Buyers Guide for Health Insurance

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Introduction

If you have ever been sick or injured, you know how important it is to have health coverage. But if you're confused about what kind is best for you, you're not alone.

What types of health coverage are available? If your employer offers you a choice of health plans, what should you know before making a decision? In addition to coverage for medical expenses, do you need some other kind of insurance? What if you are too ill to work? Or, if you are over 65, will Medicare pay for all your medical expenses?

These are questions that today's consumers are asking; and these questions aren't necessarily easy to answer.

This guide will help. It discusses the basic forms of health coverage and includes a checklist to help you compare plans. It answers some commonly asked questions and also includes thumbnail descriptions of other forms of health insurance, including hospital-surgical policies, specified disease policies, catastrophic coverage, hospital indemnity insurance, and disability, long-term care, and Medicare supplement insurance.

While we know that our guide can't answer all your questions, we think it will help you make the right decisions for yourself, your family, and even your business.

Making Sense of Health Insurance

The term health insurance refers to a wide variety of insurance policies. These range from policies that cover the costs of doctors and hospitals to those that meet a specific need, such as paying for long-term care. Even disability insurance-which replaces lost income if you can't

work because of illness or accident-is considered health insurance, even though it's not specifically for medical expenses.

But when people talk about health insurance, they usually mean the kind of insurance offered by employers to employees, the kind that covers medical bills, surgery, and hospital expenses. You may have heard this kind of health insurance referred to as comprehensive or major medical policies, alluding to the broad protection they offer. But the fact is, neither of these terms is particularly helpful to the consumer.

Today, when people talk about broad health care coverage, instead of using the term "major medical," they are more likely to refer to fee-for-service or managed care. These terms apply to different kinds of coverage or health plans. Moreover, you will also hear about specific kinds of managed care plans: health maintenance organizations or HMO's, preferred provider organizations or PPO's, and point-of-service or POS plans.

While fee-for-service and managed care plans differ in important ways, in some ways they are similar. Both cover an array of medical, surgical, and hospital expenses. Most offer some coverage for prescription drugs, and some include coverage for dentists and other providers. But there are many important differences that will make one or the other form of coverage the right one for you.

The section below is designed to acquaint you with the basics of fee-for-service and managed care plans. But remember: The detailed differences between one plan and another can only be understood by careful reading of the materials provided by insurers, your employee benefits specialist, or your agent or broker.

Fee-for-Service

This type of coverage generally assumes that the medical provider (usually a doctor or hospital) will be paid a fee for each service rendered to the patient-you or a family member covered under your policy. With fee-for-service insurance, you go to the doctor of your choice and you or your doctor or hospital submits a claim to your insurance company for reimbursement. You will only receive reimbursement for "covered" medical expenses, the ones listed in your benefits summary.

When a service is covered under your policy, you can expect to be reimbursed for some, but generally not all, of the cost. How much you will receive depends on the provisions of the policy on coinsurance and deductibles. Here's how it works: The portion of the covered medical expenses you pay is called "coinsurance." Although there are variations, fee-for-service policies often reimburse doctor bills at 80 percent of the "reasonable and customary charge." (This is the prevailing cost of a medical service in a given geographic area.) You pay the other 20 percent-your coinsurance. However, if a medical provider charges more than the reasonable and customary fee, you will have to pay the difference. For example, if the reasonable and

customary fee for a medical service is $100, the insurer will pay $80. If your doctor charged $100, you will pay $20. But if the doctor charged $105, you will pay $25.

Note that many fee-for-service plans pay hospital expenses in full; some reimburse at the 80/20 level as described above.

Deductibles are the amount of the covered expenses you must pay each year before the insurer starts to reimburse you. These might range from$100 to $300 per year per individual, or $500 or more per family. Generally, the higher the deductible, the lower the monthly, quarterly, or annual premiums.

