Health Insurance Smarts

Health Insurance 101

Health insurance, like other forms of insurance, helps protect you from high costs and financial risk. If you are sick or injured and use the services of a doctor, hospital, or other health-care provider, health insurance can help to pay for the cost of those services.

There are affordable ways for many consumers to purchase health insurance. There are also requirements for insurance plans. These requirements include mandates for both consumers and insurers. They specify rights and protections for consumers, as well as items and services that health insurance plans, or contracts, must include. Although these requirements for health insurance plans standardize the benefits that are offered, how health insurance works is still confusing for many consumers.

Requirements

There are now consumer protections and requirements in place for health insurance. First, while the tax penalty for not having health insurance has been repealed, it is still a good idea for everyone to have health insurance. Many people have insurance through their jobs, through a private policy (including COBRA), or through a public program (Medicare, KanCare, VA, TRICARE, or Indian Health Service). Others may obtain coverage through the health insurance marketplace.

Second, health insurers are required to cover everyone. They **cannot** refuse coverage to anyone who wants to purchase a policy.

Third, large employers must offer health insurance coverage to their employees. Implementation started in 2015 for employers with 100 or more employees and in 2016 for employers with 50 to 99 employees.

Consumer Protections

New consumer protections are now required in health insurance plans. The protections include the following features.

- No one can be turned down for insurance for any (nonfinancial) reason, even if they have a pre-existing condition.
- No one can lose insurance if they are sick.
- All policies are guaranteed to be renewed if the premiums are paid on time. If you do not pay your premiums, the insurance company can cancel your policy.
- There are no maximum annual or lifetime limits on coverage of essential benefits.
- There is coverage of a range of essential benefits, including preventive services.
- There are limits on how much insurance can cost and how much premium costs can rise year-to-year.

The Health Insurance Contract

A health insurance policy is a legally binding contract between the insurance company and the insured. The contract has specific language that details how the policy will work. For example, it usually covers a one-year period and can be renewed annually. The policy also describes the benefits covered and how much you will pay in premiums and other costs. It may direct you to seek health care through a specific set of health-care providers called a network.

What is covered. The policy details the types of health-care services, or benefits,

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that are covered and those that are excluded. All policies must now cover what are referred to as "10 essential health benefits." These are the types of services usually covered in most large employer policies.

Although referred to as benefits, they are actually items and services within 10 categories. They are:

- Outpatient care
- Trips to the emergency room
- Hospitalization
- Care before and after your baby is born
- Mental health and substance use disorder services
- Prescription drugs
- Services and devices to help you recover if you are injured or have a disability or chronic condition
- Lab tests
- Preventive and wellness services and care for managing a chronic disease
- Pediatric services for children under age 19, including dental and vision care (though these may not be covered in all policies offered by the insurer, they will be covered in some of the policies)

The preventive services must be covered at no direct cost to the consumer beyond their health insurance premium. Policies may cover more than these essential benefits, but policies typically do not cover every type of medical care. They may exclude specific procedures and services. Any policy exclusion should be clearly spelled out in the policy. Common exclusions include vision and dental care (except for children), home care, and cosmetic surgery.

Paying for coverage and care. Health insurance helps lessen the worry about large medical bills, but there are costs. You pay for some of the costs of your care and the insurance company pays some. As with other types of insurance, health insurance involves premiums, deductibles, and different types of copayments. The more benefits the insurance company agrees to provide, the higher the premium you will be required to pay up front for that enhanced coverage.

Premiums must be paid whether or not you use your insurance. They are usually paid monthly but can be paid quarterly or yearly. Nonpayment is a reason for a policy to be canceled. Premiums are set based on the amount of coverage you are purchasing. More comprehensive policies have larger premiums. Depending on how you get health insurance, you may be responsible for the entire premium or your employer may pay all or a portion of it. Some families may qualify for tax subsidies that assist in paying their health insurance premiums.

When you pay deductibles, coinsurance, and copayments you are sharing the costs of health care with your insurer. This is called cost sharing.

A deductible is one of the methods of cost sharing. The deductible is the amount you must pay before your health insurance plan begins to pay any of your health care expenses. Your deductible may not apply to all services. It may be different depending on the provider you use. It is important to understand how the deductible is calculated. In some policies, the entire family deductible must be met before other types of cost sharing begin. In other policies, each family member needs only to meet her or his individual deductible before other types of cost sharing begin.

After you meet the requirements of your deductible, there are two additional ways you and the insurance company share the costs of your health care. One is coinsurance and the other is copayment. A policy may include both types of cost sharing.

Coinsurance is your share of the cost of covered services. You might be sharing the costs of services on a percentage basis. You may have a policy where you pay 20 percent of the cost of each service and your insurer pays 80 percent. The coinsurance amount is often billed, so you will pay it after you have received services.

When you have a copayment, you pay a fixed amount, rather than a percentage, for a covered service. For example, you may pay $20 for each visit to your

family doctor and $10 for a generic drug prescription. Copayments are usually paid at the time of service.

All policies must now have an annual out-of-pocket maximum. The annual maximum is the most you will have to pay for covered health services in a given year in addition to the amount you pay for premiums. Premium costs are NOT included when calculating the out-of-pocket maximum.

Each time you use a service, you accumulate charges for health-care services that are applied to your deductible for that year. Once the deductible is met, you pay some level of coinsurance or copayment until you reach your annual out-of-pocket maximum or limit. After you've paid an amount equal to your out-of-pocket limit, you have paid the maximum your policy requires you to pay for that year. (See Figure 1.) Most people will never use that much health care, so you are likely paying less out-of-pocket in a given year. All further covered health-care expenses for that year are the responsibility of the insurance company.

