

Medical Expense Insurance

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Overview

Medical-expense insurance, often referred to as health insurance, has become a big issue for many people. The costs associated with health care have been increasing, and if you find yourself in poor health, the cost of obtaining the care you need may be alarming. Health insurance helps you protect against the risk of high health-care costs by paying for some or all of these costs if you need health care. However, because health-care costs have been increasing, health insurance premiums (which must be paid to maintain the insurance) have also been increasing.

About 90 percent of people covered by a health insurance plan receive it as a benefit from their employer. However, if you are not covered by an employer-sponsored plan, you can buy a health policy on your own. This publication identifies some of the most popular types of health-care insurance plans, and discusses their features.

Traditional Plans

Until the mid-1970s, most employees were covered under a “traditional” or “indemnity” health plan. Under a traditional plan, you are allowed to see any doctor you want. You or your doctor can then submit a claim to the insurance company to be paid back for the expense. Not all expenses are covered. For example, cosmetic surgery, diagnostic testing, x-rays, and sometimes pregnancy are excluded. Therefore, you are not reimbursed for these expenses.

Traditional plans probably will not reimburse you for the entire cost of covered expenses. Generally, the insurance will cover 80 percent of the expense, and you may be asked to pay the remaining 20 percent of costs. This cost sharing is known as co-insurance. There also may be a maximum amount an insurance company is willing to pay. Therefore, you would be responsible

for paying 100 percent of any costs over the maximum amount or what is sometimes called the “usual and customary” charges.

Due to a focus on costs by many insurance companies, these types of plans are offered less often. The most popular types of health insurance today are “managed-care plans.”

Managed-Care Plans

Managed-care plans have grown rapidly over the years. These plans include Preferred Provider Organizations (PPOs), Health Maintenance Organizations (HMOs), and Point of Service (POS) plans.

Preferred Provider Organizations (PPOs)

A PPO is the type of managed-care plan most like a traditional health plan. Under a PPO plan, you can choose to see any doctor at any time. However, you may save money on your costs if you choose to see a doctor who is part of the PPO network. The PPO contracts with a group of doctors for discounted prices. This practice is known as developing an “in-network” relationship. Therefore, if you choose to see an “in-network” doctor, the costs may be discounted. When you visit the “in-network” doctor, you will likely be asked for a co-payment, which may average \$10 to \$30. Then, the PPO pays the doctor’s remaining charges.

As with a traditional plan, the PPO will not pay 100 percent of the costs after the co-payment has been deducted. The percentage that the PPO will pay varies. However, let us assume that for a particular “in-network” doctor visit, they are willing to pay 80 percent. This means you will then be billed for the remaining 20 percent.



If you see an “out-of-network” doctor, the PPO will likely pay for some of the costs, but the percentage will be lower than if you had seen an “in-network” doctor. Therefore, using the same example as above, the PPO may pay only 60 percent of the costs, leaving you to be billed for the remaining 40 percent.

In summary, with a PPO plan, you have the option to see any doctor you want, including specialists. In addition, because the PPO has contracts with doctors, the premiums for a PPO policy are generally lower than for traditional plans.

Health Maintenance Organizations (HMOs)

Under an HMO, you will need to choose a “primary care physician.” This physician is usually a general practitioner. As with a PPO, the HMO develops relationships with a network of doctors, but unlike a PPO, the HMO generally will require you to visit only those doctors within the established network. Therefore, your “primary care physician” will need to be an “in-network” doctor.

If you require care, you will need to visit your “primary care physician” first. If you visit your primary care physician, and that physician then refers you to see another doctor or a specialist, the visit to the specialist will then be covered under your HMO policy.

A co-payment (usually \$10 to \$30) will be required for each visit. However, once the co-payment is made, there will be no additional co-insurance amount billed. The entire cost (100 percent) will then be paid by the HMO.

Another important aspect of an HMO is the emphasis on “preventive” care. Preventive care means seeing your doctor about your health before there is a problem so that the doctor may help you prevent the illness. An HMO will cover preventive care. Traditional plans and PPO plans may also cover some preventive visits, but not to the degree that HMO plans are willing to provide.

