Health Insurance Smarts

Health Insurance 102

There are new affordable ways for many consumers to purchase health insurance. There are also new requirements for health insurance policies that standardize the benefits offered. However, knowing how to pick the best policy (also known as a plan) for your health needs, at the best price, can be confusing.

Health Insurance Is a Contract

A health insurance policy is a legally binding contract between an insurance company and the insured (you and your family members). That contract has specific language detailing how the contract will work. It usually covers a one-year period and typically can be renewed annually. The policy provides details about the benefits covered and how much you will pay. Most health plans will direct you to seek care through a selected set of health-care providers. This group of providers is called a network.

There are differences between health insurance policies that include: which health-care services are covered and which are excluded, which providers are in the network, and how much you will pay for premiums and other costs. If you have more than one health insurance plan to choose from, it is useful to take the time to study these differences before making a decision.

Different types of health insurance plans meet different needs. It is important to view the summary of benefits to know what the plan's features are and how they work. It is also important to understand the names of types of plans. A PPO (Preferred Provider Organization) is a type of plan where the insurer contracts with the providers and does not restrict your use of services beyond sending you to a contracted provider. An HMO (Health Maintenance Organization) also directs you to contracted providers, but it may direct you to see a primary-care provider before seeing a specialist or other provider. An EPO (Exclusive Provider Organization) plan covers services only if you go to doctors, specialists, or hospitals in the plan's network except in an emergency. Finally, with POS (Point of Service) plans you pay less if you use doctors, hospitals, and other health-care providers that belong to the plan's network. POS plans also require you to get a referral from your primary-care provider in order to see a specialist.

To brush up on how insurance works and the specifics of health insurance policies, you may want to review the information in another fact sheet in this series, Health Insurance 101 (MF3188). It is available through the K-State Research and Extension online bookstore (*www.ksre.ksu.edu/bookstore*). Simply search for the title or publication number.

Choosing a Plan

Review the details of the plans available to you before you make a choice so you can pick the plan that best meets the needs of you and your family. Also, health insurance plans change from year to year. It is important to review the details of the plans available to you each time you have the opportunity to sign up for health coverage inside the marketplace, through an employer, or outside the marketplace. It does get easier once you master how to make an informed choice. You learn to look for certain features.

There may even be instances when you and your family members are better off with different policies. While this can get tricky,

K-STATE Research and Extension

Kansas State University Agricultural Experiment Station and Cooperative Extension Service

if you have the flexibility to purchase plans specific to individual family members, that is sometimes the best choice. For example, younger adults typically don't need quite the same coverage as their middle-aged parents. Policies for younger adults are usually much less expensive, which can make separate policies a reasonable choice. Spouses may also have different health insurance options through their employers, and possibly different health-care needs, so considering different policies may be wise.

What benefits do you need? Everyone has different medical situations. Some people require more health care and services, others require less. You may also know that you are at risk for particular needs — home health care, for example. You may know what kind of medical care you need now; some future needs are not predictable. The best you can do is plan around the needs you know you have today.

The benefit packages offered in policies describe what kinds of health-care services are covered. These are likely to remain about the same from year to year. Most are mandated benefits required by law. This means that most plans are now required to cover the same basic set of benefits. These are referred to as the "10 essential health benefits." These are the types of services usually covered in policies offered by large employers.

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 chronic disease management; and pediatric services for children under age 19, including dental and vision care. The preventive services must be covered at no direct cost to the consumer beyond the health insurance premium.

Some policies provide additional coverage, and your family may have special needs. It is therefore important to pay attention to the benefit packages offered in the policies you are considering.

One of the major differences among insurance policies is the prescription drugs they cover. You can find the drugs that the plan covers in a list the insurer calls a "drug formulary." If you are already on medications, it is important to review the list to see that the drugs you and your doctor prefer are on the formulary. Since these formularies change from year to year, you should look at this list each time you have the opportunity to sign up for a new health insurance plan or renew an existing one.

Which health-care providers do you prefer to use, and which can you use? Most plans now have specific networks of providers. To manage costs, insurers negotiate with physicians, surgeons, hospitals, pharmacies, labs, and other health-care providers for the prices for those providers' services. Those who reach an agreement with the insurer are called network providers. The policy may require you to use only network providers. If you choose to see a provider that is not in the network — known as going out of the network — the policy will likely cover less of the cost for the service and require you to pay more, or all, of the cost.

To keep your costs as low as possible, it is best to see network providers. Some plans may even offer several networks of providers, and charge more for some, less for others. This is another reason it is important that you know the network status of the doctor and other providers, including pharmacies, you prefer to use. The selection of network providers is another aspect that is likely to change from year to year. Provider networks can also change during the year. The insurer must give you notice when a provider leaves the network, but there is little you can do when a preferred health-care provider and insurance company choose to part ways. You are still in the health plan but may have to choose new providers. So you aren't caught off guard, it is important to review the network status of your preferred providers each time you seek service.

If you regularly travel away from your local area, you may want to enroll in a plan that includes a regional or national network of providers. That way, if you need medical care while away from home, you will not be faced with paying more for services from out-of-network providers.

