

Quick Guide to Health Insurance: Employer-Sponsored & Individual Plans

Health insurance can be confusing. To understand your options and find coverage that's appropriate for you, there are some health insurance basics that are helpful to know.

Types of Health Insurance Plans:

There are two main payment systems when you receive medical care:

- **Fee-for-service:** a health care provider is paid a fee for each service provided. With these plans, you can go to any provider willing to see you. You pay for a portion of your care, and the insurer pays the rest.
- **Managed Care:** health care providers contract with a health insurance company to be a part of its network. If you go to a provider in the network, the provider has agreed to a certain payment rate for treating you (i.e., allowed amount). Regardless of what the provider bills, it's that "allowed amount" that will determine your final cost. You typically pay a portion of the allowed amount, depending on your plan.



Common Types of Managed Care Plans

- **Health Maintenance Organizations (HMOs):** your health care services start with your primary care physician, and you usually need a referral before you can see any other health care provider, except in an emergency. For example, if you get a skin rash, you first go to your primary care physician. If needed, that physician will refer you to a dermatologist in your network. Generally, HMOs have smaller networks of providers, and providers outside of your network will not be covered by your HMO. While you may have less choice in providers, HMOs are often less expensive.
- **Exclusive Provider Organizations (EPOs):** generally, you do not need to start with your primary care physician. Typically, EPOs have larger provider networks than HMOs, but will not pay for any services obtained outside of the network.
- **Preferred Provider Organizations (PPOs):** generally, you do not need to start with your primary care physician. While most PPOs have some out-of-network coverage, staying inside your network means lower out-of-pocket costs. Typically, PPOs cost more than HMOs, but you have more choice and control.

When choosing a plan, you should consider your personal needs and the options available in your area.

Health Insurance Terms:

There are a few other terms related to health insurance that you should understand.

- **Monthly premium:** what you pay each month to have coverage – you pay these costs even if you never get medical care. It's like paying for car insurance all year, but never filing a claim.

Then there are costs that you have to pay when you get medical care, often called "out-of-pocket" costs. The specific amount of those costs will depend on your plan.

- **Annual deductible:** the amount you have to pay out-of-pocket each year, before your health insurance policy kicks in. This fixed dollar amount could be \$500 or \$5,000. Some plans have a \$0 deductible.
- **Co-payment:** a fixed dollar amount you pay when you get medical care. For example, when you visit the doctor's office you might have a \$20 co-payment; if you go to see a specialist, you might have a \$40 co-payment. You usually pay your co-payment at the time you get care.

Health Insurance Terms (continued):

- **Co-insurance (aka cost-share):** a percentage difference in what the insurance company pays for your medical expenses and what you pay for your medical expenses. For example, if you have an 80/20 plan, the insurance company pays 80% of your medical expenses and you are responsible for 20% of your medical expenses, after paying your deductible.
- **Out-of-pocket maximum:** a fixed dollar amount that is the most that you will have to pay for your medical expenses out-of-pocket during the year. Your out-of-pocket maximum will depend on your plan. It is a very important thing to find out! Generally, you reach your out-of-pocket maximum by paying your deductible, plus any co-payments that you make during the year, plus any co-insurance payments you make. So, it's everything that you pay, except your monthly premiums. Once you reach your out-of-pocket maximum, your insurance pays 100% of your medical expenses for the rest of the year. Most insurance companies only count expenses towards the out-of-pocket maximum that are from in-network providers. Also, some employer-sponsored plans may carve out expenses from the out-of-pocket maximum (e.g., co-payments won't count towards your out-of-pocket maximum).

Out-of-pocket Maximum Example:

Mark was in an accident. He went to the emergency room and then spent a week in the hospital that is in his plan's network. Mark ends up with a \$102,000 hospital bill. His health insurance plan has an emergency room co-pay of \$250, a deductible of \$2,000, an 80/20 co-insurance, and an out-of-pocket maximum of \$4,000. How much of that does Mark actually have to pay?

