Comparing Health Insurance Plans

Perhaps you're starting a new job or trying to integrate employee benefits with your new spouse. Or maybe you're shopping for individual health insurance coverage. One of the challenges when comparing health plans is that many different types of plans are available, including indemnity plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans. If you are offered the chance to choose among different types of plans, you'll first have to decide which type best suits your needs. Then, you can begin comparing and evaluating policies.

Compare Premiums

The premium may be the first thing you look at when trying to choose a health plan. Individual coverage can be expensive because the insurer takes on more risk by covering just one person. However, if an individual policy is your only option, you should compare the premiums charged by several different insurers. Even though companies all use certain information to price a policy (e.g., your age and health), premiums may still vary widely among companies. You can eliminate policies that cost more than you can afford. Also, try to get some idea of how much premiums will increase as you age and as the cost of medical care rises.

You should also look at cost when you're comparing group health plans. Even if two plans provide similar coverage, the group premiums may differ. That's because the premium in each case is based on facts about that particular group (e.g., average age). In addition, keep in mind that the employer or other group often pays all or part of the group premium. The less premium you have to pay, the more attractive the plan. Finally, find out how much it will cost to cover your family members under the plan.

Compare Deductibles, Co-Payments, and Coinsurance

These costs often vary widely among health plans, and some plans may not impose them at all. This is something to look at closely when comparing plans, because these additional costs can greatly affect your total out-of-pocket cost. The deductible is the amount that you have to pay toward your medical expenses before your insurance company begins to cover you. The co-payment is the amount that you have to pay each time you visit a health-care provider or need a prescription. Finally, coinsurance is the percentage of your medical costs that you have to pay after you satisfy any deductible that applies (not including any co-payments you're required to make). Consider the following questions:

- Will you have to satisfy an individual deductible, a family deductible, or both? What are the amounts?
- Do you have to satisfy the deductible annually, or every time you are hospitalized?
- Do different deductibles apply to different types of care? For example, you may have to pay a $500-per-year deductible for hospitalization, but only a $100-per-year deductible for doctors' visits.
- How much is the co-payment when you see your doctor for routine care? When you see a specialist? When you are admitted to the hospital? When you pick up a prescription?
- What percentage of your medical costs will you have to pay after you satisfy your deductible? A common coinsurance rate is 20 percent.
- What is your out-of-pocket maximum? To limit your liability, you may no longer have to make coinsurance payments once your medical expenses for the year reach a certain level (e.g., your insurer pays 100 percent of your annual expenses over $10,000).
- Do you have the flexibility to change the amount of your deductibles and/or co-payments? Choosing higher amounts may help you lower your premium.

Compare Coverage and Features

It's equally important to assess each plan's coverage and specific features. Here are some issues to think about:

- What coverage exclusions apply? Specific types of illnesses, injuries, treatments, and procedures may not be covered at all under the plan. The plan should clearly state what these are. However, beginning in 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA) prohibits health plans from denying children coverage based on preexisting conditions or from including pre-existing condition exclusions for children. Beginning in 2014, all health insurers must sell coverage to everyone who applies, regardless of their medical history or health status, nor will plans be able to exclude coverage for those medical conditions.
- What coverage limitations are you subject to? For example, some plans impose a waiting period before you can be

covered for pre-existing conditions. Like exclusions, limitations should be spelled out in the plan.
- Does the plan fully or only partially cover the following expenses: surgery, hospitalization, routine medical exams, diagnostic procedures, visits to a specialist, maternity care, immunizations, rehabilitation, and home health care? You'll find that the level of coverage often varies in each of these areas.
- Does the plan impose a maximum benefit ceiling, and if so, what is it? PPACA prohibits individual and group plans from placing lifetime dollar limits on available coverage.
- How much freedom do you have in choosing your own doctors and health-care providers? For example, can you go outside your plan's network? Do you need referrals to see specialists?
- Does the plan require you to get approval from the insurance company for coverage of certain types of care? For example, if you're terminally ill, certain types of experimental treatment may need to be approved by your insurer.
- Does the plan offer any extras as part of the standard coverage? Some items that may be of interest to you are vision care, dental care, prescription drug coverage, and mental health coverage.
- Does the plan offer family coverage, as many employer-sponsored plans do? This can be very important if you have a spouse and/or children in need of health coverage.
- What optional riders and endorsements are available? Adding these features can allow you to tailor a plan to your individual needs.

For the best results when comparing plans, you should balance coverage and features against cost. This will allow you to determine which plan gives you the best overall value for your money.

Compare Insurance Companies

It's also a good idea to compare the insurance companies behind the plans--your satisfaction with a company may mean a lot over the long run. Here are some questions that may help you weed out insurers:

- Does the insurer provide good customer service? You want to speak to a knowledgeable, polite customer service representative when you call your insurance company. Unfortunately, busy insurance companies may keep you on hold for a long time before you get through to a representative. Look for a company that has a toll-free number and longer-than-average customer service hours.
- How does the insurer pay claims? Will the provider bill the insurance company directly, or will you be expected to pay the provider and then file a claim with your insurer? It may not matter much in terms of cost, but it's a lot more complicated if you have to fill out forms or pay upfront every time you seek health care. Also, check with your doctor to find out which insurers generally pay claims on time.
- Is the insurer financially stable? Make sure that the insurer you choose is financially sound and will be able to pay its claims. You can get information on the financial stability of most insurers from your state's insurance department or from a firm that rates insurance companies (e.g., A. M. Best, Moody's).
- If you're comparing group plans, are your coworkers satisfied with the plan they've chosen? Do they have trouble getting their claims paid?

We're here to help! Contact Sentinel Benefits & Financial Group for the guidance you need.

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