Finally, keep in mind that there may be differences among the plans available to you regarding whether or not you must see a primary-care provider before seeking the services of a specialist. Primary-care providers — often called family doctors — can be physicians, nurse practitioners, obstetricians or gynecologists, pediatricians, or general internists.

In plans that require you to see a primary-care provider before consulting with a specialist, the primary-care physician gives you a formal referral to a specialist after determining that you need specialty care. Some plans allow you to go to certain kinds of specialists without first seeking a referral. Others allow you to go directly to a specialist without the step of obtaining a referral from a primary-care provider. Pay attention to these differences in plans if this is important to you.

What costs are you comfortable paying? Without health insurance, you and your family would be responsible for the full cost of all of your health-care needs. Because you cannot know exactly what your health needs will be in the future, it would be difficult to budget for the costs of health care without insurance. With health insurance, you share the costs of your health care with an insurance company and others in the plan. It offers you a more certain and affordable way to manage your medical expenses because you can anticipate your costs.

All health insurance policies expect you to pay a combination of premiums, deductibles, coinsurance, and copayments. There will be differences among policies regarding how much you will pay.

Premiums are the fixed charge that you pay for the policy regardless of whether or not you use your insurance. The premium amount can vary greatly based on the comprehensiveness of the policy and the amount of cost sharing. Premiums are typically paid monthly but can be paid four times per year or even just one time each year. Nonpayment of the premium is a reason for a policy to be canceled. You may be responsible for the entire premium, or your employer may pay all or a portion of it. If you buy a policy through the health insurance marketplace, depending on your income, you may be eligible for subsidies to help pay for the premium and some of the out-of-pocket expenses.

Deductibles are one way you and your insurance company share the costs of your health care. Coinsurance and copayments are two additional ways.

The deductible is the amount you must pay before your health insurance policy begins to pay any of your health-care expenses. Your deductible may not apply to all services. For example, you may have a deductible applied for prescription drugs and another for office visits. You may also have different deductibles for in-network and out-of-network services. When family members have more than one policy, each family member usually must meet his or her individual deductible. Some policies have options for aggregate deductibles, where the medical expenses of all family members are included in one deductible the family has to meet before other cost sharing begins. Understanding how the deductible is calculated and applied in the plans you are considering is important to understand the total costs of those plans.

Coinsurance and copayments are two additional ways you share the cost of your health care with the insurance company. A policy may include both types of cost sharing. For example, it may require a coinsurance amount for hospital fees and copayments for prescription medications.

When you share costs with coinsurance, you pay a percentage of each service used. The policy may be such that you pay 20 percent of the cost of each service and the insurance plan pays the remaining 80 percent. Coinsurance amounts are often billed, so you will pay it after you have received the service.

When you share costs with copayments, you pay a fixed amount, rather than a percentage, for a covered service. For example, the policy may require you to pay $20 for each visit to your family doctor or $10 for a prescription for a generic drug, regardless of the full expense for that service or product. Copayments are usually paid at the time of service.

All policies must now have an annual out-of-pocket maximum. For plans sold in the Health Insurance Marketplace, the out-of-pocket maximum in 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.

Each time you are charged for using a covered health service (doctor visit, lab work, or prescription drug, as examples), you accumulate health-care expenses that are applied to your deductible. Once you pay for health-care services equaling the amount of your deductible, you enter the next cost-sharing phase. You continue to share costs with your health plan (through coinsurance and copayments) until you reach the maximum out-of-pocket amount specified in the policy. Once you reach that maximum, you have paid the maximum your policy required you to pay for the year. All of your additional health-care expenses are the responsibility of the insurance company. You may still have to pay the full charge for excluded benefits, those types of health-care services that your health plan does not cover, at any amount.

Not all health-care expenses count toward your out-of-pocket maximum. Premiums are NOT included when calculating the out-of-pocket maximum. Deductibles ARE included when calculating the out-of-pocket maximum. Cost-sharing payments (coinsurance and copayments) ARE included when calculating the out-of-pocket maximum. When estimating your total health-care costs for the year, start by adding the total of your premiums plus the out-of-pocket maximum. (Most people will never use that much health care, so you are likely paying less out-of-pocket in a given year.) Then, estimate the total of any other anticipated health-care expenses.

If you will be purchasing health insurance through the health insurance marketplace, you will be able to choose from several health plan categories. The differences among the categories reflect differences in how you and the insurer will share the costs of care. Plans in each category (bronze, silver, gold, and platinum) pay different amounts of the total costs of the average person's health care. In other words, the plans' premiums, deductibles, coinsurance, copayments, and out-of-pocket maximums will differ by category. The quality and amount of care you get has nothing to do with these categories.

There are several plans available in the health insurance marketplace in each category. Each plan has a different combination of deductibles and cost sharing. Plans with lower premiums, for example in the bronze category, will have higher deductibles and cost-sharing amounts. On average, the health plan will pay 60 percent, and the consumer will pay 40 percent. Premiums are higher for plans that cover more of the costs when a consumer uses services. In the silver category, for example, the health plan will pay 70 percent on average, and the consumer will pay 30 percent. The actual percentage you would pay in a given year, in total or per service, would depend on the actual services you used.

