

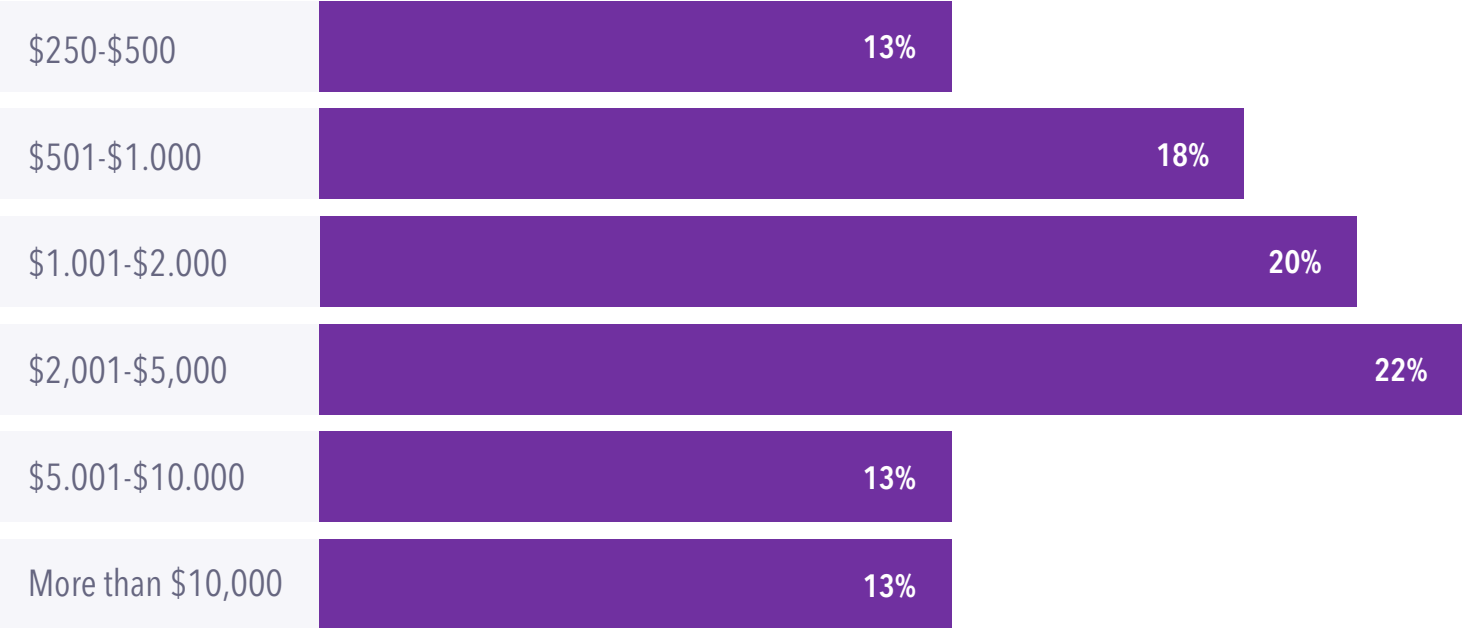


The Wrong Health Insurance Could Cost You Thousands - **How to Buy the Best Coverage**

More than 100 million people in the United States are burdened by healthcare debt – despite 61% of them having health insurance.

