PONTCHARTRAIN CANCER CENTER

Your Step-By-Step Guide to Finding the Right Insurance Plan

Step 1: Find your marketplace

Most people get health insurance through an employer. If you're one of them, you won't need to use the government insurance exchanges, or marketplaces. Essentially, your work is your marketplace.

If your employer offers health insurance and you still wish to search for an alternative plan in the exchanges, you can. But plans in the marketplace are likely to cost a lot more. Most employers that provide insurance pay a portion of workers' premiums, so they'll likely offer the least expensive option.

If your job doesn't provide a health insurance benefit, shop on your state's Affordable Care Act marketplace or state healthcare exchange, if available, or the federal marketplace to find the lowest premiums. Start by going to HealthCare.gov and entering your ZIP code. You'll be sent to your state's exchange if your state is green on the map below. Otherwise, you'll use the federal marketplace. A more in-depth breakdown of the Marketplace is further down in this packet.

You can also purchase health insurance through a private exchange or directly from an insurer. If you choose these options, you won't be eligible for premium subsidies, which are income-based discounts on your monthly premiums.

Step 2: Compare types of health insurance plans

You'll encounter ~~some~~ many letters that look like alphabet soup while shopping for plans; the most common types are HMOs, PPOs, EPOs, or POS plans. The kind you choose will help determine your out-of-pocket costs and which doctors you can see.

While comparing plans, look for a summary of benefits. Online marketplaces usually provide a link to the summary and show the cost near the plan's title. A provider directory, which lists the doctors and clinics that participate in the plan's network, should also be available. If you're going through an employer, ask your workplace benefits administrator for the summary of benefits.

COMPARING HEALTH INSURANCE PLANS: HMO VS. PPO VS. EPO VS. POS

Plan Type	Do you have to stay in network to get coverage?	Do procedures & specialists require a referral?	Best for you if:
HMO: Health Maintenance Organization	Yes, except for emergencies.	Yes	You want lower out-of-pocket costs and a primary doctor that coordinates your care for you, including ordering tests and working with your specialists.
PPO: Preferred Provider Organization	No, but in-network care is less expensive.	No	You want more provider options and no required referrals.
EPO: Exclusive Provider Organization	Yes, except for emergencies.	No	You want lower out-of-pocket costs but no required referrals.
POS: Point of Service Plan	No, but in-network care is less expensive; you need a referral to go out of network.	Yes	You want more provider options and a primary doctor that coordinates your care for you, including ordering tests and working with your specialists.

When comparing different plans, put your family's medical needs under the microscope. Using premium cost as the most important criterion for making health plan choices could be a mistake, because the least expensive plan is not always the best one for a given individual. Other factors that should be taken into consideration include employees' health status, the doctors and hospitals they use, and the prescription medications they take. Look at the amount and type of treatment you've received in the past. Though it's impossible to predict every medical expense, being aware of trends can help you make an informed decision.

If you choose a plan that requires referrals, such as an HMO or POS, you must see a primary care physician before scheduling a procedure or visiting with a specialist. Because of this requirement, many people prefer other plans.

POS and HMO plans may be better if you don't mind your primary doctor choosing specialists for you; one benefit of this system is that there's less work on your end, since your doctor's staff coordinates visits and handles medical records. If you do choose a POS plan and go out of network, make sure to get the referral from your doctor ahead of time to reduce out-of-pocket costs.

If you'd rather choose your doctors, you might be happier with a PPO or EPO. An EPO may also help you lower costs if you find providers in network; this is more likely to be the case in a larger metro area. A PPO might be better if you live in a remote or rural area with limited access to doctors and care, as you may be forced to go out of network.

Step 3: Compare health plan networks

Costs are lower when you go to an in-network doctor because insurance companies contract lower rates with in-network providers. When you go out of network, those doctors don't have contracted rates, which costs your insurance company, and you, more.

If you have preferred doctors and want to keep seeing them, make sure they're in the provider directories for the plan you're considering. You can also directly ask your doctors if they take a particular health plan. Being able to continue seeing their current medical providers is top of mind for people when evaluating new health plans. However, answering this question can be a moving target as contracts between doctors, hospitals and insurance companies can change from year to year.

If you don't have a preferred doctor, you'll probably want a plan with a large network so you have more choices. A larger network is especially important if you live in a rural community, since you'll be more likely to find a local doctor who takes your plan.

Eliminate any plans that don't have local in-network doctors and those with very few provider options compared with other plans.

Step 4: Compare out-of-pocket costs

Nearly as important as network size is how costs are shared. Any plan's summary of benefits should clearly lay out how much you'll have to pay out of pocket for services. The federal marketplace website offers snapshots of these costs for comparison, as do many state marketplaces.