If you shop in the health insurance marketplace, depending on your income, you may be eligible for subsidies to help pay for your premiums and some out-of-pocket expenses. Go to *https://www.healthcare.gov/lower-costs/* to determine if you qualify for financial assistance when purchasing a plan through the health insurance marketplace.

The health insurance marketplace offers one additional category of health insurance plans. These are the catastrophic coverage plans, and they are only available to people under age 30 or those who qualify for a "hardship" exemption. Catastrophic plans begin paying for care only after you have first paid for all of your health-care expenses up to the total of the deductible.

Health Insurance 102

Weighing the Costs and the Risks

As you begin to comparison shop among the insurance companies and policies available to you, the plan with the lowest premium may or may not be your best choice. If you are relatively healthy and expect to use few health services, or you are a person comfortable with carrying risk, then you may decide to choose a policy with a low premium. Such plans will likely have the highest out-of-pocket costs. If you pick a policy with the lowest premiums, then you need to be prepared to pay more out-of-pocket if you unexpectedly use more health-care services than you anticipated.

If you want to balance the regular expense of premiums with the out-of-pocket expenses for health-care services, then you may want to consider a plan with somewhat higher premiums but lower out-of-pocket costs. In this case, you still need to be prepared to pay the out-of-pocket costs if you unexpectedly use more health-care services than you anticipated but the amount will be lower than in the previous example.

If you expect to need a lot of health care during the year or are not comfortable with unknown risk, then you may prefer to pay a higher premium up front with the expectation of much lower out-of-pocket costs when you use health-care services. Purchasing a plan that pays a greater percentage of the total costs of the average person's care may make sense if you are more comfortable budgeting for the monthly premium costs than trying to anticipate and budget for out-of-pocket expenses.

Those who are eligible to purchase a catastrophic policy with a low premium but a very high deductible need to be prepared to bear most of the everyday costs of health care on their own.

Making the Choice

When choosing a health insurance plan for you and your family there is much to consider. What benefits do you need? Which health-care providers do you prefer to use, and which can you use? What costs are you comfortable paying? Do you have an emergency or "rainy day" fund to cover expenses in case of sickness, job loss, or economic downturn?

All of these factors should be considered when deciding which policy best suits your needs. The right plan for you and your family will depend on your health and your financial situation.

- Determine which benefits beyond the essential health benefits covered by all policies are most important to you and your family.
- Check the drug formulary for your prescription drugs and the list of network pharmacies when looking at your options.
- Check to make sure the providers you want to use are in the plan's provider network. Weigh the costs of not only the premium, but also the deductible, coinsurance, and copayments for the plans you are considering.

Remember, you cannot be denied health insurance coverage because of a pre-existing condition. You cannot have a policy canceled because you are sick, so go ahead and make a choice!

Health Insurance 102

Important Terms

Cost Sharing: A type of arrangement where your insurer and you share the expenses of covered health-care services. This generally includes deductibles, coinsurance, and copayments, but it typically does not include balance billing amounts for non-network providers, the cost of non-covered services, or premiums (the monthly fixed charge you pay regardless if you use your insurance). Cost sharing in Medicaid and CHIP, however, includes premiums.

Deductible: The specific type of cost sharing that occurs before any other. It is the annual amount you owe for health-care services your health insurance plan covers before your insurer begins to pay. For example, if your deductible is $1,000, your insurer won't pay anything until you've met your $1,000 deductible for covered health-care services subject to the deductible in a given year. The deductible may not apply to all services.

Coinsurance: The specific type of cost sharing that is calculated as a percentage. After you pay enough to reach your annual deductible, you and your insurer share the remainder of your health-care costs for the year, which are split as a percentage. For example, in a 20 percent coinsurance arrangement, you would pay $20 on every $100 bill. A 50 percent coinsurance arrangement would mean you'd pay $50 on every $100 bill.

Copayment: The specific type of cost sharing assigned as a fixed amount. For example, you may pay $15 every time you purchase a prescription drug regardless of the cost of that drug. The fixed amount can vary by the type of covered health-care service and may or may not require you to first meet your annual deductible.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health-care services.

Out-of-pocket maximum/limit: The most you pay during a policy period (usually one year) before your health insurance or plan starts to pay 100 percent for covered essential health benefits. This limit must include deductibles, coinsurance, copayments, or similar charges, in addition to any other expenditures required of an individual for a qualified medical expense under the essential health benefits. This limit does not have to count premiums, balance billing amounts for non-network providers, other out-of-network cost-sharing, or spending for nonessential health benefits.

For more information, contact:

Elizabeth Kiss, Ph.D.
Professor and extension specialist
dekiss4@ksu.edu

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.

K-STATE Research and Extension

Publications from Kansas State University are available at: ***bookstore.ksre.ksu.edu***

Kansas State University Agricultural Experiment Station and Cooperative Extension Service
K-State Research and Extension is an equal opportunity provider and employer. Issued in furtherance of Cooperative Extension Work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, Director of K-State Research and Extension, Kansas State University, County Extension Councils, Extension Districts. **MF3189 rev.** **January 2025**