Policies typically have an out-of-pocket maximum. This means that once your expenses reach a certain amount in a given calendar year, the reasonable and customary fee for covered benefits will be paid in full by the insurer. (If your doctor bills you more than the reasonable and customary charge, you may still have to pay a portion of the bill.) Note that Medicare limits how much a physician may charge you above the usual amount.

There also may be lifetime limits on benefits paid under the policy. Most experts recommend that you look for a policy whose lifetime limit is at least $1 million. Anything less may prove to be inadequate.

Managed Care

The three major types of managed care plans are health maintenance organizations (HMO's), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. In managed care plans, instead of paying separately for each service that you receive, your coverage is paid in advance. This is called prepaid care.

For example, you may decide to join a local HMO where you pay a monthly or quarterly premium. That premium is the same whether you use the plan's services or not. The plan may charge a co payment for certain services-for example, $10 for an office visit, or $5 for every prescription. So, if you join this HMO, you may find that you have few out-of-pocket expenses for medical care-as long as you use doctors or hospitals that participate in or are part of the HMO. Your share may be only the small co payments; generally, you will not have deductibles or coinsurance.

One of the interesting things about HMO's is that they deliver care directly to patients. Patients sometimes go to a medical facility to see the nurses and doctors or to a specific doctor's office. Another common model is a network of individual practitioners. In these individual practice associations (IPA's), you will get your care in a physician's office.

If you belong to an HMO, typically you must receive your medical care through the plan. Generally, you will select a primary care physician who coordinates your care. Primary care physicians may be family practice doctors, internists, pediatricians, or other types of doctors. The primary care physician is responsible for referring you to specialists when needed. While most of these specialists will be "participating providers" in the HMO, there are circumstances in which patients enrolled in an HMO may be referred to providers outside the HMO network and still receive coverage.

PPO's and POS plans are categorized as managed care plans. (Indeed, many people call POS plans "an HMO with a point-of-service option.") From the consumer's point of view, these plans combine features of fee-for-service and HMO's. They offer more flexibility than HMO's, but premiums are likely to be somewhat higher.

With a PPO or a POS plan, unlike most HMO's, you will get some reimbursement if you receive a covered service from a provider who is not in the plan. Of course, choosing a provider outside the plan's network will cost you more than choosing a provider in the network. These plans will act like fee-for-service plans and charge you coinsurance when you go outside the network.

What is the difference between a PPO and a POS plan? A POS plan has primary care physicians who coordinate patient care; and in most cases, PPO plans do not. But there are exceptions!

HMO's and POs have contracts with doctors, hospitals, and other providers. They have negotiated certain fees with these providers-and, as long as you get your care from these providers, they should not ask you for additional payment. (Of course, if your plan requires a co payment at the time you receive care, you will have to pay that.)

Always look carefully at the description of the plans you are considering for the conditions of payment. Check with your employer, your benefits manager, or your state department of insurance to find out about laws that may regulate who is responsible for payment.

Self-insured Plans

Your employer may have set up a financial arrangement that helps cover employees' health care expenses. Sometimes employers do this and have the "health plan" administered by an insurance company; but sometimes there is no outside administrator. With self-insured health plans, certain federal laws may apply. Thus, if you have problems with a plan that isn't state regulated, it's probably a good idea to talk to an attorney who specializes in health law.

Appropriate Care

HMOs, PPOs, and fee-for-service plans often share certain features, including pre authorization, utilization review, and discharge planning.

For example, you may be asked to get authorization from your plan or insurer before admission to a hospital for certain types of surgery. Utilization review is the process by which a plan determines whether a specific medical or surgical service is appropriate and/or medically necessary. Discharge planning is an approach that facilitates the transfer of a patient to a more cost-effective facility if the patient no longer needs to stay in the hospital. For example, if, following surgery, you no longer need hospitalization but cannot be cared for at home, you may be transferred to a skilled nursing facility.

Almost all fee-for-service plans apply managed care techniques to contain costs and guarantee appropriate care; and an increasing number of managed care plans contain fee-for-service elements. While the distinctions among plans are growing increasingly blurred, the number of options available to consumers increases every day.

