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Understanding Health Insurance Costs in the United States.

LET'S LEARN ABOUT HEALTH INSURANCE

So why even learn about health insurance? Is it really important?

Being young, you are likely healthy and focused on many other more important activities so health insurance is likely low on your list of things to learn. But it's important to learn because health insurance helps protect us financially from unexpected accidents and illness. We never expect it to happen but as you get older, start working full time, have a family and help support your parents, you will find health incidents do happen and its best to be prepared.

To understand the importance of insurance lets see what would happen if you did not have insurance. Here are a few examples of what it will cost if you get injured playing sports or get a really bad cold and need to go to the hospital for a few days.

Fixing a broken leg can cost up to $7,500

The average cost of a 3-day hospital stay is around $30,000

Health insurance provides important financial protection in case you have a serious accident or serious illness. You can end up broke and losing everything just to pay a bill. But by getting health insurance and paying a monthly premium you can be protected against unexpected high costs of health services.

SOURCE: WWW.HEALTHCARE.GOV

Understanding Health Insurance Costs

BY ALLAN KIRBY

Lets learn the basics of Health Insurance:

So you are looking into health insurance plans and are trying to figure out what it is going to cost to have health insurance coverage. One would think all you do is pay a monthly premium and the insurance company just pays the bills for any health service or prescription drugs you use; right? Well not exactly, as we will show it's a little more complicated than that. Sometimes you pay for some or all of the health care costs and other times the insurance company pays some or all of the costs.

"Knowing who pays for the health care and prescription drugs can be a little confusing at times."

So let's explain how health insurance costs work. To begin we have to understand a few principal ideas on how you pay for insurance and what you receive from that insurance.

1. Premiums

This is what you pay to the insurance company in order to receive health benefits. Your premium is normally paid monthly and the amount you pay depends on a number of factors such as:

1. You get insurance through an employer or purchase yourself.
2. Insurance is for an individual or family.
3. Your age and even the state you live in.

Once you pick an insurance plan and start to pay the monthly premium you will now be insured, which is great because you can get some services for free by your insurance company.

Preventive care

Preventive care is a medical service that prevents you from getting sick and keeps you away from the emergency room. This can include annual check ups and doctor visits as well as immunizations, contraception, allergy medication, vaccines, and screening for diabetes and cholesterol.

Why would insurance companies give you these services at no extra cost? The answer is simple, keeping customers healthy means many customers will not be sick and if they do, it will reduce the chances of them getting severely sick. This in turn reduces the insurance companies' cost of paying for their clients' care. It's in their best interest to keep people healthy and productive so the customers can keep paying their premiums.

"Alert: You need to be careful with plans that have low monthly premiums but higher deductibles. They may end up costing more than a higher premium and lower deductible insurance plan."

2. Deductibles

Okay, so let's say you have health insurance and you are receiving preventive care as part of your plan; what happens when you need additional care? These additional services such as emergency room visits due to an accident, getting seriously ill or seeing a specialist will cost you. You will be required to initially pay extra for these services, and yes that means additional money above your monthly premium. This comes in the form of deductibles which requires the plan holder to go through a set of levels which determine who pays for the additional services, which is explained below.

Level 1: Deductible

A deductible is the amount you pay for a covered health care service before your insurance plan starts to pay. With a $600 deductible, for example, you pay the first $600 of covered services yourself. This deductible is reset at the beginning of each year you have your insurance. Let's say you go to the emergency room because you fell and hurt yourself and the bill for your emergency room visit is $600. If your deductible is $600 or less, you pay everything. The good news is, once you have paid a total of $600 in covered insurance you do not pay the deductible again. After you pay your maximum deductible you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Note: You will likely find that family plans will have both individual deductibles that applies to each person, and a family deductible, which applies to all family members.

