OPEN ENROLLMENT

Understanding Your Health Plan and Your Cost-Sharing Responsibilities

NCRM National Organization of Rheumatology Management

AIMEDALLIANCE

During this open enrollment season, it is important to choose a healthcare plan that will provide meaningful coverage without impacting your financial stability. If you understand the basic components of a health plan and how out-of-pocket costs are calculated, you will be better suited to select a plan that meets your needs.

What terminology do I need to understand when selecting a health plan?

Health plans use key terms to explain how much you will be required to pay and whether any restrictions will be placed on your coverage and benefits. These terms include:

Copay or Copayment: A flat fee that you pay each time you use a covered health care service or medication.

Copayment Assistance: Financial assistance provided to you by drug manufacturers or other third-parties to help you purchase your medication.

Coinsurance: Instead of a flat fee, you pay a percentage of the costs of a covered health care service or medication after you have paid your deductible. For example, if your doctor's office visit costs $100 and your coinsurance is 20 percent, then you would pay $20 after you meet your deductible.

Cost-sharing: The portion you pay out of your own pocket for health care services or medications. Cost sharing generally includes copays, coinsurance, deductibles, and other charges, but does not include premiums or amounts owed for treatments or services that are not covered by your health plan.

Deductible: The amount you pay out of your own pocket for covered health care services or medications before your health plan will begin paying. For example, if you have a $1,000 deductible, you must cover $1,000 worth of health care services or medications before your plan will start paying for those services.

Formulary or Drug List: A list of prescription medications that your health plan covers.

Formulary Tiers: Medications on a formulary are usually grouped into tiers. Your copay or coinsurance amount is based on which tier your medication is in, and the higher the tier, the more you will owe. Most formularies include three or four tiers.

Maximum Out-of-Pocket Limit: The maximum amount you will have to pay for covered health care services or medications in a plan year. Once you have paid this amount on copayments, coinsurance, or deductibles, your health plan will pay 100 percent of the costs for all covered benefits.

Premium: The monthly payment that a plan enrollee makes to the health insurer to maintain coverage.

Prior Authorization: A requirement that your health plan determine whether a prescribed health care service or medication is medical necessary before you undergo the service or fill the prescription. Sometimes called preauthorization, prior approval, or precertification.

Specialty Drug: A higher-cost prescription medication that typically treats complex or chronic conditions.

Step Therapy: A requirement that you try and fail on an alternative medication before your plan will cover the medication your health care provider originally prescribed to you.

Additional definitions can be found in Aimed Alliance's "Health Insurance Matters Glossary of Terms" located here: https://aimedalliance.org/wp-content/uploads/2020/06/HealthInsuranceMattersGlossary.pdf

What do I need to consider when choosing a health plan?

When you are shopping for a health insurance plan, there are several other factors to consider.

1. What are the different types of traditional health plans?

Whether you sign up for health insurance through your employer or through a marketplace exchange, you may be offered several types of health plans. These plans have different benefits and drawbacks that you should be aware of before enrolling.

Health Maintenance Organization (HMO): A plan that provides all health services through a network of health care providers (e.g., physicians, nurses, therapists) and facilities (e.g., hospitals, medical offices, clinics).

- **Pros**: Premiums and copays are relatively low in comparison to other plans. Less paperwork as compared with other plans.
- **Cons**: The plan will limit your ability to obtain services outside of your plan's network. You may not be able to choose your health care provider. You will need a referral from your primary care provider (PCP) before you can see a specialist.

Preferred Provider Organization (PPO): A plan that includes a network of doctors, hospitals, and other providers and institutes that have agreed to charge less for plan members.

- **Pros**: You do not need a referral from your PCP to see a specialist. You can also see out-of-network providers.
- **Cons**: You will have to pay more if you go outside of your plan's network. You may have to meet your plan's deductible before it will cover the cost of out-of-network services. You may have higher premiums than with an HMO.

Exclusive Provider Organization (EPO): This is a managed care plan in which your health services will only be covered if you see physicians, specialists, or hospitals in your plan's network. Your plan will also cover out-of-network services in emergency situations.

- **Pros**: You do not need to obtain a referral from your PCP to see an in-network specialist. Your premiums may be lower than in a PPO plan.
- **Cons**: There is no coverage for out-of-network providers or services.

