



Choosing the Best Plan for You: A Tool for Purchasing Coverage in the Health Insurance Exchange

The Affordable Care Act (ACA) makes health insurance available to nearly all Americans and the law requires people to maintain health coverage. That coverage can be obtained through a government program (like Medicare or Medicaid), an employer, directly through an insurer, or through a policy purchased through a health insurance marketplace (also known as a state health insurance exchange) where you can buy an individual or family policy.

This tool guides you through the characteristics of health plans offered in the marketplace (also known as qualified health plans) to help you select the best plan for yourself or for a person you are assisting. The tool is structured as follows:

- 1. Overview of Plan Design.** Review of plan benefit design and generosity of various plan options.
- 2. Financial Assistance in the Marketplace.** Overview of financial assistance that may help you pay for the cost of a plan.
- 3. Key Components of Plan Selection.** Guidance through a set of considerations to evaluate available plans.

Overview of Plan Design

New insurance reforms affect all plans

All plans offered on the marketplace will meet certain new guidelines specified by the Affordable Care Act. You cannot be denied coverage because of a pre-existing condition. Plans cannot charge more based on medical history or current health care needs. Health plans must offer a set of preventive services for free, such as immunizations, women's health services, and screening colonoscopies. All plans must cover ten categories of essential health care benefits including doctor's visits, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription medicines, and rehabilitation care.

Bronze, silver, gold, and platinum indicate generosity of coverage

To make comparisons easier, plans will fall into one of four levels of coverage—platinum, gold, silver, and bronze. Each level corresponds to the portion of health care costs that the plan covers, ranging from most generous to least generous. Platinum plans have the highest premiums and lowest out-of-pocket costs, while bronze plans have the lowest premiums and the highest out-of-pocket costs. On average, platinum plans cover 90% of an average enrollee's health care spending, and the patient covers 10% (plus his or her premiums). On the other end, bronze plans cover 60% of an average enrollees' health care

***Note:** The purpose of this tool is to describe some of the factors a patient may wish to use to evaluate health plans. Each person should make an independent decision about his/her selection of a plan based on individual circumstances and adequacy of coverage in consultation with trusted advisors. Other information is available through your state's insurance marketplace.*

spending, and patients are responsible for the remaining 40%. In between, silver plans cover 70% and gold plans cover 80% of health care costs. If you are under 30 years old or if the other marketplace options are not affordable to you under the standard in the ACA, you may be eligible to buy a plan that is less expensive than a bronze plan but that provides limited benefits until you have very high health costs.

At first glance, bronze plans may be most appealing because of their low premiums. However, enrollees with regular or chronic health care needs may have to pay significant out-of-pocket costs to fill a prescription, visit the doctor, or obtain care for an unforeseen medical need. In addition, some individuals with low incomes will receive significant additional subsidies if they buy a silver plan; and in some cases they could end up paying significantly more in the long-run if they buy a bronze plan.

The Affordable Care Act also caps the amount you can be asked to spend out-of-pocket each year at \$6,350 in total (medical and prescription drug) spending. The maximum is \$12,700 for a family. This annual out-of-pocket maximum applies to all marketplace plans—bronze through platinum—though many plans will have a lower maximum than \$6,350. Out-of-pocket spending that applies toward the cap includes deductibles, copayments, coinsurance, and cost-sharing (but not premiums).

Deciding on a metal level is the first step in understanding which plan may be right for you. You also will want to understand how your plan's benefits are designed so that you strike the balance between coverage that meets your health care needs and the amount you are willing to pay in premiums and out-of-pocket costs. All plans within a single metal level are not the same, and depending on your particular health needs and the prescription medications you take, the amount you pay out-of-pocket each year could vary significantly within the same metal level. See the *Key Components of Plan Selection* section for a guide to choosing among plans in a given level of coverage.

Quick Tips

- All exchange plans cover a set of essential health benefits, and you cannot be denied coverage or charged more because of a pre-existing condition.
- Metal levels—bronze, silver, gold, and platinum—describe the overall generosity of each health plan. Platinum plans cover the highest percentage of health care costs, 90% on average, but have the highest premiums.
- Plans at the same metal level and similar premium may have wide variation in out-of-pocket costs, depending on your health needs.

Financial Assistance in the Marketplace

People who wish to purchase coverage in the marketplace will need to provide information on their income. The marketplace then will determine whether they qualify for health insurance through Medicaid, for subsidies to help pay the costs of a marketplace plan, or for unsubsidized coverage in the marketplace.

Tax credits help middle and lower income individuals pay health plan premiums

For lower and moderate-income individuals and families, the federal government will provide assistance to help pay for premiums. Subsidies are determined on a sliding scale based on income. People at the

lower end of the income scale get the most help. The subsidy is based on the premium for the second lowest cost silver plan available in the state’s marketplace; that means the amount of the subsidy is generally fixed, regardless of which plan an individual picks. The individual pays more in a more expensive plan and less in a less expensive plan.

