Choosing the Right Healthcare Plan
Navigating the health insurance system is one of the most stress-laden experiences that American adults face every year. Not only are we required to choose (sometimes involuntarily) the plan we will utilize, but often, we must research and request additional information from the insurance company to confirm that coverage will help keep us healthy with diabetes.

Much like our disease, choosing the right healthcare plan is a complex decision-making process that involves numbers and calculated risks/benefits discussions. And like our disease, if we make choices without having the full information, it can have unfortunate consequences. Ironically, as important as these decisions are, we are never given instruction in school on how to choose our healthcare plans and what all of the specialized terminology means to women with diabetes.

Types of Health Insurance Plans

PPO or Preferred Provider Organization

PPOs provide you the most choice when it comes to your medical care, permitting you to use providers and services, regardless of being on the insurance plan’s list of preferred providers. You’ll pay more to see a medical professional, hospital, or service that isn’t part of their network and you will not need a referral to do so. A referral is the process by which your primary care provider selects the specialist or service needed within the network of the insurance plan.

POS or Point-of-Service Plan

Point-of Service Plans are less flexible than PPOs, but still permit you to opt for care from outside of the plan’s list of preferred providers with a referral. POS plans require you to choose a primary physician from a list provided to you and they will coordinate referrals for you to other providers within the network. You will also need a referral from your primary physician for any care outside of the preferred list. Those out-of-network referrals will result in higher out-of-pocket costs.

EPO or Exclusive Provider Organization

While you will not need a referral, EPOs are restrictive health insurance plans, limiting coverage and payments to providers, hospitals, and services on a list. The one exception would be in an emergency situation outside of the coverage area.
HMO or Health Maintenance Organization

Health Maintenance Organizations are the most limiting of all health insurance plan types. Coverage is limited to their list of providers, hospitals, and services. You choose your primary care physician and that person coordinates all of your referrals, which must be within the plan. If you choose to go outside of the preferred plan list, you will bear the entire cost of any service you receive, except in the case of an emergency.

HDHP

High Deductible Health Plans have become popular with employers and health insurance providers over the past few years. The monthly premium is often lower than other plans, but is offset with high deductibles. These types of plans may cover some preventative care, but most often are categorized as “catastrophic” health insurance plans, to be used by individuals who feel they do not need health insurance, but don’t want to risk not having any coverage at all.

How Do You Pay for It All?

Premiums

A premium is the fixed payment made to the insurance company on a monthly or quarterly basis to benefit from the health care plan you’ve selected. Currently, the cost of your premium will be based on the type of plan you’ve chosen, number of family members covered, and your age. (Changes in federal healthcare laws may allow preexisting conditions like diabetes to increase the premium cost.) If you do not pay this premium by its due date, you will lose your health insurance coverage.

Deductible

A deductible is the amount you, as the patient, pay out-of-pocket for a medical professional’s visit, pharmacy prescription, diagnostic test, or service before insurance will pay for services. Once you have paid the full deductible, insurance will cover a portion of the payments made for your health care services. The amount you’ll pay for your deductible will vary, but cannot currently exceed $7,150 for an individual plan and $14,300 for a family plan.

Copay/Co-Insurance

With some health insurance plans, you are required to pay a copay for medical visits, medications, or procedures. These may be a fixed amount (i.e., $20 for a primary care physician visit) or a percentage of the cost to obtain medical services (i.e., 20% of the primary care physician visit after you’ve met your deductible). With few plan exceptions, you’ll always pay a portion of the cost of all healthcare-related services.
Health Savings Accounts (HSA) — Only with HDHP

HDHPs allow individuals to maintain a Health Savings Account, which permits pre-tax dollars to be deposited into this type of bank account and used for medical expenses. Money may be deposited by the individual with coverage, an employer, or a third-party, but may only be withdrawn without a tax penalty for medical reimbursements or payments. The maximum contribution into a HSA for 2018 is $3,450 for an individual and $6,900 for a family annually, but if the funds are not used, they can be rolled over to the next year.

Flexible Spending Accounts (FSA)

Some employer-based health insurance plans will offer a flexible spending account, which like an HSA, allows pre-tax dollars to be used for medical expenses during the calendar year. The amount an individual selects to place into the account must match closely to what will be spent on medical services (and some over-the-counter medications or supplies), as only $500 per year is allowed to be rolled over annually.

Out-of-Pocket Maximum

There is a limit on how much you pay annually (excluding your monthly premium) before your health insurance plan will pay 100% of covered benefits. Under the Affordable Care Act, in 2017 the out-of-pocket maximum limit is $7,150 for an individual and $13,700 for an annual plan. Every plan will have a different out-of-pocket maximum limit amount, with HDHP tending towards the higher or highest deductible due to lower premiums.