Most people with significant medical debt owe over \$1,000

Share of adults with medical debt, by the amount of debt they owe, 2019



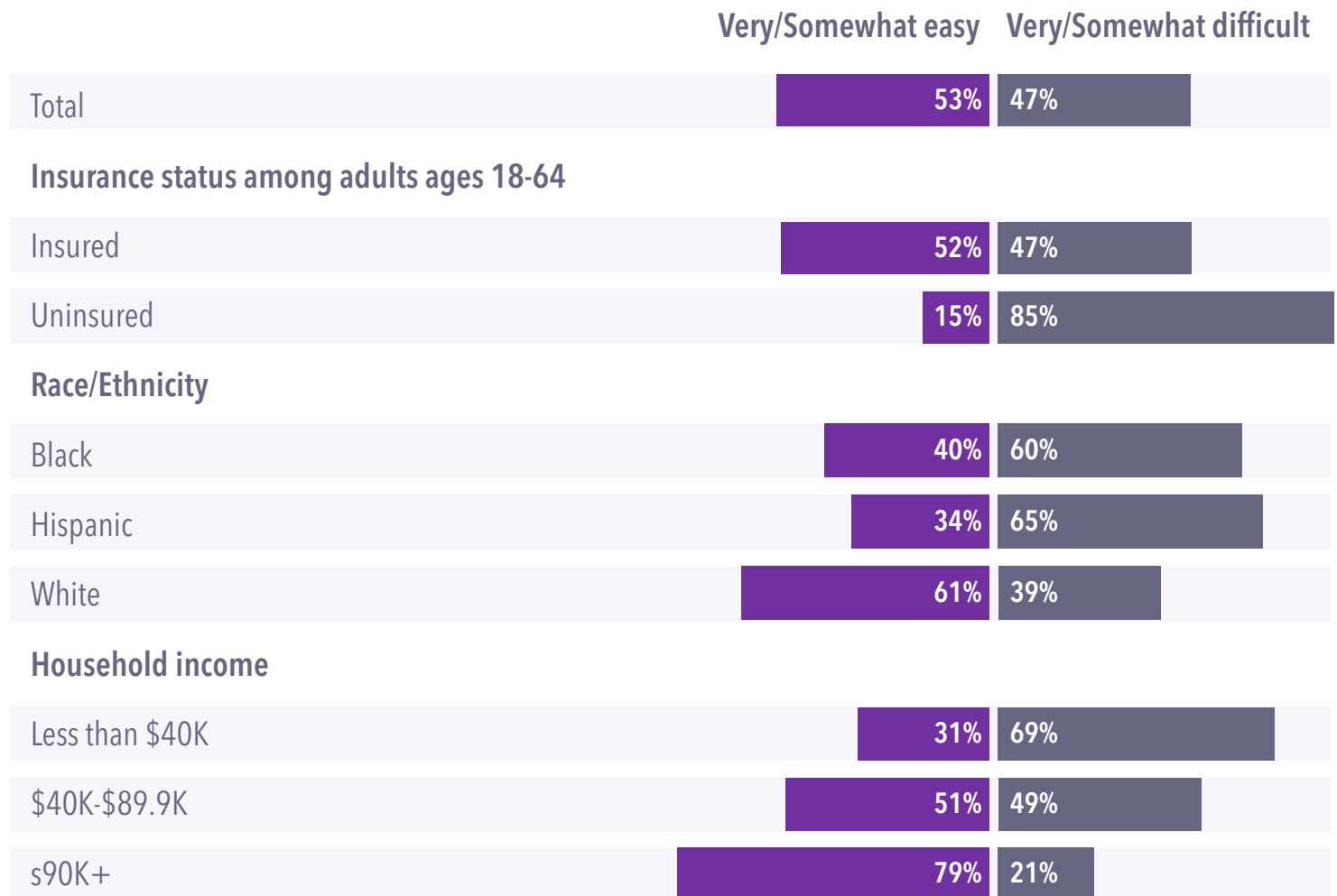
Note: This analysis is limited to adults owing over \$250 in medical debt.
Source: KFF Analysis of U.S. Survey and Income and Program Participation (SIP) data

Medical bills can strain household budgets, forcing parents to make impossible choices such as buying food or paying off part of the debt, or putting children at a crossroads: finishing their studies or helping cover healthcare expenses.



Half Of Adults Say It Is Difficult To Afford Health Care Costs, Including Large Shares Of The Uninsured, Black And Hispanic Adults, And Those With Lower Incomes

In general, how easy or difficult is it for you to afford your health care costs?



SOURCE: KFF Health Care Debt Survey (Feb. 25-Mar. 20, 2022)

A significant portion of these debts could be avoided if policyholders were more informed, asked questions, and had a better understanding of their coverage. That's because in the United States, debt isn't always a consequence of pricey treatments for serious conditions; something as simple as a blood test or an emergency room visit for a fall can result in an unpleasant surprise bill in the mail months later. And even having coverage but not understanding how it works plus a pervasive culture of surprise billing in the United States leave you at peril.



Surprise medical bills are causing people to avoid preventive care and delay needed care which increases health care costs in the long run



40%

report that they have gone without a routine check-up



39%

have gone without a routine physical or other preventive health care screening



39%

did not see a doctor when they (or a family member) were injured

SOURCE: Healthsparq

Making a Choice For Your Health

When the time comes to choose coverage, it's important to keep one's own health in mind as well as how often the policy will be used. For example, someone who is under the age of 30, in relatively good health, and unlikely to need their insurance very often may opt for a **catastrophic plan**, which covers essential health services and has the highest cost-sharing requirements. While monthly premiums for such plans may be lower, these policies usually carry high **deductibles** (the amount a patient must pay out-of-pocket before the insurance provider starts to cover 100% of costs). In the case of a medical emergency, for instance, the policyholder would be responsible for the bulk of medical expenses.

