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A Guide For Health Care And Insurance Usage: Four Factors That Inform Americans' Health Care Decisions

(NAPSA)—Access to quality health care and reliable insurance coverage is in a constant state of change. Regardless of your health care services and treatments, there are basic terms and concepts that are universal in the health care industry. Below is a guide to help you navigate these terms and effectively use your insurance.

Here are four factors to think about when making health care decisions:

- **Choosing a doctor/hospital**
- **Filling prescriptions**
- **Using insurance and paying for care**
- **Reviewing/changing plan benefits during open enrollment.**

These factors may seem simple, but to make informed decisions and find quality, affordable care, it's important to have a basic understanding of your health insurance plan.

The fourth annual Transamerica Center for Health Services (TCHS) consumer health care survey found that affordability is the most important aspect of the U.S. health care system to Americans. On average, two in five (41 percent) consumers say being able to afford their medical care is at the top of their health care priority list and 56 percent of Americans feel health care costs are a very or somewhat significant source of stress—just behind housing costs, money and the economy.

Taking a healthy interest in what's in your health care plan can help you save time, trouble and money.

1. Understanding Your Health Plan and Choosing a Doctor/Hospital

Most people seek guidance on finding a new doctor, clinic or hospital when a health concern arises or when moving to a new neighborhood. Step one is to figure out what type of health plan you have and what it covers. Here are some types of health plans:[1]

- **Fee for Service**
- **Preferred Provider Organization (PPO)**
- **Health Maintenance Organization (HMO)**
- **High-Deductible Health Plan (HDHP).**

Fee for Service is the simplest—you can pick any doctor or hospital at any time, but after the deductible is reached, you will have a set cost (usually a percentage of the charges) for your visit and services.[2,3] For example, if your doctor charges $100 for a visit and treatment, your insurer may pay 80 percent ($80) and you'll pay 20 percent ($20).

A Preferred Provider Organization (PPO) plan offers you a list of doctors or hospitals that are preferred and may help reduce your costs. It's best to pick a doctor on the preferred list or "in-network" for your primary care physician. You can visit any doctor or hospital outside of the preferred list, but you'll likely pay much more for their services.

This is defined as "in-network" and "out-of-network." If the doctor, hospital or health care facility you visit is part of your insurance company's network, your bill will be lower, but if you go out of network for a checkup or specialized service, it will be more expensive.

A Health Maintenance Organization (HMO) plan is more restrictive and provides a list of doctors, clinics or hospitals that are required for your health care services. Similar to a PPO, you must choose a doctor who will be your primary care physician and who can refer you to specialists (also within network) as needed. Generally, these plans will not pay for out-of-network service unless it is an emergency and only in specific situations.

A High-Deductible Health Plan (HDHP) is growing in popularity among employer-based health coverage. These plans work like fee-for-service plans, but cover a smaller percentage of costs up front. After insurance processing, you'll be responsible for the balance of medical charges up until the annual deductible is met (can be thousands of dollars). Once your deductible is reached, your insurer pays out most (or all) of your medical costs for the rest of the year.

Most plans list the doctors and hospitals that they cover online—but you can also call and find out which doctors or hospitals in your area are part of your plan. Usually, doctors are connected to one or more hospitals. If there is a particular doctor or hospital you prefer, you can call the clinic or hospital to check which insurance plans they accept.

2. Filling Your Prescription

Medications health plans help cover the cost of prescription medications and are listed in a formulary. As with doctors and hospitals, you can check if your medications are covered by the formulary before choosing a plan.

If you need medication that's not on your plan's formulary, you should contact your insurance company to find out if you can still receive the drug or a generic version and at what cost. Some insurance companies may provide a one-time refill of your medication after you first enroll.[4] Ask your insurance company if it offers a one-time refill until you can discuss taking alternative medications with your doctor. If you are unable to obtain a one-time refill, you have the right to explore your health insurance company's drug exceptions process, which allows you to receive a prescribed drug that's not covered by your health plan. In most cases, to gain approval through the exceptions process, your doctor must confirm (orally or in writing) that the drug is appropriate for your medical condition and it meets other criteria set by your insurance company.

3. Putting Your Insurance to Work and Paying for Care

First, you need to calculate your monthly premium and out-of-pocket expenses. Your premium is the amount you pay for insurance every month and your out-of-pocket is the amount you have to pay when you go to see the doctor. Typically the higher the premium, the lower out-of-pocket costs you have to pay and vice versa.

If you have regular, ongoing medical care or prescription medications, you may want to consider a higher premium/lower out-of-pocket cost plan to limit your costs for those regular treatments that can add up—the cheapest premium will not necessarily save you money. Your plan should provide a summary of benefits and how much you pay for different types of care.

4. Reviewing/Changing Plan Benefits During Open Enrollment

Lastly, regardless of your health plan (via employer, an exchange, a broker, the government or another channel), you should take time to review your benefits and make changes or switch your health plan during open enrollment, which typically takes place in the fall. Americans comparison shop for homes, cars and other important purchases, so shopping for insurance plans shouldn't be different. The more you understand your health plan and insurance coverage, the more empowered you'll be to make smart decisions for yourself and your family.

For more information on the Transamerica Center for Health Studies, visit www.transamericacenterforhealthstudies.org.

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1MedlinePlus. (3 September 2016). Understanding Health Insurance Plans. Retrieved from: https://medlineplus.gov/ency/patientinstructions/000879.htm

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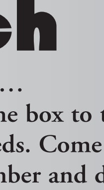

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