A FIELD GUIDE TO HEALTH INSURANCE

Types of Healthcare coverage in the United States:
- **Medicaid**: Income-based, government healthcare program. (Varies by state, typically around $16,762)
- **Medicare**: Age-based government healthcare program. (Eligibility at age 65)
- **Marketplace Plans**: Purchased through healthcare.gov or a state-sponsored exchange during the Open Enrollment period.
- **Non-ACA plans**: Often referred to as “short-term,” “skinny,” or “off-exchange” plans.
- **Employer Sponsored**: Typically offered to full-time employees, often after a probationary period, may or may not involve an employee contribution. This can also take the form of COBRA coverage, for a limited time.
- **Healthcare Sharing**: An alternative to insurance in which members pool money to cover health expenses.

The Affordable Care Act (Obamacare), Philosophy, Evolution, and Current Status:
Passed in 2010, with most new policies implemented in 2014.
Most transformative legislation since 1965 - creation of Medicare and Medicaid

Arguably the most significant changes - Insurers are required to:
1. Accept all applicants
2. Charge the same rates regardless of preexisting conditions
3. All plans cover a list of essential health benefits.

Secondly, subsidies were introduced for those with qualifying incomes levels.

A Note on Underwriting
Underwriting refers to the process by which an insurer evaluates the risk of enrolling a particular individual or group in coverage. A number of factors can be taken into account and can impact price or in some cases lead to an application for coverage being denied. For example, a smoker applying for an underwritten plan will see a higher price than a comparable nonsmoker. A more extreme example would be a professional skydiver or racecar driver applying for life insurance, who could be denied coverage due to the inherent dangers of their occupation. Underwriting is involved in some group plans, all short-term plans, and no Marketplace plans.

Plan options - ACA or non ACA? - fine print of coverage.
For those who need to have one or more essential health benefits covered, have preexisting conditions, or qualify for a significant subsidy, enrolling in a Marketplace plan is an obvious choice.

There are a number of factors to consider when deciding whether to enroll in an ACA plan:
*Do you have any preexisting conditions for which you need coverage?*
*What do you use insurance for? Just for a worst-case scenario? Regular appointments? What are your expenses? Are there any significant expenses on the horizon (e.g. surgery, pregnancy) or are you mostly just having occasional appointments for simple concerns?*
Group or individual plan?
For small business owners with one or more employees, there are a number of options for how to set up coverage:

Some people simply don’t offer anything. Employers with less than 50 full-time employees are not required to offer health insurance. Additional compensation may be offered in place of benefits.

Some cover individual plans for employees, including short-term plans in some cases. Beginning in 2020 there will be a new program which allows employers to pay for employees individual ACA plans.

Group plans can be set up for any business with 2 or more W2 employees. (1099 contract workers can be covered as well). Very small groups (2-4 members) can be more expensive to insure, and in those cases a set of employer-sponsored individual plans may be more economical.

There are some organizations that offer association coverage in which self-employed individuals can reap the benefits of a group plan.

Funding a group plan
At the most generous end of the spectrum, there are employers who pay 100% of monthly premiums for their employees. Paying 100% is pretty rare - most employers require at least some contribution, whether a flat rate or a percentage of the monthly premium.

As you may have seen, there has been a recent development in the restaurant industry in which a 1-4% surcharge (optional, and can be removed from the bill) has been added to bills in order to offset the cost of healthcare for employees. As healthcare costs continue to rise, the number of businesses embracing alternative funding structures is likely to grow year over year.

Interpreting the plan - looking at terms:
**Premium** - the monthly payment required to continue coverage.
**Deductible** - the amount you pay for care before the insurer begins to cover its share of costs.
**Copay** - the amount of a bill that you are responsible for paying. Copays are a flat rate such as $40/visit.
**Coinsurance** - similar to a copay, but it is a percentage of the after-discount bill, rather than a flat rate.
**Out-of-Pocket Maximum** - the maximum amount that you will be required to pay for cost-sharing, after which the insurer covers all care at 100%.
**Coverage Period Maximum** - The maximum amount that a plan will cover - this does not apply to all plans.
**Referrals/Prior Authorization** - Referrals are required by HMO plans. Prior authorization is important for approval of some procedures and treatments.
**Network Types** - HMO/EPO/PPO/Reference Based Pricing - more freedom of choice typically costs more.
Networks
There are several basic structures of networks, each with its own set of pros and cons:

HMO (Health Maintenance Organization)
This is the most restrictive type of plan, in which you work with a specific doctor called a “primary care physician” who coordinates your care, providing referrals for any other provider visits.