But if a person is over 45 or 50 years old and has an existing medical condition, such as diabetes or hypertension, they will likely visit their doctor on a regular basis and may benefit from a health insurance policy with higher monthly premiums and a lower deductible. This way, they can avoid having to pay a lot of money every time they see a specialist or get a test done. The official website of the federal government's health insurance marketplace, HealthCare.gov, lists the **different plan options**.

What most people fail to consider – or simply don't know – is that the deductible amount "resets" annually; that is, the amount that the policyholder has paid returns to \$0 at the beginning of a plan year. For example, if a policy has a \$2,000 deductible and the policyholder paid \$1,200 out of pocket in 2022, this will NOT result in a deductible of \$800 in 2023. The following year, their deductible will reset back to \$2,000.



Cheaper Doesn't Necessarily Mean Less Costly

It's common for people to get excited when they find a health insurance plan that has low monthly premiums, or a family plan that costs \$400 a month, for instance. They're focused on keeping monthly expenses as low as possible, and they assume an inexpensive plan is the best option. But more affordable policies usually carry high deductibles, inevitably resulting in higher out-of-pocket costs in most medical situations.

Once again, policyholders should weigh potential costs and how often they expect to require medical services. A helpful analogy can be found in the way people think about car insurance: They often select the cheapest plan, assuming "nothing will happen" – until an accident occurs and they discover that their policy covers almost nothing.

If a person gets health insurance through their employer, they may still have the option to choose between different plans and insurance providers. The same advice applies in these cases: The best option in the medium and long term will correspond to the policyholder's health and cost expectations.

The Affordable Care Act (ACA), enacted in 2010, covers **10 essential health benefits**, and many preventive tests and screenings are free, as well as access to specific women's health services and **birth control**. This coverage is offered in every state, but some states go a step further, requiring that insurers cover additional services and procedures. There may even be different levels of coverage within an individual state.

Understanding the Language

Purchasing health insurance and selecting the best plan requires a little vocabulary. These are the basic terms everyone should know:

Premium.

This is the amount paid each month for medical coverage. Insurance acquired through the ACA marketplace typically offers subsidies that help cover these costs, depending on a person's income, state of residence, and the number of people in their household. Millions of uninsured people qualify for **zero-premium plans**, and an even higher number qualify for plans with monthly premiums of \$10 or less.

Cost-sharing.

This umbrella term refers to the portion of costs that policyholders must pay out of pocket for rendered services. That includes deductibles, copays, and coinsurance. These expenses come up when people visit the doctor, fill a prescription, get testing (excluding preventive screenings), or undergo a procedure, and they are separate from premiums, the monthly cost of having insurance.

Deductible.

This is the amount of money a person must pay for health services before their insurance begins to cover costs. At the start of each year, as explained above, a person's deductible "resets" to zero. This is why the first doctor's appointments and prescriptions of the year may appear very costly, since most people have not yet met their deductible. Your insurer will begin to cover 100% of most services once you have met your annual deductible.



Copay and Coinsurance.

Once the deductible has been met, a person may still have to make payments when they go to the doctor, in the form of a fixed copay or coinsurance or a percentage of total costs. For example, if a plan covers 80% of the cost of a service, a patient's coinsurance will be the 20% remaining cost.

Out-of Pocket Maximum.

All the shared costs listed above have limits. If a person uses their health insurance very frequently in a single year, they could reach their out-of-pocket maximum – the highest amount they will have to pay for health services rendered in a given calendar year. This is the threshold above the deductible; if the policyholder meets it, they will not have copays or coinsurance expenses for the rest of the year, and their insurance will pay 100% of the cost of covered health services.

In the popular imagination, health insurance is seen as a requirement for older adults with preexisting conditions. But the reality is that health coverage has no age: EVERYONE needs to have it. Some conditions and services may be linked to the passing of time, but thousands are not, from acne and preventive vaccines to mental health treatment; from the flu and infections like COVID-19 to digestive issues and reproductive health. And then, of course, there is the unexpected: accidents, injuries, and other emergencies that require urgent medical attention.

The Bottom Line

If you want the best and most cost-effective health coverage, you'll have to learn as much as you can about your plan options. Brokers and agents do not have their interests aligned with yours: They will always seek to maximize their commissions, which rarely results in finding the policy that will best serve you.

This is where Healthbird comes in. **Healthbird has developed an AI-based tool that will provide you with policy options tailored to your specific needs, using just a few data points.**

Healthbird and its AI are not based on commissions, and we have very good reasons for building our product this way. **Our mission is to seek what's best for you, aligning our core values with yours. We know our company will profit in the long term from serving you in the best possible way.**

Knowledge and understanding are always the paths to a good life, and health insurance is no exception. We are here to help you learn, become more informed, and make better decisions to benefit your well-being.

