



A Guide to Assist New Jersey Consumer Selection of Health Insurance Plans for 2015

**How Much Will the
Plan Cost?**

**Which Providers
Are Participating in
the Plan?**



**What Health Care
Services Will the
Plan Cover?**

**Where to Find
Details about
Available Plans?**

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About the Sentinel Project

The Sentinel Project is a collaboration between Seton Hall Law School and the New Jersey Appleseed Public Interest Law Center, dedicated to assuring that consumers gain meaningful access to the broad range of health care services required by the Affordable Care Act.

The Sentinel Project will collect information from individual consumers, advocates, community groups, health care providers, health insurance plans, and state and federal government regulators, to assess health plans' compliance with the new law.

As part of the Project, attorneys and law students will provide advice and assistance to consumers denied access to care that is covered but unavailable – due to outright denial of an insurance claim or because an inadequate network of providers results in them having to wait for long periods or travel long distances for health care.

The Project will use the information it gathers to create a feedback loop between consumers' experiences on the ground and those interested in ensuring access, including health insurance plans, government regulators, and the public. Its goal is to support implementation of the new law and improve consumers' access to appropriate medical care.

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A Guide to Assist New Jersey Consumer

Selection of Health Insurance Plans for 2015

Open enrollment 2015 is here, and it is time to make sure consumers have health insurance in 2015. From **November 15, 2014 to February 15, 2015**, New Jersey consumers can shop for and enroll in a plan for themselves and their families through www.HealthCare.gov, the federal **Marketplace**. Five companies are offering many plans to New Jersey consumers for 2015 – AmeriHealth, Health Republic, Horizon, Oscar, and United Healthcare.

Here are some issues and questions for consumers to keep in mind as they shop so that they can choose the plan that is best for them.

See the **Resources** section below for links to useful worksheets that can help assisters and consumers keep track of the details of different plans when comparing options available on the Marketplace.

How Much Will the Plan Cost?

Consumers should understand the **total costs** they are likely to have to pay out of their own pockets for different plans.

Premiums: The **premium** is the price of membership in an insurance plan. This is a set amount the consumer will pay to the company every year for the policy, often in equal monthly payments.

When a consumer searches for a plan on HealthCare.gov, the search result lists available plans starting with the one with the

least expensive premium and then going down to the most expensive premium. The premiums listed will be reduced by the amount of the **premium tax credit (PTC)** to which the consumer is entitled as a result of his or her income.

It's easy for consumers to focus on plans with the lowest premiums.

But the **premium is only part of the total costs** that consumers will have to pay out-of-pocket throughout the year to access healthcare.

Premium Tax Credit (PTC):

Consumers making less than 400% of the federal poverty level may qualify for a premium tax credit to help them pay for health insurance through the Marketplace. These PTCs are available to consumers based on their household income and size.

For example, qualified individuals making between \$11,670 to \$46,680 and a family of 4 with household income between \$23,850 to \$95,400 are eligible for PTCs. The lower the household income within these ranges, the greater the amount of assistance.

When consumers shop for plans through HealthCare.gov, they will be asked questions to determine if they are eligible for a PTC. If they are, the premiums quoted for available plans will reflect the PTC.

So if a plan normally costs \$600 per month, and a consumer is eligible for \$200 per month in a PTC, HealthCare.gov will show the available plan with a monthly premium of \$400 to reflect the PTC.

Cost Sharing Reductions (CSR):

Consumers may qualify for help paying their out-of-pocket cost sharing costs, including deductibles, copays, and coinsurance. These cost sharing reductions are available to consumers making less than 250% of the federal poverty level based on their 2015 household income and size.

For example, qualified individuals making between \$11,670 to \$29,175 and a family of 4 with household income between \$23,850 to \$59,625 are eligible for CSRs. The lower the household income within these ranges, the greater the amount of assistance. Importantly, consumers must select a **silver plan** to receive a CSR.

When consumers enroll through HealthCare.gov, they will be told whether they qualify for a CSR. Like with the PTC, when HealthCare.gov determines that a consumer qualifies for a CSR, the Marketplace web site lowers the deductible and out-of-pocket maximum amounts quoted for each plan available to that consumer to reflect the amount of assistance the consumer is eligible to receive.

HealthCare.gov

HealthCare.gov has a detailed **glossary** that defines terms that are used to describe health insurance: <https://www.healthcare.gov/glossary>

Cost Sharing: In addition to paying premiums each year, plans generally require consumers to pay **cost sharing**, money consumers pay when they get services. There are different types of cost sharing that plans may require from consumers.

- **Deductibles:** Most plans have a **deductible**, an amount a consumer must pay before the plan will pay for medical services that are covered by the plan. A consumer who has paid his premium and seeks covered services will have to pay the deductible out-of-pocket. Once a consumer has paid the deductible, his insurance plan will begin paying its share of the health care costs.

For example, imagine a consumer who goes to a physician for a \$3,000 service that is covered by his plan. The plan has a \$2,000 deductible. If the consumer has not paid any money out-of-pocket towards his deductible in that plan year, the consumer will have to pay \$2,000 out-of-pocket. The plan will pay its share of the remaining \$1,000 in charges.

