SHOPPING FOR HEALTH INSURANCE IN VIRGINIA

Getting Started

You want to buy health insurance, but how do you choose the best plan for your needs? The Bureau of Insurance wants to assist you by offering helpful information to understand your health insurance choices. In the next few pages you will learn about individual health insurance coverage on and off the Marketplace, when to buy insurance, important things to look for, and where to go to make your purchase.

What is an Affordable Care Act (ACA) Health Insurance Plan?

An ACA plan is one that, among other things, provides coverage of 10 essential health benefit categories without lifetime or annual dollar limits; preventive care services without copays, coinsurance and deductibles; cannot be canceled based on your health; cannot be denied based on your health; and cannot have a higher premium based on your health. An ACA plan can only be bought during the open enrollment period unless you have a change in status.

NOTE: There are other types of health coverage available that do not provide all these protections and that can exclude coverage based on pre-existing conditions. That coverage can be bought at any time during the year. Premiums for those policies can be lower if you are healthy, but if you get sick you might need more coverage and would not be able to enroll into an ACA plan until the next open enrollment period.

Health Insurance Marketplace ACA Plans

The Marketplace is where you can apply for and purchase a Marketplace ACA plan and see if you qualify for cost savings. With the Marketplace, you can compare health plans and premium rates offered by private insurers online. The ACA created premium tax credits and cost-sharing reduction (deductibles, coinsurance or copayments) plans to help cut costs for eligible consumers who buy a plan through the Health Insurance Marketplace. The ONLY way to get a premium tax credit or, if eligible based on your income, to buy plans with reduced cost-sharing is to buy a plan through the Marketplace or a certified enrollment partner's website.

To learn more about the Marketplace, or to apply for coverage through the Marketplace, you can contact the Marketplace at 1-800-318-2596, or online at www.HealthCare.gov. To verify a certified enrollment partner, the website is as follows: www.HealthCare.gov/direct-enrollment/.

ACA Plans Outside of the Marketplace

ACA plans also are available for purchase outside of the Marketplace. Like coverage inside the Marketplace, you must apply for coverage during the annual Open Enrollment Period. Health insurance companies will charge the same premium for coverage sold inside or outside the Marketplace. However, premium assistance or reduced cost-sharing for eligible applicants is only available inside the Marketplace. Be sure to check with resources available to you, including your insurance agent, to help you understand your health insurance options outside of the Marketplace.

When Can I Buy an ACA Plan?

If you are shopping for individual health insurance coverage, the ONLY time you can buy an ACA plan inside or outside the Marketplace is during the annual **Open Enrollment Period**, except for a triggering event explained below. Open Enrollment for 2023 coverage **begins November 1, 2022 and ends January 15, 2023**. Enroll by December 15, 2022 for coverage that starts January 1, 2023.

When Open Enrollment is closed, the ONLY way you can buy a new ACA plan is if you do so within 60 days of experiencing a triggering event. Examples of triggering life events include:

- Losing a job due to a layoff, a reduction in hours, loss of student health coverage, quitting a job, etc.
- Gaining a dependent due to marriage, birth, adoption, or placement in foster care. Pregnancy is not a triggering event.
- Divorce
- Loss of dependent status (*e.g.* aging off your parents' plan)
- Moving to another state or outside of your health benefit plan's service area
- Exhaustion of COBRA coverage
- Losing eligibility for Medicaid or Family Access to Medical Insurance Security or FAMIS
- Income increase or decrease that changes your eligibility for subsidies if you are enrolled in a Marketplace plan
- Change in immigration status

Refer to www.HealthCare.gov/coverage-outside-open-enrollment/special-enrollment-period/ for more information regarding Special Enrollment Periods.

Medicaid

Depending on your circumstance or income level, you may qualify for other assistance such as Medicaid or FAMIS. In Virginia, the Medicaid program is administered by the Department of Medical Assistance Services (DMAS). When applying for health insurance coverage through the Marketplace (www.HealthCare.gov), it will provide you with information on this program if you qualify. For more information concerning Virginia Medicaid programs, visit www.coverva.org or call 1-855-242-8282.

Types of Plan Networks

ACA plans cover hospital care, doctor visits and prescriptions. How these benefits are delivered varies by type of plan:

Health Maintenance Organizations (HMOs): Under an HMO, you may be required to choose a primary care physician (PCP) from the HMO's provider network. Your PCP is responsible for managing your health care. Specialty care usually requires a PCP referral. Except for emergency treatment, you generally are required to use a network provider to receive covered benefits and services. Non-emergency treatment received outside the network is usually not covered.

Preferred Provider Organizations (PPOs): Under a PPO, the insurance carrier enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you choose whether to seek care from a doctor or hospital who is a preferred or participating provider of your PPO with less out-of-pocket expense to you, or from a non-participating provider when you pay a higher deductible, copayment, or applicable coinsurance. Specialty care usually does not require a PCP referral.

Point-of-Service (POS): A hybrid of the PPO and HMO models, a POS may require you to select a PCP, as with a HMO, but you may also go to an out-of-network provider and pay more out-of-pocket, as with a PPO. POS plans generally offer less coverage for health care services received from providers outside the network than for services received from providers within the network. Specialty care usually does not require a PCP referral.

Exclusive Provider Organization (EPO): Under an EPO, health care coverage is provided only for services rendered through a specified network of hospitals, doctors and other health care providers, except in emergency situations. Specialty care usually requires a PCP referral.

Metal Levels (Levels of Coverage)

To help you compare costs and levels of coverage, ACA plans and policies in the individual and small employer group markets are divided into four tiers, or "metal levels." Generally, unless you qualify for a silver plan at reduced cost-sharing based on your income, plans with lower cost-sharing will have higher premiums, while plans with higher cost-sharing will have lower premiums.