- Mark pays his co-pay of \$250 at the time of his emergency room visit, which leaves \$101,750.
- Then he has to pay the rest of his \$2,000 deductible ($\$2,000 - \$250 = \$1,750$), which leaves \$100,000.
- Then the insurer will pay 80% of the bill and Mark is responsible for 20% of \$100,000, which is \$20,000.
- But his plan has an out-of-pocket maximum of \$4,000. Because he has already paid his \$2,000 deductible out-of-pocket, Mark only needs to pay another \$2,000 to reach his \$4,000 out-of-pocket maximum and the health insurance company will pay the rest.

Prescription Drug Terms:

There are some other helpful terms to understand about prescription drug coverage:

- **Brand-name drugs:** a prescription drug with a specific name from the company that sells the drug. At a point in the future, usually after a patent expires, a generic version of a drug may be available and sold by other companies.
- **Generic drugs:** a prescription drug that contains the same chemical substance as a brand-name drug.
- **Specialty drugs:** prescription drugs that have a high cost, high complexity, and/or require a high touch. Many drugs for cancer are considered specialty drugs.
- **Formulary:** a list of prescription drugs that a health plan will cover and for how much. Understanding and using a plan's formulary will help you save money on medications. Some plans have formularies with two or more cost levels, known as tiers. A drug on a higher tier will have higher out-of-pocket costs for you. The highest tier in most formularies is the "specialty" tier, which includes many cancer drugs. The co-payment and co-insurance amounts will depend on the tier of the prescription drug you are taking. For example, a tier 1 drug may have a \$10 co-payment, while a tier 5 specialty drug may have a 30% co-insurance amount.
- **Step therapy:** when an insurance company requires patients to try a generic or lower cost drug before getting a brand-name or more expensive drug. If the lower cost drug doesn't work or causes a bad reaction, the patient would be allowed to "step up" to another medicine. If your insurance company uses step therapy, it is important to work with your health care team to show that taking a specific drug is medically necessary for you and why the insurance company should make an exception to their process.



- Generally, if a drug doesn't appear on the formulary, the insurance company will not cover it. However, you may be able to file an appeal called an "exception request" based on medical necessity. There are different types of exception requests:
 - Non-formulary drug exception: a request to cover a non-formulary drug.
 - Tier exception: a request to treat a drug as if it were in a lower tier, reducing your out-of-pocket costs.
 - Brand exception: a request to cover a higher-cost brand name drug even if a generic is available.

Generally, once an exception request is received, the request must be decided within 48 hours for non-urgent cases and 24 hours for urgent cases.

Some health insurance policies have separate deductibles and out-of-pocket maximums for prescription drugs. If your plan does have these separate amounts, you will have to meet the deductibles for both your medical care and your prescription drugs before the health insurance policy starts paying its share of the co-insurance for each type of care.

Prescription Drug Cost Example:

Noah's Plan: Deductible = \$1,000; Co-payment = \$50; Co-insurance = 70/30 plan; OOP maximum = \$1,500

If Noah has a prescription for a drug that costs \$10,000, how much does he pay?

- His co-pay of \$50: $\$10,000 - \$50 = \$9,950$ left
- His remaining deductible of \$950: $\$9,950 - \$950 = \$9,000$ left
- His co-insurance amount of 30%: 30% of \$9,000, which equals \$2,700

But his out-of-pocket maximum is only \$1,500. So, after paying the \$50 co-payment and the remaining \$950 of the deductible, he has paid \$1,000 out-of-pocket and only needs to pay another \$500 of the \$2,700 co-insurance amount, to reach his \$1,500 out-of-pocket maximum. His plan will pick up the rest of the costs.

