

Affordable Care Act Fact Sheet: Key Considerations for Choosing a Health Plan

Background. Virtually everyone in the United States will face choices about selecting and enrolling in a health insurance plan at different times in their lives. If you or a loved one is living with MS, you know these choices can have significant impact on your personal and family finances as well as your access to health care. Fortunately, the process of learning about health coverage, comparing among available coverage options and enrolling in the plan that best meets your needs is getting easier now that major provisions of the Affordable Care Act are taking effect.

Coverage and the MS Community. Most people with MS and their families that already have coverage offered by an employer will likely have few, if any, changes in their choice of [job-based health plans](#). They are also most likely to have past experience with their plan's annual open enrollment period. If this describes you, your coverage choices are not expected to change significantly with the new law, although you may notice other differences to your plan and benefits. Reviewing the "Key Considerations" below before your annual open enrollment period begins may be helpful to you.

Uninsured. Others who are currently without health insurance, as well as [those who buy their own](#) ("individual") coverage, and certain others eligible for job-based coverage from smaller businesses will be directed to the new online health insurance Marketplace (or "Exchanges") to start the process of comparing and enrolling in a health plan as of October 2013. In addition to the Key Considerations below, there are additional considerations described further on for those who will be purchasing coverage through the Marketplace.

Key Considerations for Choosing a Health Plan. Among the new legal requirements for health insurers and plans are new standards for all written descriptions of plan benefits, their costs and explanations of how the plan works. To assure prospective plan members get information that helps make "apples-to-apples" comparisons between different health plan options, insurance companies and group health plans must provide a **Summary of Benefits and Coverage (SBC)** and a **Uniform Glossary** of terms.

- **Summary of Benefits and Coverage (SBC).** If you are a current or prospective plan member, you have the right to a customized version of a short, plain-language Summary of Benefits and Coverage (similar to this [sample](#)) for every health plan you are eligible for during your initial open enrollment period, before you re-enroll and at any time upon request to the health plan. There is a lot of information on each SBC that is specific to each health plan, and it is recommended that you *take your time reviewing it and asking questions*. Additional details such as which prescription drugs are included in the plan's formulary may be obtained from the plan through a toll free number or a hyper-link on the SBC form.
- **Uniform Glossary of Terms.** A [Uniform Glossary](#) of terms used in health coverage and medical care is an important resource for definitions of health insurance

terminology such as “co-insurance,” “medically necessary,” “out-of-pocket limits,” and more. Understanding these terms can help you compare your plan choices and take best advantage of the coverage you get from a health plan.

- ***Consider All Costs.*** Look at all of your potential costs in a health plan, and not just the premium. A good rule of thumb about your costs in a health plan is the higher the monthly premium, the greater the coverage (and lower copayments and/or co-insurance when you use health care); the lower your premium the less coverage from the plan (and higher the costs to you when you use care).
- ***In Network Providers Less Expensive.*** Health plans typically cover a greater portion of the total cost of healthcare services when you use doctors, hospitals, pharmacies and other health care providers that are in the plan’s provider network. (To be an “in-network provider” means the provider has agreed to the plan’s pre-negotiated payment rate.) Examine the list of network providers of any health plan you are considering, and don’t hesitate to ask for verification as these lists can change frequently. It may be necessary to use out-of-network provider(s) for certain needs from time to time, but it is best to know in advance whether a provider is ‘inside’ or ‘outside’ of your network so you can plan accordingly.
- ***Prescription Drug Formulary.*** Coverage of prescription drugs can be especially important for people with MS, and health insurers and plans are free to pick and choose which drugs to include on their formularies (lists of prescription drugs the plan will cover) and which to exclude. Carefully check to be sure that the drug(s) you or your family member with MS takes is on the formulary before committing to a health plan.
- ***Prescription Drug Tiers, Out of Pocket Costs.*** There can also be wide variation in the amount of coverage provided for drugs on the formulary, and this can be especially true for the so-called “specialty pharmaceuticals,” such as MS drugs. Does the plan you are considering use ‘*tiered*’ formularies, with different out-of-pocket costs for covered drugs? If yes, the amount you will have to pay for a prescription in a typical tiered drug plan will cost you the least for a Tier 1 (generic drug), a higher amount for a preferred Tier 2 brand name drug, a still higher amount for a non-preferred Tier 3 drug, and the highest amount in out-of-costs for a Tier 4 or ‘specialty’ drug.
- ***Minimum Value of Coverage Required.*** Other new standards set to take effect in 2014 will help assure that health plans provide at least a certain *minimum value* (MV) of coverage overall. With exceptions, the minimum value of coverage offered by individual and group health plans in the future is 60% of all covered benefits. The MV amount for any health plan offered to you should be made very clear.
- ***No-Cost Preventive Coverage.*** Remember to take advantage of your preventive health benefits, such as all evidence-based cancer screening tests and vaccines. Under the Affordable Care Act, these benefits must be included in all individual and group health plans with no additional charge to you in deductible or copayment

amount. The inclusion of these benefits can help you save money and take care of your health.

- **Evaluate Your Options.** Take your time evaluating your plan options. Initial and open enrollment periods are designed to allow prospective members adequate time to consider their options and completing the enrollment process before the deadline. All important dates and deadlines should be clearly presented, including the deadline for enrolling and the *effective date* (the day when coverage actually starts).

Additional Considerations for Choosing a Health Plan in the Marketplace or Exchange:

- **Health Plan Options.** All of the health plans sold through the Marketplace or Exchanges must cover the same general *‘essential health benefits’* (listed below), but they will vary by the amount of coverage they provide, and in the specific services they cover under each. There will be four categories of Marketplace insurance plans: Bronze, Silver, Gold, and Platinum. These “metal tier” categories were created to help you choose a plan that’s right for you.
 - **Platinum** plans will have the highest premium and will cover approximately 90% of the costs of covered services, leaving only 10% of the cost to you.
 - **Gold** level plans will cover approximately 80% while you would pay 20%;
 - **Silver** will cover 70% and you pay 30%
 - **Bronze** level plans will be the least expensive and will cover approximately 60% and you pay 40%. (As noted above, 60% is the minimum value that all group plans must offer or face a potential penalty.)
- **Catastrophic Coverage Option.** The one exception to the ‘metal tier’ plans described above will be a *catastrophic plan* for certain eligible individuals only. These plans will only be available to people under age 30, and to others with low incomes for whom other insurance is not considered affordable per income guidelines in the federal law. A catastrophic plan is a high deductible plan, requiring you to pay all of your medical costs up to a certain amount, usually several thousand dollars. Costs for essential health benefits over that amount are generally paid by the insurance company. Catastrophic plans only cover preventive benefits and up to three primary care visits per year at no cost.
- **Essential Health Benefits for All.** The essential health benefits that all qualified plans must cover are:
 - Ambulatory patient services (outpatient care you get without being admitted to a hospital)
 - Emergency services
 - Hospitalization
 - Maternity and newborn care (care before and after your baby is born)
 - Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
 - Prescription drugs

- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Remember that the essential health benefits are general terms, and coverage of specific services, items and medicines will vary from plan to plan.