

The background of the cover is a low-angle photograph of a modern building's facade, featuring a grid of dark lines against a clear blue sky. The text is centered in the upper half of the image.

SMART HEALTH BENEFITS

Your Roadmap to Health Coverage

2009 Edition
Smart Publishing

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Introduction

“The greatest wealth is health.”

-- Virgil

Healthcare is important. After food and shelter, healthcare is our basic means for survival. And while the healthcare system in the United States is often criticized for flaws in its structure and operation, there is no denying the fact that in this country the quality of healthcare ranks near the highest in the world.

With hundreds, if not thousands, of coverage options, state specific policies and regulations, confusing terminology, and multiple financial structures, healthcare coverage can be a frustrating and time consuming process.

To specifically address healthcare coverage in a straightforward manner, Smart Health Benefits is structured as follows:

- **[Healthcare Options](#)**: An in-depth discussion of COBRA, private health insurance, and a variety of other healthcare alternatives. Key highlights include descriptions, eligibility, enrollment, and costs. Objective: *Determine the best plan for you.*
- **[Financial Factor Comparison](#)**: A money-saving guide to your overall healthcare program. Objective: *Get the most value possible.*
- **[Choosing a Health Plan](#)**: A roadmap for analyzing the critical variables relevant to your health plan. Objective: *Ask the right questions.*
- **[Key Terms](#)**: Definitions and commentary for the many technical terms and annoying acronyms you will encounter when evaluating healthcare alternatives. Objective: *Know the lingo.*
- **[Time and Money Saving Tips](#)**: Additional time and money saving recommendations.

Through reading and applying the information in this book you will gain a level of knowledge and understanding regarding healthcare coverage possessed by very few people today.

To your health and your wealth!

Healthcare Options

Self Insurance

Self insurance means that you don't buy insurance and instead assume all of the financial risk yourself. If you are out of work, and have been relatively healthy over the course of the last few years, it may be tempting from a financial standpoint to self insure. In addition, the premiums associated with COBRA or individual health insurance in your state might be prohibitively expensive. The following thoughts might be going through your head:

- “I take good care of myself and rarely need to go to the doctor. And, I don't take any medicines. Why should I get health insurance?”
- “Health insurance would be great, but the \$700 per month for my COBRA is just too expensive right now.”
- “My health is fine at the moment, but the medical condition I experienced six years ago is going to cause the insurance companies to charge me a fortune in premiums. I'll take the risk of paying for my own healthcare.”



The reasoning in all three of these scenarios is certainly justifiable. You don't think that the benefits of health insurance justify what you would be paying for it. While this may indeed be true in many cases, there are a few important risks surrounding self insurance that you must consider:

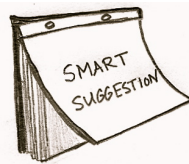
- **Probability:** Unlike nearly every other product or service that you purchase, the rationale for obtaining health insurance is not necessarily to extract value from the service that you are purchasing, but rather to protect against low probability events. No matter how stellar your current health condition, it is impossible for anyone to predict with clarity the likelihood of needing an expensive medical procedure at some point in the future.
- **Lack of preventive care:** Data indicates that uninsured individuals are more likely to experience health problems because of a lack of preventive care. When you are paying 100% of your own medical costs, there is a tendency to postpone various routine screening treatment, e.g. annual physicals, which can result in medical issues going undetected. (Note: You can argue that if you are self insured you

If you are self insured and in need of emergency medical attention, an emergency room cannot turn you away. They will treat you, but they will also charge you for any service you receive.

are more likely to take care of yourself and seek help when there are early warning signs, but in practice this is rarely the case.)

- **A gap in coverage:** Federal law in the United States considers someone who goes without health insurance for more than 63 days to have a “gap in coverage.”

Consequently, insurance regulators allow insurance companies to discriminate against people who have had their health insurance coverage lapse. First, if you sign up for a group health insurance policy with a new employer, the insurance company will have the right to exclude coverage of any pre-existing conditions for up to a year. In addition, if you have been without health coverage for more than 63 days and apply for individual coverage, insurance companies may refuse to cover your pre-existing conditions, or may choose to not cover you at all!



Smart Suggestion: Don't let your medical coverage lapse. A gap in coverage will make it harder to obtain health insurance in the future.

