Health Insurance

Health insurance is one type of insurance you're pretty much guaranteed to use. We all need medical attention from time to time, and some of us need it quite frequently. When care is needed, you want to focus on getting better not on how you're going to come up with the money to pay your medical bills. A good health insurance plan allows you to focus on what's most important, your physical well-being.

Is there anyone who doesn't need health insurance? Not really. Even if you're young, healthy and haven't had to see a doctor in years, you never know when you might be involved in an accident or be diagnosed with a serious medical condition. While your health insurance coverage will pay for things that aren't too costly like routine doctor's visits or lab tests, the main reason to have coverage is to have protection against the potentially catastrophic expenses of serious illness or injury.

There are five main types of health insurance plans. Traditional indemnity plans are at one end of the spectrum, and health maintenance organizations (HMOs) are at the other. Preferred provider organizations (PPOs) and point-of-service plans (POS) combine features of both indemnity plans and HMOs, but are generally considered managed care plans. A new option, created by Congress in 2003, is a Health Savings Account (HSA). It combines a high-deductible health plan (HMO, PPO or Indemnity) with a tax-advantaged savings account.

It's important to understand the differences among the types of plans, and we encourage you to read through this section to familiarize yourself with each. But you should bear in mind that distinctions among plans grow increasingly blurred every day. Almost all indemnity plans (also called fee-for-service plans) apply managed care techniques to contain costs and guarantee appropriate care. Likewise, an increasing number of managed care plans contain fee-for-service elements. The most important thing to keep in mind is that there are more health insurance options available today than ever before, and that's good news for consumers.

Indemnity Plans

Indemnity plans With an indemnity plan, you can go to the doctor of your choice, and you, your doctor or your hospital submits a claim to your insurance company for reimbursement. Just note that you will only be reimbursed for "covered" medical expenses, a list of which can be found in your benefits summary. The good news is that the vast majority of procedures will be covered under an indemnity plan.

Indemnity plans pay a sizable percentage of what they consider the "usual and customary" charge for covered services in your area. The insurer generally pays 80 percent of the usual and customary costs and you pay the other 20 percent, which is known as the coinsurance. If the provider charges more than the usual and customary rates, you will have to pay both the coinsurance and the excess charges.

For example, if your insurer determines that the usual and customary fee for "X medical service" is $100, the insurer will pay $80 and you will be required to pay the remaining $20. However, if your doctor charges more than the usual and customary fee, $105 for example, you would be required to pay the additional $5, making your total expense $25. Many indemnity plans reimburse at the 80/20 level, but some reimburse at other levels, such as 70/30.

In addition to the coinsurance, most indemnity plans have deductibles. These are amounts of covered expenses you must pay before the insurer will start reimbursing you for your medical bills. These might range from $100 to $300 per year per individual, or $500, $1,000 or more per family. Generally, the higher the deductible, the lower

the premiums, which are the monthly, quarterly, or annual payments for the insurance.

Indemnity policies typically have an out-of-pocket maximum. This means that once your covered expenses reach a certain amount in a given calendar year, the insurer will pay the usual and customary fee in full. However, if your doctor charges you more than the usual and customary fee, you still may have to pay a portion of the bill.

Some policies also have lifetime limits on benefits. Most experts recommend that you look for a policy that has a lifetime limit of at least $1 million.

HMOs

With a health maintenance organization (HMO), instead of paying for each individual service that you receive, you pay a set premium. In return, HMOs offer you a range of health benefits, including preventive care.

With an HMO, you choose a primary care physician affiliated with your plan, usually a general practitioner, to coordinate your care. Generally, you must receive a referral from your primary care physician before visiting a specialist in your provider network. With rare exceptions, your HMO will require that you seek care within its network of providers doctors, hospitals, and labs – with whom your HMO has negotiated a fee schedule. Negotiating discounts from providers is one of the main ways HMOs keep healthcare costs in check. HMOs are generally the most affordable type of health insurance plan.

In addition to your premiums, most HMOs require a copayment for certain services, for example, $10 or $20 for an office visit. Some, but not all, HMOs will apply copayments to hospitalizations as well.