How Do I Get Health Coverage?

Health insurance is generally available through groups and to individuals. Premiums-the regular fees that you pay for health insurance coverage-are generally lower for group coverage. When you receive group insurance at work, the premium usually is paid through your employer.

Group health insurance is typically offered through employers, although unions, professional associations, and other organizations also offer it. As an employee benefit, group health insurance has many advantages. Much-although not all-of the cost may be borne by the employer. Premium costs are frequently lower because economies of scale in large groups make administration less expensive. With group insurance, if you enroll when you first become eligible for coverage, you generally will not be asked for evidence that you are insurable. (Enrollment usually occurs when you first take a job, and/or during a specified period each year, which is called open enrollment.) Some employers offer employees a choice of fee-for-service and managed care plans. In addition, some group plans offer dental insurance as well as medical.

Individual health insurance is a good option if you work for a small company that does not offer health insurance or if you are self-employed. Buying individual insurance allows you to tailor a plan to fit your needs from the insurance company of your choice. It requires careful shopping, because coverage and costs vary from company to company. In evaluating policies, consider what medical services are covered, what benefits are paid, and how much you must pay in deductibles and coinsurance. You may keep premiums down by accepting a higher deductible.

What Happens to My Insurance if I Lose My Job?

If you have had health coverage as an employee benefit and you leave your job, voluntarily or otherwise, one of your first concerns will be maintaining protection against the costs of health care. You can do this in one of several ways:

First, you should know that under a federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA), group health plans sponsored by employers with 20 or more employees are required to offer continued coverage for you and your dependents for 18 months after you leave your job. (Under the same law, following an employee's death or divorce, the worker's family has the right to continue coverage for up to three years.) If you wish to continue your group coverage under this option, you must notify your employer within 60 days. You must also pay the entire premium, up to 102 percent of the cost of the coverage.

If COBRA does not apply in your case-perhaps because you work for an employer with fewer than 20 employees-you may be able to convert your group policy to individual coverage. The advantage of that option is that you may not have to pass a medical exam, although an exclusion based on a preexisting condition may apply, depending on your medical history and your insurance history.

If COBRA doesn't apply and converting your group coverage is not for you, then, if you are healthy, not yet eligible for Medicare, and expect to take another job, you might consider an interim or short-term policy. These policies provide medical insurance for people with a short-term need, such as those temporarily between jobs or those making the transition between college and a job. These policies, typically written for two to six months and renewable once, cover hospitalization, intensive care, and surgical and doctors' care provided in the hospital, as well as expenses for related services performed outside the hospital, such as X-rays or laboratory tests.

Another possibility is obtaining coverage through an association. Many trade and professional associations offer their members health coverage-often HMO's-as well as basic hospital-surgical policies and disability and long-term care insurance. If you are self-employed, you may find association membership an attractive route.

Frequently Asked Questions

Q. What is the first thing I should know about buying health coverage?

A. Your aim should be to insure yourself and your family against the most serious and financially disastrous losses that can result from an illness or accident. If you are offered health benefits at work, carefully review the plans' literature to make sure the one you select fits your needs. If you purchase individual coverage, buy a policy that will cover major expenses and pay them to the highest maximum level. Save money on premiums, if necessary, by taking large deductibles and paying smaller costs out-of-pocket.

Q. Can I buy a single health insurance policy that will provide all the benefits I'm likely to need?

A. No. Although you can select a plan or buy a policy that should cover most medical, hospital, surgical, and pharmaceutical bills, no single policy covers everything. Moreover, you may want

to consider additional single-purpose policies like long-term care or disability income insurance. If you are over 65, you may want a Medicare supplement policy to fill in the gaps in Medicare coverage.