This is where it's useful to know a few health insurance vocabulary words. As the consumer, your portion of costs consists of the deductible, copayments, and

coinsurance. The total you spend out of pocket in a year is limited, and that maximum is also listed in your plan information. In general, the lower your premium, the higher your out-of-pocket costs.

Cost-sharing options vary, so your goal is to narrow down choices based on out-of-pocket costs. A plan that pays a higher portion of your medical costs, but has higher monthly premiums, is better if:

- You see a doctor, whether a primary physician or a specialist, frequently.
- You frequently need emergency care.
- You take expensive or brand-name medications on a regular basis.
- You are expecting a baby, plan to have a baby, or have small children.
- You have a planned surgery coming up.
- You've recently been diagnosed with a chronic condition such as diabetes or cancer.

A plan with higher out-of-pocket costs and lower monthly premiums is the financially smart choice if:

- You can't afford the higher monthly premiums for a plan with lower out-of-pocket costs.
- You are in good health and rarely see a doctor.

Step 5: Compare benefits

By now, you likely have your options narrowed down to just a few. To further reduce your choices, go back to that summary of benefits to see which plans cover a wider scope of services. Some may have better coverage for things like physical therapy or mental health care, while others might have better emergency coverage.

If you skip this quick, but important step, you could miss out on a plan that's much better tailored to you and your family.

Once you're down to a couple of options, it's time to address any lingering questions. In some cases, only speaking with a person will do, so call the customer service line of the insurers you're considering. Write your questions down ahead of time, and have a pen or computer handy to record the answers.

Your questions will be based on your current health situation, but here are some examples of what you could ask:

- I take a certain medication. How is that covered under this plan?
- Which drugs for this disease are covered under this plan?
- What maternity services are covered?
- What happens if I get sick when traveling abroad?
- How do I get started signing up, and what documents will I need?

A final tip: Don't forget to discontinue your old plan before the new one starts if you switch.

Checklist: Choosing a health insurance plan

Here's a quick checklist that summarizes the steps above:

1. Go to your marketplace and view your plan options side by side.
2. Decide which type of plan — HMO, PPO, EPO, or POS — is best for you and your family.
3. Eliminate plans that exclude your doctor or any local doctors in the provider network.
4. Determine whether you want more health coverage and higher premiums, or lower premiums and higher-out-of-pocket costs.
5. Make sure any plan you choose will pay for your regular and necessary care, like prescriptions and specialists

A Little More Coverage In and Out of the ACA Marketplace

In the United States, all health coverage options fall into one of two general categories. You can obtain **individual coverage** for yourself and/or your families by reaching out to insurers directly, or receive **group coverage** as an eligible employee or student. With the arrival of the Affordable Care Act, the parameters and regulations pertaining to both types of coverage have been altered significantly.

Insurers INSIDE the ACA Healthcare Exchange: The Obama Administration has created the **ACA Healthcare Exchange** to serve as an online marketplace for individual health coverage shoppers. The Exchange lists different coverage options that fall into one of the following **five categories** (all percentages listed below represent averages):

- **Bronze:** Policyholders pay 40% co-insurance, plans pay 60%
- **Silver:** Policyholders pay 30% co-insurance, plans pay 70%
- **Gold:** Policyholders pay 20% co-insurance, plans pay 80%
- **Platinum:** Policyholders pay 10% co-insurance, plans pay 90%
- **Catastrophic:** Policy-holders pay 40% or more co-insurance, plans pay 60% or less. This option is generally only available to men and women under the age of 30 or those who qualify for a **hardship exemption**. Exemptions may be granted to individuals who receive insurance coverage for nine months or more of the year (but not the entire year), U.S. citizens who live abroad, and other people who meet the criteria.

Generally speaking, Gold and Platinum plans are the most cost-effective option for individuals who require frequent physician visits or regular prescriptions. Silver, Bronze, and Catastrophic plans are more suitable for individuals who may be lower risk and do not require frequent visits to the doctor.

Open enrollment for the ACA Marketplace is Nov. 1 – Dec. 15.

Insurers OUTSIDE the ACA Healthcare Exchange: Under the ACA, individuals who do not receive group coverage must apply for an individual plan; otherwise they receive a penalty that increases incrementally for each year they remain uninsured. However, individuals seeking coverage are not required to use the ACA Healthcare Exchange and may choose to purchase a plan from insurance companies who are not listed on the site. The Exchange is designed to simplify the process of choosing an insurance plan.

