SO, YOU HAVE HEALTH INSURANCE. NOW WHAT?

Tips for Arizona consumers deciding whether to keep their individual health insurance plan or switch to a new plan.

Many consumers who buy their own health insurance face a big decision right now. Should you renew your existing plan, or switch to a new one? Here are tips for consumers, and a checklist to help you make the decision that's right for you.

TOP TIPS

1. **SHOP AROUND.** Although insurance companies must cover a variety of services and can no longer deny coverage to people with pre-existing conditions, plans range from catastrophic plans with high deductibles to plans with more comprehensive coverage. In addition to looking at your existing health insurer's plans, check out the health insurance marketplace at healthcare.gov. You can schedule a free in-person appointment at coveraz.org/connector or by calling (602)218-3900.

2. **FIND OUT IF YOU CAN PAY LESS, OR GET MORE FOR YOUR MONEY.** Many Arizonans are qualifying for financial help that could lower your monthly premium or out-of-pocket costs. While health insurance costs depend on your specific financial situation and medical needs, individuals in Arizona earning $16,000 a year or less are likely to qualify for AHCCCS, and individuals earning $40,000 a year or less are likely to qualify for financial assistance in the health insurance marketplace. Go to healthcare.gov or call (602)218-3900 for more information.

3. **GET HELP COMPARING YOUR OPTIONS AND APPLYING**. In addition to insurance agents and brokers, specially trained people such as navigators, certified application counselors and application assisters are available to help at no cost to you. You can find people in your area at coveraz.org/connector or by calling (602)218-3900.

4. **UNDERSTAND WHAT YOU'RE GETTING INTO.** Before renewing your plan or picking a different one, make sure you understand the costs, what's covered and what's excluded, and what providers are included in the plan's network. Use our checklist for help.

5. **REMEMBER THE HEALTH INSURANCE MARKETPLACE IS OPEN** from November 15, 2014 – February 15, 2015. Even if you renew your current individual plan now, you can still switch to a plan in the health insurance marketplace as long as you do so by February 15, 2015.

DECISION CHECKLIST

Find the Summary of Benefits and Coverage (SBC) for each plan you are considering.
Insurance companies must provide you with the SBC for the plans you are considering, in addition to a short glossary of terms. A link to the SBC and glossary is on the health insurance marketplace website for every plan offered there. You can see a sample SBC here: www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/sample-completed-sbc.doc

Check to see what's covered, and what's excluded.
The services in the checklist below are considered "essential health benefits" and all of them must be included in plans under the Affordable Care Act. Some Arizonans have older health plans that do not include the ACA's consumer protections, and it is common for these pre-ACA plans to lack coverage for some of these services.

Using the SBC, check to see what services are covered, and note any limits on coverage – such as any annual limit on the number of covered doctor's office visits.

- *Hospitalization*
- *Outpatient care (care you get without being admitted to a hospital, such as office visits, chemotherapy, etc.)*
- *Emergency services*
- *Maternity and newborn care*
- *Mental health and substance use disorder services, including behavioral health reatment such as counseling*
- *Prescription drugs*
- *Laboratory services, such as x-rays*
- *Preventive and wellness services, and chronic disease management*
- *Pediatric services, including oral and vision care*
- *Services and devices to help you gain or recover mental and physical skills if you have injuries, disabilities, or chronic conditions*

Where to find it: See a list of what's covered starting on page 2, and a summary of exclusions and additional coverage on page 5. See whether the plan provides minimum essential coverage on page 6 of the SBC. For more detailed information on excluded services, get the "plan document" by visiting the website or call the toll free number listed at the top of page 1 of the SBC.

For pre-ACA plans, see if care for pre-existing conditions is excluded.
It's important to do this even if you don't think you have a pre-existing condition. That's because if a medical problem is discovered in the year ahead, and it's determined that the problem started before your coverage began, the insurer may count that as a pre-existing condition and not cover the cost of your care. Find a full list of exclusions in the plan document from your insurance company.

Look at the provider network.
Many insurance companies are moving toward having narrower provider networks, and explain that doing so enables them to negotiate lower prices and keep premiums lower. Whether you are staying with the same plan, switching to a different plan with the same insurer, or changing insurers entirely, it's important to understand which providers you'll be able to visit in-network.

