Choosing a Health Plan You Can Afford

About this fact sheet

When choosing a health plan, remember that what makes a plan affordable is all the costs that you'll pay—not just the amount of the monthly premium. Deductibles, copayments, and co-insurance add up!

1. How do I pick an affordable plan?

When deciding which health plan you can afford, consider two kinds of costs:

- **How much will you pay each month to have insurance** (premiums)?
- **In addition to your monthly premiums, how much will you pay out of your pocket for care you get?** There are different types of out-of-pocket costs. They are called deductibles, copayments, and co-insurance.

The type of plan you buy matters. Lower monthly premiums won't always save you money. If you pay more each month in premiums, your plan will also pay more for services (and you'll pay less out of pocket). But if you pay less each month in premiums, your plan will charge you more for the services you get throughout the year.

The marketplace makes it easy to compare plans by dividing them into four categories based on how much health care each plan pays for. The categories are bronze, silver, gold, and platinum. Bronze plans pay for the least of your health care, so you have to pay more money for services like doctor visits (but you pay less in monthly premiums). Platinum plans pay for the most of your health care (but you pay more in monthly premiums.)

Use the categories of plans to help you compare ballpark costs. Once you choose a category, you can compare the plans within that category until you find the plan that's right for you. Each plan will be slightly different in which services it pays for, which doctors and providers you can visit, how much you'll pay each month in premiums, and how much additional money you will pay out of your pocket to get services and prescriptions.

Before comparing the costs of each plan, think about how often you and your family might go to the doctor or the hospital in the coming year, and which prescriptions you may need. Use those estimates to figure out which plan is most affordable for you.

2. What other costs will I pay in addition to my monthly premium?

There are four types of additional out-of-pocket costs that you should consider when choosing a health plan.

MORE INFORMATION

To learn more about the different categories of plans, see Families USA's ***Understanding the Differences between Platinum, Gold, Silver, and Bronze Plans.***

Deductibles

Before your plan begins to pay for your health care costs (for example, a hospital stay), it requires you to pay a certain amount of money first—called a "deductible." Each plan sets a different deductible amount. Once the costs you pay add up to the deductible set by the plan, the plan begins to pay for many of your health care costs. You must still pay part of the cost for many services, but they will be less after you have paid your deductible. See below for an explanation of copayments and co-insurance, which are costs that you must pay even after you have paid your deductible.

Some plans might have separate deductibles for different kinds of health care, such as one deductible for prescription drugs and another deductible for other services.

Think about how you will pay for the full cost of health care (like doctor visits and prescriptions) until you have paid your plan's deductible. For example, if you need to see a doctor and get lab tests before you pay your deductible, would you be able to pay the full cost of that visit?

Preventive Care Is Free

Once you enroll in a plan, certain preventive care is free, but you must pay the full cost of any other care that you need until you pay all of your deductible. Plans cannot charge you any copayments or co-insurance for these preventive services. **You can see a full list of these services at healthcare.gov.**

Copayments and Co-Insurance

You usually have to pay part of each health care service that you receive (like seeing a doctor), even after you have paid your deductible. This amount is called either a copayment or co-insurance.

Plans charge copayments or co-insurance fees for doctor visits, prescriptions, hospital stays, and other services.

- **Copayments** are a set dollar amount that you pay each time you receive a service (for example, a $20 fee for each doctor's visit).
- **Co-insurance** is a part of the cost for a service that you must pay. For example, 20 percent co-insurance for a hospital visit means that you must pay 20 percent of the total cost of your hospital visit.

Plans have different copayments or co-insurance amounts. They depend on the type of service or prescription and whether the doctor or provider that gives you the service accepts your insurance.

When comparing plans, look at the co-insurance and copayments that each plan charges for the health care services that you and your family will need. Think about how often you might get this service, and ask yourself whether you can afford a plan's copayment or co-insurance each time.