Whether an individual chooses to shop for a health plan within or outside the Exchange should ultimately **depend on his or her annual income**. Individuals who earn 400% of the federal poverty level (in 2016 this was $47,080 per year for individuals or $97,000 per year for four-member households) or less may be entitled to a tax subsidy that helps them pay for their insurance. This option is only available through plans listed on the Exchange; off-marketplace plans award no such tax benefit. On the other hand, individuals who earn more than 400% of the federal poverty level per year (making them ineligible for the subsidy) may find a less expensive health plan outside the marketplace.

Those who choose to browse plans outside the marketplace are encouraged to do so with the assistance of an insurance broker. Brokers will help you locate a health plan that meets your criteria, their services are free of charge because they earn commissions directly from the insurance companies on plans sold.

Understand your out-of-pocket costs

No matter how good the plan, health insurance is rarely free, so it's important to know how much you'll be paying out of your own pocket. The most obvious cost associated with your policy is the premium. If you're covered by an employer's plan or other group plan, your premium will be lower than if you have an individual policy. How low depends on the characteristics of the group and what portion of the premium your employer or group pays. With an individual policy, your premium depends on your age, health, and other personal factors. Be sure to plan on the possibility of premium increases down the road.

In addition to the premium, your policy may require you to pay these other out-of-pocket costs:

- Deductible: This is the amount (typically, an annual amount) that you must pay toward your medical costs before your insurer begins to cover you. The most popular deductible is currently $250 or $500.
- Co-payment: This is the amount that you'll have to pay each time you visit a health-care professional or buy a prescription (e.g., $10).
- Coinsurance: This is the percentage of your medical costs that you'll have to pay after you satisfy any deductible (e.g., 20 percent); typically capped at a maximum dollar figure for out-of-pocket costs.

These extra costs can greatly affect the total cost of your policy, so make sure you know what they are. For example, if you take lots of medications, those little co-payments can really add up over time. Reading your policy should tell you everything you need to know about deductibles, co-payments, and coinsurance.

What else should you know?

Understanding your health insurance policy involves other things, too. There are many specific provisions and features that you should pay close attention to as you're reading your policy. These often vary among policies, and it would be impossible to list all the things you might find. But here are some common provisions and features of many health insurance policies:

- Limitations and exclusions: Most policies provide limited coverage (or none) for certain things. For example, cosmetic surgery may not be covered. Your policy should clearly spell out all its limitations and exclusions.
- Stop-loss provision: This provision limits your liability for your medical expenses. Typically, this means that you no longer must make coinsurance payments when your expenses exceed a certain threshold. Common loss levels are $5,000 to $10,000.
- Benefit ceiling: Also known as the maximum lifetime payout, this provision specifies the maximum amount that your insurer will pay on your behalf. Keep in mind that your policy's benefit ceiling may be well below what many insurance experts recommend, which is a maximum of $1 million.
- Family coverage: Many policies allow you to also cover your spouse and children, but your premium will be higher. Some policies with family coverage have a family deductible that must be satisfied before coverage kicks in for anyone in the family.
- Riders and endorsements: These are optional features that you can often buy to modify your policy's standard coverage or add extra coverage. If you'd like to better tailor your policy to your needs, ask your insurer what riders or endorsements are available and at what cost.

Understanding Your Medical Bills

After you visit your doctor, your doctor's office submits a bill (also called a claim) to your insurance company. A claim lists the services your doctor provided to you. The insurance company uses the information in the claim to pay your doctor for those services.

When the insurance company pays your doctor, it might send you a report called an Explanation of Benefits, or EOB, that shows you what it did. You need to be able to read and understand the EOB to know what your insurance company is paying for, what it's not paying for, and why. An EOB is not a bill.

Your doctor's office might send you a statement. A statement shows how much your doctor's office billed your insurance company for the services you received. If you receive a statement before your insurance company pays your doctor, you do not need to pay the amounts listed at that time. After your insurance company pays your doctor, you may need to pay the doctor any balance due.

Keep in mind that not all insurance companies send EOBs, and not all doctors' offices send statements. You may receive one or the other or both.

You should use what you learn to review your EOBs and billing statements carefully. Here are some things to look for:

- If the dates of service and description of services on your EOB and billing statement aren't the same, or if they don't match other records you may have of the visit, contact your doctor's office first.
- If you have questions about why your insurance company did not cover something or about the amount you must pay, contact your insurance company.
- If more than 60 days have passed and your insurance company still hasn't paid your doctor, contact your insurance company.

Finally, you should keep your EOBs and statements organized (e.g., filed by date) so that you can access them easily should questions arise.