COBRA

Description

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a law that was passed by Congress in 1986. COBRA provides you the option to continue your current healthcare plan (i.e. your former employer's group health insurance) at the group rate that your former employer pays. COBRA enables you to continue to go to the same doctors, receive the same prescriptions, and be treated at the same hospitals you're accustomed to. The most important feature of COBRA is that if you have a pre-existing medical condition (e.g. diabetes) you do not have to worry about qualifying for a new plan. In addition, because of the tremendous variety in health coverage options, COBRA provides the ease of having access to plan that you are already familiar with, saving you the time of evaluating and enrolling in a new health insurance plan. According to various surveys, anywhere between 25% and 50% of people who are eligible for COBRA sign up under the plan. COBRA coverage generally lasts for 18 months, with extensions available in certain instances.

You will also be eligible for COBRA if you have had your work hours reduced to the point where your employer no longer contributes to your health insurance.

Eligibility and Enrollment

As long as your employer had a group health plan for 20 or more employees, you can sign up for COBRA. COBRA is also available if you are a member of an employee organization (e.g. a union), or if you work for the government. It does not matter if you quit or were laid off, or if you were part-time or full-time. Timing is important, however. To enroll in COBRA, you must elect coverage **within 60 days of your departure** from your former employer. Enrollment is a matter

Smart Suggestion: The 60 day window for COBRA works to your benefit. It enables you to search for alternative health coverage during that time period, without the risk of going without health insurance. If you don't find a better alternative, you can always sign up for COBRA.

of filling out an application form that should be provided by your former employer when you leave.

If you were previously covered under your employer's health plan and have not received information about COBRA, contact your human resources or benefits manager immediately.

One other positive feature of COBRA is that coverage is retroactive. As an example, let's say

you leave your current employer and find another job that will offer you health coverage, but the new job doesn't start for 45 days. Then, two weeks after you leave your previous job, you

require hospitalization. If you haven't yet signed up for COBRA, you can still be covered by your old insurance plan by electing to sign up for COBRA within the 60 day window. (Note: You are also covered under your employer's plan through the end of the month during which your employment ends.)

Costs

The cost of COBRA will depend on the state you live in and the type of health plan your former employer offered. While employed, your company generally will pay some portion of your health coverage cost as part of your "benefits package." Effectively, the company subsidizes a portion of the health insurance premium. The amount that a company will contribute depends

Smart Suggestion: Some companies may subsidize a portion of your COBRA costs as part of your separation agreement. If you are already out of work and paying for COBRA, contact the human resources person at your former employer to see if they have made any changes to their policies.

on the type of health coverage offered, but averages around 75% of the premium, with the remainder of the cost coming out of your paycheck. As a large organization, your employer gets a volume discount when purchasing what is referred to as group insurance. In many cases, this group insurance is cheaper than what it would cost you to purchase health insurance on your own. Under COBRA, you benefit from being able to continue on the group insurance plan at the

If you allow time to pass between the date of your departure and the time you make the decision to sign up for COBRA, you will have to pay retroactively for the time period that has elapsed.

group rate, but you are required to fund 100% of this cost, plus 2% for administrative fees. According to the Kaiser Family Foundation and the Health Research & Educational Trust, in 2008 the average annual premium for employer sponsored health plans was \$4,707 (or \$392 per month) for individuals and \$12,680 (or \$1,057 per month) for families.

Ideal Consumer

As discussed, the primary benefit of COBRA is that you have the ability to continue with your company health plan, no questions asked. And clearly, the main challenge of COBRA is the expense, which is cost prohibitive to many people, particularly if you are out of work. To decide if COBRA is right for you, use the following three categories as a framework:

- **Personal Factors:** Your age and current medical condition are most important here. COBRA is a great option for workers who are between the ages of 50 and 65 (at age 65,

you will automatically receive Medicare coverage from the government). In addition, COBRA works well if you have a pre-existing medical condition that would potentially prevent you from enrolling in other types of health coverage.

- **Coverage Factors:** Because you are already familiar with your current plan, COBRA offers the convenience of staying with this plan, and the associated doctors, hospitals, and medicines. If you are satisfied with the health plan provided by your former employer, COBRA will be a decent option for your health coverage.
- **Financial Factors:** The primary focus here is the cost of the premium, and how this compares with the premiums for other plans offering coverage that match your needs. As mentioned, the cost of COBRA varies widely by state, and the cost of family coverage significantly exceeds the cost of individual coverage. COBRA affords you the benefit of group rates, which may be the best option depending on the other two factors. (Also, see the discussion below regarding the COBRA subsidy associated with the American Recovery and Reinvestment Act.)

