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MAKING SENSE OF HEALTH INSURANCE

Making sense of health insurance is important, whether you're using the plan you have, working with your employer to restructure a plan, or looking for a new plan. A good way to start is by breaking the issue into three parts: the financial features that establish your financial exposure, the networks and other structural components that frame how you access care, and common tax-advantaged accounts that help you cover your health care costs.

FIVE KEY HEALTH INSURANCE FEATURES THAT AFFECT PLAN MEMBERS' FINANCES

PREMIUM

The **premium** is the regular payment you make to access health insurance, regardless of how much or how little you use the insurance. Payments are typically deducted from an employee's salary. Usually, the more you pay in premiums, the less you pay in deductibles, copayments, and other out-of-pocket costs, and vice versa.

Employee premium payments can vary depending on things like if just the employee is covered, whether family coverage subsidizes employee-only coverage, and how much employers contribute. Premiums often receive the bulk of the focus when people discuss insurance, but don't forget to consider how premiums and out-of-pocket costs relate to each other.

DEDUCTIBLE

With access to the plan, you and your covered dependents can receive health care goods and services, but someone–you or the insurance company, for example–has to pay for them. Before the insurance will pay for almost anything, it will require that you cover the costs up to a certain dollar amount (the **deductible**). Many plans pay for some types of preventive care before the deductible.

Deductibles can lead to quicker or slower plan-paid costs, depending on how they're structured. They vary based on who's covered, the type of benefits used, whether care is obtained from an in- or out-of-network provider, and whether families must pay the full deductible before the plan starts to cover the costs of any covered family member.

COPAYMENT AND COINSURANCE

Once you've met your deductible, the insurance company steps in to pay most of the costs–the amount a doctor charges for seeing her patient or that a lab charges for doing blood tests, for example. Even so, you'll usually have to pay a portion of the cost determined as either a fixed dollar amount (a **copayment**) or a percentage of the costs (**coinsurance**).

Plans with copayments may have higher premiums than those with coinsurance, because copayments are capped at a set dollar amount and are usually smaller. With coinsurance, plan members pay more when doctors charge more. High out-of-pocket costs can lead members to skip care–even care recommended by health professionals.

CAPPED OUT-OF-POCKET EXPENSES

Federal rules **cap the amount you pay** for covered benefits in most insurance plans. Payments toward your deductible and your copayments and coinsurance count toward the cap, but some expenses, like for premiums and things not covered by the plan, don't.

High-deductible health plans (HDHPs) have federal maximums that are lower than non-HDHP plans, but, in either case, you can have a cap lower than the max. There's plenty of fine print regarding these limits.

THREE HEALTH INSURANCE STRUCTURES THAT AFFECT PLAN MEMBERS' ACCESS TO CARE

FULLY INSURED AND SELF-INSURED PLANS

A **fully insured plan** is one in which, in exchange for premium payments, an insurance company assumes the financial risk of paying for the health care used by plan members. When a school district or other entity takes on that risk, it's a **self-insured plan**.

Self-insured plans usually contract with an insurance company to administer the plan and for access to its provider network. They are often more flexible with design and allow greater access to data on the cost and types of benefits used by plan members and their covered dependents.

IN-NETWORK AND OUT-OF-NETWORK PROVIDER NETWORKS

To keep costs down and improve plan members' health, insurance companies maintain a group of **in-network providers**–including doctors, hospitals, and labs. Those not in the network are called **out-of-network or non-network providers**. Networks can be narrow (with relatively fewer providers) or broad.

For most things, insurers charge plan members more for out-of-network services, in part because in-network providers have agreed to accept lower payment rates. Narrow networks can sometimes lead to lower premiums, but they are more restrictive in where and from whom plan members can seek care.

TYPES OF PLANS: PPO, HMO, EPO, AND POS

Preferred provider organizations (PPOs) establish a network of providers, but members can see out-of-network providers without a referral and at a higher cost. **Health maintenance organizations (HMOs)** generally require plan members to use providers working for or on behalf of the HMO, with referrals needed for specialists. **Exclusive provider organizations (EPOs)** combine aspects of PPOs and HMOs (no in-network referral but no out-of-network care). A **point-of-service plan (POS)** is like a PPO but it may require referrals.

Regardless of plan type, when you receive emergency services, the copayment or coinsurance that you have to pay is usually the same whether you went to an in-network or out-of-network facility. Whether it matters to someone if a plan is more restrictive in allowing access to specialists and out-of-network providers usually depends on their particular needs.

THREE COMMON TAX-ADVANTAGED HEALTH CARE ACCOUNTS

HEALTH SAVINGS ACCOUNTS (HSAS)

An employee, an employer, or others can fund an employee's **HSA**, and contributions to an account, payments for medical expenses, and gains on investments are generally not federally taxable to the account holder. Account balances roll over from year to year and follow the account holder if the account holder leaves the employer. An HSA must be paired with an HSA-qualified high-deductible health plan (HDHP) to receive contributions.

HSAs are designed to pay for unreimbursed, IRS-approved medical expenses. They are subject to annual contribution limits and complex rules. Heads up: HSA contributions can't be made for people enrolled in Medicare (but HSA funds contributed before then can be used), and retroactive coverage can be tricky when HSA contributions have been recently made. Dependent children are defined as under the federal tax code (not extended up to age 26 like under the Affordable Care Act).

HEALTH REIMBURSEMENT ARRANGEMENTS (HRAS)

HRAs can only be funded by employers, and they can limit the types of IRS-approved, unreimbursed medical expenses they'll cover. They do not have to be coupled with an HSA-qualified HDHP. Account balances do not have to roll over every year (although they can), and HRA balances cannot be used to pay for non-medical benefits (or cash withdrawals). Contributions, reimbursements, and investment gains are generally not federally taxable to the account holder.

Unlike HSAs, contributions to HRAs are not subject to a federal cap and do not have a federal minimum annual deductible. HRAs are subject to complex rules regarding when and how they can be used. They can be integrated with ACA-compliant group health plans and, for plan years starting in 2020, a new type of HRA can be integrated with individual-market coverage. Reimbursements are okay for dependent children up to age 26.

HEALTH FLEXIBLE SPENDING ARRANGEMENTS (HEALTH FSAS)

Employers set up **health FSAs**, and employees can defer pre-tax pay into the account up to the federally determined maximum. General-purpose FSAs can be used to reimburse any IRS-approved medical expenses, but FSAs can be limited in scope. At the end of the plan year, employees forfeit unused FSA money.

FSAs can have a grace period for employees to spend unused funds at the end of the plan year, or they can allow limited rollovers. The types of expenses reimbursed can be limited. Reimbursements are okay for dependent children up to age 26.

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