One of the interesting things about HMOs is that they deliver care directly to patients. Patients may go to an HMO's medical facility to see the nurses and doctors. Another common model is a network of individual practitioners. In these individual practice associations (IPAs), you will get your care in the office of a physician who may accept patients from different health plans.

PPOs

A preferred provider organization (PPO) is the form of managed care closest to an indemnity plan, which typically allows you to see any doctor, any time. A PPO negotiates discounts with doctors, hospitals and other providers, who then become part of the PPO network.

When you see a physician in the network, you typically make a copayment, a fixed fee for service, such as $25. When you see a physician out of the network, you'll still receive coverage, but your insurance will only cover only a portion of the bill, usually 70, 80 or 90 percent. The remaining amount, known as coinsurance, is your responsibility. For example, the insurer may reimburse you for 80 percent of the cost of the doctor's visit if you go to a provider outside the network. So after an office visit, you'll owe 20 percent of the total bill, plus your copayment.

In addition to the coinsurance, PPOs may also have deductibles. These are amounts of covered expenses you must pay before the insurer will start reimbursing you for your medical bills. 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 premiums, which are the monthly, quarterly, or annual payments for the insurance.

One of the things people like about PPOs is the ability to make self-referrals. That means you can see any doctor you want, including specialists inside and outside the PPO network, without a referral. Also, premiums are usually lower than indemnity plans because of the negotiated provider discounts.

POS Plans

POS plans A point-of-service plan (POS) combines elements of both a health maintenance organization (HMO) and a preferred provider organization (PPO). The plan allows you to use a primary care physician to coordinate your care, or you can self-direct your care at the "point of service."

When medical care is needed, you generally have to two or three options, depending on the particular health plan:

1. You can go through a primary care physician, in which case the services will be covered under HMO-like guidelines (i.e., usually just a copayment will be required).
2. You can access care through a PPO provider and the services will be covered under in-network PPO guidelines (i.e., a copayment is required, and you may have to pay coinsurance as well; this is the portion of the bill that is your responsibility to pay, usually 20 percent or so).
3. You can obtain services from a provider outside of the HMO and PPO networks. These services will be reimbursed according to out-of-network rules (i.e., usually a copayment and higher coinsurance charge will be required).

In addition to the coinsurance, POS plans may have deductibles. These are amounts of covered expenses you must pay before the insurer will start reimbursing you for your medical bills. Deductibles might range from $100 to $300 per year per individual, or $500 or more per family. Generally, the higher the deductible, the lower the premiums.

HSAs

A Health Savings Accounts (HSA) is a type of medical savings account that allows you to save money to pay for current and future medical expenses on a tax-free basis. In order to be eligible for a HSA, you must be covered by a high-deductible plan and not have any other health insurance. HSAs are a good option for individuals who want to protect themselves from catastrophic health-care costs, but don't anticipate many day-to-day medical costs. They also can serve as a lower-cost alternative to more traditional health plans for small businesses.

Here's how the program works. You can sign up for an HSA if your employer offers such a plan (individuals can buy these plans as well, though not in every state). An HSA must be paired with a health insurance plan that requires an annual deductible of at least $1,100 for individuals or $2,200 for families. Total out-of-pocket costs for these plans, including deductibles and copayments, can't exceed $5,600 for an individual or $11,200 for a family in 2008, though these amounts change from year to year. Despite the high deductibles, some plans still offer full coverage or require only a small copayment for preventative care, such as an annual physical or a well-child checkup.

High-deductible health plans typically have lower premiums than HMOs, PPOs or POS plans, but they come with the potential for higher out-of-pocket costs. To offset that risk, you (or your employer) can contribute up to $2,900 annually (individual) or $5,800 (family) to a tax-advantaged HSA account in 2008. Again, these figures change from year to year. These contributions reduce your taxable income (or they are tax-free if made by your employer), and money in your HSA can be used to pay any qualified medical expense now or in the future. An attractive feature of HSAs is that they can pay for expenses that your regular health plan ordinarily doesn't cover, such as eyeglasses and hearing aids. In addition, while the money is in the account, it can be invested, and the investment gains are tax-free as long as they are used for qualified medical expenses.

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