- **Copayments:** Many plans have **copayments**, a fixed amount a consumer must pay at the time of receiving a service. Plans sometimes require different copays for different services. For example, a plan may require a consumer to pay \$40 for each visit with a specialist and \$75 if a consumer seeks care in an emergency room.

- **Coinsurance:** Similarly, some plans require consumers to pay **coinsurance**, a percentage of the cost of care the consumer must pay at the time of service. For example, if the price of a doctor's office visit is \$100, and the plan includes a 20% coinsurance requirement, the consumer will pay \$20 in coinsurance for the office visit. Like with copayments, plans may require different coinsurance amounts for different services. For example, consumers may have to pay 30% coinsurance for physician fees for out-patient surgery but a 50% coinsurance for prescription drugs.

Out-of-Pocket Limit: Each plan has an **out-of-pocket limit, or maximum**, which is the most money a consumer will have to pay during the plan year for covered **essential health benefits** services. (For more information about essential health benefits, see discussion in **"What Health Care Services Will the Plan Cover?"** section below.)

For 2015, the maximum out-of-pocket cost limit for any individual Marketplace plan may be no more than \$6,600 for an individual plan and \$13,200 for a family plan. Once a consumer pays **deductibles, copayments**, and/or **coinsurance** totaling this amount out-of-pocket during a plan year, the consumer will not have any further cost sharing obligations for covered essential health benefits during the remainder of that plan year, and the insurance company will

pay the remaining covered health care expenses. Cost sharing amounts **restart again each plan year**.

A plan's **out-of-pocket limit** is an important number for consumers to know because it helps them estimate how much they could have to pay in a plan year for covered health care services. But it is very important to understand that **some health care costs will not count toward a plan's out-of-pocket limit**. Specifically, the following health care costs (which are discussed elsewhere in this guide) generally *will not apply* to a consumer's out-of-pocket maximum, so the consumer usually will be responsible for the full amount of these costs:

- What a consumer has to pay in **premiums**.
- The costs for health care services that are **not covered** by the plan.
- Cost sharing for health care that is covered by the plan but is not an **essential health benefit**.
- The costs for health care services given by doctors who are not in the plan's network (see discussion below), or if the plan offers out-of-network benefits, out-of-network cost sharing and **balance-billed charges**.
- Penalties imposed for not getting **pre-certification** for services.

Because plans can differ on what costs they count towards the out-of-pocket maximum, consumers should check with each plan they are considering.

Balancing Premiums and Cost Sharing:

There *generally* is a **trade-off between premium and cost sharing**: plans that have lower premiums each month often require consumers to pay higher amounts of cost sharing each time they receive health care services. Plans with higher premiums, on the other hand, may impose lower cost sharing obligations on consumers at the time they receive care.

Plans available through the Marketplace are grouped into **four "metal levels"** of coverage – **bronze, silver, gold, and platinum**. The categories are based on the percentage that the plan pays of the average overall cost of providing **essential health benefits** to members.

Catastrophic plans: The ACA also permits consumers under age 30 and certain individuals who qualify for one of 14 hardship exemptions to buy a **catastrophic health plan**. These plans tend to have lower monthly premiums than any other plans, but they also have much higher deductibles. For example, several catastrophic plans available to New Jersey consumers have a \$6,600 deductible for an individual. These plans protect consumers from very high medical costs.

Bronze plans tend to have the lowest premiums of all of the metal levels, but consumers will pay the highest out-of-pocket costs when they receive health care.

Platinum plans, on the other end of the metal levels spectrum, tend to have the highest premiums, but consumers will pay the lowest cost sharing of all of the metal levels.



It may be worth it for consumers with known medical conditions to select a plan that has a higher premium but lower cost sharing each time the consumer gets care. Their total out-of-pocket costs for health care throughout the year may be less than if they paid a lower premium but had higher cost sharing each time they access health care services.

Consumers who do not expect to need much health care *may* find that it costs less out-of-pocket in total throughout the year to select a plan with a lower premium even if they have to pay a higher amount of cost sharing each time they access care.

This assumes, however, that the consumer will not need to access care often throughout the year. We get insurance to protect us from unexpected events. The healthiest person could be diagnosed tomorrow with an illness that requires expensive treatments. Consumers need to make sure that their plan offers coverage that will protect them in the event of an

unexpected health crisis. This requires balancing premiums with cost sharing to make sure consumers can access care when they need it.

Although **bronze plans** may be attractive to consumers because their monthly premiums are the lowest, consumers need to consider the higher cost sharing they will have to pay when they want to access care in exchange for the lower premium. As discussed in the

Things to Keep in Mind When Considering which Metal Level to Choose:

- **Premium tax credits** will be based on the premium for the **second lowest cost silver plan**. But consumers who qualify for PTCs may use those credits to help them purchase plans at **any of the four metal levels**.
- Consumers who qualify for **cost sharing reduction subsidies** *must* purchase a **silver plan** to receive the benefit of the CSR.
- Consumers are not eligible to receive PTCs *or* CSRs to help them pay for **catastrophic coverage**.

