The most important questions to ask when picking a health care plan

Choosing health insurance in the US is notoriously difficult. Let this guide help.

It isn't in your head: Selecting a health insurance plan in the US is notoriously difficult, regardless of whether you're choosing a plan through your employer or you're shopping on the health insurance marketplace. From needing to learn a variety of terms — HMO, PPO, deductible, premium, coinsurance — to familiarizing yourself with a wide range of insurance companies and plans available, shopping for health insurance could be the most complicated thing you do all year.

"Things change year to year, so even if you think that you've got it figured out, you could have a plan that works super and then the insurers will make changes and then that can throw things off for you next year," says **Jessy Foster,** the deputy director of policy and partnerships at the Pennsylvania Health Access Network. "There's a lack of transparency ... that makes it hard for people to know what the cost of any specific service is going to be."

There are generally **four ways to get health insurance** in the US: employer-sponsored health insurance, individual or private plans purchased through the **health care marketplace** formed by the **Affordable Care Act**, Medicare, and Medicaid.

You can't just decide to do so whenever you want, however. There are a few conditions under which you can enroll in health insurance:

- If you start a new job, you'll be able to elect health coverage if your employer offers it.
- If you're turning 65, you can **sign up for Medicare**.
- If you are low-income, you may qualify for free or reduced-cost health insurance through **Medicaid**. Each state has its own eligibility requirements.
- If you're turning 26 and are still on your parents' plan, you'll need to get on your employer's plan or find coverage through the **health care** marketplace.
- If you've experienced a **qualifying life event** — like losing coverage, getting married, having a baby, or moving — you can enroll in health insurance.
- Otherwise, you can sign up or make changes to your existing plan during open enrollment. Employers set their own open enrollment period for employees to make their selections. **Open enrollment for the health care marketplace** is November 1 through January 15.

Whether you've just turned 26 and are making your first plan selection or are making a change during open enrollment, here are some questions to ask yourself before choosing health insurance. No single factor will determine your choice; rather, take all things into consideration.

What is my budget?

The language associated with health insurance can be confusing. Here are important terms to know:

- The **premium** is the amount you pay every month to your insurer for coverage. If you get your insurance through your job, this comes out of your paycheck before taxes are taken out.

- The **deductible** is the amount of money you pay for health services before your insurance kicks in.
- Once you've hit your deductible, you'll pay **copayments** for any **health care** service that's covered under your plan. The amount — for instance, $20 — is fixed for each appointment.
- **Coinsurance** works similarly but is a percentage of the cost of a covered service and not a flat fee; again, this is only applicable after you've hit your deductible.
- **Out-of-pocket maximum** is the most you have to pay for deductibles, copayments, and coinsurance in a given year. Once you hit the out-of-pocket maximum, your insurer pays 100 percent of the costs. This cost doesn't include your monthly premium or out-of-network care.
- For example, your **premium could be $115** a month with a $2,000 deductible. You'll need to pay for the first $2,000 of covered services yourself; after that point, when you go to a doctor, you'll only pay a copay (say, $20 for a doctor's appointment) or coinsurance (where you'll be responsible for 30 percent of the total bill, for instance). Once you hit your out-of-pocket maximum — say, $4,000 — after spending that amount on deductibles, copayments, and coinsurance, you won't pay anything for services.

When selecting a plan from the marketplace, you'll have four price options to choose from: bronze, silver, gold, and platinum. Bronze has the lowest monthly premium but highest copays and deductibles. As you ascend from silver to platinum, the monthly premium rises but the copays and deductibles are lower.

For people who are shopping for health care on the marketplace and have lower incomes but don't qualify for Medicaid, they're likely to qualify for **cost-sharing reductions**, Foster says. A cost-sharing reduction lowers the amount of copayments, deductibles, and coinsurance. But you must enroll in a silver-level plan to get the extra assistance. "If they are eligible for that extra assistance," she says, "that might lower or, in some cases, totally get rid of some of those deductibles and those plans will suddenly become comparable to a gold-level plan or, in some cases, even better."

Even if you don't qualify for cost-sharing reductions, you likely have access to **tax credits** that lower your monthly premium if you're purchasing insurance through the marketplace. These credits are based on your income and your household (i.e. if you're single, married, or have children).

You'll want to take all costs into consideration when choosing a plan, not just the premium.

"Comparing premiums across health plans is like comparing apples to oranges to lemons to limes," says Noah Lang, the CEO and co-founder of **Stride Health**, a platform that helps independent workers find the best Affordable Care Act health insurance plan for their needs. "These are different fundamental financial products you're buying at the end of the day."

What can you realistically spend on a premium each month? How much money comes out of each paycheck for health insurance? What is the maximum amount you would be okay with spending for a doctor's visit? Would enrolling in Medicare cost less than remaining on your employer plan if you're over 65 and still working?

Would you rather pay a higher premium but get charged less when receiving care? Or do you feel more comfortable paying a lower premium monthly but shouldering higher costs for care?

What are my medical needs?

To help determine your answer to the latter two questions, you'll need to evaluate what your medical needs are and whether your doctors are in-network. There are different types of plans that determine your network of providers. You'll most likely encounter plans that fall under one of five plan types: health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), point of service (POS), and high-deductible health plans (HDHP).

