DISRUPTIVE DIALOGUE

HEALTHCARE 101
PART 1

OVERVIEW OF PRIVATE HEALTH INSURANCE IN THE U.S.

PART 1 – THE BASICS

SUMMARY

- Health insurance can be confusing when comparing plans and understanding eligibility.
- Insurance is becoming cost prohibitive.
- Preventive care is often fully covered. Think of it like getting a tune up or oil change for your car.
- WE NEED TO BECOME BETTER CONSUMERS OF HEALTHCARE TO MAKE IT WORK!
- DO YOUR HOMEWORK AHEAD OF TIME AND TREAT IT LIKE CAR INSURANCE OR RENTING AN APARTMENT.
- Start researching what works for you in the fall and call health plans or government hotlines and talk to a person.

WHAT IS PRIVATE HEALTH INSURANCE?

- Coverage provided by non-government entities.

- Accessed through:
  - Employer-sponsored plans
  - Individual plans (ACA Marketplace or direct)
  - Associations or unions

ENROLLMENT & ACCESS

- Most people get coverage through work; open enrollment each year.
- ACA Marketplace available for individuals without employer coverage.

ENROLLMENT & ACCESS

November 1 to January 15

- **Is considered the time period when people can apply for health insurance coverage through the Affordable Care Act (ACA) Marketplace. It is commonly referred to as OPEN ENROLLMENT.**

Key dates to remember:

November 1: Open enrollment begins, and you can start enrolling in or changing health plans.

December 15: This is the last day to enroll or change your plan if you want your coverage to begin on ***January 1*** of the following year.

January 15: Open enrollment ends. This is the last day to enroll in or change Marketplace plans for the year.

- If you enroll between December 16 and January 15, your coverage will begin on February 1.

Note

- **The recently passed OBBA will shorten this enrollment period, but that will not go into effect until next year.**

https://www.healthinsurance.org/open-enrollment/#:~:text=In%20DC%20and%2031%20states,2024%2C%20the%20stay%20was%20vacated.

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ENROLLMENT & ACCESS

Employer-sponsored plans

- If you get health insurance through your employer, your company will have its own open enrollment period, which may differ from the Marketplace dates.

Medicare

- There are specific enrollment periods for Medicare, including an Annual Enrollment Period (AEP) from October 15 to December 7 each year and other periods for initial enrollment or changing plans.

Medicaid and CHIP

- You can apply for Medicaid or the Children's Health Insurance Program (CHIP) at any time of the year if you qualify.

State-based marketplaces

- Some states have their own health insurance exchanges and may have slightly different open enrollment dates.

Special Enrollment Periods

- If you miss the open enrollment period, you can only enroll in or change plans if you qualify for a Special Enrollment Period (SEP) due to a major life event, such as losing health coverage, getting married, having a baby, or moving.

NOTE – Some of the dates above may change with the recently passed OBBA legislation.

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COSTS TO PATIENTS

1. **Premiums**
   - The amount paid monthly (or annually) to maintain coverage, regardless of whether care is used.
2. **Deductible**
   - The amount the patient must pay out-of-pocket for healthcare services before the insurance begins to pay.
3. **Copayments (Copays)**
   - A fixed amount paid for a specific service (e.g., $30 for a doctor visit or $10 for a prescription).
4. **Coinsurance**
   - The percentage of the cost the patient pays after the deductible is met (e.g., 20% of a hospital bill).
5. **Out-of-Pocket Maximum**
   - The most a patient would have to pay in a year (includes deductible, copays, and coinsurance). Does not include Premiums.
   - Once reached, the insurance covers 100% of in-network covered services.
6. **Network Restrictions**
   - **In-network vs. out-of-network** providers can have drastically different costs.
   - Out-of-network care may not be covered or may involve much higher cost-sharing.
7. **Prescription Drug Coverage**
   - **Tiered pricing** often applies, with different cost levels for generics, brand-name, and specialty drugs.
   - Formularies (lists of covered drugs) can vary and affect cost.

https://www.kff.org/report-section/ehbs-2024-section-1-cost-of-health-insurance/

COSTS TO PATIENTS

Premiums

- Monthly payments whether care is used or not.
- The average annual health insurance premiums in 2024 ***for an individual*** was $8951 (increased 6% in 2024).
- The average annual health insurance premium ***for a family of four*** in 2024 was $25,572. This increased 7% in 2024 and has gone up 24% since 2019 and 52% since 2014.