Other Considerations

If you worked for a small company (between 2 and 19 employees), or if your company has gone out of business, many states have enacted “mini COBRA” laws. Mini-COBRA works the same way as regular COBRA in that you have the option to continue with your group health insurance plan. Below is a list of states that have mini-COBRA and the number of months you can stay on the program:

States Offering Mini-COBRA / Months of Coverage Availability

Alabama	NA	Kentucky	18	North Dakota	36
Alaska	NA	Louisiana	12	Ohio	6
Arizona	NA	Maine	12	Oklahoma	6
Arkansas	4	Maryland	18	Oregon	6
California	36	Massachusetts	36	Pennsylvania	NA
Colorado	18	Michigan	NA	Rhode Island	18
Connecticut	36	Minnesota	36	South Carolina	6
Delaware	NA	Mississippi	12	South Dakota	36
District of Columbia	3	Missouri	9	Tennessee	15
Florida	29	Montana	NA	Texas	36
Georgia	3	Nebraska	12	Utah	6
Hawaii	3	Nevada	36	Vermont	12
Idaho	NA	New Hampshire	36	Virginia	NA
Illinois	24	New Jersey	36	Washington	NA
Indiana	NA	New Mexico	6	West Virginia	18
Iowa	9	New York	36	Wisconsin	18
Kansas	6	North Carolina	18	Wyoming	12

Note: If your state does not have mini-COBRA, you can check out all of the other options mentioned later in this section.

Stimulus Plan Update

The American Recovery and Reinvestment Act was passed in February 2009. Included in this bill is a **subsidy that offsets 65% of the cost of COBRA** insurance premiums. The subsidy will last for nine months and is not retroactive; in other words you will not be compensated for COBRA premiums already paid.

The recent government stimulus plan is providing a 65% subsidy of COBRA costs for 9 months, if you qualify. *This could save you hundreds of dollars per month!*

To be eligible for this subsidy, you must meet the following requirements:

- Been laid off between September 1, 2008 and December 31, 2009
- Have been covered under your employer’s health plan at the time you were laid off
- Earn less than \$125,000 per year (\$250,000 for joint filers)

Note: If you meet the eligibility requirements above, but you have not yet signed up for COBRA and your election period (the 60 days) has passed, this plan gives you the option to sign up for COBRA again. Contact a human resources representative at your former employer to find out more.

Individual Health Insurance

Description

Individual insurance is purchased outside of a group plan. Individual insurance offers you the opportunity to customize your health coverage to your specific needs. Many people are unaware that you can apply for health insurance on your own. Individual insurance can take many forms, as described in the [Key Terms](#). The most prevalent types of individual insurance, HMOs and PPOs, warrant further discussion.

The terms “individual health insurance” and “private health insurance” are used interchangeably. Don’t get confused by use of the word “individual” – it refers to health insurance purchased for either a single person or a family.

- **Health Maintenance Organization (HMO):** Two primary features distinguish HMOs from other managed care plans: (i) HMOs require that you seek a referral from a primary care physician prior to seeing a specialist and (ii) HMOs do not provide insurance coverage for you to see out-of-network doctors, meaning that if you need to see a doctor who is not contracted with the HMO, you will have to pay 100% of the cost. Because of these limitations, HMOs are typically the most affordable healthcare option. Despite the restriction regarding out-of-network doctors, the HMO networks are broad and will likely be large enough to have a doctor who meets your needs.
- **Preferred Provider Organization (PPO):** A PPO offers greater flexibility compared to an HMO. As a member of a PPO, you can see in-network and out-of-network doctors, and you may seek the care of a specialist without the referral of a primary care physician. In addition, you have the option of receiving treatment at out-of-network hospitals and other medical facilities. You pay for this flexibility though higher premiums, deductibles, and co-insurance.

Smart Suggestion: Go online. Many insurance brokers conduct business online, allowing you to compare multiple coverage alternatives and financial factors.

Eligibility and Enrollment

There are no strict eligibility requirements for individual health insurance. Rather, there are implicit eligibility requirements for certain medical plans. In other words, depending on which state you live in, your age, medical history, and current health condition, insurance companies will decide if they would like to provide coverage to you and at what rate. While it may sound like insurance companies have the upper hand in this transaction, it’s because they do. Fortunately, there are many competing

insurance companies in the market, which creates the opportunity for you to find good coverage at reasonable rates if you're willing to spend some time to sort through the options.