Level 2: Copayment or Coinsurance

At this level, you are now going to share the costs for your health services or prescription drugs you use with your health insurance company. You are no longer paying a deductible but you are still paying for a portion of the health services you are using. Generally speaking there are two methods that are used to share the costs of a service which are Copay (copayment) and Coinsurance. The type of sharing and the amount you pay for each health service will depend on what your insurance plan provides; however, we can help you understand the difference between the two methods of cost sharing:

Copay is a fixed rate fee you pay for the cost of the service or drug, for example fixed rate of $25.

Coinsurance is a fixed percentage you pay for the cost of the service or drug, insurance pays the remaining, example (20% you 80% insurance company).

You will continue to share costs with your insurance provider until a point where the insurance company pays for everything, this is called "out of pocket maximum".

It's the maximum amount of money you will pay for your health insurance. Using our example above, let's say things are not going well and you end up in the emergency room again. The bill this time is only $400, since you have paid your deductible of $600, you are on level two, which is cost sharing. If you have a copay fixed rate and it's set at $150 for an emergency visit, you pay $150 to the hospital and insurance covers the remaining $250.

Level 3 - Insurance pays everything

Yes, there is a point where you will no longer pay for a portion of your health services and the insurance company pays for everything. This is called your out of pocket maximum, it's the most you will end up paying for services covered in your insurance plan for the year. It's calculated by totalling your deductibles + copayments / coinsurance for care and services up until you reach your out of pocket maximum. Using our example above our two hospital emergency visits have cost us $600 (Our deductible) + $150 (copay) giving us a total of $750 out of pocket. If the maximum is $1000 per year, then you would just need to payout an additional $250 in order to max out your out of pocket.

"Alert: Even when you reach your out of pocket limit, you still have to pay your monthly premiums. Additionally your health plan only pays 100% of the costs up until the last day of the yearly plan, it then reset in the new year."

3. In network and out of network health providers

This is an often forgotten detail of health care insurance information, but a detail that can have a significant impact on your health care costs. It's important to know because you could end up with thousands of dollars in medical bills, worse you can even end up bankrupt.

In-Network

When you purchase insurance you will have what's called In-network health care. These are health care providers such as hospitals, doctors, specialists and pharmacies that have an agreement with your chosen insurance company to provide medical care to their insured members, usually at a discount rate which saves the insurance company and you money.

Out-of-Network

"Out-of-network" means the health care services you are seeking such as hospitals, doctors, specialists and pharmacies do not have an agreement with your insurance company to provide care. Additionally the cost for the service may or may not be covered and the prices might be much higher than your In-network. Now your insurance companies may have some out-of-network benefits, medical services from an out-of-network provider will usually cost more out-of-pocket than an in-network provider.

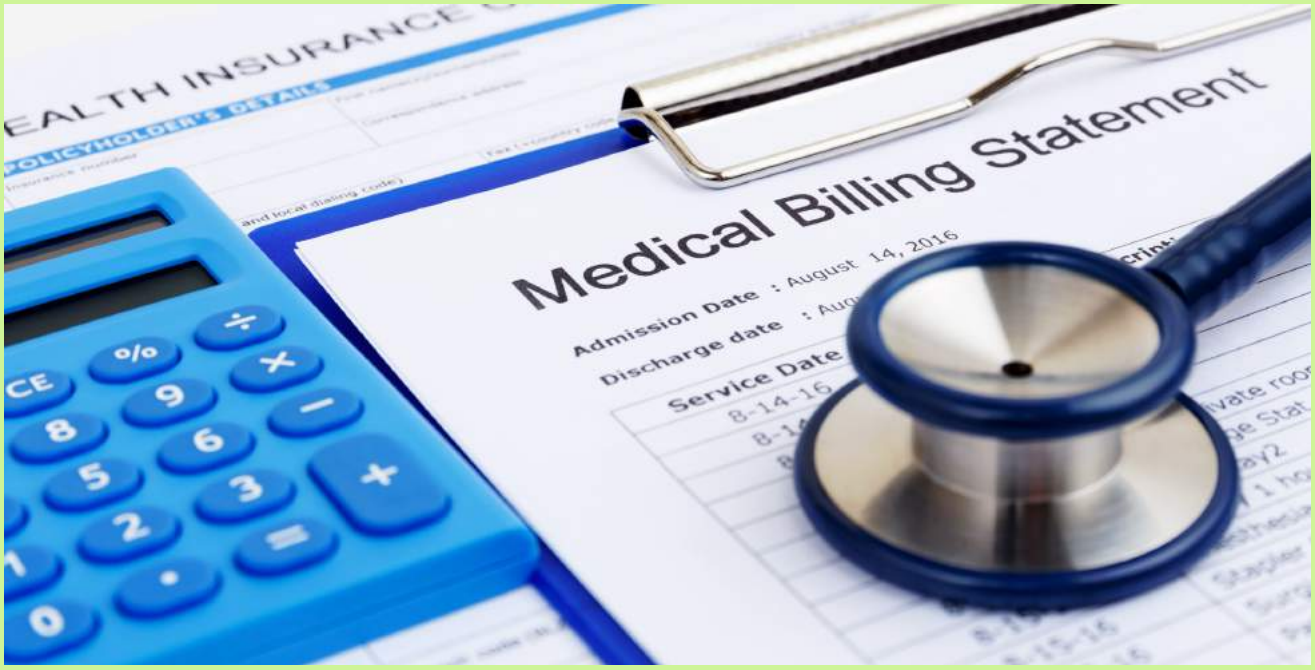
"Alert: In network services can be tricky: For example you can have an in network hospital but some services and specialist within the hospital may be out of network, never assume you are covered for all health services at your in network hospital. Find out first and ask questions"