For plans sold in the health insurance marketplace, the out-of-pocket maximum for 2025 is set at $9,200 for an individual plan and $18,400 for a family plan. Your out-of-pocket limit may be less than that amount but it may not be more.

Who provides services? Most plans have a network of providers. To manage costs, insurers negotiate prices and contract with different doctors, hospitals, pharmacies, labs, and other health-care providers for those providers' services. These providers are then in the network.

The policy may require that you see only network providers, or it may require you to pay more of the charges if you use a provider that is not in the network. In some instances, the insurance company will not pay any of the costs if you use a non-network provider. To keep your costs as low as possible, it is best to only see network providers. (See Figure 2.)

Shopping in the Health Insurance Marketplace

If you don't already have health insurance coverage through your employer or through one of the public programs (Medicare, KanCare, TRICARE, VA, Indian Health Service), you can purchase a plan in the private market from an insurance company or insurance agent. You may also shop among the plans offered in your area through the health insurance marketplace. If you shop in the health insurance marketplace, depending on your income, you may be eligible for subsidies to help pay for the premium and some out-of-pocket expenses.

The health insurance marketplace is found at *healthcare.gov*. You are eligible to buy a qualified health plan from the marketplace in the state in which you live, if you are a United States citizen or a resident lawfully present in the U.S. and are not in prison or jail.

Figure 1: Example of health plan cost sharing

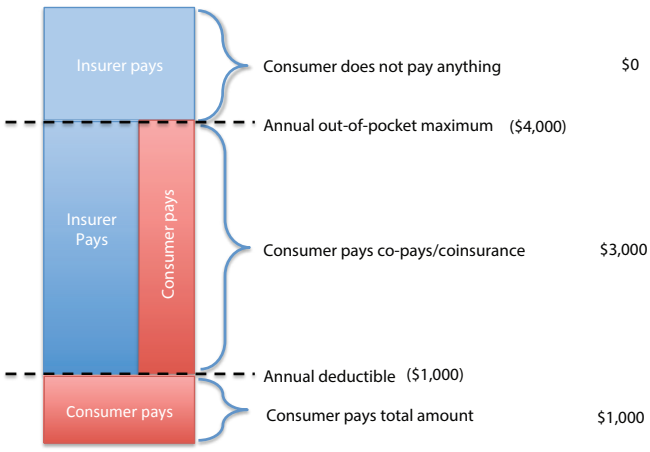
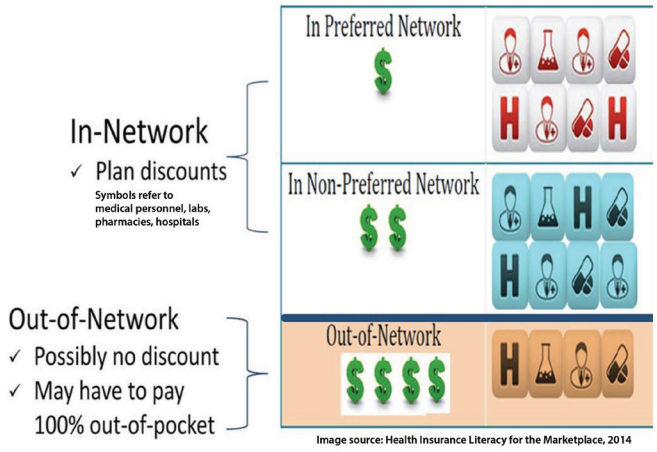


Figure 2: Differences between getting services in-network and out-of-network



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Types of plans. Plans offered through the health insurance marketplace fall into four categories: bronze, silver, gold, and platinum. All these plans offer the same set of essential health benefits, though some may offer additional benefits.

Total costs for plans in each category will vary, but in general plans with lower premiums will have higher out-of-pocket costs. For example, the bronze level plans tend to have the lowest monthly premiums but higher out-of-pocket costs. Bronze plans pay on average about 60 percent of the cost of providing essential benefits to policy holders. Plans at the bronze level may be good for individuals who are relatively healthy and who do not need a lot of medical care or prescription drugs.

Generally, plans with higher premiums will have lower out-of-pocket costs. The platinum level plans tend to have the highest monthly premiums and the lowest out-of-pocket costs. Platinum plans may be most appropriate for those who believe they will use a high level of health-care services or who want to pay lower out-of-pocket costs.

The number and type of plans offered vary by state. They may also vary by county within a state.

Certain consumers qualify to purchase high-deductible plans called catastrophic plans. They are available to those under age 30 or those over age 30 who qualify for a "hardship exemption." Hardship exemptions are granted based on income and other factors. Learn more about hardship exemptions at *healthcare.gov.*

Financial assistance for families. Some lower- and middle-income families are eligible for assistance in paying for their health insurance expenses if they purchase a plan through the health insurance marketplace. One type of assistance is a premium assistance tax credit. Those who qualify pay lower monthly premiums.

Another type of assistance is a cost-sharing reduction. Those who qualify pay lower deductibles, copayments, and coinsurance if they enroll in a plan within the silver category or tier.

Income and family size determines who qualifies for both of these types of financial assistance. When you buy insurance through the marketplace, a determination will be made on your eligibility for the premium tax credits or cost-sharing reduction.

Health insurance can be confusing for many consumers. Having health insurance can help lessen the worry about large medical bills. Understanding what your policy covers, how you share the costs with your insurance company, and which providers are in your network is important.

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Health Insurance Smarts was created in 2013 by a team of K-State Research and Extension professionals. The team members were: Elizabeth Kiss, assistant professor and extension specialist; Erin Petersilie, Walnut Creek District family and consumer sciences agent; Roberta Riportella, Kansas Health Foundation Professor of Community Health; Debra Wood, Central Kansas District family resource management agent; Katie Allen, communications specialist; Janie Dunstan, graphic designer; and Linda Gilmore, editor.

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