Point-of-Service Plan (POS): This plan combines aspects of HMOs and PPOs. Your in-network PCP will monitor your health, serve as your point-of-service, and make referrals to either in-network or out-of-network providers.

- **Pros**: You have more freedom to choose your health care provider than with an HMO.
- **Cons**: You will need a referral from your PCP to see specialists. You may be charged a higher percentage to see in-network specialists than what you are charged to see your PCP. If you see an out-of-network specialist, you may be charged even more. You may also have to complete paperwork yourself and file for reimbursement from your plan.

Catastrophic Plan: These are plans with low monthly premiums and very high deductibles that are only available for individuals under the age of 30 or who qualify for a hardship or an affordability exemption.

- **Pros**: Lower premiums. Free preventive care, even if you have not met your deductible. You can see your PCP three times before you must meet your deductible.
- **Cons**: Deductibles are high. You cannot use a premium tax credit to reduce your costs.

High-Deductible Health Plan (HDHP): This is an HMO, PPO, EPO, or POS with a high deductible.

- **Pros**: Unlike catastrophic plans, these plans can be used with health savings accounts and have no age or hardship / affordability requirements. You can use a premium tax credit subsidy.
- **Cons**: You will have to pay high out-of-pocket costs.

2. What are short-term plans?

Unlike traditional health plans that last for a full year, short-term health plans provide coverage for limited periods of time. They are intended to bridge gaps in health care coverage during times of transition (e.g., if you are between jobs). As of September 1, 2024, short-term plans can only last three months with one, one-month extension (a maximum of four months). These plans also do not have to comply with certain federal laws requiring comprehensive coverage.

- **Pros**: These plans can be flexible. Coverage ranges from 30 days to 3 or 4 months. Their premiums are typically lower than traditional plans. You can cancel these plans easily and at any time.

- **Cons**: They can reject, charge more, or otherwise discriminate against individuals based on their health condition. They are not required to cover many of the treatments that traditional plans cover or provide certain categories of coverage, such as preventive care or mental health care. Instead, these plans are designed to primarily cover emergency medical care. Additionally, there is no limit on how much these plans can charge you in out-of-pocket costs per year.

3. Does my plan have to cover certain categories of benefits?

If you purchase a health plan in your state's marketplace exchange or through Healthcare.gov, then your plan must cover, to some extent, ten categories of benefits referred to as "essential health benefits" or "EHBs."

EHBs include:

- Doctor visits
- Emergency services
- Hospitalizations
- Maternity and newborn care
- Mental health and addiction treatment services
- Prescription medications, rehabilitative and habilitative services (i.e., those that help patients with skills necessary for daily functioning) and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

If you purchase your health plan through your work or an association, or if you have a short-term plan, your plan is not required to cover all EHBs.

4. Can my health plan treat me differently if I have a preexisting condition or develop a new condition?

If your health plan is offered through your state's marketplace exchange, Healthcare.gov, or your employer, then your plan cannot exclude you from coverage or charge you more because you have a preexisting condition or develop a new condition.

However, short-term plans are permitted to treat you differently if you have a preexisting condition or develop a new condition.

If you do not want a short-term plan, be sure to look for language in the plan that states that it is a short-term plan that does not have to comply with federal laws regarding preexisting conditions. If you are not sure whether it is a short-term plan, be sure to call the insurer to double-check before you enroll.

5. Is there a limit on how much my health plan can make me pay out of pocket?

Yes, if you purchase a health plan in your state's marketplace exchange or through Healthcare.gov, or if your employer offers a health plan that covers any of the EHBs, then there is a limit on what your health plan can charge you within the plan year. The maximum out-of-pocket limits for 2024 are $9,450 for individuals and $18,900 for families. For 2025 the caps are $9,200 for individuals and $18,400 for families. These out-of-pocket caps include copayments, coinsurance, and deductible amounts. Once you have paid the maximum out-of-pocket amount, your plan will cover 100 percent of your costs for covered health care services and treatments.

If you purchase a short-term plan, then there is no cap on the amount you must pay out of pocket each year.

How do I determine what my plan will cover?

In addition to understanding the type of insurance plan that is most appropriate for you or your loved ones, you should also determine whether the plan covers the specific treatments and services that you may need and how much you will owe.