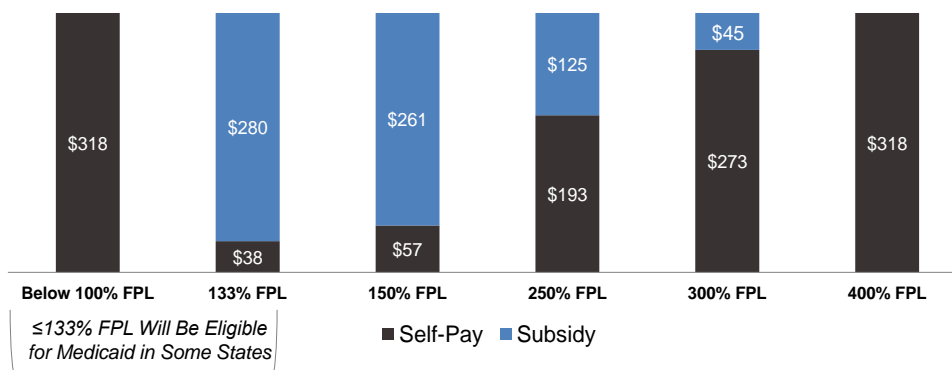
Individuals or families with income between 100% and 133% of the Federal Poverty Level (FPL) get the most help paying premiums. This group includes individuals with income between about \$11,500 and \$15,000. For a family of four, these income levels are between about \$23,500 and \$31,000. If one of these families enrolled in the second-lowest cost silver plan, they would contribute only about 2% of their income toward their premium. For example, an individual making \$15,000 a year would pay approximately \$25 a month toward his or her premium for the second lowest cost silver plan. The remainder of the premium is paid by the government. These subsidies are not available to individuals who are eligible for Medicaid, Medicare, or who have an affordable offer of employer coverage.

On the other end of the income spectrum, individuals and families up to 400% of the Federal Poverty Level also may qualify for premium subsidies. This group includes individuals with income up to about \$46,000. For a family of four, this income level is about \$94,000. This group will have to contribute about 9.5% of their income to purchase the second lowest cost silver plan. An individual making \$45,000 a year would pay approximately \$356 a month, or \$4,275 a year, for coverage in the second lowest cost silver plan.

Figure 1 offers an example of premium tax credits in California. The subsidies in your state may be different, based on the cost of the second lowest cost silver plan offered on the marketplace. Family size, age, and region will also help to determine the subsidy amount for which you qualify. Individuals with incomes below 100% of poverty are typically not eligible for Marketplace subsidies. In some states these individuals will be eligible for Medicaid. Legal immigrants who are not eligible for Medicaid may receive a premium subsidy in a marketplace plan, even if their income is below 100% FPL.

Figure 1

Example: Premium Subsidy By Income Level for Blue Shield’s Silver Plan (Region 1 in California)



Individuals should also be careful when estimating their income if they apply for premium subsidies. If a person’s total yearly income is higher than what the person estimated when he or she applied for premium

subsidies, it is possible that the Internal Revenue Service (IRS) may require some of that subsidy to be repaid when the person files his or her taxes. Therefore, individuals may want to factor in expected increases in their income over the course of the year when they apply for coverage. For example, some individuals may work extra hours during the Christmas holiday season or may receive a year-end bonus that could affect the level of subsidy for which they qualify. Individuals who are not sure what their income will be in the future should report their current income, but be sure to tell the marketplace when their income changes. Reporting income changes will help ensure people get the subsidies they are entitled to and to reduce the likelihood they have to repay subsidies at the end of the year. Individuals can also choose to take a smaller subsidy than they are entitled to, so they avoid having to repay part of the subsidy. If at the end of the year they are entitled to a larger subsidy than they have received, they will receive that money with their tax rebate.

People with limited income also may qualify for help to reduce the out-of-pocket costs of a plan

The lowest income people who are eligible for premium tax credits also qualify for cost-sharing assistance. This means that the federal government will help pay for out-of-pocket costs such as deductibles, coinsurance, and copays. You will qualify for such assistance if you make between 100% and 250% of the Federal Poverty Level, about \$11,500 to \$28,700 as an individual, or \$23,500 to \$59,000 for a family of four.

Cost-sharing assistance lowers the out-of-pocket maximum for people who qualify. Much like premium subsidies, the maximum out-of-pocket cost an individual or family pays is based on income. For those making 100% to 200% of the Federal Poverty Level, the out-of-pocket maximum is reduced by two-thirds from \$6,350 to about \$2,117. For those making 200% to 250% of the Federal Poverty Level, the out-of-pocket maximum is reduced by one-fifth from \$6,350 to \$5,080. For a family, these out-of-pocket maximums are doubled.

