The background of the entire page is a dark wood-grain texture. In the upper left, there is a hand-drawn illustration of a compass. In the lower right, there is a hand-drawn illustration of a pair of glasses. The text is overlaid on this background.

THE CONFUSED
PARENT'S GUIDE

to

HEALTH
INSURANCE

chadhayesmd.com

The Confused Parent's Guide to Health Insurance

Health insurance is a complicated topic, but it's one that affects all of us, and one that you need to understand. I've put together this quick guide to help you with some of the basics. I've tried to ensure its accuracy, but it's no substitute for getting assistance from an insurance expert prior to signing up for a new policy, or for reading the details of your existing plan.

If you'd like to know *exactly* what your existing plan covers, your Summary of Benefits is a great place to start. Your insurance company should have provided this when you signed up for the plan. If you don't have a copy, you can usually find one on the insurance company's website or by calling the customer service number on your insurance card.

HOW TO THINK ABOUT HEALTH INSURANCE

Health insurance—for better or worse—is different from every other type of insurance we have. Insurance was originally designed to cover unexpected events. You would never think of filing an auto insurance claim because your gas tank is empty, or a homeowner's insurance claim for a dirty air filter.

But with health insurance, routine expenses *are* covered—often better than the unexpected ones. This is designed to ensure that everyone has access to basic healthcare, and also to save costs by catching problems early when they are less expensive to treat. The good news is that things like routine screenings, immunizations, and other preventive services are free (sort of), so there's no reason not to take advantage of them. The obvious downside is that you're paying for them anyway, indirectly (with your premiums).

It's important to remember that insurance companies don't make money by helping you out. Really, they function a lot like casinos. The insurance business model works because—on average—they make more money from each person than they spend. This means that for most healthy people, having commercial health insurance doesn't help you at all.

If you were to save the amount that you pay in premiums every month—combined with whatever your employer pays, and simply pay cash for all your healthcare, you would probably save money. If that weren't true, all the insurance companies would have gone out of business a long time ago. The extra money they take in goes to paying for people with higher healthcare costs, and to building ridiculous cash reserves. (Don't get me started.)

WHAT YOU'LL PAY

Premium

This is the monthly amount that you pay just to have insurance, whether you use it or not. Premiums may be paid in part by your employer. If you purchase individual health insurance, you may be eligible for a subsidy to help cover this cost. This depends on your family's income level, and the cut-off for qualifying for a subsidy is a modified adjusted gross income (MAGI) of 400% of the federal poverty level. For a family of 4, this comes out to \$97,200. If you make more than that, you'll pay the premiums on your own.

Deductible

Your deductible is the amount that you pay out-of-pocket (not including premiums) before you start receiving insurance benefits. For many plans, preventive services and some other office visits are covered with no deductible—meaning that you wouldn't have to pay out-of-pocket for these visits. But for emergency room visits, hospitalizations, and other medical services, you essentially pay the full cost until you meet your deductible. Most plans will have individual and family deductibles; once the family deductible is met, your benefits become active for everyone in the family. For most plans, deductibles reset at the beginning of the calendar year, but this can vary with your plan.

Co-payment

This refers to a fixed amount that you will pay for a visit. The amount varies widely with your plan and the type of visit (primary care/specialist/urgent care), but co-pays are usually in the \$10-50 range. You may be billed for additional charges as well, but you should expect to pay the co-pay before you leave the office.

Co-insurance

This is also an amount that you are required to pay, but it is a percentage instead of a fixed dollar amount. For instance, you may be required to pay 50% of the cost for hospitalizations, maternity services, or emergency room visits. The remainder of the cost would be covered by your insurance company (once your deductible is met).

Out-of-pocket maximum

In the extremely unfortunate event that you meet your out-of-pocket maximum for the year, you won't have to pay anything for healthcare for the remainder of the year. The goal of this maximum is to prevent bankruptcy caused by medical expenses. It's nice to have a cap, but it's not cheap getting there—usually several thousand dollars per family member,

TYPES OF PLANS

There are several distinct types of plans that differ primarily based on cost and your ability to choose your providers. Those that offer the most freedom carry the highest costs, and those that restrict you to a very narrow network are the least expensive. The reason for this is that to be in-network with an insurance company, a doctor has to agree (among other things) to accept their payment rates. This saves the insurance company money; in exchange, the doctor presumably gets more patients.

Your insurance company gets to decide which doctors you can see. Most insurance companies offer a find-a-doctor function on their website, but these databases aren't always accurate. It's usually best to call the doctor's office and ask if they are in-network with your specific plan.