Helpful Tip: HealthCare.gov lets consumers **filter search results** by a number of factors, including **health plan categories**. So consumers who qualify for cost sharing reductions, for example, should narrow the search results to silver plans.

Network section below, consumers also should look at the network of health care providers that will be available with different plans.

Many of the plans available to New Jersey consumers through the Marketplace for 2015 have **significant deductibles**, up to \$2,500 for an individual and \$5,000 for a family. There have been some concerns expressed that consumers will not seek care because they are unable to meet these deductibles and therefore will not access needed care.

It is important for consumers to examine the details of plans because **plans vary** regarding cost-sharing details. For example, **some plans do not apply the deductible to prescription coverage**, which means the plan will start paying its share of the costs for prescriptions even if the consumer has not paid the deductible out-of-pocket yet during that plan year.

There also are several plans available to New Jersey consumers for 2015 that **do not require consumers to meet a deductible** before the plan will start paying its share of certain health care services, such as some or all primary care or specialist office visits or lab work. Some consumers see deductibles as barriers to coverage, while some do not. For either group, awareness of plans' treatment of deductibles can be important in selecting the best coverage for each consumer.

As discussed below, the Affordable Care Act (ACA) requires all plans to provide certain **preventive care services** to consumers at **no out-of-pocket cost**, which means that the plan's deductible and cost sharing requirements will not apply to these services if they are received from an **in-network provider**. Consumers need to know what services are preventive so they may specifically request those from providers at no out-of-pocket cost to themselves.

Networks: Which Providers Are Participating in the Plan?

Consumers may also want to learn which doctors, pharmacies, hospitals, and other health care providers and suppliers are participating in different health insurance plans that they are considering purchasing.

In-network Benefits: Insurance companies create **networks** of health care providers to provide consumers with covered health care services. These providers agree to provide health care services to members of the plan. Health care providers who have contracted with the plan may be referred to as **in-network, preferred, or participating providers**. Many of the plans offered to New Jersey consumers through **HealthCare.gov** for 2015 do not provide any coverage for services provided by health care providers who are outside of the plan's network. That means these plans *will not pay* for health care services from providers who are not part of the plan's network.

Consumers with plans that require them to use network providers are responsible for all of the costs billed by providers who are not part of the plan's network. Providers who are not in-network may charge consumers rates that are higher than the plan's contracted rates. Plans **usually do not count** costs spent by consumers for services received outside of the plan's network toward the consumer's out-of-pocket maximum or the plan's deductible.

Is my provider in-network or out-of-network?

Out-of-Network Benefits: Some plans available to New Jersey consumers through the Marketplace for 2015 do provide **out-of-network benefits**, meaning that the plan will pay for a part of the cost of services provided by health care providers who are not part of the plan's network. But generally it still costs consumers more money out-of-pocket to receive services from out-of-network providers even when a plan includes coverage for out-of-network services.

For one, plans that include out-of-network benefits usually require consumers to pay higher amounts of cost sharing if they receive services from providers who are not in the plan's network. These plans generally have a separate **out-of-network deductible**

that consumers must pay out-of-pocket before the plan will pay towards any services received outside of the plan's network. They also generally have separate, often higher, **out-of-network coinsurance or copayment** amounts and an **out-of-network out-of-pocket maximum**.

So when consumers do seek services from in-network providers, it usually will not matter how much they may have spent out-of-pocket for out-of-network care during that same plan year. They generally still will need to satisfy the in-network deductible before the plan will start paying for in-network services, and they still will have to pay the in-network out-of-pocket maximum before the plan will cover all costs.

Consumers must also be aware that even if their plan has out-of-network benefits, the plan will only pay for covered services based on an allowed amount. If an out-of-network provider charges more than the plan's allowed amount, that out-of-network provider may bill the consumer for the difference. This is called **out-of-network balance billing** – the out-of-network health care provider may bill the consumer for the difference between his normal charge and what the plan allows or permits.

HealthCare.gov provides this example: If an out-of-network hospital charges \$1,500 for an overnight stay, and the plan's allowed amount is \$1,000, the out-of-network provider may balance bill the consumer for the \$500 difference, and this \$500 usually will not count towards the plan's in-network

out-of-pocket maximum. Out-of-network balance-billed charges paid by a consumer generally do not count towards the in-network out-of-pocket maximum or deductible.

Examining Network Options: Because it usually will cost significantly more money out-of-pocket for consumers to receive care from providers who are not within a plan's network, consumers should examine the networks carefully before selecting a plan. They should know the type, location, availability, and quality of the providers that are within the plan's network, and they may wish to determine whether their own health care providers are in-network.

If a plan offers a rich network with a diverse selection of quality providers from a variety of specialties who are accepting new patients relatively close to where a consumer lives, then the consumer may not need a plan with out-of-network coverage. Federal and New Jersey law require plans to satisfy requirements that are supposed to ensure that networks are adequate.