People who qualify for cost-sharing reductions will receive notification of their eligibility when they apply for coverage in a marketplace. To gain access to the cost-sharing reductions, eligible individuals, and families must enroll in a silver plan that is designed with the appropriate level of reduced cost sharing. The marketplace will direct eligible individuals and families to the correct set of plans. When these individuals compare among plans on the marketplace website, the cost-sharing levels displayed should reflect the reduced cost-sharing amounts.

Quick Tips

- You may qualify for a subsidy to use toward paying your premium, and some individuals will also get help with out-of-pocket costs. Your state's exchange website or enrollment hotline will verify if you qualify for help when you sign up to purchase coverage.
- If you qualify for a premium subsidy, you will not have to pay your entire premium cost upfront; the federal government will pay its portion directly to your health plan, and you will be billed for your monthly contribution only.
- You must purchase the silver plan variation that applies to your income level to access your cost-sharing assistance.

Key Components of Plan Selection

Plan Generosity

Premium costs and the generosity of coverage vary with the metal level of the plan you select. Your state marketplace website may have a cost calculator that helps you to estimate your premium and out-of-pocket costs under various plan options.

If you have a chronic condition, take several prescriptions, or need an expensive medical treatment in the near future, selecting a gold or platinum plan may be a better choice for you. Your cost sharing and total out-of-pocket spending may be lower under such a plan, though premiums may be higher. You will need to balance your need for health care services with the amount you want to pay in premium and out-of-pocket costs.

Individuals who expect less extensive health care needs may prefer to purchase less expensive bronze or silver plans. Importantly, people who receive cost-sharing reductions must enroll in the silver plan variation that applies to their income level to receive the benefit of the cost-sharing reduction.

Once you decide the level of coverage that is right for you, there are other decisions to make. Each state will have several plans at each metal level. The next three sections of this toolkit will help you sort through other factors to consider when enrolling in a marketplace plan—covered benefits and costs, provider networks, and coverage of prescription medications.

Covered Benefits and Costs

It is important to enroll in a plan that covers the health care services you and your family utilize most frequently. Plans are required to cover services across a variety of categories, but the specific kinds of care you need may not be included in the benefits of every health plan, even if you are comparing plans in the same metal level. You will also want to understand the cost-sharing structure under your plan—the deductible, copayments, and coinsurance. Finally, you should identify any limits on covered items or services, such as the number of times you can receive a recurring treatment or whether you need plan authorization before receiving a covered service. You can use the [Checklist for the Health Insurance Marketplace](#) to help you gather the information you should consider to select the plan that meets your needs.

Marketplace websites will display each plan's benefits in a standardized way so that you can compare across your options more easily. The plan also must provide information about the services that are excluded from coverage. If you or your immediate family members have specific health care needs, you should narrow your options to the plans that cover those specific services. If you or your family receives health care items or services that are not covered by the plan, you will have to pay for the entire cost of that care.

In most states, plans within the same metal level will vary in cost-sharing requirements. Marketplace websites will include a summary of deductibles, copayments, and coinsurance for different types of covered services. You may have a single deductible for all care or you may have separate deductibles, one for medical services and a second deductible for prescription drug costs. For example, one silver plan could require you to pay the first \$1,000 of your care out-of-pocket; another may have a \$500 deductible

but will ask you to pay a higher portion of your costs after you spend \$500. If you have unanticipated costs, such as an accident or sudden illness, a plan with a large deductible could leave you with significant medical bills.

Each plan website will include information about cost sharing, which may be different for specialist visits than for primary care visits. The amount you pay for a specialist visit could vary significantly from plan to plan. For example, if you are diabetic and regularly see an endocrinologist, you may want to choose a plan with a lower cost for specialist visits. Plans also will require you to share in the cost of prescription medicines.

Marketplace plans may limit the number of times you can utilize certain services during the year. If you seek care from a chiropractor, physical therapist, or mental health professional, for example, be sure to compare across plans to ensure the plan covers enough visits per year to meet your needs.

Provider Networks

Marketplace plans must have a network with a sufficient number of providers such as doctors and hospitals. They also must include a sufficient number and geographic distribution of providers who serve predominately low-income, medically underserved individuals.

It's important to understand which health care providers—such as physicians, pharmacies, and hospitals—are in the network of the plan you choose. Plans will have networks of providers from whom you can receive the most affordable care. These networks may include preferred versus non-preferred providers. Preferred providers will charge less out-of-pocket than non-preferred providers. You may not have any coverage for care that you receive from providers who are not in the plan's network. This means that any amount you spend out-of-pocket for providers who are not in your plan's network will not count toward the out-of-pocket maximum.