- What does Noah pay next month for his prescription? \$0

Types of Pharmacies:

There are different types of pharmacies that may be covered by your plan:

- Retail pharmacies: generally a physical location where you go to pick up your prescriptions.
- Mail-order pharmacies: some retail pharmacies also provide mail-order benefits, where you get your prescriptions in the mail. Some health plans require you to get your prescription through a mail-order service if it is an ongoing prescription (e.g., a drug you will be taking for more than 2-3 months).
- Specialty pharmacies: a pharmacy that provides specialty drugs.

Tips on Lowering Drug Costs:

- Understand your plan's prescription coverage:
 - Does your plan require that you get your drugs from an in-network pharmacy?
 - Does your plan charge you less if you use a mail-order pharmacy?
- Understand your state's laws:
 - Does your state have a limit on the out-of-pocket costs for specific types of drugs (e.g., oral chemotherapy parity laws)? Visit <https://TriageCancer.org/StateLaws> to learn more.
 - Does your state have a State Pharmaceutical Assistance Programs (SPAP)? Visit www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx to learn more.
- Understand the different types of help that pharmaceutical companies provide. The companies that make your medicines may provide support to help you understand your insurance coverage. Many of them also offer financial assistance resources such as co-pay assistance or free medication for eligible patients.
- Visit Cancer Finances—an interactive toolkit for navigating finances: <https://CancerFinances.org>

Considerations for Picking a Health Insurance Plan:

Finding the right health insurance plan can feel overwhelming. There are a few key things to consider when picking a health insurance plan:

- What will the plan actually cost me?
- Are my health care providers and facilities included in the plan's network?
- Does the plan cover my prescription drugs and any pharmacies I use?

When comparing plans, it can be tempting to just choose the one with the lowest monthly premium. But, to figure out the total cost for the year, including your out-of-pocket expenses, you have to do some math:

(Plan's monthly premium x 12 months) + Plan's out-of-pocket maximum = Total annual cost

Picking a Plan Example:

- Plan A is an HMO with a monthly premium of \$25; an annual deductible of \$2,500; a 70/30 co-insurance; and an out-of-pocket maximum of \$7,000.
- Plan B is a PPO with a monthly premium of \$100; an annual deductible of \$1,500; an 80/20 co-insurance; and an out-of-pocket maximum of \$4,000.

At first glance, it may seem that Plan A is less expensive because of its low monthly premium. But you have to do the math!

- Plan A: (\$25 premium x 12 months = \$300) + out-of-pocket maximum of \$7,000 = Total cost of \$7,300.
- Plan B: (\$100 premium x 12 months = \$1,200) + out-of-pocket maximum of \$4,000 = Total cost of \$5,200.

After doing the math, Plan B is actually the more affordable plan if your medical expenses reach the out-of-pocket maximum.

You also need to check if your health care providers and facilities are in the plan's network. And then, check to see if the plan covers any prescription drugs you are taking.



More Resources on Health Insurance Options & How to Pick a Plan:

- Animated Video: <https://TriageCancer.org/Video-PickingaPlan>
- Quick Guide to Health Insurance Options: <https://TriageCancer.org/QuickGuide-HealthInsuranceOptions>
- Health Insurance Chapter of Cancer Finances—an interactive toolkit for navigating finances after cancer: <https://CancerFinances.org>
- Webinar—Tips on How To Choose & Use Your Health Insurance: <https://TriageCancer.org/Webinar-HealthInsuranceTips>

When Your Insurance Plan Says No:

At some point during cancer treatment, you may experience a denial of coverage from an insurer, whether for an imaging scan, prescription drug, treatment, procedure, or genetic test. Most people take “no” for an answer. But those who don't accept the denial, and file an appeal, may actually win and get coverage for the care prescribed by their health care team!

For more information about appealing a claim denial, read the Quick Guide to Appeals for Employer-Sponsored & Individual Insurance at <https://TriageCancer.org/QuickGuide-Appeals> or watch <https://TriageCancer.org/Webinar-Appeals>.

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