NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

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. 13.

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.