Critical Items to Consider when Selecting a Health Plan

Selecting individual health insurance is confusing to a lot of people. Most of the time, coverage is available through a job, so most people never have to deal with it. Here are some terms that most people don't know about. And the new world of Health Care Reform is adding to the confusion…..for most people it has NOT gotten any easier.

One good thing that's important as a result of **Health Care Reform** is that many preventive services are now required to be covered prior to meeting the deductible, at no cost, when seeing a provider contracted with your health plan—this is the same with all plans, so take advantage of it!

Deductibles

Generally the deductible is how much you pay before the coverage kicks in. There may be some benefits available prior to meeting the deductible; you need to read the available information. When choosing an insurance plan deductible, the lower the deductible, the higher the premium. And we now have plans with no deductible—is this the way to go? It depends on your situation.

Co-Insurance

Once the deductible has been met, this describes the percentage the insurance company pays and the percentage you pay. Common combinations are 80/20, 70/30, with the insurance company paying the larger number.

Out of pocket or Co-payment Maximums

Once you have met the deductible, and you are paying your share of the co-insurance, when you reach the out of pocket maximum you are covered for the majority of costs for the remainder of the calendar year. Some plans will still require the member to pay certain co-payments such as office visits and prescriptions. This is an important number to take into consideration when selecting a plan—how much of a financial hit could you handle if something 'really bad' happened?

What do the plans look like now, what's changed?

Now, the 'rates are the rates'—you cannot be given higher rates higher than the standard, there's no more medical underwriting/review. You will now see the 'metal' categories of plans—Platinum, Gold, Silver and Bronze. There are also Catastrophic plans which are available only to those under 30, or if you can prove financial hardship in paying for a metal plan when you're over 30.

Networks—can I keep my doctor?

This has been the upheaval of all time—not all doctors and hospitals are contracted with all carriers, so it's even more important than ever to check that. Many doctors are dropping their insurance contracts, or have opted not to take the 'new' plans. And by California state law, the networks are the same 'on and off' Covered California, the state exchange, for individual plans. But a lot of offices aren't aware of that.

What can be done to save on rates?

Not much because of the "Ten Essential Health benefits" that are required to be included in all plans. Including the ever popular pediatric dental which has to be included whether you have kids under age 19 or not. Plans are required to cover more things, so shopping is more important than ever.

Rate Increases

On individual health plans, generally there was an annual rate increase based on when you enrolled. Now, that occurs for everyone January 1st each year, regardless of when you bought the plan—the days of the initial 12 month rate guarantees are gone, which wasn't widely shared with agents. All members in the same region/same plan/in the same age bracket will have the same rate change. Rates may also change outside of the annual increase due to birthdays or if you move to another location with different rates.

Speaking of Covered California…

Should you buy through Covered CA or not? The main reason to through Covered CA is if you are eligible for subsidies. That's the only way to get them. It is an extra step, no question, so let's talk about it, see if it makes sense for you.

If it's still confusing, let me help you figure out what makes the most sense for your situation!

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