What’s Covered

Preventative Care

Every healthcare insurance plan, through the Affordable Care Act, must provide the following services at no charge if they are done within the insurance's network, including:

- Screenings for depression, diabetes, blood pressure issues, cholesterol, colon cancer (if you are over 50), and sexually transmitted diseases
- Contraception
- Mammograms (every 1 to 2 years if you are over 40 years of age)
- Well-woman visits
- Vaccines and flu shots

It is crucial to make the well-woman visits annually to ensure you are taking advantage of the preventative care services.
In Network/Out of Network

Every insurance plan has negotiated discounted pricing contracts with medical providers, hospitals, pharmacies, and services to be included in the network. If a provider or service is “in network,” you’ll be offered a discounted rate or copay.

However, if a provider or service is “out of network,” you will either pay a higher rate (often with a little to no discount) or your insurance plan will not cover the charge at all. In that case, you would be responsible for all charges.

Specialist

Medical professionals who focus on a certain part of the body or mind (and have additional training in that area) are specialists. Women with diabetes often incorporate specialists into their healthcare team, including podiatrists, cardiologists, and endocrinologists. Most insurance plans require a higher copay or lower the percentage amount for specialist coverage.

Prescriptions

While prescriptions are covered under your insurance plan, you may find that the cost of obtaining these medications can vary widely. Some plans require you to pay for your prescriptions as part of your deductible, so until you’ve met it, you’re paying out-of-pocket. Others will use a tiered cost system, so you may pay $20 for one medication and $60 for another.

Formularies are the lists of what prescriptions your insurance will cover. If a particular medication (or device) is not on the list, you will pay out-of-pocket or at the highest tiered rate. Formularies change annually, based on agreements with insurance companies and pharmacy benefit managers.

Durable Medical Equipment (DME)

Durable Medical Equipment is any prescribed device or item that provides you with a “therapeutic” benefit that can be reused. Wheelchairs, oxygen, and hospital beds are often the examples given. For women with diabetes, DME coverage can include insulin pumps and pump supplies, blood glucose monitors, orthotics, and continuous glucose monitors.
Ensuring You Get the Best Insurance Coverage For Your Needs

When beginning the process of choosing your health insurance plan, have the following items written down and readily available:

- Your complete list of prescriptions and the dosages
- All of your medical professionals on your current healthcare team, including specialists
- Your preferred hospital
- Where you go to get your mammograms and other tests

Research

For any plan that you are considering, you’ll need to research the following:

*List of Healthcare Providers and Services*

Each insurance company has its own network and is available for your review before you select a plan. With your list close by, find out if the following are in network:

- Your primary care physician and specialists
- Your preferred hospital
- The radiology center where you receive your mammogram and your diagnostic testing facility
- Your preferred pharmacy

*Formulary*

Insurance companies must provide an updated list of medications that they cover during the open enrollment period. Using your list of prescriptions, check to see if:

- Is the medication covered, and if so, what tier is it listed under?
- If any of your medications aren't covered, what is their policy on exemptions? (It should be stated in the formulary guide.)

*Determine the Annual Costs of Your Care*

A low premium, high deductible plan may not be financially beneficial for you — but then again, despite first glance, it might. It’s crucial that you explore what you will pay for your care on an annual basis.

Some individuals find they are better served with a low- or no-deductible plan because they see many specialists or require significant durable medical equipment expenses. Others realize, after a detailed and personalized review, that they may actually save money over the year with a high-deductible plan.
Choosing the Right Healthcare Plan

For each plan you are considering, gather the following:

- **Monthly premium**
- **Deductible (if any) that would** need to be met before insurance covers costs
- **Costs of primary care visits** (either the fixed copay or the percentage you would pay for the visit)
- **Costs of specialist visits** (either the fixed copay or the percentage you would pay for the visit)
- **Monthly cost of medications** under the plan’s formulary
- **Emergency room and surgery** costs (if needed)
- **Durable medical equipment costs**

**An Example**

Amy is a 45-year-old woman living with type 2 diabetes. She is a non-smoker living in Virginia and is comparing two options for health insurance in her area.

Amy sees her primary care physician once per year and two specialists annually: her cardiologist and her gynecologist. She also sees an advanced registered nurse practitioner (ARNP) who is a certified diabetes educator (CDE) four times per year. She takes a basal insulin and oral diabetes medications and uses a continuous glucose monitor (CGM) and a blood glucose monitor to manage her diabetes.