1. Is there a plan deductible, and if so, how does it affect what I pay for health services and medications?

Be sure to determine whether your plan has a deductible and how much it is. You will have to pay this amount before your health plan will begin covering the costs of your health care services and medications. In some plans, your deductible may be thousands of dollars, which means you will have to pay thousands of dollars before your plan covers your benefits. Other plans may cover certain services before you reach your deductible. Additionally, your plan may include different types of deductibles, such as:

- An individual or family deductible, depending on whether you have an individual or a family plan.
- An in-network and out-of-network deductible, which is based on whether you receive treatment from an in-network or out-of-network provider.
- A prescription medication deductible, which must be met before the plan will cover the costs of your medications.

Even after you meet your deductible, you may still be required to pay copayments and coinsurance, depending on the type of health plan you have and the services you use.

Before you enroll in a plan, be sure to contact your insurer to determine how much your medication or health care service will cost out of pocket before you have met your deductible.

2. How do I determine how much I owe for doctors' visits?

You will need to know whether your doctor is in-network or out-of-network, whether your plan covers out-of-network providers, whether you owe a copay or coinsurance, and whether your plan will cover any costs before you meet your deductible.

To determine whether your doctor is in-network or out-of-network, you will need to locate your health plan's directory and search for your doctor. You should be able to find your plan's directory online. If you cannot find it, you should call your health insurer to ask whether your doctor is in-network. If your doctor is not in-network and you are comfortable seeing a different doctor, you can ask your insurer for the name of another doctor who is in-network.

Copayment and coinsurance rates may vary based on plan type and whether your provider is in-network or out-of-network. For example, if your doctor is out-of-network and your plan is an HMO, then you may have to pay 100 percent of the cost for that visit. You can determine what your plan's rates are for in-network and out-of-network providers by looking at your plan's summary of benefits and coverage (SBC), which is a brief overview of your plan's cost-sharing requirements. Your plan's SBC should be available online. If you cannot locate it, call your insurer and ask for a copy.

Your plan may also charge you different rates based on whether you are seeing your PCP or a specialist. If you are seeing a specialist, you may need a referral from your PCP before your plan will cover your visit to the specialist. This information should also be available in the SBC.

If your plan charges you co-insurance, you will need to know how much each service costs so you can calculate how much you owe. You may want to contact your doctor to find out what his or her rates are. For example, if your doctor charges $200 per visit, and you owe a 30 percent coinsurance, you will have to pay $60 per visit once your deductible is met.

Finally, you will need to know whether you have to meet your deductible before your plan will cover any portion of your visit. Some plans will cover doctors' visits and other services before you must meet your deductible, and some will not. To make this determination, you should find your plan's SBC.

3. How do I determine how much I owe for my prescription?

You will need to locate your health plan's formulary. Once you find the formulary, look to see if your medication is listed. You will then need to determine whether your medication is on a tier. If it is on a lower tier, such as the first tier, you may have a small copay. If your medication is on a higher tier, you may owe a coinsurance, which is a percentage of the drug cost. You may need to cross-reference the formulary with your plan's SBC. The SBC will provide info on how much medications cost based on which tier they are on. If you do owe a co-insurance, you may not be able to tell how much you will pay out of pocket based on the plan documents. In that case, you should call the insurer directly and find out.

If you cannot find your medication on the formulary, look for a formulary exclusion list. If your medication is on the exclusion list, that means your medication is not covered and you will be required to pay 100

percent of the cost of your medication. You may be able to get your plan to cover an excluded drug by filing for an exemption or appeal. You can learn about the steps to file for an exemption or appeal at www. CoverageRights.org.

4. Can my plan change whether it will cover my medication mid-year?

You should be aware that many plans include language that allow a plan to change your prescription benefits after the plan year has begun. This means that your plan may change whether it will cover your medication, how much you owe for your medication, and whether you have to meet additional requirements before you can access your medication. To determine whether your plan can make these types of changes, locate your plan's formulary and look for language that allows the plan to make changes after the plan year has begun. If you cannot locate that language, you can call your insurer to double-check.

If your plan does make a change, it must notify you in writing before the change occurs. If you want to stay on your current medication, you can file for an exemption or appeal. You can learn about the steps to file for an exemption or appeal at www.CoverageRights.org.

