- o Do you have a health condition, like diabetes, that needs frequent monitoring?
- o Do you expect to have any major health related expenses, such as pregnancy care, this year?
- o Do you have medications you'll need covered by your insurance?
- o Do you have specific doctors, clinics, or other providers you want to have in your plan?

✓ What's your budget?

Depending on your income, you and your family may get help with your health insurance premiums, or qualify for free or low-cost health insurance. Remember that health insurance will protect you from financial risk if you get sick or need care. Insurance covers many basic health services with no additional cost for you and if you get sick or need urgent care, insurance will cover many of the services you'll need. Be prepared to pay your first month's premium before coverage will be effective.

- o What can you afford for monthly health insurance premiums and an annual deductible?
- o Would higher cost-sharing with lower premiums be better for you, or lower cost-sharing with higher premiums?
- o Would you prefer a plan with lower cost-sharing but less flexibility to see specialists or plan with more flexibility and higher costs to you?

✓ Would in-person assistance help you understand your options and make your decision?

Choosing between health insurance plans can be difficult. If you need help applying for insurance or determining which plan is right for you, you can get in-person assistance (sometimes called "navigators" or "assistors") in-person at local organizations, by phone, or online. You can find local help here: localhelp.healthcare.gov.

✓ Have you gathered important documents for you and your family?

- o Social Security cards
- o Income documents, such as tax returns or W2s
- o Citizenship and immigration documents
- o Name of doctors or medicine

✓ Have you reviewed important health insurance terms to help you understand your coverage options?

See below for definitions of many of the terms that you'll see as you enroll in coverage as well as terms used in this checklist.

Key terms to know before you enroll:

- Coinsurance is one of the ways you share the cost of medical care with your health insurance company. Coinsurance is calculated as percentage of the allowed amount for a service. For example, if the health insurance or plan's allowed amount for an office visit is $100, and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance company pays the rest of the allowed amount.
- A copayment (sometimes called a "co-pay") is the money you pay for your health services such as a doctor's appointment or when you visit the hospital; it is one of the ways you share the cost of medical care with your health insurance company. Co-payments are set dollar amounts and do not fluctuate with the allowed amount for a service but may be different for different services like a visit to your primary care provider or a specialist.
- Cost-sharing refers to the share of medical costs that you pay out of your own pocket. Cost-sharing generally includes deductibles, coinsurance, and copayments, or similar charges, but doesn't include premiums.

- A deductible is the amount you pay for covered health care services before your health plan begins to pay your health care bills. For example, if your deductible is $1,000, your plan won't pay for your health services until you've paid $1,000 yourself. However, any payments you make for services your plan does not cover—perhaps acupuncture or message therapy—will not count towards your deductible. The deductible does not apply to preventive services—including well-woman visits, birth control, and breastfeeding support and supplies—which are covered without any patient cost-sharing and any other services your plan excludes from the deductible.
  - Premium is the monthly amount you must pay towards your health insurance coverage. You pay this whether you use health services or not.
  - Health insurance is a way to help pay for your health care. You pay premiums to the health insurance company, even when you are well. In return, the health insurance company pays most of you medical bills when you get sick or hurt.