Where to find it: On the first page of the SBC, you'll find answers about whether the plan uses a network of providers, and a website and/or toll free number for a list of participating providers.

✔ Note the premium and factor in any tax credits.

Premiums for individual plans may increase for the coming year. Check with your insurance company to see what the premium will be if you continue your plan.

For plans sold through the health insurance marketplace, see if you qualify for a tax credit to lower your monthly premium. Find out if you qualify for lower premiums before making your final decision.

✔ Understand the out-of-pocket costs.

For each plan you consider, note the out-of-pocket cost amounts. These are likely to differ depending on whether you visit an in-network or out-of-network provider. Here are the three main types of out-of-pocket costs:

Co-pay: *A flat amount you pay when you get medical care.*

Deductible: *The amount which you must pay yourself before your insurance covers any costs. For example, a plan with a $1,000 deductible would require you to pay for your first $1,000 of medical care each year before the insurance company would cover any portion of the cost.*

Co-insurance: *This cost-sharing method usually kicks in after you hit your deductible. It requires a patient to pick up a certain percentage of the cost of a procedure while the plan covers the rest. For example, a plan with 80/20 hospital co-insurance will cover 80% of the cost of your hospital stay, and 20% of the costs will be your responsibility.*

Where to find it*: The list of in-network and out-of-network co-pays, deductibles and co-insurance starts on page 2 of the SBC.*

✔ Weigh your options and decide

Once you have the complete picture of the premium, potential out-of-pocket costs, provider network, and what's covered under each plan, you'll have an easier time weighing your options.

Remember that you can get free help comparing plans and signing up by contacting a health insurance agent or broker, or a person specially trained to help you with the health insurance marketplace such as a navigator, certified application counselor or an application assister.

✔ Estimating your potential total costs for the year.

You can use the "out-of-pocket maximum" listed on the marketplace or the SBC to help estimate your potential total costs for the year. The out-of-pocket maximum can work differently in plans outside the marketplace versus those inside the marketplace, and is often even more complicated in pre-ACA plans. The formulas below can help.

Note: *These estimates only include the costs for care covered by your insurance. If your plan doesn't cover care you need, such as prescription drugs or more than a fixed number of physical therapy visits, you would pay the entire cost, not just a co-pay or deductible. In addition, these estimates only include the out-of-pocket costs for care received in-network. Care received from providers outside the network will likely cost more and may or may not be capped by an out-of-pocket maximum.*

Plans inside the health insurance marketplace:

The out-of-pocket maximum is the most you'll pay in out-of-pocket costs in a year for in-network essential health services, including all copays, deductibles and co-insurance. Here is a simple formula to estimate potential total costs for the year, as long as your providers are in-network:

> ***Potential yearly cost for in-network essential benefits =***
> *(Monthly Premium x 12 months) + Out-of-Pocket Maximum*

Plans outside the health insurance marketplace:

Some plans outside the marketplace have one out-of-pocket maximum for medical care, and either an additional maximum for Rx drugs, or no cap at all on your Rx out-of-pocket costs. If you are looking at such a plan, add any additional out-of-pocket-maximum to the formula. If the plan has no cap on out-of-pocket Rx drug costs, do your best to estimate your Rx costs for the upcoming year and insert that into the formula.

> ***Potential yearly cost for in-network essential benefits =***
> *(Monthly Premium x 12 months) + Out-of-Pocket Maximum + Rx Out-of-Pocket Maximum or Rx cost estimate*

Pre-ACA plans:

These plans often have even more types of out-of-pocket maximums, such as a separate one for maternity care or mental health services. In addition, it's common for these plans NOT to count co-pays and deductibles toward any out-of-pocket maximum. If this is the case with your current plan, you'll need to do quite a bit more math to get an estimate.

> ***Potential yearly cost for in-network covered benefits =***
> *(Monthly Premium x 12 months) + Out-of-Pocket Maximum + Rx Out-of-Pocket Maximum + Any Additional Out-of-Pocket Maximums + Deductible + Any Additional Deductibles + Estimated Annual Total Copays*

This is where it's especially important to remember that this estimate only includes out-of-pocket costs for covered services. If the plan doesn't include coverage for care you need, such as doctor's visits or prescription drugs, you'll pay the entire cost, not just the co-pay or deductible.