How to slash your medical bills

Stop overspending on health care with our easy tips

Co-pays and deductibles can gobble up a lot of cash every year. Even with good insurance, you're probably paying more for medical bills than you'd like. And we all know that health care in the U.S. costs more than anywhere else in the world. So how can you save money in our maddeningly complicated system? These seven tips can save you big bucks.

1. Don't go out of network if you don't have to. That dermatologist your friend raved about? Yeah, it's tempting to make an appointment and be done with it. But it's probably not worth it if she's not in your insurance plan's network. If you have a health-maintenance organization, it won't pay a cent. Even if you have a preferred provider-organization (PPO) plan that allows you to go out of network, it's probably not going to pay as much as you think—and you'll be on the hook for the rest. Every plan has to have a full range of qualified specialists, so you should always try to find a doctor in your network. Your plan's website should have a searchable list of local providers.

A few tips for finding the right one for you: Look for someone who is board-certified in her specialty. Ask the office staff and the doctor about things such as wait time and weekend coverage. If you are looking for a primary care doctor, try to find one who practices within a patient-centered medical home. They are more likely to have helpful features, such as online medical records you can access from home, evening and weekend hours, and staffers to help you coordinate your care.

2. Avoid ERs for routine problems.

Emergency rooms are attached to hospitals, the most expensive possible place to get medical care. Insurance plans don't want you to go to the ER for routine problems such as a fever, a stomach bug, or an ear infection. That's why so many insurers charge so much for ER visits. A popular Anthem Blue Cross PPO for government employees, for instance, charges a $125 co-pay, and one plan sold on the California Health Insurance Marketplace comes with a whopping $250 ER co-pay! Of course, for a true emergency—chest pain, serious bleeding, trouble breathing, sudden one-sided weakness, and the like—you should absolutely go to the ER. But for other medical concerns, choose a doctor's office with extended hours, an urgent-care clinic, or a drugstore walk-in clinic, where you'll pay a smaller co-pay. Just make sure the one you select is in your insurance plan's network.

ILLUSTRATIONS: LEO ESPINOSA

3. Pay cash for generic drugs.

Co-pays for a 30-day supply of many prescription drugs—even generics—have crept up to $10 and beyond. But for certain drugs, there's an easy way to pay less: Don't use your insurance. At chain stores including CVS, Rite Aid, Target, Walgreens, and Walmart, you can buy many popular generics for as little as $4 for a month's supply or $10 for 90 days' worth. Ask at the pharmacy for a list of those drugs before you fill your next script. And if yours isn't on it, ask your doctor whether you might be able to swap your current medication for a cheaper one.

4. Price-shop for tests and procedures. Not so long ago that would have been impossible because there was no way to find out prices of medical care in advance. But many insurance companies have started to put some pricing info online. If you register on your insurer's website, you'll probably be able to see and compare in-network prices in your area for routine things such as MRIs, colonoscopies, and hernia repair. Prepare to be shocked at the range of prices. In Chicago, the in-network price of an MRI of the lower back ranges from $606 to $3,382, depending on where you go. That's according to an analysis of employer health-plan claims by Castlight Health, a consulting firm. In Indianapolis, a test for blood lipids can cost anywhere from $15 to $202. In San Diego, a CT scan of the head can range from $271 to $1,699. Picking a less costly provider could save you hundreds or even thousands of dollars every time.

5. Skip care you don't need. Doctors sometimes prescribe tests and treatments on autopilot, but that doesn't mean you need everything they suggest. For example, you rarely need antibiotics for bronchitis, sinusitis, or an upper respiratory infection, because those are almost always caused by viruses, which aren't cured by antibiotics. You usually don't need imaging tests for headaches or back pain, and unless you have symptoms of heart disease, you can skip getting an electrocardiogram or stress test. A project called Choosing Wisely has assembled a list of unnecessary procedures based on research and the advice of medical experts. Learn more at *ConsumerReports.org/cro/choosingwisely*.

6. Spend pretax dollars. If you have access to a flexible spending account or a health-savings account, put money in it if you can. Not sure what these are? Both are funded by paycheck deductions with pretax dollars. You can get an FSA only if your employer offers it, but it works with any kind of health plan. HSAs can be set up only in conjunction with certain high-deductible insurance plans. Your employer may offer one and may contribute to yours, or you can buy one on most state health-insurance exchanges. With either type of account, you use the money for co-pays, deductibles, and care that your plan doesn't cover, such as glasses, hearing aids, and orthodontia. Warning: Don't put more into an FSA than you can spend in a year, or you'll lose it. By contrast, unspent HSA money is yours to keep, even if you switch jobs or insurance plans.

7. Don't overpay your medical bills.

Medical billing involves all kinds of complicated codes, rules, and handoffs from the doctor's office to the insurance company and back again. Mistakes can happen at any step of the way. To avoid paying for services that your insurance should have covered, never pay a doctor or hospital bill until you receive an explanation-of-benefits notice from your insurance company. The EOB will tell you what the bill was, what the insurance paid, and what (if anything) you owe. If the doctor's bill doesn't match the information on the EOB—or if you think your insurance company should have paid but didn't—call your insurance company's customer-service number to find out what went wrong. Often it's something as simple as an incorrect billing code or a typo in your name, birth date, or policy number. And remember: If a doctor or hospital is in your health plan's network, they have signed a contract that says they can't bill you extra beyond what your insurer allows. If they try to overbill you, send the provider a copy of your EOB to remind them of that fact.

AVOID THE GAP!

There are lots of ways to lose your insurance and reasons to have to change it. The rules surrounding those transitions can be complicated and obscure, and there's a good chance no one will tell you about them. But if you mess up, you could end up stuck for months without any insurance. Here's what you need to know:

IF YOU LEAVE A JOB

What do to You can get a plan through your state health-insurance marketplace right away instead of waiting for fall open enrollment. But that option expires after 60 days; after that you really will have to wait. The same applies if you turn 26 and get kicked off your parents' plan. Either way, go to *healthcare.gov* for more info.

IF YOU TURN 65

What do to If you are 65 or older, you have to sign up for Medicare as soon as you (or your spouse, if that's how you get your insurance) quits working. If you don't realize that (and a lot of people don't), you may find yourself without full coverage for your medical bills. If you are about to reach the age of Medicare, download the "Medicare & You" booklet from *medicare.gov*. If you still have questions, get answers from the State Health Insurance Assistance Program (SHIP); find your state's contact info here: *ConsumerReports.org/cro/SHIP*.

IF YOUR KID TURNS 19

What do to If she is on the Children's Health Insurance program (CHIP), her coverage will end at 19. Before your child's birthday arrives, check with your state's social services agency. (That's your go-to resource for Medicaid info, too.)

Whatever your situation, you really should force yourself to sit down and read the literature that came with your plan, as well as any notices you receive. In pre-health-reform days, you often needed to be a detective to find key info. Now, every plan (except for Medicare) has to come with a summary of benefits and coverage that lays out all of the details. If you get your health insurance through an employer, ask your human-resources department for a copy. If you get your insurance through a state health-insurance marketplace, you can find a copy online.