Point of Service (POS) Plan

A POS plan combines characteristics of both a PPO and an HMO. Under a POS plan, you may choose to see your “primary care physician.” If you do see your

primary care physician, the expense will be covered like an HMO plan.

However, you may also choose to see any other doctor of your choosing. If the doctor you choose to see is “in-network,” but not your primary care physician, the expenses will be covered similarly to that of an “in-network” PPO. Therefore, you may only be required to pay 20 percent of the covered expenses. However, if the doctor is “out-of-network,” you may still visit the doctor, but may be required to pay 40 percent of the covered expenses.

In-Network or Out-of-Network

When you sign up for any managed-care plan, your insurance representative or insurance agent will provide you with a list of “in-network” physicians. You may then choose your “primary care physician” if the plan is an HMO or POS plan from the provided list. Your family physician may already be part of the network, so be sure to check if you can choose your favorite family physician as your primary care physician.

Complaints about Your Managed-Care Policy

If your managed-care organization turns down a claim or refuses to authorize treatment, you should first follow the complaint procedure in the document you received from the organization. If you are still having problems contact the Managed Care Ombudsman at the Virginia Bureau of Insurance. For more information visit the Bureau of Insurance website at <http://www.scc.virginia.gov/division/boi/webpages/boiombudman.asp>.

What Is a Deductible?

Most health-care plans will require you to pay a pre-set dollar amount, known as a deductible, on your covered expenses before they will begin to pay you back for your medical costs. You may be given a choice of deductibles to choose from when you sign up for your policy. Deductibles may range from \$250 to \$1,500 per year. The higher you set your deductible, the lower the premiums will be for your coverage.

What if I Can't Get Health Insurance from My Employer?

If you cannot get employer-provided coverage, you may purchase an individual health insurance policy. Talk to a local health insurance agent, or call an insurance company and ask about the policies they have to offer. You may also be able to apply for coverage on an insurance company's website. You can get a list of companies doing business in Virginia on the Bureau of Insurance website at <http://www.scc.virginia.gov/division/boi/webpages/boiindividhealthinscoverage.htm>.

Be aware that individual coverage may be more expensive than an employer provided plan. If you can't afford health insurance, and you are over 65 years old or have certain disabilities, then you can obtain health coverage from Medicare. If you cannot afford coverage, but don't meet the Medicare requirements, you may still be able to obtain health insurance from the Medicaid program.

Virginia does not offer risk pool medical insurance for people who do not qualify for private health insurance due to pre-existing conditions and cannot qualify for Medicaid.

When shopping for a policy, it is important to consider what medical expenses you need covered. Are you more interested in preventive care for your whole family or covering against a catastrophic illness for yourself

only? Are both important to you? If possible, be sure to buy a policy that meets all of your health needs and is also within your budget. Generally, the more flexible a policy is and the lower its deductible, the more it will cost. An insurance agent may be able to help you decide on exactly what type of policy fits your needs. If you need help finding an agent, you may want to visit the Association of Health Insurance Advisors at <http://www.ahia.net/>.

Where Can I Get more Information?

Your insurance agent likely will be able to provide you with more information, but you can also find more information on health insurance at the Insurance Information Institute and Life and Health Insurance Foundation for Education. Visit their websites at <http://www.iii.org/> and <http://www.life-line.org/hi.html>. You can also download a health insurance guide from the Bureau of Insurance at <http://www.scc.virginia.gov/division/boi/webpages/boipublications.htm#healthinsurance>.

Information from The Review for CFP® Certification Examination: Insurance Planning and Risk Management, The American College, Bryn Mawr, Pennsylvania and the Life and Health Insurance Foundation for Education (<http://www.life-line.org/index.html>) and the Virginia Bureau of Insurance (<http://www.scc.virginia.gov/division/boi/webpages/boihomepage.htm>) were used to prepare this document.