In recent years, some insurance companies have created **narrower networks** with fewer participating providers as a way of keeping premiums low. It generally is not clear from HealthCare.gov or insurance company web sites which plans have narrow networks.

Another strategy that some plans use to keep insurance premiums down is to create **tiers** within a plan's network. Consumers may get care from any of the providers within the network. But the plan identifies

some providers as **Tier 1** and some as **Tier 2** providers. Consumers pay lower cost sharing amounts if they seek services from a Tier 1 provider and higher out-of-pocket charges if they get services from a Tier 2 provider.

Plans in New Jersey are experimenting with tiering. Some plans only vary copays or coinsurance for different tiers, but some also have a higher deductible and higher out-of-pocket maximum for Tier 2 providers.

Some plans are tiering only hospitals, while others are creating tiers of physicians as well. There are also tiered plans that are focused in certain geographic areas of the state to encourage consumers to seek care from local participating providers in exchange for lower out-of-pocket costs.

Sometimes a plan name includes the word, "tier," so consumers will know that the plan has tiers. But usually it is not clear from the search result on HealthCare.gov that a plan has tiered benefits, so consumers will need to look more carefully at plan details, as discussed below in the ***"Where to Find Details about Available Plans"*** section.



Using Provider Directories: Each insurance company keeps a list of the providers who are participating in its networks, which is called a **provider directory**. Consumers should check the directory to see if their

health care providers participate in the network before selecting any plan, including individual providers and facilities like hospitals and FQHCs. They also should look to see if their provider is in a tiered network so they are aware if they will have higher out-of-pocket costs.

If consumers' providers are not participating, consumers should consider whether there are alternative providers in the network, or if they would prefer to continue shopping until they find a plan with which their providers participate.

It is important to note that networks *may* vary from plan to plan offered by the same insurance company. So, just because a specific provider is in-network for one plan offered by a company does not mean that she is in-network for another plan offered by the same company. Consumers need to be sure they are searching the provider directory for the specific plan they are considering. For more information on *how* to find the provider directory for each plan, see the section below, [*"Where to Find Details about Available Plans."*](#)

What Health Care Services Will the Plan Cover?

All health insurance plans sold through HealthCare.gov must provide coverage for at least ten categories of health care, referred to as **essential health benefits or EHB**. These ten categories are ambulatory patient services; emergency services; hospitalization; maternity and newborn

care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.



Plans sold through HealthCare.gov in New Jersey also must meet requirements based on New Jersey law, such as the state's autism coverage mandate.

As a result, the plans available through HealthCare.gov will tend to vary more with respect to their premiums, cost sharing, and networks than with respect to specific health care services that they cover. There are some important points for consumers to know, though, about what services different plans cover:

Pediatric Dental Coverage: Pediatric dental is one of the ten EHB categories, but it is not available as part of many of the health insurance plans available to New Jersey consumers through HealthCare.gov. Instead, consumers with children may need to purchase a separate, standalone pediatric dental policy. Consumers can search for available pediatric dental plans by selecting the **“Dental Plans” tab** rather than the **“Health Plans” tab** when searching for available plans on HealthCare.gov.

Prescription Coverage: The ACA requires plans sold through the Marketplace to include coverage for **prescription drugs**, but the statute does not require plans to cover every drug. Each plan has a list of prescription drugs that are covered under the plan, which is called a **formulary** or **drug list**.



Usually plans divide covered drugs into different categories or **tiers**, which often (but not always) have different copays or coinsurance requirements. Commonly, a drug formulary has three tiers: Tier 1 often has the lowest out-of-pocket costs and usually includes generic drugs, although that is not always the case. Tier 2 then usually has a higher cost sharing amount than Tier 1 and often includes brand name drugs. Tier 3 generally has the highest copay or coinsurance requirement.

Some **“specialty drugs,”** for example to treat cancer, multiple sclerosis, or other serious diseases, often are in the most expensive tier. Consumers requiring access to these drugs should take special care to check the plan formularies to see how much the plan covers, and how much the consumer will be required to pay out-of-pocket for these drugs.

Some of the plans offered for 2015 include a cap on the out-of-pocket cost for each prescription filled. This may be a very important benefit for consumers to consider, particularly for consumers who need expensive medications.

Plans may impose limitations on the coverage of certain drugs. For example, a plan may require **prior authorization, or preauthorization,** of certain medications, which means the consumer or provider must get the plan to approve the prescription before the plan will pay its share for the medication. If the consumer does not get preauthorization, the plan may not cover the drug, even if it is on the plan’s formulary.

Plans also may impose **quantity limits** on certain prescriptions, limiting the amount of a drug that the plan will cover.

Consumers should check the plan’s **formulary** to see if the prescriptions they are taking are covered by the plan, to learn in what tier or category the plan places the prescriptions, and to see if the prescriptions are subject to any additional limitations, such as preauthorization or quantity limits. Some formularies let consumers search by prescriptions requiring precertification.