Q. I'm planning to keep working after age 65. Will I be covered by Medicare or by my company's health insurance?

A. If you work for a company with 20 or more employees, your employer must offer you (through age 69) the same health insurance coverage offered to younger employees. After you reach age 65, you may choose between Medicare and your company's plan as your primary insurer. If you elect to remain in the company plan, it will pay first-for all benefits covered under the plan-before Medicare is billed. In most instances, it is to your advantage to accept continued employer coverage.

But be sure to enroll in Medicare Part A, which covers hospitalization and can supplement your group coverage at no additional cost to you. You can save on Medicare premiums by not enrolling in Medicare Part B until you finally retire. Bear in mind, though, that delayed enrollment is more expensive and entails a waiting period for coverage.

Q. I had a serious health condition that appears to be stabilized. Can I buy individual health coverage?

A. Depending on what your condition is and when it was diagnosed and treated, you can probably buy health coverage. However, the insurer may do one of three things: Provide full protection but with a higher premium, as might be the case with a chronic disease, such as diabetes; modify the benefits to increase the deductible; exclude the specific medical problem from coverage, if it is a clearly defined condition, as long as the insurer abides by state and federal laws on exclusions.

Q. One of my medical bills was turned down by the insurance company (or health plan). Is there anything I can do?

A. Ask the insurance company why the claim was rejected. If the answer is that the service isn't covered under your policy, and you're sure that it is covered, check to see that the provider entered the correct diagnosis or procedure code on the insurance claim form. Also check that your deductible was correctly calculated.

Make sure that you didn't skip an essential step under your plan, such as pre admission certification. If everything is in order, ask the insurer to review the claim.

Comparing Plans

Whether you end up choosing a fee-for-service plan or a form of managed care, you must examine a benefits summary or an outline of coverage-the description of policy benefits,

exclusions, and provisions that makes it easier to understand a particular policy and compare it with others.

Look at this information closely. Think about your personal situation. After all, you may not mind that pregnancy is not covered, but you may want coverage for psychological counseling. Do you want coverage for your whole family or just yourself? Are you concerned with preventive care and checkups? Or would you be comfortable in a managed care setting that might restrict your choice somewhat but give you broad coverage and convenience? These are questions that only you can answer.

Here are some of the things to look at when choosing and comparing health insurance plans

Health Insurance Checklist

- Covered medical services
- Inpatient hospital services
- Outpatient surgery
- Physician visits (in the hospital)
- Office visits
- Skilled nursing care
- Medical tests and X-rays
- Prescription drugs
- Mental health care
- Drug and alcohol abuse treatment
- Home health care visits
- Rehabilitation facility care
- Physical therapy
- Speech therapy
- Hospice care
- Maternity care
- Chiropractic treatment
- Preventive care and checkups
- Well-baby care
- Dental care

Are there any medical service limits, exclusions, or preexisting conditions that will affect you or your family?

What types of utilization review, pre authorization, or certification procedures are included?

Costs:

How much is the premium?

$_____

Are there any discounts available for good health or healthy behaviors (e.g., non-smoker)?

_____

How much is the annual deductible?

$_____ per person

$_____ per family

What coinsurance or co-payments apply?

_____ % after I meet my deductible

$__ _____ co-pay or % coinsurance per office visit

$__ _____ co-pay or % coinsurance for "wellness" care (includes well-baby care, annual eye exam, physical, etc.)

$_____ % co-pay or coinsurance for inpatient hospital care

A Final Word

If you get health care coverage at work, or through a trade or professional association or a union, you are almost certainly enrolled under a group contract. Generally, the contract is between the group and the insurer, and your employer has done comparison shopping before offering the plan to the employees. Nevertheless, while some employers only offer one plan, some offer more than one. Compare plans carefully!

If you are buying individual insurance, or any form of insurance that you purchase directly, read and compare the policies you are considering before you buy one, and make sure you understand all of the provisions. Marketing or sales literature is no substitute for the actual policy. Read the policy itself before you buy.

Ask for a summary of each policy's benefits or an outline of coverage. Good agents and good insurance companies want you to know what you are buying. Don't be afraid to ask your benefits manager or insurance agent to explain anything that is unclear.