The marketplace website must offer a link to each plan's network of providers. When you are choosing a plan, you may want to make sure that your primary care physician—the person you see for an annual physical or when you have the flu—is in the plan's network. Otherwise, you will have to switch to a participating physician in order to receive the plan's benefits. You should also check to see if any specialists you may need are in the plan's network. Finally, be sure that your preferred pharmacies and hospitals are in-network as well. Checking the provider networks of marketplace plans will help you narrow down the options and choose a plan that will best meet your needs.

Coverage for Prescription Medications

Coverage for prescription medications is an important consideration for choosing your health plan. The set of medicines that a plan covers is called the plan's formulary. Formularies often cover medications on different tiers. Each tier has an associated cost-sharing amount. Lower tiers usually have smaller out-of-pocket costs than higher tiers. Plans may have very high out-of-pocket costs associated with therapies covered on higher tiers.

Plans can arrange formularies into many different tier structures. A typical four-tier formulary may have generic medications on Tier 1; preferred brand-name products on Tier 2; non-preferred brand therapies on Tier 3; and specialty or biologic medications on Tier 4. Cost sharing may be a fixed copayment amount

for each tier or may be coinsurance, which requires an individual to pay a percentage of the medicine's price. Estimating the amount a person will have to pay in coinsurance may be more difficult, given that a patient may not know the overall cost of each medicine he or she takes.

Understanding whether the medicines you take are covered by your health plan and the out-of-pocket costs for each will help you choose the best plan for you.

Quick Tips

- Estimate your predictable annual health needs.
- Consider, based on your anticipated health needs and your cost preferences, the right level of coverage for you—platinum, gold, silver, or bronze.
- Check to see that the physicians you visit most often are “in network” in the plans you are considering.
- Review the formulary for the prescriptions you take to understand which plan provides you the best access and least out-of-pocket cost for your medications.
- Use the [Checklist for the Health Insurance Marketplace](#) to help weigh your options among the plans available to you.

Conclusion

The 2016 Enrollment Period will begin on November 1, 2015. During the Open Enrollment Period, you will have a chance to sign up for a marketplace plan using your state's marketplace website, phone hotline, or in-person. If you purchase a plan by December 15, 2015, you will have health insurance coverage beginning January 1, 2016. Open Enrollment ends on January 31, 2016.

When you are comparing options during the Open Enrollment Period, you will likely have many choices. Narrowing down the plan offerings by comparing plan coverage and cost to your expected health care needs will make it easier to pick the plan that is best for you. This guide gives you the tools you will need to choose the best plan for you, so you can have access to the health care you want beginning in 2016.

Additional Resources

- **Premium Assistance Calculator**
<http://kff.org/interactive/subsidy-calculator/>
Kaiser Family Foundation
- **Health Reform Frequently Asked Questions**
<http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/>
Kaiser Family Foundation
- **Welcome to the Marketplace Enrollment Consumer Center**
<https://www.healthcare.gov/marketplace/individual/>
Healthcare.gov

Appendix: Premium and Cost-Sharing Subsidies

Premium Subsidies: Sliding scale tax credits to limit premium spending as a percent of income for individuals under 400% FPL; Applies to the second lowest cost Silver plan available in the exchange

Income (% FPL)	Income Range for Individual	Premiums Limited to % of Income	Estimated Annual Premium Cost (assuming \$5,200 Silver annual premium)
Individual Coverage			
100 up to 133% FPL ¹	\$11,490 – \$15,282	2.0%	\$230 – \$306
133 up to 150% FPL	\$15,282 – \$17,235	3.0 - 4.0%	\$458 – \$689
150 up to 200% FPL	\$17,235 – \$22,980	4.0 – 6.3%	\$689 – \$1,448
200 up to 250% FPL	\$22,980 – \$28,725	6.3 – 8.05%	\$1,448 – \$2,312
250 up to 300% FPL	\$28,725 – \$34,470	8.05 – 9.5%	\$2,312 – \$3,275
300 up to 400% FPL	\$34,470 – \$45,960	9.5%	\$3,275 – \$4,366

Cost-Sharing Subsidies: Provides cost-sharing subsidies for individuals with incomes below 250% FPL

Household Income	OOP Limit	Average percent of total cost paid by health plan
100 – 150% FPL	\$2,250	94%
150 – 200% FPL	\$2,250	87%
200 – 250% FPL	\$5,200	73%
250 – 400% FPL	\$6,350	70%

FPL = Federal Poverty Level

OOP = Out-of-Pocket

According to 2013 figures, 100% of FPL for an individual is \$11,490 and for a family of 4 is \$23,550. In some states individuals in this income group will be eligible for Medicaid and will receive coverage through that program instead of through marketplace premium subsidies.