Then consumers need to find out what cost sharing will apply based on how the plan tiers or categorizes the drugs. As discussed above, consumers also will want to know whether prescriptions are subject to the plan's deductible.

It is important to note that several plans available for 2015 do not cover a medication prescribed by an out-of-network doctor even if it is filled by an in-network pharmacy. It also appears that there are some plans that will not cover a prescription filled by an in-network pharmacy that was written by an out-of-network doctor even though the plan has out-of-network benefits.

Preventive Services: The ACA requires health plans sold through the Marketplace to provide **preventive services** to plan members without any cost sharing if they receive care from an in-network provider. This means that consumers do not have to pay a copayment or coinsurance to receive these services even if they have not met their deductible.



HealthCare.gov defines preventive services as “routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.” Examples of preventive services include blood pressure

and depression screening for all adults; colorectal screening for adults over age 50; breast cancer mammography screenings every 1 to 2 years for women over age 40; and a number of vaccines for children and adults.

Consumers can access the complete list of health care services that are considered **preventive health services** for adults, women, and children on HealthCare.gov:

<https://www.healthcare.gov/preventive-care-benefits/>

This list may be updated from time-to-time based on the recommendations of the U.S. Preventive Services Task Force.

Consumers should also be sure to use an in-network provider when seeking preventive services. Plans are only required to provide preventive services at no cost within the plan's network, and plans vary regarding what they will cover if a consumer seeks preventive services from outside of the plan's network. Some plans require the consumer to pay some share of the cost. Others impose a financial cap on the amount of preventive services they will cover out-of-network. And some other plans refuse to cover preventive care when it is obtained outside of the plan's network.

Visit Limits: Although plans in the Marketplace may not set an annual or lifetime dollar limit on the money they will spend to cover consumers' essential health benefits, they are permitted to set **visit limits** for some services, as long as these non-dollar limits comply with federal and

state requirements. For example, plans may limit physical therapy to no more than thirty treatments per year. Visit limits are also common for routine gynecological examinations, dental and vision visits, and speech and occupational therapy. When consumers search for available plans on HealthCare.gov, the search result will not include information about visit limits. Consumers need to check plan materials to learn what visit limits apply to their coverage, as is described below in the section called, “[Where to Find Details about Available Plans.](#)”

PRECERTIFICATION REQUIRED

Pre-certification: Plans sometimes impose additional requirements before they will pay for certain health care services that are covered by the plan. HealthCare.gov defines **pre-certification**, which is also sometimes called **preauthorization, prior authorization, or prior approval**, as a decision by the plan “that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary.”

For example, many plans require consumers to get pre-certification before getting particular high-cost tests, like MRIs, or certain surgeries. Plans are not permitted to require pre-certification in an emergency.

Referrals: Some plans may also require consumers to get written orders called **referrals** from their primary care doctor to see a specialist or get certain medical services, even if the specialist is in the plan’s network and the service is covered by the plan. Referrals are especially common in Health Maintenance Organizations (HMOs), although other kinds of plans may require them as well.

If a consumer fails to get pre-certification or a referral before having the service, the plan may require the consumer to pay a penalty, or it may refuse to pay for the service.

Exclusions: While federal and state laws require Marketplace plans to cover a wide variety of health care services, there remain a number of services that plans may exclude from coverage. Examples of services excluded from some New Jersey plans available on HealthCare.gov include acupuncture, cosmetic surgery, adult dental care, long-term care, private-duty nursing, infertility treatment, non-emergency care when traveling outside of the country, routine adult eye care, routine foot care, and weight loss programs.

As discussed below, consumers need to review plan materials carefully to determine what health care services are excluded from a plan’s coverage. If consumers know of a specific service that they will need, they should contact the insurance company to confirm whether it is covered.



Types of Health Insurance Plans

Insurance companies commonly describe their plans as one of four types:

- **Health Maintenance Organization (HMO)** plans usually limit coverage to care from providers within the plan's network, will not cover out-of-network services except in emergencies, and require consumers to get a referral from their primary care provider (PCP) for specialist care.
- **Point of Service (POS)** plans often have out-of-network benefits, although consumers will pay less when they stay within the network. They also commonly require consumers to get referrals from PCPs for specialist visits.
- **Preferred Provider Organization (PPO)** plans generally include both in- and out-of-network benefits, often with higher cost sharing for out-of-network care, but do not require referrals from PCPs.
- **Exclusive Provider Organization (EPO)** plans generally are managed care plans that only cover services obtained from in-network providers except in emergencies. Some EPO plans do not require referrals from PCPs while others do.

The boundaries of these definitions blur. If an insurance company markets a plan as an EPO, a consumer will not know from that label whether that plan requires referrals. Consumers must read past the plan-type labels on HealthCare.gov to understand their benefits.



Where to Find Details about Available Plans?



