How to pick a health insurance plan

The three most important questions you need to ask

Health care can be very expensive. Having a baby costs about $30,000, and so does the average three-day hospital stay. Health insurance is a way to reduce those costs to an amount that you can manage by sharing the risk with others. That works because most people are mostly healthy most of the time, so their premiums help pay for the expenses of the small number who are sick or injured.

Here are the three major questions you need to ask when picking a plan.

1. What does the plan cover?

Insurance sold to people and small businesseses must cover 10 “essential health benefits." Any plan you buy, whether through your state's Health Insurance Marketplace or not, will pay for these services.

- Emergency services
- Hospitalization
- Laboratory tests
- Maternity and newborn care
- Mental health and substance-abuse treatment
- Outpatient care (doctors and other services you receive outside of a hospital)
- Pediatric services, including dental and vision care.
- Prescription drugs
- Preventive services (such as immunizations and mammograms) and management of chronic diseases such as diabetes
- Rehabilitation services

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The rules for insurance provided by large employers are a little different but the vast majority them will cover the same set of benefits. To make sure, ask your employer for the Summary of Benefits and Coverage, a standard form that will state exactly what the plan covers and doesn't cover.

It's important to know, though that some older plans may not cover this whole list of services. These are plans sold to individuals or small business (with up to 100 employees) that started before the new health reform law took full effect in 2014. Under certain circumstances these plans can be renewed even though they don't have all the consumer protections available with newer plans. If you have such a plan your insurance company will send you a notice about it before the annual renewal date. Then you can consider whether to keep it or to switch to a new plan.

Get rankings of health insurance plans nationwide at:
http://www.consumerreports.org/health/insurance/health-insurance-plans.htm

Use this resource to:

- Choose a plan category such as private HMO or PPO, or Medicare HMO or PPO.
- Choose a state.
- Customize your search to compare plans' scores and their performance in measures such as consumer satisfaction and providing preventive services.

2. How much does the plan cost?

You pay for health insurance in two ways:

- The monthly premium that you pay to purchase your plan.
- The out-of-pocket expenses you pay when you receive medical care. Those are some combination of deductibles, coinsurance, and copays.

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In general, if you pay a higher premium upfront, you will pay less when you receive medical care, and vice versa.

If you purchase coverage through your state's Health Insurance Marketplace, you may be eligible for income-based subsidies that lower the cost of your premium and in some cases your out-of-pocket expenses.

Premiums

To make comparison easier, plans sold to individuals are grouped in standardized "metal tiers" with various combinations of premiums and cost sharing:

- Bronze plans cover 60 percent of the average member's total health care costs and thus have the lowest premiums but the highest out-of-pocket costs. Individual deductibles for Bronze plans in 2014 average $5,081, according to an analysis by HealthPocket, a private health insurance data-crunching firm.
- Silver plans cover 70 percent and have higher premiums and lower out-of-pocket costs than Bronze plans, with an average individual deductible of $2,907.
- Gold plans cover 80 percent and have higher premiums and lower out-of-pocket costs than Silver plans, with an average individual deductible of $1,277.
- Platinum plans will cover 90 percent and have the highest premiums and lowest out-of-pocket costs, with an average individual deductible of $347.

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Which of those plans is right for you depends on your health and your financial situation:

• If you already know you have an expensive medical condition, consider a plan with a higher premium that covers more of your costs.

• If you are generally healthy you might come out ahead paying a lower premium and a bigger share of your health costs, because those costs are most likely not going to be that high. Of course, you need to be prepared to pay more if you do unexpectedly become sick or injured.

Out-of-pocket expenses

The terms "cost sharing" or "out-of-pocket costs" refer to the proportion of your medical bills you will be responsible for paying when you actually receive health care. Cost sharing does not include your monthly premium.

Unfortunately cost sharing is not standardized from plan to plan and provisions can sometimes be complicated.

If you buy insurance through your state marketplace, you'll be able to see and compare the cost-sharing structure of plans before you buy. If you get insurance through a job, the information will be on the Summary of Benefits and Coverage form.

These are the four cost-sharing terms you will see.

DEDUCTIBLE. The amount you pay every year before the insurance company starts paying its share of the costs. If the deductible is $2,000, then you would pay cash for the first $2,000 in health care you receive each year, after which the insurance company would start paying its share.

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In every plan you can buy, preventive services will be covered in full even if you haven't used up your deductible for the year. Some plans will also pay a portion of your costs for a few other services, usually doctor visits and prescription drugs, even before your deductible has been met. This is more common with Gold and Platinum plans but some Silver and Bronze plans also cover some services before the deductible has been met. The only way to figure out whether a plan covers some services "not subject to the deductible" is to study its provisions very carefully.

COPAY. A fixed dollar amount you pay for certain types of care. You might pay $30 for a doctor visit and the insurance company will pick up the rest. Plans with higher premiums generally have lower copays, and vice versa. And some plans do not have copays at all. They use other methods of cost sharing.

COINSURANCE. The percentage of the cost of your medical care that you have to pay. For an MRI that costs $1,000, you might pay 20 percent ($200). Your insurance company will pay the other 80 percent ($800). Plans with higher premiums generally pick up a larger portion of the bill.

OUT-OF-POCKET LIMIT. The most cost-sharing you will ever have to pay in a year. It is the total of your deductible, copays, and coinsurance (but does not include your premiums). Once you hit this limit, the insurance company will pick up 100 percent of your costs for the remainder of the year. Most people never pay enough cost-sharing to hit the out-of-pocket limit but it can happen if you require a lot of costly treatment. Plans with higher premiums generally have lower out-of-pocket limits.

In 2014, the out-of-pocket limit for plans sold to a person and to small groups cannot be more than $6,350 per person or $12,700 for a family. But most Silver, Gold, and Platinum plans have lower out-of-pocket limits than that. In 2015, the maximum out-of-pocket limits allowed will increase slightly. They will be $6,450 for an individual and $12,900 for a family.

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3. Which doctors and hospitals are in it?

Every health insurance plan has a network of providers—doctors, hospitals, laboratories, imaging centers, and pharmacies that have signed contracts with the insurance company agreeing to provide their services to plan members at a specific price.

If a doctor is not in your plan's network, the insurance company may not cover the bill, or may require you to pay a much higher share of the cost. So if you have doctors you want to continue to see, you will want them to be in the plan's network.

Some state Health Insurance Marketplaces, including those operated through the federal HealthCare.gov site, have links to provider directories that you can see before you buy. But the directories are not standardized and may be hard to use or out of date. Moreover, to keep costs down, many of the plans sold through the state Health Insurance Marketplaces have smaller networks than you may be used to. That is why you should check and double-check with the health plan and
your doctor's billing office to make sure your desired providers are in the network of the plan you are considering.

If you are given a choice of insurance through a job, you can obtain provider lists from participating insurance companies, or from the company's employee benefits department. You can use our hospital Ratings (subscription required) to research the quality of the hospitals in your network.

Source: Consumer Reports

For more information, visit:

http://www.consumerreports.org/cro/2012/09/understanding-health-insurance/index.htm

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