- **HMOs cover** care you receive from in-network providers, with exceptions for emergencies. You'll need a referral to see a specialist. HMOs generally have lower premiums and out-of-pocket and prescription costs.
- **PPOs** have a list of preferred providers that cost less if you use them. This list may be broad or limited, so definitely see if your preferred providers are on it. You don't have to stay in-network for care, but it will be more expensive to go out of network. You don't need a referral to see a specialist. PPOs are also more expensive.
- **EPOs** have lower monthly premiums than PPOs but require you to stay in-network when seeking care. You typically don't need a referral to see a specialist.
- **POS plans** allow patients to choose between staying in-network and going out of network for providers, but you'll pay more for out-of-network services. You'll need a referral before going to a specialist. POS plans may be **more expensive than HMOs and less expensive than PPOs**.
- **HDHPs** have lower monthly premiums, but as the name implies, a higher deductible — for 2023, the minimum HDHP deductible is $1,500 for individuals and $3,000 for families. You may be able to see both in-network and out-of-network providers, based on the plan. You'll also be able to open a health savings account (HSA), an account that you and/or your employer can contribute to that you can use to pay for medical expenses not covered by the HDHP, like copays and prescriptions. The funds in an HSA are not subject to federal income tax.

Determine your health priorities based on the plan options available, Foster says. If your priority is staying with your preferred doctor, you may want a PPO. If you want to see a lot of specialists and don't want to get a referral every time, a PPO or EPO might work for you. If you haven't been to the doctor in a while but suspect you'll need to catch up on a lot of appointments, you may want a plan that has lower copays and a higher monthly premium. If you're mainly focused on keeping costs down and are generally healthy, you could opt for a high-deductible plan. Just be aware of the exact dollar amount in these high-deductible plans. "We've seen some really, really high deductible plans where it's $7,000 to $8,000 per person, or double that for the family," Foster says, "and not a realistic amount that most people can pay."

While it's hard to know in advance, consider how often you will be seeking medical care. Are those preferred providers and prescriptions covered? Will you want to seek referrals from your primary care doctor? If you're anticipating surgery or pregnancy, you may want to choose a plan with a lower deductible. If you regularly visit specialists, you'll want a plan that doesn't require referrals but lists your doctor as an in-network provider. If you don't anticipate seeking care beyond a preventative visit, you may want a plan with a lower premium.

"If you're one of these people that says 'I want a plan where I don't have to have referrals, I can see any doctor that accepts Medicare, I can go to any hospital or facility that accepts Medicare,'

then that type of flexibility will cost you money," says David Luna, the president and co-founder of **Connie Health**, a digital platform that helps seniors choose a Medicare plan. "If you're okay with having a plan similar to your employer plan where you're paying zero [in premiums], but when you use it, you're paying a copayment, then you would look at a Medicare Advantage plan."

Keep in mind that some plans don't offer **dental** or **vision** coverage and you might need to add on those services through the marketplace or a separate plan offered by your employer.

Does this plan cover doctors and medications I already know and like?

A lower premium won't be as effective if your preferred providers are out of network. "If you have a doctor you love and you want to keep, that might drive you to pick a health plan that you're willing to spend more for," Lang says.

While researching plans, look through their provider list to see if your doctors are in-network. Most insurance providers have a searchable directory where you can input your practitioner's name. "You don't want to enroll in a health plan that doesn't have very many doctors or one clinic in your area," Lang says, "because then you might not have easy access to care."

Don't forget to look up any specialists you see, too: dermatologists, therapists, chiropractors, orthopedic surgeons, or fertility clinics. If you're unsure if a provider is in-network, call them and ask.

Some plans have **tiered provider networks** where they are priced based on the value of care they provide, Foster says. Keep in mind where your preferred providers fall if your plan is tiered. "There can be a tier one, tier two, tier three," Foster says. "Tier one might be, let's say $10, $20 copay. But if your doctor's in-network but they're tier three, that $20 copay might suddenly be $80 per visit."

Similarly, check to see if your current prescriptions are included in the plan's **formulary**, a list of prescription drugs covered by the plan.

Could I use some help with this?

It's completely normal to still have questions even after reviewing plans. For help navigating the health care marketplace online portal, you can call the **Marketplace Call Center** where someone can walk you through enrollment. Platforms like Stride Health allow for a more user-friendly enrollment experience, plus offer free support from advisers, Lang says.

You can seek the help of a professional **navigator** or **assister** who can answer your questions and help you enroll. Navigators are funded by federal or state grants while assisters are funded by different grants administered by the states. These services are free and you can chat in person, over the phone, or online. Navigators and assisters are unbiased and will not vouch for one insurance company or plan over another. The government maintains a **searchable database** where you can find local navigators and assisters. According to Foster, it can be difficult to get an appointment with a navigator or assister during the first few days and last days of open enrollment. Make a plan early if you want to work with these professionals.

You can also opt to get **contacted directly** by a **health insurance agent or broker**, who is trained to help you enroll in a plan. Agents and brokers may work for a specific health insurance company and thus won't sell plans for companies they don't represent; they may also earn commissions. You don't need to pay extra to work with agents or brokers.

"Ask all the questions. Don't be shy," Foster says. "I always tell folks if it was easy, we wouldn't have jobs like navigators and assisters because we would be obsolete."