The average cost of health insurance premiums can vary significantly based on various factors, such as:

- **Age:** Older individuals generally pay more due to increased health risks.
- **Location –** where you live
- **Plan type**
- **Benefit Design**
- **Subsidies:** Individuals and families with lower incomes may qualify for subsidies to help lower the cost of health insurance through the ACA
- **Other Factors can include**: Health Status, Tobacco Use, etc.

https://www.kff.org/report-section/ehbs-2024-section-1-cost-of-health-insurance/

FACTORS THAT INFLUENCE PREMIUMS

Where you live matters

- Local healthcare costs and market competition can influence premiums.
  - Expensive hospitals in the area can drive up insurance costs, as well as the number of hospitals in the area.
  - The number of health plans that serve an area can also have an impact

- Areas with high concentrations of older populations, their economic conditions, and the presence of major metropolitan areas with higher income levels can influence these regional differences.

- **Highest Spending** - Generally, regions like the New England and Mideast states tend to have higher healthcare costs and premiums, as do states like New York and Alaska.

- **Lowest Spending -** The Rocky Mountain and Southwest regions. Some states like Maryland often have lower premiums.

- **Specific Cities –** Even the cities in which you live can impact your premium rates.
  - Metro areas with high concentrations of professional jobs and higher income levels tend to spend the most per capita on healthcare.

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FACTORS THAT INFLUENCE PREMIUMS

Plan Type

- Many employers offer group health insurance plans that have lower premiums than individual health insurance policies.
  - Individual versus family
  - Benefit Design – under your control
    - HMO, PPO, HDHP
  - Self-Insured versus Fully-Insured – determined by your employer

- If employer-sponsored coverage isn't an option, you may be eligible for a plan through Healthcare.gov.

- ***Marketplace exchange plans*** are considered private insurance even though they are offered through a government-run exchange.
- While the exchanges themselves (like HealthCare.gov) are public entities, the plans available on them are offered by private insurance companies.

- Metal Tiers include – **Platinum** (highest Premiums) ⟶ **Gold** ⟶ **Silver** ⟶ **Bronze** (lowest Premiums)

FACTORS THAT INFLUENCE PREMIUMS

Benefit design

- Significantly impacts health insurance premiums because it determines how health care costs are shared between the insurer and the insured.

Types of Benefit Design

- **Health Maintenance Organization - HMO**: Lower premiums but limited to a network and requires referrals.
- **Preferred Provider Organization - PPO**: More flexibility but higher premiums and out-of-pocket costs.
- **High-Deductible Health Plans (HDHP)**: Lower premiums, high deductibles, eligible for HSAs (Health Savings Accounts).
- **Low-deductible plans**: Higher premiums because the insurer assumes more upfront risk.

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FACTORS THAT INFLUENCE PREMIUMS

Benefit design -
Significantly impacts health insurance premiums because it determines how health care costs are shared between the insurer and the insured.

Design Type	PCP Required	Referrals Needed	Out-of-Network Coverage	Premiums	Deductibles	Best For
HMO (Health Maintenance Org)	✅ Yes	✅ Yes	❌ Emergencies only	$ Low	$ Low	People who want low cost and are okay with limited choice
PPO (Preferred Provider Org)	❌ No	❌ No	✅ Yes (higher cost)	$ $ High	$ $ Medium-High	People who want provider flexibility without referrals
EPO (Exclusive Provider Org)	❌ No	❌ No	❌ No	$ Low-Med	$ Medium	People who want lower premiums but still some flexibility
POS (Point of Service)	✅ Yes	✅ Yes	✅ Yes (higher cost)	$ $ Medium	$ Medium	People who want moderate flexibility and coordinated care
HDHP + HSA	❌ No	❌ No	✅ Yes	$ Very Low	$ $ $ High	Healthy individuals or families who want to save on premiums and use an HSA
Tiered Network Plan	❌ Varies	❌ Varies	✅ Yes (often limited)	$ Low-Med	$ Medium	Cost-conscious people who are okay navigating tiered providers
VBID (Value-Based Insurance Design)	❌ Varies	❌ Varies	✅ Yes	$ Varies	$ Varies	People with chronic conditions or who use preventive care regularly

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BENEFIT DESIGNS

🧠 Which Design Is Best For You?

Situation	Recommended Design(s)	Why
Young & Healthy	**HDHP + HSA**	Save on premiums, build up HSA savings, low expected usage
Chronic Condition	**VBID, PPO, or POS**	Access to specialists, lower costs for high-value services
Budget-Conscious	**HMO or Tiered Network Plan**	Low premiums and predictable costs
Want Flexibility	**PPO or POS**	No referral needed, more provider choice
Prefer Care Coordination	**HMO or POS**	Primary care provider manages your care