When consumers search for plans on HealthCare.gov, the site provides only some of the important cost, network, and coverage information that consumers should consider before choosing a plan. Consumers will see:

- the name of the insurance company and the specific plan, the metal level, the type of plan, and the plan ID number;
- the estimated monthly premium (reflecting any premium tax credit the consumer is eligible for);
- the estimated deductible and out-of-pocket maximum (for a family, if the consumer is shopping for more than one person, and reflecting the amount of any cost sharing reduction for which the consumer is eligible); and
- copay and coinsurance amounts for primary doctor, specialist doctor, emergency room care, and generic drugs, sometimes indicating whether deductibles apply, but not always.

But there are a variety of details about each plan that consumers will not be able to tell from the original search return screen on HealthCare.gov. For example, consumers will not always know from the main search screen whether the deductible applies to all health care services, such as prescriptions or

office visits, so they will not have a complete picture of how much they need to pay out-of-pocket for health care. They also will not know whether the plan offers out-of-network benefits and, if it does, how deductibles, copays, coinsurance, and out-of-pocket maximums will vary depending on whether the consumer receives care in or out of the network.

Learn the Details before You Sign Up!

There are a number of ways for consumers to track down additional details about available plans to help them consider what plan is best for them:

“Learn More about This Plan”: Consumers can click on the blue ***“Learn More about This Plan”*** bar at the bottom of each plan quote in HealthCare.gov, which will bring them to a page with much more information about the plan, such as:

- ***Costs for Medical Care and Other Services:***
 - whether additional health care services, beyond the few categories listed in the main search results in HealthCare.gov, are covered by the plan and, if they are, what deductibles, copays, and coinsurance amounts apply, including hearing aids, eye exams, laboratory charges, X-rays, infertility treatment, private-duty nursing, bariatric surgery, skilled nursing facility, mental/behavioral health outpatient and inpatient services, outpatient rehabilitation

services, habilitation services, chiropractic care, acupuncture, emergency room services, inpatient hospital services, inpatient physician and surgical services, and adult and child dental services

- whether consumers can use a **Health Savings Plan (HSA)** with the plan, which is a medical savings account that consumers with qualifying high deductible health plans may use to pay for qualified medical expenses using pre-tax dollars
- **Prescription Drug Coverage:**
 - copay or coinsurance amounts at the different tier levels
 - in many cases, a link to the formulary for the plan, which lists drugs that are covered by the plan and in what tier they are categorized
 - whether the deductible applies to prescription drugs and what the out-of-pocket maximum is
- **Access to Doctors and Hospitals:**
 - link to the provider directory (see below)
 - whether the plan includes a national provider network or is a multi-state plan

Additional Links on HealthCare.gov: In the summary of each plan in HealthCare.gov's main search return, consumers also will find links to the **Summary of Benefits, Plan Brochure, Provider Directory, and List of Covered Drugs**:

- **Summary of Benefits and Coverage or "SBC":** The SBC starts as a standard form with the same columns and rows. Each plan on the Marketplace fills in the template with specific cost and coverage information about its plan. By looking at SBCs for different available plans, consumers may compare the costs and coverage of the different plans they are considering buying.

The SBC, although still just a summary of the actual plan, provides much more detail about the plan's coverage and cost sharing requirements than HealthCare.gov's main search result or even its "Learn More about This Plan" page. For example, it indicates:

- whether the plan offers **out-of-network coverage** and, if it does, how **cost sharing** will vary depending on if the consumer uses an in-network or out-of-network provider, including the amount of the **out-of-network deductible and out-of-pocket limit**
- whether the network is **tiered** and, if it is, what the consumer's **cost sharing** amounts will be at different tiers
- whether the **deductible** applies to particular health care services
- how **prescriptions** are **tiered**, the **cost sharing** at these different tiers, and any **additional limits** on prescription coverage, such as pre-authorization or quantity limits
- **Pre-certification** and **referral** requirements

- **Visit limits** for certain services
- Examples of some, but not necessarily all, of the health care services that are **excluded** from the plan's coverage
- **Examples** of how much the plan would pay and how much consumers would have to pay out-of-pocket for two health care services covered by the plan, namely, a normal childbirth and routine care for type 2 diabetes

SBCs: Summary of Benefits and Coverage

- **Plan Brochure:** Unlike the “Learn More about This Plan” page and SBC, which offer standardized information about the plan, the plan brochure is marketing material that the insurance company uses to inform consumers about its insurance plan options.

Depending on the company, consumers may find valuable information by reviewing the plan's brochure. For example, one insurance company's brochure includes a handy chart that summarizes the terms of all the plans it offers, so consumers can easily scan the columns to see how different features change among and between the plans. Other brochures are less helpful, simply providing links to the plan's SBC and

provider directory, which already are available on HealthCare.gov.

Important Issues to Note re: Summary of Benefits and Coverage or SBCs:

- SBCs are intended to make it easier to compare plans, but **the categories are not always clear**. For example, when describing the benefits for prescription drugs, several plans interpret the “Out-of-Network Provider” column in the SBC as describing the benefits, if any, when an out-of-network provider writes a prescription that is filled at an in-network pharmacy (and not the benefits when a non-participating pharmacy fills a prescription).
- At least as of the date of this report, the **links to some SBCs from HealthCare.gov are broken or at least difficult to navigate**. For example, some links bring consumers to a pdf file with several SBCs for plans at different metal levels. Others link to the company's main page, leaving consumers to root around for the correct SBC. Consumers need to confirm that the plan name in the top left of the SBC matches the name of the plan they are considering on HealthCare.gov. If there is any doubt or confusion, consumers should contact the plan for the correct SBC.

