

# FAIRHEALTH® Consumer ACCESS



FALL 2016

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## It's Open Enrollment Time

Although The leaves are changing color, the kids are back in school, and that means it's open enrollment season. This is your chance to enroll (or re-enroll) in a health plan for the coming year.

If you receive your health insurance through your employer, you probably signed onto your health plan when you were hired. But, that doesn't mean you have to stay with it forever. If your employer offers a choice of plans, during open enrollment season you have a chance to reconsider which plan is best for you. You can review plan materials, ask questions about plan choices, choose a different plan, sign up for new plan offerings and add or drop dependents.

Many businesses have their open enrollment season in the fall, with coverage to become effective at the start of the new year. The window for making changes may only last a few weeks, so ask your human resources department or manager when your company's open enrollment season will take place. That'll give you more time to think about your options.

This issue of *FAIR Health Consumer Access* can help. No single health plan is right for everybody. For tips on how to choose a health plan, read [Picking the Best Health Plan for You](#). For information on how to manage costs associated with your health plan, read [The Facts about Cost Sharing](#).

## Open Enrollment, Government Style

Getting health insurance through an employer is usually a good idea, because many employers pay part of the premium—the cost of keeping you covered. But, if your employer doesn't offer health insurance, or you don't like your employer's plan options or are self-employed, you can buy coverage on your own.

You may want to use resources offered by the government to help you find a plan. The federal government and many states operate a Health Insurance Marketplace or Exchange. Those are websites that offer a selection of health plans at competitive prices. If you live in one of the states on [this list](#), use your state's Marketplace. If not, use the [federal Marketplace](#). The advice in this issue of *FAIR Health Consumer Access* will be just as useful whether you are shopping for

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a plan through the Marketplace or evaluating options offered by an employer.

Open enrollment for coverage through the federal Marketplace in 2017 begins November 1, 2016. If you want your coverage to begin on the first day of 2017, you need to enroll in or change plans by December 15, 2016. If you miss that date, you still have until January 31, 2017 to enroll in or change a 2017 plan.

If your income is under certain limits, you may qualify for public health insurance through Medicaid or the Children's Health Insurance Program (CHIP). If you qualify, you can enroll at any time of the year. Check [here](#) to see if you qualify. If you're age 65 or older, you can enroll in the government's Medicare program. (You may also qualify for Medicare if you have a disability or permanent kidney failure.) Click [here](#) for information on when and how to apply for Medicare. Even if you don't qualify for those programs, you may be able to get financial assistance (based on your income) for a plan you purchase through the Marketplace. See [The Facts about Cost Sharing](#).

If you're an immigrant, you may be eligible to use the Marketplace or enroll in public health programs. See our *FH Health Insurance 101* article, [Immigration and Health Insurance Coverage: What Are Your Options?](#)

## If You Miss Open Enrollment

If you miss your employer's or the Marketplace's open enrollment period, don't worry. Most employers let you make changes to your health coverage for certain life events, no matter when they happen. Those events may include marriage, the birth of a child or loss of coverage under a spouse's plan. The Health Insurance Marketplace allows "special enrollment periods" for similar sorts of events.

Still, open enrollment season is the best time to think about what you're looking for from a health plan. This season, why not take the time to do that?

## Picking the Best Health Plan for You

What's No health plan is right for everybody. To pick the plan that's best for you and your family, study the available types of plans and pick the one that best fits your healthcare needs and your budget.

## Different Healthcare Needs

- **Need for ongoing care.** If you're a healthy young adult, you may hardly ever need to see a doctor. In that case, you may want to pay as little as possible for health insurance while still being protected against a medical

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catastrophe. If you or a dependent family member have one or more chronic diseases that require regular treatment, however, you may need a lot of healthcare. In that case, you may be willing to pay more for health insurance that covers the care you need.

- **Concerns about network size.** The size of a plan’s network is another factor to consider. A network is the group of providers (doctors, hospitals, labs and so on) who have agreed to accept your insurer’s contracted rate as payment in full for their services. Receiving coverage from network providers is always your most affordable option. If you have a number of medical conditions, you may want to be sure that the health plan’s network is broad enough to include all the specialists you may need.
- **Need for out-of-network coverage.** Do you want to be covered even if you go outside the health plan’s network? Then pick a type of health plan that allows you to do that.

Here are the basic levels of coverage, types of networks and types of health plans.

## Levels of Coverage

To help you think about levels of coverage, the government’s [Health Insurance Marketplace](#) classifies plans into four “metal” categories. What makes them different is how much you pay for coverage and care compared to how much your insurer pays (based on estimated averages for a typical population). At lower metal categories, such as bronze, your premium is lower, but you pay more if you need healthcare. That may be a good idea if you don’t use much healthcare. At higher metal categories, such as platinum, your insurer pays most of your healthcare costs, but your premium is higher. That may be a good idea if you use a lot of healthcare.

From lowest to highest level of coverage, the categories are:

- Bronze: insurer pays 60 percent; you pay 40 percent;
- Silver: insurer pays 70 percent; you pay 30 percent;
- Gold: insurer pays 80 percent; you pay 20 percent; and
- Platinum: insurer pays 90 percent; you pay 10 percent.

The Marketplace also offers catastrophic health plans, which have low premiums but a very high deductible—\$6,850 in 2016. (A deductible is how much you have to pay before your insurance starts to pay anything.) To qualify for one of those plans, you have to be under age 30 or have a [hardship exemption](#) from the requirement to have health insurance.

