Checklist to Choose a Health Plan

The Affordable Care Act (ACA) created new health insurance exchanges or marketplaces where people who do not have other sources of insurance can purchase an individual or family policy. Plans on the Marketplace are grouped into 4 levels based on the amount of insurance coverage and overall price, but the individual plans can vary widely. It will be important for you to consider a range of factors when purchasing a plan on the Marketplace to help minimize your overall costs and maximize your access to needed healthcare services. This checklist identifies key questions that can help you make an informed decision when picking a plan.

General Questions

☐ Do you and/or your family members have coverage through a government insurance program—Medicare, Medicaid, CHIP, VA, or TRICARE? If so, you don’t necessarily have to make any changes.

☐ Do you have access to coverage through an employer? If so, you don’t necessarily have to make any changes. Have you already purchased your own coverage? If so, you may be able to keep your plan but you should check whether you may be eligible for subsidies in the exchange.

Estimating your Health Needs

☐ How many times a year do you visit a doctor? Do you see a primary care doctor, specialists, or both?

☐ How many times a year do you visit an urgent care center or emergency room?

☐ Have you been hospitalized in the last year? How long is your typical hospital stay?

☐ Do you expect to need surgery or another major procedure in the next year?

☐ Do you take any prescription medications? Include medications from a pharmacy or that are administered at the doctor’s office. Be sure to think about any medications you may have been prescribed but do not currently take because you cannot afford them.

☐ Do you have any chronic conditions that could put you at risk of high health costs?

Financial Assistance

☐ You may qualify for a premium tax credit if your annual household income is below 400% of the federal poverty line—that’s about $46,000 for an individual and $94,000 for a family of four. You can use a premium subsidy for any plan offered on the exchange.

☐ You may qualify for assistance with the share of health costs that are not covered by insurance if your annual household income is between 100% and 250% of the federal poverty line—that’s about $11,500 to $28,700 for an individual and $23,600 to $58,900 for a family of four. In order to receive assistance with your share of health costs, you have to enroll in a silver plan.

Determining the Right Level Plan

☐ Do you know if you qualify for Medicaid? You will be notified if you qualify during the first step of applying for an exchange plan.

☐ Are you in good health with low current healthcare costs? Do you have savings you could use for unanticipated health costs? If so, a bronze or silver plan may work for you.

☐ Are your health care needs and costs moderate? Are you concerned about your ability to pay for unexpected medical costs out of pocket? If so, a silver or gold plan may work for you.

☐ Do you have a chronic condition or significant health care costs? Are you concerned that you may not be able to pay for unexpected health costs? If so, a gold or platinum plan may work for you.
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Covered Benefits and Costs

☐ Are the services you and your family need covered by the health plan? Although all plans cover certain key benefits, there will be some variation in the services covered by each exchange plan.

☐ What is the plan’s deductible? The deductible is the amount you have to pay before a health plan starts to pay for your care. Are there separate deductibles for medical and prescription drug costs?

☐ What are you required to pay for physician visits? Is it different for a primary care physician or a specialist? What share of a hospitalization would you be required to pay?

☐ Does the plan you are considering limit any services to a number of visits or sessions per year? This may apply to specific types of services, like chiropractic care or physical therapy.

Coverage for Prescription Medications

☐ Are the medications you take regularly covered on the plan’s formulary? A formulary is the list of medicines covered by a health plan. The exchange website will include a link to the formulary so that you can see the list of covered medications.

☐ Formularies typically have several tiers with patients asked to pay more for medicines on higher tiers. Which formulary tiers include your prescriptions? What are the costs you will have to pay for each tier? Will you pay a set amount (a co-pay) or a percent of the medicine’s cost (coinsurance)?

☐ Is there a separate deductible for prescription medications? If you regularly take prescription(s) but rarely use other health services, you might spend less on health costs if you choose a plan with a lower separate deductible for prescriptions instead of one higher deductible for all costs.

☐ Is there a separate out-of-pocket maximum for prescription drugs? If plans tend to require you to pay for a significant percent of the cost of your medicine and you use few other health services, you may pay less overall if you choose a plan with a separate out-of-pocket maximum for prescriptions.

Access to Providers

☐ Are the physicians you see regularly in the plan’s network? If you see doctors not in the plan’s network, you may be charged more in out-of-pocket costs and that spending may not count toward the limit on your out-of-pocket costs.

☐ Is your preferred hospital in the plan’s network?

☐ Will the plan require a referral to see a specialist or get other services?

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