Insight

Primer: Health Insurance – Understanding What You Pay

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The process of purchasing health insurance can be a time-consuming and complicated task for Americans. Consumers may purchase health insurance with little understanding of their financial risks and potential obligations beyond their monthly premium. In fact, there are many variables that go into determining what an insured individual's total annual contribution to his or her health costs will ultimately be. This primer outlines the different ways that individuals could incur medical costs through the design of their health insurance plan and its coverage structure.

Definitions

First, it is important to know the different mechanisms through which costs can be shared. The list below offers the main avenues of costs for an insured individual:

- Premiums: Insured individuals make monthly payments to the insurer for continued coverage, which are known as premiums. This amount can vary depending on the plan, described under the Affordable Care Act (ACA) as a plan's 'metal level', or actuarial value. The cost of the premium may be mitigated for individuals and families purchasing insurance through an ACA compliant exchange plan, if they are available for income-based subsidies. In the case of employer-sponsored insurance (ESI) a portion of the premium is generally paid by the employer.[1]
- Deductibles: Another important figure to include when calculating the value of an insurance plan are deductibles. Deductibles are the amount an insured individual is required to pay out-of-pocket before the insurance company begins paying any expenses.[2] Under most insurance plans, however, some benefits, such as preventive care, are covered in full even before this limit has been reached. Deductibles may be measured either on an annual or episodic basis, though the former is more common. Deductibles, like copays and coinsurance, are an out-of-pocket expense that may be paid for using an Health Savings Account if the individual is enrolled in an eligible health insurance plan.[3]
- Copays: A cost-sharing tool, copays are used by insurance companies to make sure that patients have some 'skin in the game' and prevent the over-utilization of services. Copays are a fixed dollar amount an insured individual pays to a health care provider for each visit, service, or treatment.[4] The amount of this payment may vary within plans by provider, specialty, and whether charges are in or out of the plan's health care provider network. Copays can add up if a patient makes frequent visits to health care providers, even if only minimal expenses are incurred. It is even possible that the copay for a health care visit may exceed the actual cost of the visit at the insurer's negotiated rate, yet the insured is still required to make the full payment.
- Coinsurance: Similar to a copayment, coinsurance is a fixed percentage of the cost of a health care visit that the patient must pay to the provider.[5] The exact percentage of the bill that must be covered by coinsurance may vary by doctor, specialty, and network participation. Coinsurance is more likely to become expensive if a patient incurs very large bills. Unlike a copay, however, coinsurance can never exceed a fraction of the insurer's negotiated payment rate.

It is possible for a patient to be responsible for both copay and coinsurance under a single plan, particularly for complex visits, such as an ER visit accompanied by a visit from a specialist or which requires prescription drugs. In this situation the patient could pay coinsurance for the hospital visit, and the standard copay for the specialist or prescription drug.

Deductibles, copay, and coinsurance are all tools to discourage overutilization of health care services. However, the purpose of insurance is to protect insureds from catastrophic losses, and so all health insurance plans now have out-of-pocket-maximums (OOPM) to limit an insured person's total financial liability.[6] An OOPM is reached when a patient's deductible plus other eligible payments, such as copayments and coinsurance, equal or exceed a total allowable limit. Once the OOPM has been reached, the insurer will cover all subsequent health care expenses for the remainder of the plan year, including coinsurance and copays. In 2016, federal law caps the OOPM for an individual at $6,850, and $13,700 for a family.

It is important to keep in mind, however, that the OOPM calculation does not include most out-of-network costs or excluded benefits, such as elective surgery. Premium payments also do not count towards an insured's OOPM. Therefore, when calculating total financial liability under a given health plan, it is necessary to consider not just the monthly premium, but the total OOPM that would need to be reached if there were a catastrophic health event.

Cost-Sharing in Exchanges

The design of the ACA's health insurance exchanges creates some perverse incentives that could make it difficult for unsuspecting shoppers to recognize the true cost of their plan. The law allows for federal subsidies to be distributed so as to make the second-cheapest silver level plan 'affordable' to all Americans. Whether the plan is affordable is determined only by the premium, and does not account for other out-of-pocket expenses within the plan coverage. Because the second-cheapest silver plan is the benchmark, there is a race to the bottom among plan sponsors to offer the lowest premiums possible; yet plan sponsors are unlikely to accept significant cuts to their profitability, so they will compensate by increasing one or more of the cost-sharing mechanisms described above.

This cost-shifting is apparent upon studying the actual costs of plans across the country. With the exception of platinum level (the highest actuarial value in the exchange) plans, nearly all OOPMs are between $4,000 and $6,850 for an individual. Excluding gold plans, almost all OOPMs are between $5,000 and $6,850. These OOPMs are nearly twice the average annual benchmark premium of $3,057, with an average deductible of $3,964.[7] This means that if an individual insured with one of these plans became catastrophically ill, the up-front cost would be over $4,000 (on top of premiums), and the total cost of health care could be close to $10,000 before insurance begins to cover all medical expenses.

Luckily, this type of catastrophic event is rare, and most individuals pay little out-of-pocket beyond their annual premium. The catch is, if a catastrophic event is very unlikely, paying a higher premium to lower a deductible may be wholly unnecessary. On the other hand, individuals with higher risk of catastrophic costs could believe that the recent changes to the health insurance market and the plans available through the health insurance exchanges will keep health costs affordable without understanding the ways the potential cost-sharing expenses like deductibles, coinsurance, copay, and OOPMs could offset those savings. It is important for those purchasing or renewing their insurance plans to fully investigate the true value of each plan offered.

[1] https://www.healthcare.gov/choose-a-plan/plans-categories/.