## Broad and Narrow Networks

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All health plans have to offer a network of providers that is “adequate” to deliver the benefits they cover. But, some networks are broader than others. A broad network will give you a bigger choice of providers. A narrow network has a much more limited choice. But, narrow network plans may have lower premiums than those with broad networks. You have to judge for yourself how important it is for you to have a larger network of providers to choose from. For more information, see the article [Narrow Networks](#) in our *FH Health Insurance 101* series.

## Types of Health Plans

There are four basic types of health coverage plans. In choosing which one is best for you, think about how much flexibility you want and how much you’re willing to pay.

If most of your visits are to a primary care physician (PCP) rather than to specialists, a **Health Maintenance Organization (HMO)** or **Point of Service (POS)** plan might be best for you. In both of them, you choose a PCP who decides if you need to see a specialist and then refers you to practitioners in your network. The difference between them is that in an HMO, you’ll have to pay the full cost if you go to a provider outside the network. (That is, unless it’s an emergency. Many HMOs, and other plan types, make an exception for out-of-network emergency care.) In a POS plan, you can go to out-of-network providers, but you pay a bigger share than you would if you stayed in network.

If you prefer to be able to see specialists without a referral from a PCP, two other plan types are available. In an **Exclusive Provider Organization (EPO)**, you can see any doctor you want in your plan’s network, without a referral. But, if you visit a doctor outside your plan’s network, you’ll pay the full cost. You get the most flexibility with a **Preferred Provider Organization (PPO)**. In a PPO, you can see any doctor you want without a referral, in or out of network. But, if you visit a doctor outside the network, you’ll have higher costs. For help in estimating out-of-network costs in your area, be sure to use FAIR Health’s cost lookup tool—available in [English](#) or [Spanish](#).

For more detail on types of plans, see the *FH Health Insurance 101* article [Types of Health Plans](#). For more information on picking a health plan, see [Choosing a Health Plan](#).

It’s a lot to think about. But, taking the time to think about it can help you find the plan that works best for you.

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## The Facts about Cost Sharing

No matter what kind of health plan you get, you'll probably have to pay something. Here are the types of payments you may have to make—and how to make your dollars stretch as far as possible.

First, you'll have to pay a **premium**, a regular, often monthly, payment to buy and keep up your coverage. If you have coverage through your employer, your premium amount is usually deducted from your paycheck, before you pay tax on it. You must pay this amount whether or not you use any healthcare that month.

In addition to the premium, most health plans require **cost sharing**. That means that when you do use healthcare, you pay part of the cost and your insurance pays part.

Cost sharing takes different forms. First, you may have a **deductible**, a set dollar amount that you must pay each year before your plan starts paying for healthcare services. Next, you may have a **copay** (or copayment), a set dollar amount for each healthcare service, such as a doctor visit or a lab test. And you may have to pay **coinsurance**, a percentage of the cost of the service.

## Choosing Your Costs

When you're shopping for a health plan, read the plan documents carefully to understand what your premium and cost sharing will be. If you have questions, ask an insurance company representative or your employer's human resources department.

Ideally, you would like all the costs to be as low as possible. But, you'll still have some choices to make. For example, in a **high-deductible health plan**, your premium is lower, but your deductible is high. In many cases, that means you'll probably have to pay out of pocket for all or most of your routine care. Your insurer will only start paying once you've met your deductible. Even then, you may still have to pay copays or coinsurance, or both.

A high-deductible health plan can be a good choice if you normally don't require a lot of healthcare. If you do need a lot of healthcare, you might prefer to pay a higher premium to get lower deductibles, copays and coinsurance.

## Keeping Your Costs Low

Once you've chosen a health plan, there are several things you can do to keep your costs low. One is to use the providers (such as doctors, hospitals and labs) in the health plan's network. Those providers agree to take your insurer's contracted rate as payment in full for their services. Some types of plans won't pay anything if you use a provider

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outside the network. Others will pay a portion, but your share of the cost will usually be higher than if you use an in-network provider. (See the section on types of health plans in [Picking the Best Health Plan for You.](#))

Here are some important tips to keep in mind:

- **Spend your copays wisely.** Pay attention to tiers, or levels, of copays. Your copay may be lower for a certain tier of doctors, such as a family doctor, pediatrician or gynecologist, than for another tier, such as specialists in cardiology or immunology. Similarly, your copay may be higher for visiting an urgent care center rather than a doctor's office, and it will probably be highest for visiting an emergency room.
- **Manage prescription drug copays.** Often, prescription drugs are also assigned to copay tiers, with generic drugs cheaper than brand drugs. You can keep your costs down by knowing what the copays are for each tier and using the tier that costs the least while still doing what's necessary for your health.
- **Save by catching complex illnesses early.** Take advantage of preventive services, such as annual checkups, vaccines and cancer screenings. By law, most health plans must cover certain preventive services at no cost to you, as long as you get them from a provider in your plan's network. Click [here](#) for more information.
- **Take advantage of government assistance.** If your income is below a certain level and you get your health plan through the Health Insurance Marketplace, the government will let you know if you qualify for financial assistance. That can take the form of a premium tax credit to help you pay your premiums, or a cost-sharing reduction to lower the amount you have to pay on deductibles, copays and coinsurance. Click [here](#) for more information.

### Stretching Your Dollars

To help pay your deductible, copays and coinsurance, you can stretch your healthcare dollars by signing up for a flexible spending plan. Such plans let you set aside pretax money from your paycheck to pay for healthcare expenses. Since the money is not taxed, it gives you more money to spend than if you use income that has been taxed. There are several types of flexible spending plans with different rules. For specifics, see the article [Flexible Spending Plans](#) in our *FH Health Insurance 101* series. You might also be interested in our articles on [cost sharing](#) and [high-deductible health plans](#).