Out-of-Pocket Limit

The out-of-pocket limit is the most you could pay for care in a year, adding up your deductible, copayments, and co-insurance payments. Each plan sets a different out-of-pocket limit. Once you have paid that amount, your plan will pay the full cost of all of your covered health care services for the rest of the year.

In 2017, the highest out-of-pocket limit that a health plan can have will be $7,150 for individual coverage or $14,300 for family coverage.

If you have high medical expenses:

Some plans have lower out-of-pocket limits, so the plan starts paying for all covered services sooner. This may be a good option if you have very high medical expenses.

If you are eligible for extra help paying your out-of-pocket health care costs, you will be able to buy a health plan with a lower out-of-pocket limit.

Services that Your Plan Won't Pay For

You must pay the full cost of any health care service or prescription that your plan does not cover. You may also need to pay more for care you get from a doctor, hospital, or clinic that is out of your plan's network and does not accept your insurance. The money you pay for services that are not covered or that you get from a doctor outside your plan's network will not count toward paying your deductible or reaching your out-of-pocket limit for the year.

Make sure that the plan you choose covers the health care and prescriptions that you and your family need. Also make sure that the providers you want to see are in the plan's network and will accept your insurance.

To learn more about the services that plans must cover and to find out how to get information about each plan's benefits, see Families USA's *Choosing a Health Plan that's Right for You.*

3. How do I save up money for my health care costs if I buy a health plan with a high deductible?

A Health Savings Account (called an HSA) is a savings account that you can set up to help you save money for copayments, deductibles, and certain other medical expenses that you must pay. To use an HSA in 2017, you must be enrolled in a health plan with a deductible of $1,300 or higher (individual coverage). For family coverage, your deductible must be $2,600 or higher.

In 2017, the most that you can put into your HSA is $3,400 (for individual coverage) and $6,750 (for family coverage). If you are over the age of 55, you might be allowed to set aside more money.

You do not need to pay taxes on money that you put in your HSA, which can make it a better option than a regular savings account for paying out-of-pocket costs.

✻ *When deciding how much to set aside in an HSA, keep in mind that the costs you need to save up for usually include more than just your plan's deductible. For example, even after you pay your deductible, you still have to pay copayments or co-insurance for the care you get until you reach your plan's out-of-pocket limit.*

For more information about the rules for HSAs, see IRS Publication 969, available at http://www.irs.gov/publications/p969/index.html, or contact the Internal Revenue Service at 1-800-829-1040.

The complete *What You Need to Know about Health Insurance* series:

Applying for Health Insurance
Answering Questions about Your Family When Applying for Health Insurance
Answering Questions about Your Family's Income When Applying for Health Insurance
Applying for a Marketplace Plan if You Can Get Health Insurance through Your Job
What to Do if You Are Uninsured after Open Enrollment

Getting Financial Assistance
Getting Financial Assistance to Pay for Health Insurance
Deciding How Much Financial Assistance to Use to Lower Your Monthly Premiums
Will I Be Able to Get Financial Help to Pay for Health Insurance?
How Getting Financial Assistance to Pay for Health Insurance Affects Your Taxes
Getting Extra Financial Assistance to Help Pay Health Care Costs

Choosing a Health Plan
Choosing the Health Plan that's Right for You
Choosing a Health Plan You Can Afford
Understanding the Differences between Platinum, Gold, Silver, and Bronze Plans
Understanding Catastrophic Health Insurance
Buying Children's Dental Coverage through the Marketplace

Keeping and Using Health Insurance
How to Use Your Health Insurance
How to Keep Your Marketplace Health Insurance
What to Do after You Buy Health Insurance in the Marketplace

Understanding the Requirement to Have Health Insurance
Understanding the Requirement to Have Health Insurance
Understanding Minimum Essential Coverage

Reference Charts and Graphics
Income Guidelines for Getting and Using Financial Assistance for Health Insurance
Income Guidelines for Getting Extra Financial Assistance to Pay for Health Care Costs
Types of Exemptions from the Requirement to Have Health Insurance

A complete list of Families USA publications is available online at www.FamiliesUSA.org/resources/publications.

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