

“Hey, Doc”



Answers to Questions You Never Thought to Ask About the New Health Insurance Marketplace

SEGMENT 5:

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Putting My Insurance to Use

What will it cost me to use this insurance?

There are different types of costs you will pay to use your insurance.

Remember that when you first buy your insurance, you pay a set monthly fee to make sure it's there for you when you need it, called a premium. That premium depends on a few things, like where you live, your age, how many people are in your family, the services you need, and whether you smoke. Depending on your income, you might also qualify for a subsidy to lower your premiums. So premiums are different for everyone. And it's important to pay those premiums on time, even when you are not using your insurance, so you are covered when a medical issue does come up.

Then, when you go to use your insurance — at the doctor's office, or hospital, or pharmacy, for instance — you share some of the costs of your medical care with the insurance company. Those costs are called deductibles, co-insurance, and co-payments. You might hear this referred to as “cost-sharing” or “out-of-pocket costs” because while your insurance plan helps cover a good portion of your medical expenses, you also pay for some of those costs out of your own pocket. And those amounts depend on which type of plan you choose and what category it falls into: bronze, silver, gold, platinum, or catastrophic. (See “What will it cost me to buy this insurance?” from heydoc.texmed.org)

What are deductibles, co-insurance, and co-payments?

Deductibles, co-insurance, and co-payments basically describe the costs you share with the insurance company and pay to physicians and other providers for your health care.

Let's start with the deductible, because that's the amount you typically have to pay first before your insurance starts to cover much of your health care costs. Say you have a \$1,000 deductible for the year. That means you're responsible for paying the first \$1,000 of your medical expenses before the insurance company helps pick up the rest. You might meet that deductible in one hospital stay, or you could meet it throughout the year in multiple doctor visits. Because your insurance policy covers one year at a time, you would meet that deductible once a year, and it resets when you renew your insurance. And depending on your plan, once you've met your deductible, your insurance will start to cover a greater portion of your medical expenses.

Which brings us to the co-insurance, which is different. Instead of a fixed amount, like the deductible, the co-insurance is the percentage of a particular medical cost that you are responsible for. Let's say it costs \$100 for an x-ray and your co-insurance is 20 percent. You would pay \$20 of that cost, and your insurance would pay the rest, \$80. Depending on your plan, that \$20 could go

towards your deductible, or sometimes the co-insurance won't kick in until after you've met your entire deductible. And the co-insurance amount can vary depending on whether you receive medical services in or outside of your health plan's network.

Lastly, each time you visit the doctor, you'll typically pay what's called a co-payment or "co-pay." It's usually a small fixed fee, like \$25, that you pay up front at each visit, not something you split with your insurance plan. But it can also vary depending on the medical service.

But marketplace plans must cover certain preventive services, like screenings and immunizations, without making you meet your deductible, or pay co-insurance or co-payments. That's if you get those services in-network.

And keep in mind that the health care law puts a limit on your out-of-pocket medical expenses each year. Once you reach that limit, your insurance usually covers 100 percent of your medical expenses.

What are the limits on out-of-pocket costs?

The health care law puts a limit on what you pay each year out of your own pocket for the medical expenses covered by your insurance, called "out-of-pocket limits." For 2014, the out-of-pocket limits are \$6,350 for an individual plan, and \$12,700 for a family plan for the year. That's the most you would pay for the year, and after you reach that limit, your health plan pays for 100 percent of the services it covers. What counts toward your out-of-pocket limits? It doesn't include your premiums. But depending on your health plan, it can include costs like deductibles, co-insurance, co-pays, and sometimes care that's out of your plan's network.

When can I receive the subsidies to help pay for my marketplace insurance?

Remember that there are two kinds of subsidies you can get to help pay for your marketplace insurance, if you qualify (See "Who gets a subsidy?" from heydoc.texmed.org). One is a tax credit that you can put toward your monthly

premiums. The other is a break on the out-of-pocket of costs you are responsible for when you use your insurance.

When it comes to the tax credit, you have three choices: You can use the full credit right away to lower the cost of your monthly premiums for the year. You can choose to put part of the tax credit toward your premiums, and if there's anything left over, you'll get the difference back after you file your taxes. Or you can wait to get the entire tax credit refunded to you after you file your taxes. In the first two options, the federal government will take your tax credit and make the payment directly to the health plan for you.

The other subsidy helps lower your out-of-pocket costs, like deductibles, co-insurance, and co-pays. But it's a little tricky. Remember the metals? The bronze, silver, gold, and platinum plans? In the bronze and silver plans, your monthly premiums are lower, but your out-of-pocket costs are higher. In gold and platinum plans, the opposite happens: They have higher premiums and lower out-of-pocket costs. This subsidy helps you get the out-of-pocket savings of a gold or platinum plan for the price of a silver one. So you would have to enroll in a silver plan to get the subsidy.