

Decoding Educator Health Care Benefits

Making sense of your health care coverage is important, whether you're reviewing the plan you are currently enrolled in, working with your employer to restructure a plan, or looking for a new plan.

Having trouble decoding your health care coverage options? NEA's health care experts have broken down some of it for you.

Copayments and Coinsurance

Once you've met your deductible, the insurance company steps in to pay its share of the costs. Even so, you'll usually have to pay a portion of the covered charge determined as either a fixed dollar amount (a copayment) or a percentage of the costs (coinsurance).

Plans with copayments may have higher premiums than those with coinsurance, because copayments are capped at a set dollar amount and the out-of-pocket cost are generally lower than with coinsurance. With coinsurance, plan members pay more when doctors charge more.

Deductibles

Before your plan pays for most services, it will require that you cover the costs up to a certain dollar amount (the deductible).

Deductibles vary based on who's covered, the type of benefits used, whether care is obtained from an in-network or out-of-network provider, and whether families must pay the full deductible before the plan starts to cover the costs of any covered family member.

Fully Insured and Self-Insured Plans

A fully insured plan is one in which, in exchange for premium payments, an insurance company assumes the financial risk of paying for the health care used by plan members. When a school district, state or other entity takes on that risk, it's a self-insured plan.

Self-insured plans usually contract with an insurance company to administer the plan and for access to its provider network. These plans are often more flexible in design and allow greater access to data on the cost and types of benefits used by plan members and their covered dependents.

Health Flexible Spending Arrangements (Health FSAs)

Employers set up health FSAs, and employees can defer pre-tax pay into the account up to the federally determined annual maximum or a lower amount set by the employer. General purpose FSAs can be used to reimburse any IRS-approved medical expenses. Reimbursements are okay for dependent children up to age 26.

FSAs can also be established that are limited in scope, such as covering dental or vision out-of-pocket covered expenses only. At the end of the plan year, employees generally forfeit unused FSA money. FSAs can have a grace period for employees to spend unused funds at the end of the plan year, or they can allow limited rollovers.

Health Reimbursement Arrangements (HRAs)

HRAs can only be funded by employers, and they can limit the types of IRS-approved, unreimbursed medical expenses they'll cover. They do not have to be coupled with an HSA-qualified HDHP but often are. Account balances do not have to roll over every year (although they can), and HRA balances cannot be used to pay for non-medical benefits (or cash withdrawals).

Unlike HSAs, contributions to HRAs are not subject to a federal cap and do not require a federal minimum annual deductible. HRAs are subject to complex rules regarding when and how they can be used. Contributions, reimbursements, and investment gains are generally not federally taxable to the account holder.

Health Savings Accounts (HSAs)

An HSA must be paired with an HSA-qualified high-deductible health plan (HDHP) in order to receive contributions. HSAs are designed to pay for unreimbursed, IRS-approved medical expenses. They are subject to federal annual deductibles, out-of-pocket, and contribution limits.

An employee, an employer, or others can fund an employee's HSA, and contributions to an account, payments for medical expenses, and gains on investments are generally not federally taxable to the account holder. HSA balances roll over from year to year and follow the account holder if the account holder leaves the employer.

In-Network And Out-Of-Network Provider Network

To keep costs down and improve plan members' health, insurance companies contract with and maintain a group of in-network providers—including doctors, hospitals, and labs. Those not in the network are called out-of-network or non-network providers.

Networks can be narrow (with relatively fewer providers) or broad. For most things, plans charge members more for out-of-network services, in part because in-network providers have agreed to accept a negotiated and often lower payment rate.

Out-Of-Pocket Expenses

Federal rules cap the amount you pay for covered benefits (out-of-pocket expenses) in most health plans. Payments toward your deductible, your copayments and/or coinsurance count toward the cap, but some expenses, like for premiums, don't. High-deductible health plans (HDHPs) with a health savings account (HSA) are required under federal law to have annual minimum and maximum deductible levels and a limit on the maximum out-of-pocket levels.

Premiums

The premium is the regular payment you make to access health coverage, regardless of how much or how little you use the plan. Payments are typically deducted on a pre-tax basis from an employee's paycheck. Usually, the more you pay in premiums, the less you pay in deductibles, copayments, and other out-of-pocket costs, and vice versa.

Premiums often receive the bulk of the focus when people discuss health plan coverage, but don't forget to consider how premiums and out-of-pocket costs relate to each other.

Need more guidance before choosing your health care plan? Check out our resources at nea.org/healthplan.