*Please note that this is purely hypothetical and generalized.*

<table>
<thead>
<tr>
<th>Costs</th>
<th>High Deductible Health Plan (HDHP)/EPO</th>
<th>Health Maintenance Organization (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Premium</td>
<td>$3,420 ($285/month)</td>
<td>$5,880 ($490/month)</td>
</tr>
<tr>
<td>Deductible</td>
<td>$5,750</td>
<td>$1,300</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket</td>
<td>$7,150</td>
<td>$4,800</td>
</tr>
</tbody>
</table>

**After Deductible Met**

<table>
<thead>
<tr>
<th>Costs</th>
<th>High Deductible Health Plan (HDHP)/EPO</th>
<th>Health Maintenance Organization (HMO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Primary Visit</td>
<td>$75 (50% Coinsurance)</td>
<td>$ 20 copay</td>
</tr>
<tr>
<td>Cost of Specialist Visit</td>
<td>$150 (50% Coinsurance)</td>
<td>$ 50 copay</td>
</tr>
<tr>
<td>Monthly Medication Cost</td>
<td>$400 (50% Coinsurance)</td>
<td>$100 tiered copay</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>$500 (50% Coinsurance)</td>
<td>$400 (40% Coinsurance)</td>
</tr>
<tr>
<td>DME Monthly Cost</td>
<td>$300 (50% Coinsurance)</td>
<td>$120 (20% Coinsurance)</td>
</tr>
</tbody>
</table>

**Which type of insurance would be best for Amy?**

It depends on how flexible Amy is, how much monthly she budgets for her medical expenses and how much risk she is willing to assume.
High Deductible Health Plan/EPO

As EPOs are the most restrictive type of plan, she discovers that while her cardiologist is within the network, none of the remaining medical team she has would be covered. She would need to select new providers for her diabetes, gynecological, and primary care.

She would meet her $5,750 deductible quickly, as her monthly medication and DME costs alone would be $1400/month (She pays 100% until her deductible is met). Based on the number of visits to her medical team and the cost of those visits, she will meet her maximum out-of-pocket deductible by mid-year, with all of her medical costs covered at 100% by the insurance company.

Amy’s total cost = Annual Premium + Maximum Out-Of-Pocket
$10,570 = $3,420 + $7,150

Health Maintenance Organization

HMOs also may be restrictive, but fortunately, all of her medical team turns out to be part of the HMO’s network. She will meet the $1,300 deductible by the end of February, with her medications and DME payments costing $700 per month. In March, she would pay $220 per month for her medications and DME payments.

Amy’s medical professional visits would cost $320 annually under this plan. She wouldn’t be likely to meet her out-of-pocket maximum of $4,800, as her deductible of $1,300 added to the $320 for her medical appointments and $2,200 for medications and DME after she met the deductible would be $3,820.

Amy’s total cost = Annual Premium + Annual Overall Costs
$9,700 = $5,880 + $3,820

Amy would be better served financially (and perhaps emotionally) by choosing the HMO. While the premium is higher, her monthly costs are reasonable after a relatively low deductible is met.

This is not always the case, which is why you must carefully examine all the aspects of the true costs of your plan. If Amy had any additional expenditures (perhaps a single ER visit), she could meet her out-of-pocket maximum, which would make the HMO plan worse from a financial standpoint.
Choosing the Right Healthcare Plan

<table>
<thead>
<tr>
<th>Costs</th>
<th>Your Information</th>
<th>Proposed Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Premium</td>
<td></td>
<td>$_____________</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td>$_____________</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket</td>
<td></td>
<td>$_____________</td>
</tr>
<tr>
<td><strong>After Deductible Met</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of Primary Visit</td>
<td>(# of visits x proposed copay or coinsurance)</td>
<td>$_____________</td>
</tr>
<tr>
<td>Cost of Specialist Visit</td>
<td>(# of visits for each specialist x proposed copay or coinsurance)</td>
<td>$_____________</td>
</tr>
<tr>
<td>Monthly Medication Cost</td>
<td>(# of medications under proposed plan)</td>
<td>$_____________</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>(estimated cost/copay of ER visit under proposed plan)</td>
<td>$_____________</td>
</tr>
<tr>
<td>DME Monthly Cost</td>
<td>(monthly cost under proposed plan)</td>
<td>$_____________</td>
</tr>
</tbody>
</table>

For your estimated annual cost for the proposed plan, use the following equation:

You will need to determine if you will meet your out-of-pocket maximum for this plan. To do so, combine the cost of all the items under the “After Deductible Met” section and subtract the deductible. If the cost is greater than the out-of-pocket maximum, you’ll use the out-of-pocket maximum in your total estimated cost. If not, use the sum of all the items listed in that category.

**Total Estimated Cost = Annual Premium + Deductible + (either Out-Of-Pocket Maximum or sum of all items under After Deductible Met section)**

The Annual Cost of Your Healthcare Plan Isn’t All Financial

The example given above is just one way to examine what you need from your insurer. Financial cost is one of the largest decision factors, but you also need to determine the emotional cost.

For some women, it’s perfectly acceptable to change doctors, but others have developed a beneficial, helpful relationship with their medical team and would be loathe to leave their practice. When it comes to medications, changing from one type of generic to another may not be a big deal, but for many women with diabetes, once they have found an insulin that helps them manage their diabetes, they will fight to maintain their successful treatment plan.

By researching each healthcare plan’s details and determining what your annual financial (and emotional) costs would be, you can make a more informed choice.