It’s important to note that you can’t go out of network with this type of plan.

PPO (Preferred Provider Organization)
A PPO allows you to see almost any provider without a referral, whether or not they are in-network. There is a preference for in-network providers, and the amount of coinsurance is more favorable when you use in-network providers.

EPO (Exclusive Provider Organization)
This is similar to the HMO design with its requirement that you only see in-network providers. The advantage with this structure is that you’re free to see specialists and other non-primary providers without needing a referral.

Reference Based Pricing (there is no network/everything is in-network)
This is a recent development in which rather than having defined networks, the insurer offers a set price for each specific service/appointment/procedure.

Assessing costs and benefits - determining what is most cost effective
While we purchase health insurance in order to protect ourselves from the unpredictable, there are some thoughts to consider in picking a plan:

Are there any major expenses that you’re anticipating this year?
Can you use a somewhat limited network to meet all of your needs?
Would it be more cost effective to make certain purchases out of pocket?

Sample Plan
What to look out for when selecting a plan

Small, opaque, or impractical networks - any legitimate insurer will provide a means of browsing providers - look for your specific providers, and also look at where providers are on the map, and compare the total amount of in-network providers for one plan with that of another.

Fixed indemnity plans/plan maximums - some plans that are non-ACA compliant may use fixed indemnity (set dollar amounts for reimbursement) or will have low maximums that could be insufficient in the event of something major.

What is excluded? - non-ACA plans can exclude coverage for preexisting conditions, and rarely cover mental health or maternity care. This doesn't mean the option can't be a good fit, but it's vital to read over all of the fine print.

What about renewal? - Unlike an ACA plan, which can simply be renewed year after year, short-term plans require a new application each time. This is one of the most worrisome aspects of a short-term plan since health issues that have developed while on the plan may not be covered/the application may not be approved. The severity of this could vary, since there are other ways to access coverage such as an ACA plan or an employer-sponsored plan.

To describe the nature of short-term coverage most concisely: these plans cost less because they cover less - and that can be a positive or negative, depending on your specific needs.

Additional Coverage

Supplemental plans - building better coverage with multiple pieces:

- **Accident plans**: help to pay deductible in the event of an accident.
- **Critical Illness plans**: help to pay deductible in the event of a Critical Illness.
- **Sickness and Hospitalization plans**: help to pay deductible in the event of hospitalization.
- **Life insurance**: pays a lump sum death benefit, may offer accelerated benefits in some cases.

Using your plan:

**A proactive approach to billing**: Try to communicate with providers as much as possible in order to ensure that services are billed in a way that is aligned with the language in your insurance plan. For example, if your plan covers “behavioral health,” and you see a psychotherapist, the language in their billing should reflect the terminology used in the plan.

Also, check with your provider about how they are billing various services - with an ACA-compliant plan, preventive services are covered at 100% and you are not responsible for cost-sharing.

**Dealing with claims**: Ideally, communicating effectively before and during the time of service, your claims should be accurate and reasonable. If you get a large or
unexpected bill, read it over carefully and see if there were any errors, communicating with the insurer if necessary. In the event of a very large bill that would present a hardship, reach out to the insurer as soon as possible to see what they can offer in the form of a payment plan.

Questions / Next Steps
Open Enrollment via Healthcare.gov will be open from November 1 to December 15. Group and short-term plans are not subject to an enrollment period.

If you’d like help finding a plan for next year, or simply have questions, please feel free to reach out, whether by phone: 616.648.9384 or by email: dylan@healthwisepartners.net