Some doctors choose not to contract with any insurance companies, so they would be out-of-network with every plan. Your out-of-pocket costs will likely be higher for out-of-network providers; depending on your plan, you may have to cover the entire cost yourself.

HMO (Health Maintenance Organization)

These plans provide the least freedom to choose your providers. All specialist visits require referrals from your primary doctor, and out-of-network services are not covered. Out-of-pocket costs tend to be lower than other types of plans.

POS (Point of Service)

Point-of-service plans are slightly different from an HMO plan in that you are allowed to see out-of-network providers (with higher out-of-pocket costs). Referrals are still needed for specialist visits.

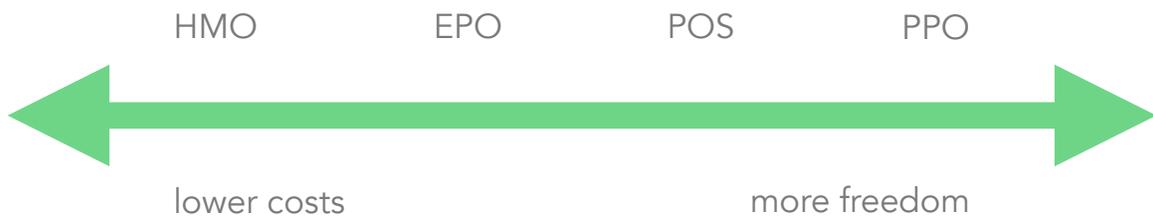
EPO (Exclusive Provider Organization)

You can choose any doctor (including specialists) within the insurance company's network. No referrals are needed. However, out-of-network services are *not* covered, so if you wanted to see a doctor outside the insurance company's network, you would be responsible for the full cost.

PPO (Preferred Provider Organization)

Offers the most freedom to choose your provider, but at the highest premiums. You are free to see out-of-network doctors, but you will be responsible for a larger portion of the cost for out-of-network visits. Some plans do not provide out-of-network coverage for preventive services — more on this later.

TYPES OF PLANS



LEVELS OF COVERAGE

Within each plan type, there are various levels of coverage. Somebody decided to name them after metals: bronze, silver, and gold. These are pretty simple to understand. Bronze plans have the lowest monthly premiums, but require you to pay a higher cost for each visit. Gold plans have much higher premiums, but mean that you'll have lower out-of-pocket costs for each visit. Silver—just like in the Olympics—is in the middle.

LEVELS OF COVERAGE



CATASTROPHIC PLANS

If catastrophic plans were a metal, they would be lead. They're not very expensive, but they have potential to cause quite a financial burden. Now available only to young adults (under 30), these plans are more like your auto insurance. They don't cover routine care and are intended only as a last resort for expensive and unexpected events. The monthly premiums are the lowest you'll find, but you'll likely pay the full price for the majority of your healthcare.

GOING UNINSURED

For people who don't get health insurance through their employer and don't qualify for subsidies, health insurance premiums can be really expensive—like \$20,000 per year (or more) for the family. This cost has led many to consider going without insurance.

The Affordable Care Act's "Individual Mandate" tried to eliminate this by creating a penalty for those who choose to go uninsured. The penalty applies to those who go two or more months during the year without health insurance. For 2017, the penalty is the higher of either:

1. \$695 per adult + \$347.50 per child, with a maximum of \$2,085 per family; or
2. 2.5% of your modified adjusted gross income (MAGI).

For some families, the decision to go uninsured may be reasonable. But remember that, in addition to the penalty, you also are choosing to accept a great deal of risk. It may very well be cheaper to pay the penalty and pay out-of-pocket for healthcare. But if you happen to get into a terrible car accident, or your kid gets leukemia...you're on your own.

PREVENTIVE SERVICES

Preventive services are things like well-child visits, immunizations, and routine screening tests. The Affordable Care Act requires that insurance companies cover preventive services without any cost-sharing from the patient. The goal is to ensure that people don't avoid important preventive care because of the cost—which keeps people healthy and lowers overall costs. This is important, especially in pediatrics, because immunizations are not cheap. (The cost to immunize a baby in the first year of life is in the neighborhood of \$2,000—well worth it, but expensive, nonetheless.) However, there are three key points to be aware of:

1. Plans that existed prior to the Affordable Care Act are exempt from this requirement and can still require co-payments, co-insurance, and deductibles for preventive care.
2. If a problem is discovered and addressed during a routine visit, the provider may bill for a problem-based visit in addition to the preventive visit. This may require out-of-pocket expense from the patient.

3. Some insurance companies will cover out-of-network services for sick visits but not for preventive services—so if you choose to see an out-of-network doctor for well visits, you may be responsible for the entire cost of the visit, including any immunizations.