Cost-sharing is the portion you will pay for covered services, at least until you meet your annual out-of-pocket limit. The Metal Levels are designed to provide different levels of insurance coverage, with Platinum plans offering the highest level of coverage, and Bronze plans the lowest level of coverage. The plans cover between 60% and 90% of the expected medical services costs, ranging from the lowest level to the highest as follows: *Bronze, Silver, Gold* and *Platinum.*

Catastrophic plans are available to persons who are either (i) age 30 or less, or (ii) have a hardship. These are comparable to a Bronze level plan but do not pay any benefits until the deductible is met with two exceptions: (1) there is no cost share for preventive services, and (2) the enrolled person can have three doctor office visits at the plan's cost share before meeting the deductible.

ACA plan tax credits are not available for catastrophic plans.

Essential Health Benefits (EHBs)

The Affordable Care Act requires that individual and small group health insurance coverage cover EHBs, which include at least the following ten categories:

1. Ambulatory patient services (outpatient health services provided to members who are not confined to a health care institution)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatments
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services, including chronic disease management
10. Pediatric services, including oral and vision care. Some ACA plans may exclude pediatric oral care but separate plans that offer this service are available for purchase.

Health insurance companies cannot impose annual or lifetime dollar limits on EHBs. Also, regardless of the ACA plan, all in-network preventive health services must be made available to consumers with no cost-sharing.

What are the Costs?

- **Monthly Premiums**

  The monthly bill from your insurance company is called a premium. Insurance companies set a base rate for everyone who buys a health insurance plan and then adjusts the rate based on factors such as the number of people in your family that you are shopping for, age, location and tobacco use. The result after taking these factors into account is your monthly premium.

- **Copays**

  Fees charged at the time you receive a service, whether a trip to the doctor or picking up a prescription at the pharmacy, are called copays. Copays can differ depending on the type of service received. For example, a copay to your primary care doctor might be $25 while a copay for a specialist might be $40.

- **Deductibles**

  A deductible is an amount you need to pay first before your insurance company will begin to cover the cost of care. Copays may not count toward your deductible.

- **Coinsurance**

  Coinsurance is like a copay, but instead of a set dollar amount, it is a percentage of the costs of a covered health care service you pay after you have paid your deductible.

- **Out-of-Pocket Limit**

  The out-of-pocket limit is the most you will have to pay each year for EHBs covered outside of your monthly premium. Out-of-pocket costs include deductibles, coinsurance and copays for covered services. If you receive care that is not covered by your insurance, those costs will not be limited by this amount.

Out-of-Pocket Limit includes: copays, coinsurance and deductible for Essential Health Benefits (EHBs)

Out-of-Pocket Limit does not include: premiums and non-covered amounts

When you meet the Out-of-Pocket Limit for the calendar year:

- **you can stop paying copays, coinsurance, and deductibles for EHBs**
- **you continue to pay premiums and non-covered amounts.**

Comparing Health Benefit Plans and Policies

As you decide which plan to buy, it is important to compare the cost as well as the benefits and any policy exclusions. You should think about what is most important to you in a health care plan, including premium and out of pocket amounts. You should also check the plan's network of doctors, hospitals and other healthcare providers. Also review and confirm specific drugs covered and benefits that are important to you.

You may use the Health Coverage Plan Comparison Tool for plan comparison.

Now that you know where to buy a plan, when to look for a plan, basic items and services included in a plan, important things to consider, you are ready to shop! This checklist may help you review and prepare for your purchase.

Carefully:

- ✓ Make sure the providers, drugs and services important to you are available in the plan you are considering.
- ✓ Review your monthly and annual budget to determine your price range and the right combination of costs. You can use metal levels as a guide.
- ✓ Consider shopping on the marketplace at www.HealthCare.gov. You may find that you qualify for a subsidy to lower your costs.
- ✓ Make sure you have continuous coverage and always renew or purchase your insurance during open enrollment.

Important Contacts:

Are you in need of in-person help to sort out your insurance options? There are tools, resources, and qualified individuals available to assist with shopping for coverage. Visit https://coverva.org/en/find-help-in-your-area to see if there is someone in your area to assist you in applying for coverage. Navigators and certified application counselors must not ask you for money to enroll in a health plan on the Marketplace.

HealthCare.gov • See plans available • Enroll, update, change or cancel coverage • Update account information • General information about coverage and costs online • Appeal an enrollment decision • Customer Service	www.HealthCare.gov 1-800-318-2596 TTY 1-855-889-4325 www.cuidadodesalud.gov (Español)
Navigator groups offering FREE assistance: • **Enroll Virginia** • **Boat People SOS** **Find an Assister or Agent to assist you with enrollment and post-enrollment questions:**	www.enrollva.org 1-888-392-3152 www.bpsos.org (703) 538-2190 Assister - https://coverva.org/assistance/ Agent - https://localhelp.healthcare.gov
Virginia Bureau of Insurance – Life and Health Consumer Services • General insurance-related questions • Investigate insurance-related complaints	1-877-310-6560 (804) 371-9691 (In Richmond) (804) 371-9741 (Non-English Speakers) BureauofInsurance@scc.virginia.gov scc.virginia.gov/pages/Consumers
Virginia Health Benefit Exchange	1-833-740-1364 Exchangedivision@scc.virginia.gov scc.virginia.gov/pages/Details-for-Consumers
Medicaid and FAMIS Programs • Government programs offering low-cost or no-cost coverage for children, pregnant women and adults • Online eligibility screening tool	https://coverva.org 1-855-242-8282