- **Provider Directory:** As discussed above, because some plans do not cover out-of-network care, and even those that do generally require consumers to pay more out-of-pocket for that care, a plan's **provider directory** is another valuable source of information for consumers. The directory lists the providers that are in the plan's network and, if the network is tiered, which tier different providers are in. The consumers then will need to check the SBC to see what the cost sharing requirements are.

There are a few things for consumers to keep in mind when they use provider directories:

- Sometimes the **links to provider directories on HealthCare.gov bring consumers to the general web site** for the insurance company that is offering the plan and not directly to the provider directory. If the company has different networks for different plans, the consumer will need to select the appropriate network to search. Often the company's web site requires consumers to select a network to search, generally from a drop-down menu. Consumers must be sure to select the correct network, which usually is based on the plan name that is listed on HealthCare.gov.
- Although federal and state regulations regulate to some extent

As of the writing of this report, there are a few instances in New Jersey where the drop-down list of plan networks in the provider directory **does not seem to match** any of the plan names from HealthCare.gov. If these problems are not fixed, consumers should call the insurance company to alert it of the problem and ask how to search the plan's network.

the content of provider directories, they are **not standardized** among the insurance companies in New Jersey. As a result, different insurers format their directories in different ways and include different information. Many provider directories let you search by an individual provider's name as well as by a facility name. Others include helpful features, like the ability to search by the gender of or languages spoken by providers and the geographic location of the provider. Some include limited quality data regarding the plan's providers.

- Although the law requires insurance companies to maintain accurate and current information about their networks, directories do not always contain accurate information. In addition, sometimes a facility such as a hospital, is in-network, but some of the health care providers who practice there are not. As a result,

after checking the directory, consumers also should **contact the insurance company and the health care provider to confirm** that a particular provider continues to be in-network for the plan and is accepting new patients.

- **List of Covered Drugs:** As discussed above, plans have a list of all of the prescription drugs that are covered by the plan, which sometimes is called the **drug list** or **formulary**. Consumers should check to see if their prescriptions are covered by the plan and, if they are, what tier each drug is in. With this information, consumers can check the **“Learn More about This Plan”** page or the **SBC** to check what cost sharing applies to their medications. The formulary also should identify if the plan imposes any other limits or requirements on coverage of the drug, such as pre-authorization or quantity limits.



- **Contact the Insurance Company Directly:** HealthCare.gov provides a wealth of information for consumers to help them shop for health insurance. But as discussed above, there can be gaps in the materials. Even the SBC, which

contains a great deal of detail, is only a summary of the plan. Technological issues, like broken links to SBCs, formularies, or provider directories, also can limit the usefulness of HealthCare.gov to consumers as they try to evaluate which plan is best for them.



Consumers should remember that they may contact insurance companies directly to learn more about the plans. If links from HealthCare.gov are broken, consumers should be able to find provider directories, SBCs, formularies, and plan brochures on the **insurers’ web sites**. They also may find additional information about companies’ available plans, such as details about their pre-authorization requirements.

There are sure to be times when the materials on HealthCare.gov and the insurers’ web sites do not address all of a consumer’s questions. Consumers should contact the insurance company by phone (see below) to ask it to explain its plan. Consumers should not purchase insurance until their answers have been addressed.

An example of why it is so important for consumers to read beyond the information contained in the HealthCare.gov initial search result:

