



How Health Insurance Works

Healthcare in the United States can be very expensive. A single doctor's office visit may cost several hundred dollars and an average three-day hospital stay can run tens of thousands of dollars (or even more) depending on the type of care provided.

This is where health insurance comes in.

There are many types of insurance in the US, so there are lots of different rules about how they all work. All qualified health plans include emergency services, hospitalization, laboratory tests and prescription drugs.

QUALIFIED HEALTH PLANS

Health Maintenance Organization Plan (HMO)

In this plan, you must select a Primary Care Provider (PCP) from an in-network list from your plan. This is the provider you will reach out to anytime you have an issue. The insurer requires the PCP to direct your care and be a centralized source for information. If you need care outside of what your PCP can offer, your PCP will be required to provide a referral to a specialist for it to be covered.

Preferred Provider Organization Plan (PPO)

This plan also provides the patient access to a network of preferred providers. However, you may visit any of them at any time without receiving a referral first. You will pay less out-of-pocket expenses if you use an in-network provider, but if you visit a doctor that is out-of-network, you will be responsible for a greater portion of the cost. This type of plan is typically more expensive but includes a larger network of doctors. This can be important for people who travel a lot or students who live out of the area of their health plan.

Point of Service Plan (POS)

POS plans combine features from both HMO and PPO plans to create a managed care plan. Like a HMO, patients choose an in-network provider as their PCP and like PPO they can go out-of-network for a higher cost. The plan will pay more if the PCP provides a referral to an out-of-network provider.





High-Deductible Health Plan (HDHP)

A high-deductible health plan can be a HMO or PPO but offers the option to open an account called a Health Savings Account (HSA) to save money for medical expenses. When you withdraw funds to use for qualified medical expenses, you do not have to pay taxes on the money. These plans generally offer lower premiums, but you may pay higher out-of-pocket costs before meeting your deductible.

Catastrophic Health Insurance Plans

Have low monthly premiums and very high deductibles. They cover the same healthcare as other Marketplace plans but they are designed so you pay most routine medical expenses yourself. The only people who are eligible to purchase catastrophic plans are people under age 30 and anyone who has received an exception because they could not afford coverage through their job or through the Health Insurance Marketplace.

Short-Term Limited Duration Plans

These plans are intended to fill the gaps in coverage if you lose your job or coverage or if you recently started a new job and are waiting for coverage to start. These plans are very limited and often do not cover basic healthcare like maternity services or prescription drugs. Many states limit the sale of these plans, with some excluding their sale altogether, so check with the insurance commissioner in your state for more information.

Glossary

Deductible – Amount you pay for medical expenses before your health insurance pays.

Co-Pays – The amount you pay to a healthcare provider at the time you receive services, usually a fixed amount.

Co-Insurance – A certain percentage you will pay for healthcare services after your deductible is met.

Out-of-Pocket Maximum – The most you will pay during a plan year for coverage. This includes deductibles, copayments and co-insurance.

Covered Benefit – A health service (portion or all the cost) that is included under the plan's benefits. 'Covered' means that some portion of the allowable cost of a health service will be considered for payment by the insurance company. It does not mean that the service will be paid at 100%.

Uncovered Benefit – A health service that will not be eligible for payment by the health insurance company and must be paid for entirely by the patient.

Health Insurance Networks – A group of doctors and other care providers across different specialties that have a contract to provide healthcare services to members of a health insurance plan.

In-network – The insurance company negotiates a rate with the medical provider, and the medical provider agrees to take the insurance payment in lieu of the billed amount.

Out-of-network – Provider has not negotiated a rate with your insurance company. Cost sharing will be higher. Out-of-network copayments may not count towards out-of-pocket maximum. You pay the difference of the allowed amount and the billed amount after insurance pays.

Medical Cost Calculator – Provides ballpark estimates of what things should cost based on your area. For more details, try fairhealthconsumer.org/medicalcostlookup.php.

Drug Formulary – A list of prescription medications covered by your plan. If the medication is not listed on the formulary, your health insurance will not pay for the medication. Drugs are organized into tiers, which correlate to how your plan will pay for them. Preferred drugs will be cheaper, while non-preferred and specialty drugs will be more expensive.

Medications must be paid for when you get them. If you are having a hard time paying for medications, talk to your doctor or pharmacist to see if there are any discount cards or other money saving options available to you.