Using our example above, let's say that when you went to the hospital emergency room the second time, you ended up going to a different hospital, one that is not covered by your health insurance (Out-of-Network). The bill this time is not $400 but $650. In this case you will either have to pay the full $650 or if you're lucky, your insurance company will pay for some of your out of network costs, but it may be only $100, leaving you with $550 out of pocket.

In summary we have discussed your health insurance costs through:

1. Premiums.
2. Deductible.
3. Copay and CoInsurance.
4. Out of Network.

This clearly does not cover all aspects of how health insurance works but it does provide a good start. However if you ever have any questions or concerns visit www.healthcare.gov as a trusted source of health insurance information.



QUESTIONS

1. Once you start paying your monthly health insurance premiums are you:
    A. Free to use any health service and insurance will pay for it?
    B. If not what are the costs of having insurance besides the premiums.

2. Using our examples in the article, when you reach your maximum deductible:
    A. Do you pay it again later in the year?
    B. Does it reset at a particular time?

3. Do you stop paying your monthly insurance premiums once you have reached your total out of pocket maximum?

4. Even though you have reached your maximum deductible, you still have to share the costs of your health care costs with your health insurer:
    A. Do you always have to share the costs?
    B. Is there a limit?

5. What is the difference between a deductible and copay/coinsurance.

QUESTIONS CONTINED

6. What is the maximum number of times I need to visit the doctors before I stop paying both my deductible and copay if each doctor's visit costs $100.

   Assumptions:
   Deductible is $600.
   Copay is a fixed rate of $25 per use of service (ex doctor visit).
   Maximum out of pocket is $750.

7. What is the maximum number of times I need to visit the doctors before I stop paying both my deductible and insurance if each doctor's visit costs $100.

   Assumptions:
   Deductible is $500.
   Coinsurance is 20% per use of service (ex doctor visit).
   Maximum out of pocket is $800.

8. Which is better: In-Network or Out-of-Network services. Briefly explain why.

9. What is the best source of information you should go to if you have any questions or concerns about health insurance.

10. When visiting an In-network hospital should you check with the hospital to ensure the service you're looking to use is covered (In-network) and not Out-of-Network.

11. Is there a point when you no longer need to pay for your health insurance, if so when?

12. List a few factors that may affect the amount you pay for your monthly premiums.

Research

1. Can you list some common types of insurance plans (try and find 3 - 4 types of plans):

2. There is a trend to lower monthly premium, higher deductible health insurance plans. What are the potential problems you could have with such a plan.