- From the **search return** at HealthCare.gov, a consumer is told that a **silver point of service** plan for a family of 5 in Essex County has a \$5,000 **family deductible**, a \$40 **copay** for a primary doctor, a \$50 **copay** for a specialist doctor, a \$100 **copay** for emergency room care *after* meeting the **deductible**, a 50% **coinsurance** for generic drugs, and a \$12,700 **out-of-pocket maximum**.
- By clicking on the **“Learn More About This Plan” link** on HealthCare.gov, the consumer would learn a good deal more detail about the plan, including that the **deductible** does not apply to **prescription drugs**, while money the consumer spends on prescription drugs counts toward the \$12,700 **out-of-pocket maximum**. The consumer also learns that the plan does not cover **child dental care**.
- But it is not until the consumer reads the **SBC** that she learns additional potentially vital information about the plan for the first time. For example:
 - The plan has **out-of-network benefits**, so if she goes to an out-of-network provider, her **out-of-network deductible** will be \$5,000 as an individual and \$10,000 for her family, and her **out-of-pocket maximum for out-of-network care** is \$12,700 as an individual and \$25,400 for her family. (And if she stays in-network, her **individual deductible** is \$2,500.)
 - She also learns that a number of out-of-pocket costs do not count toward her **out-of-pocket maximum**, including premiums, out-of-network balance-billed charges, health care this plan does not cover, and penalties for not getting pre-certification where required by the plan.
 - Although she has a fixed **copay** without any **deductible** for primary care and specialist office visits with an **in-network provider**, if she goes to an **out-of-network provider** for these services, the **out-of-network deductible** will apply, and she will pay a 50% **coinsurance**.
 - The plan has a financial cap on the amount of **preventive care** that it will cover **out-of-network**.
 - **Blood work in-network** will not cost the consumer any money out-of-pocket, but **out-of-network blood work** will be subject to the **out-of-network deductible** and then a 50% **coinsurance**.
 - The consumer knew from the **“Learn More about This Plan”** page that the different **tiers of prescriptions** all have a 50% **coinsurance**, but for the first time she learns that this coinsurance amount is **capped** at \$125 per prescription for a 1-30 day supply and \$250 per prescription for a 31-90 day supply.
 - The plan will not cover a **prescription** filled by a pharmacy that is in the plan’s **network** if that prescription was written by a provider who is not in-network, even though the plan covers **out-of-network** health care services provided by that prescribing provider.
 - The plan imposes **visit limits** for pediatric vision coverage and speech, physical, occupational, and cognitive therapy.
 - There are a number of other plan terms disclosed to the consumer for the first time in the SBC, including **pre-certification** and **prior authorization requirements** and **in- and out-of-network copays and coinsurances** for a number of health care services.

***Resources for Consumers and Consumer Assistors to
Help with Plan Selection and Accessing Care in New Jersey***

- **HealthCare.gov** – 1-800-318-2596
 - ***From Coverage to Care: A Roadmap to Better Care and a Healthier You*** - <https://marketplace.cms.gov/outreach-and-education/downloads/c2c-roadmap.pdf>
 - ***From Coverage to Care: Discussion Guides for Community Partners*** - <https://marketplace.cms.gov/outreach-and-education/downloads/c2c-discussion-guide.pdf>
- **In-person Assistance Resources:**
 - <http://www.covernj.org/>: calendar of ACA enrollment events in New Jersey and contact information for assisters throughout the state by county
 - **Get Covered America-NJ** (to schedule in-person assistance): <https://www.getcoveredamerica.org/action-center/new-jersey/>
 - **Enroll America** (information regarding in-person assistance): <http://www.enrollamerica.org/resources/in-person-assistance/>
- **Center on Budget and Policy Priorities Marketplace Plan Comparison Worksheet:** <http://www.healthreformbeyondthebasics.org/marketplace-plan-comparison-worksheet/>
- **Harvard Law’s Center for Health Law & Policy Innovation:**
 - **Marketplace Health Plans Template Assessment Tool October 2014:** <http://www.chlpi.org/wp-content/uploads/2013/12/Marketplace-Health-Plans-Template-Assessment-Tool-Oct-2014.pdf>
 - **Marketplace Health Plans Assessment Workbook:** <http://www.chlpi.org/wp-content/uploads/2013/12/Marketplace-Health-Plans-Template-Assessment-Workbook-Oct-2014.pdf>
- **Comparison Tool by ProPublica that shows how health plan costs will change in 2015:** <http://projects.propublica.org/aca-enrollment>
- **New Jersey Individual Health Coverage Program Rates:** http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrates.htm
- **Health-Insurance Plan Rankings from the National Committee for Quality Assurance:** <http://www.consumerreports.org/health/insurance/health-insurance-plans.htm>
- **Consumer Reports’ Annotated Summary of Benefits & Coverage Form:** <http://www.consumerreports.org/health/resources/pdf/SBCinfo.pdf>
- **Health Insurance Literacy Resource Hub** - <http://www.enrollamerica.org/hil/>
- **National Association of Insurance Commissioners (NAIC) consumer education site** - http://www.insureuonline.org/insureu_type_health.htm
- **AHIP (Association of Health Insurance Plans) Foundation, *A Consumer Guide to Understanding Health Plan Networks*** - <http://www.ahipfoundation.org/Consumer-Guide.html>

If Consumers Have Trouble Accessing Care

- Trouble getting a timely, local appointment with a qualified healthcare provider?
- Inaccurate provider directories?
- Denied health care services prescribed by a health care provider?
- Suspect discriminatory treatment?
- Billed for preventive health care services?
- Facing visit limits that are inconsistent with your health provider's recommendations?
- Can't understand plan options on healthcare.gov or the insurance company's web site?
- Surprised by out-of-network charges?

Please Contact:

- **Company that issued the health plan:**
 - **AmeriHealth: 1-855-832-2009**
 - **Health Republic: 1-888-990-5706**
 - **Horizon Blue Cross Blue Shield:**
1-800-246-9352
 - **Oscar: 1-855-OSCAR-88**
 - **UnitedHealthcare: 1-800-273-8115**
- **New Jersey Department of Banking & Insurance Consumer Protection Services:**
1-888-393-1062



The Sentinel Project:
1-973-991-1190
contact@njsentinelproject.org
<http://njsentinelproject.org>



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