5. What other restrictions might I face when trying to obtain a medical service or prescription?

Your plan's formulary should tell you whether there are any restrictions on your medication. For example, you may see "QL," "ST," or "PA" next to your medication on the formulary. "QL" stands for quantity limits. It means that the plan will only cover a certain amount of the medication or cover a certain number of days. "ST" stands for step therapy, which means you may be required to try and fail on a less expensive drug first before your plan will cover your prescribed medication. "PA" stands for "prior authorization," which means that you or your doctor must get your insurer to approve of the medication before the plan will cover it.

6. If my plan does not cover a service or medication that I need, is there anything I can do?

If your plan does not cover a medical service or medication that you need, you can work with your doctor to request an exemption or to file an appeal with your insurer. You can find information on how to file an exemption or appeal at www.CoverageRights. org.

Additionally, you may be able to seek financial assistance from a patient assistance program (PAP) or copay assistance program (CAP). A PAP is a nonprofit organization that provides support to individuals in need. They may help with medication or medical service copayments, insurance premiums, and other health expenses. They may also help with utility bills and transportation needs. CAPs are programs offered by pharmaceutical manufacturers to assist in covering the cost of medication copays and coinsurance. Some manufacturers also offer PAPs to provide medications to individuals who are underinsured or uninsured.

7. Does my plan place any restrictions on copayment assistance?

Your plan may include a copay accumulator program, which means that any copayment assistance you receive will not count toward your deductible or annual out-of-pocket limit. Depending on the type of plan you have and the medication you are taking, if you reach the limit on copayment assistance, you may still need to pay down your deductible before your plan will cover your prescription.

It may be difficult to locate copay accumulator language in your plan because insurers do not have uniform terminology to describe this type of restriction. To determine whether your plan includes a copay accumulator program, call your insurer and ask if copayment assistance will count toward your deductible.

8. What if I have additional questions about my insurance coverage?

If you have additional questions about your insurance coverage, you should call your health insurer. Be sure to take detailed notes about what your insurer tells you. You should also write down the name of the representative that you spoke to and the date of your conversation. If you are not satisfied that the representative has fully answered your question, ask to speak with a supervisor.

Alternatively, you can contact Aimed Alliance at policy@aimedalliance.org or (202) 349-4089, and we will do our best to help you.

How do I sign up for a healthcare plan?

There are multiple different avenues for you to enroll in a healthcare plan. Some employers may offer coverage under a group coverage plan or you may be eligible for coverage under your spouse or partner's employer's plan. Additionally, if you are under the age of 26 you may be eligible to get insurance through your parent's plan. If none of these options are available to you, you can also get coverage from the Health Insurance Marketplace or through governmental programs such as Medicare, Medicaid, and Children's Health Insurance Program. If you are a veteran or military personnel you may be eligible to get insurance through the Veterans Health Administration or TRICARE. Finally, some states also provide health insurance plans. If you need more information on where to get health insurance coverage you can visit www.usa.gov/finding-health-insurance.

1. When is open enrollment?

If you plan on getting a health insurance plan from the Federal Health Insurance Marketplace you will need to enroll during open enrollment. Fall open enrollment is from November 1, 2024 to December 15, 2024.

2. What if I miss open enrollment for the Health Insurance Marketplace?

If you miss the open enrollment period for the Health Insurance Marketplace you may still be able to eligible to get a plan through the Marketplace under the Special Enrollment Period. You are eligible to get a plan through the marketplace under the Special Enrollment Period if one of the four qualifying life events occurred:

- Loss of health coverage;
- Changes in household;
- Changes in residence; or
- Other qualifying events such as change in income, becoming a U.S. citizen, release from incarceration, or ending AmeriCorps service.

A full list of special circumstances is available at https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/.

About Aimed Alliance

Aimed Alliance is a 501(c)(3) not-for-profit organization that seeks to protect and enhance the rights of healthcare consumers and providers. We advance our mission by conducting legal research and analysis, developing economically sound policy recommendations, educating the public, and advocating for the enforcement of laws and professional ethics.

About National Organization of Rheumatology Managers

The National Organization of Rheumatology Mangers (NORM) is a forum that promotes education, expertise and advocacy for rheumatology managers and their practices. NORM provides value across the nation by cultivating a thriving community of rheumatology managers and physicians. Together, we are focused on supporting our patients and pursuing excellence in medical practice management.

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