GLOSSARY

Let's begin with a few key definitions. Understanding important terminology pertaining to health insurance is the first step to obtaining a cost-effective coverage plan that serves all your individual or family needs.

- **Premium:** The amount you pay your insurance company for health coverage each month or year.
- **Deductible:** The amount of money you must pay out-of-pocket before coverage kicks in. Deductibles are usually set at rounded amounts (such as $500 or $1,000). Typically, the lower the premium, the higher the deductible.
- **Coinsurance:** The amount of money you owe to a medical provider once the deductible has been paid. Coinsurance is usually a predetermined percentage of the total bill. If the policy's co-insurance is set at 15% and the bill comes to $100, the policy-holder owes $15 in co-insurance.
- **Co-pay:** This type of insurance plan is like co-insurance, but with one key exception: rather than waiting until the deductible has been paid out, you must make their copayment at the time of service. Most often, copayments are standardized by your plan, meaning you'll pay the same $30 each time you see a physician, or the same $50 each time you see a specialist.
- **Out-of-pocket maximum:** The amount of money you pay for deductibles and coinsurance charges within a given year before the insurance company starts paying for all covered expenses.
- **In-network:** This term refers to physicians and medical establishments that deliver patient services covered under the insurance plan. In-network providers are generally the cheapest option for policyholders. Insurance companies typically have negotiated lower rates with in-network providers.
- **Out-of-network:** This term refers to physicians and medical establishments *not* covered under your insurance plan. Services from out-of-network providers are usually more expensive than those rendered by in-network providers. This is because out-of-network providers have not negotiated lower rates with your insurer.
- **Pre-existing condition:** Any chronic disease, disability, or other condition you have at the time of application. In some cases, symptoms or ongoing treatments related to pre-existing conditions cause premiums to be higher than usual.
- **Waiting period:** Many employer-sponsored insurance plans mandate a period of 90 days before employees can enroll in their insurance plans.
- **Enrollment period / open enrollment:** The window of time during which you can apply for health insurance or modify a plan to include your spouse and/or children. Policy-holders are unable to adjust their plan until the next open enrollment unless they experience **a qualifying life event**. These include a marriage, divorce, birth of a child, changes to individual/household income, or interstate residence relocation.
- **Dual coverage:** The act of maintaining a health plan with more than one insurer. For example, many married people receive coverage from both their employers and their spouse's employer. Others may opt to receive individual coverage from more than one insurer.
- **Coordination of benefits:** This process is applied by individuals who have two or more existing policies to ensure that their beneficiaries do not receive more than the combined maximum payout for the plans.
- **Continuation of coverage:** This is essentially an extension of insurance coverage offered to individuals no longer covered under a particular plan; it most often applies to former employees and retirees of companies that offer employee coverage. COBRA benefits (see **Group Coverage** section below) qualify as continuation coverage.

- **Referral:** An official notice from a qualified physician to an insurer that recommends specialist treatment for a current policy-holder.
- **COBRA:** Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), employees who lose their group coverage under certain circumstances can **obtain continuation coverage** for a certain period of time. These plans may be more expensive than short-term or individual plans as subscribers must pay the full premium. Qualifying circumstances might include:
    - Individuals who are fired/laid off or who voluntarily quit their jobs (employees may not qualify if they have been **terminated for 'gross misconduct'**)
    - Individuals whose hours are reduced to the point of impacting coverage availability
    - Individuals who are transitioning between jobs
    - Death, divorce, and other life events

Short-term coverage: This option (also known as a 'gap policy') is designed for individuals who are uninsured and/or waiting for their individual/group coverage to kick in. This is a cost-effective route for individuals: **the eHealthInsurance marketplace lists** short-term coverage rates starting at 85 cents per day. However, short-term coverage does not satisfy the requirements of the ACA in most cases, and policy-holders who do not obtain more robust coverage will be penalized for failure to enroll.

Group Coverage: Unlike an individual coverage plan, which requires the policy-holder to pay for the entire premium, group coverage plan premiums are divided between beneficiaries and the institution that facilitates the group coverage (i.e., a company or university). Group coverage plan-holders are bound to a physician network, but they cannot be denied coverage for pre-existing conditions.

Employer-sponsored coverage: Employers usually pay **more than 50% of the monthly premium**, and may also support premiums for employee dependents (such as spouses and children). Just as there are subsidies available to individuals who obtain insurance through the ACA Exchange, business owners may be entitled to tax benefits for providing group coverage.

Open enrollment for **Medicare** is **Oct. 15-Dec. 7, 2017** for plans starting Jan. 1, 2018

Open enrollment for the **ACA Marketplace** is **Nov. 1-Dec. 15, 2017** for plans starting Jan. 1, 2018