COVERED VS. UNCOVERED SERVICES

Each insurance plan has specific rules for which services they cover. If a service is uncovered, it means that you will pay out-of-pocket. Procedures considered to be cosmetic are typically uncovered—a common example in pediatrics is ear piercing. (I’m sure you can think of a lot more examples for adults.) Also, testing “just to know” or other procedures that aren’t medically necessary are usually considered “uncovered services.” Your provider should let you know in advance that a particular service will not be covered, and how much it will cost.

Some services—usually the expensive ones like hospitalizations, advanced imaging, or certain medications—may require a prior authorization to be covered. If your provider gets them approved beforehand, you’re covered. If not, you’re...well, it’s worth asking.

PHARMACY BENEFITS

Most insurance plans provide some sort of pharmacy coverage—but it’s not always great. In fact, for a lot of generic medications, you may find that it’s cheaper *not* to use your insurance. (The pharmacy can usually give you pricing both ways.) Medications are typically classified into tiers, with low-cost generic medications being in the lowest tier, and expensive brand-name medications in the highest tier. Your co-pay depends on the tier of the medication you are prescribed.

Additionally, each insurance company develops a formulary, which is a list of medications that they will cover. (Looking at this another way, it’s a list of medications your doctor may prescribe.) For drugs that are not on the formulary, there is often—but not always—a substitute that may be prescribed. If you find out at the pharmacy counter that a medication isn’t covered, the pharmacist will sometimes call the doctor’s office and request a change. But sometimes doctors have a good reason for choosing a particular medication, and sometimes there just aren’t any other options. In these cases, your doctor may be able to get the medication approved in advance by submitting a prior authorization.

MENTAL HEALTH

Another important benefit of the Affordable Care Act is that it requires insurance companies to cover mental health services at least as well as other medical services. The bigger problem with mental health coverage today is finding an in-network provider. Because mental health providers spend a lot of time with patients (and because insurance payments are abysmal), many psychiatrists, psychologists, therapists, and counselors have opted not to accept insurance.

And because there is an overall shortage of mental health providers, getting an appointment with an in-network provider may take a while. If you have the resources, paying out-of-pocket opens up a lot of options, and you'll probably be able to get an appointment sooner. It's a sad but very real problem with our healthcare system—not limited to mental health, but possibly most pronounced there.

NEWBORNS

When you have a new baby, you have a specified period of time (typically 30 days) to enroll the baby in your health plan. It's easy to forget about this in the postpartum fog, but it's *really* important to take care of. You will probably need your baby's social security card, which should arrive in the mail in a week or so.

Don't forget.

FLEXIBLE SPENDING ACCOUNTS/HEALTH SAVINGS ACCOUNTS

These two types of financial accounts allow you to have money deducted from your pay and deposited into a savings account that you can use for out-of-pocket healthcare expenses. The big advantage to these is that the money is taken out before taxes (so it can save you a lot of money). The disadvantage is that there is a limited list of things you can spend that money on—and in some cases, it goes away at the end of the year if you don't use it.

Contributing to a FSA or HSA, at least in a small amount, is beneficial for a lot of families. It's worth discussing with your financial advisor.

DIRECT PRIMARY CARE

Finally, I want to mention another option that is gaining popularity. Direct Primary Care (DPC) practices take insurance out of the loop completely. They accept payment directly from patients, usually in the form of a monthly or annual fee (but sometimes on a fee-for-service basis). These practices are more common in adult medicine than in pediatrics, but there are a handful of DPC pediatric practices across the country.

These practices typically offer longer appointments, less waiting, better access to your doctor, and other perks. Essentially, the doctor works directly for you—not for your insurance company. By not dealing with insurance companies, practice eliminate a lot of administrative overhead costs. Because these costs are lower, they are able to see fewer patients per day—which means they can devote more time and attention to each patient.

DPC practices vary widely in cost and in the benefits they provide, but many of them are reasonably priced. They typically involve more up-front expense, but they can keep you from wasting time in the waiting room, potentially prevent unnecessary emergency room visits, or just make your life a little less stressful. If there's a direct primary care practice in your area, it's worth finding out about their fees and the benefits they provide over a traditional practice. You may find that this practice model is a good fit for your family.

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You can find his blog, *Demystifying Pediatrics*, at chadhayesmd.com. His writing has been featured in the *Washington Post*, *Newsweek*, *KevinMD*, and *The Scientific Parent*. You can follow him on Twitter and Facebook at [@chadhayesmd](https://twitter.com/chadhayesmd).

Chad has an awesome wife, three daughters, a Bouvier des Flandres puppy, and too many hobbies to list.