The best way to enroll in an individual health plan is to go through an insurance broker.

Insurance brokers represent several insurance companies, and are paid commission by the insurance companies they work with, so there is no fee for you. You will specifically need to seek an insurance broker who sells health insurance (as some brokers will only sell auto, property, or life insurance), and who is licensed in your state.

Smart Suggestion: After applying for individual health insurance, it will take approximately 30 days before you are covered under the health plan. Therefore, it's best to apply before your current coverage expires. Don't worry – if you have already left your job, but you haven't signed up for COBRA, you can compare your COBRA plan with an individual plan that has a waiting period. You still have the option of signing up for COBRA retroactively, just in case.

Costs

To analyze the cost of this health coverage, it will be helpful to apply the framework of Personal, Coverage, and Financial Factors:

- **Personal Factors:** All of your personal factors are key drivers in the overall cost of an individual health insurance plan. Your age, medical history, current medical condition, number of dependants, and expected usage (including prescription drugs) all contribute to the determination of your premium. In addition, your state of residence can play a factor in personal insurance. In most states, health insurance companies are allowed to price their policies to fit your medical profile. In other words, for the same coverage, a healthy 25 year old will pay significantly less than a 55 year old with a chronic medical condition. A few states, however, have what is referred to as guaranteed issue policies. Guaranteed issue requires that insurance companies conducting business within the state make health insurance available to all consumers regardless of medical history or current health condition. The impact of guaranteed issue in the above example results in the 25 year old and the 55 year old paying the same rates for health coverage.
- **Coverage Factors:** Individual plans can vary greatly in terms of coverage. You may decide that you don't plan to go to the doctor, are ok with a high deductible, and really just want protection in the case of an emergency. In this case, you will be able to find a health plan with a fairly inexpensive premium. On the other hand, if you visit the doctor frequently, have a desire for specialty treatments, and need family care, you'll need a more robust coverage plan. You can still mitigate the cost of the higher premiums

associated with such a plan by asking for a plan with comparable coverage and a higher deductible.

- **Financial Factors:** Remember that if you want to offset the costs of higher premiums associated with such a plan, you can do so by opting for a higher deductible. It is up to you to determine the best trade-off for your needs: higher deductible / lower premium OR lower deductible / higher premium. The [Financial Factor Comparison](#) portion of this chapter walks through a detailed example of how to evaluate these options.

Individual health insurance will offer the greatest value to individuals or families who are young and in good health. In addition, if you are willing to accept less medical coverage than you would receive under COBRA (e.g. an HMO instead of PPO, or temporary insurance instead of an HMO), you stand to benefit from exploring individual health insurance as a viable alternative.

Seven Other Healthcare Alternatives

Coverage from Your Spouse's Group Plan

If you are married and your spouse is employed, take a look at his or her healthcare plan. A change in your employment status is considered a qualifying event. As such, you will have the option to join your spouse's plan within 30 days of the end of your employment. Joining your spouse's plan

If you are recently married, you can also sign up for coverage under your spouse's health plan by filling out an enrollment form. Your spouse will have to request this enrollment form from his or her HR representative.

may cause the premium he or she pays to increase (particularly if your spouse was previously covered under your health plan), but the adjusted premium may still be less expensive than the premiums associated with COBRA or individual health insurance.

How to Apply: Call your spouse's healthcare provider or human resources representative.

Coverage as a Dependant Under a Parent's Plan

If you under age 30, you can explore this option. The general requirement to be considered a dependant is that you must live at the same address as your parents, or be able to prove that you are financially dependent on them. Full time students are generally qualified to receive coverage as a dependant under a parent's health plan. Eligibility ceases somewhere between ages 19 and 25, depending on the plan and the state. In some instances, eligibility can go as high as age 30. While student status was traditionally required to qualify as a dependant under a parent's plan, over 30 states have adopted policies where you can be covered as an adult dependant, regardless of whether or not you are in school.

How to Apply: Call your parent's healthcare provider. Find the number on your parent's policy.

Temporary Health Insurance

Temporary health insurance, also referred to as "short-term health insurance," provides limited coverage for a limited time period (generally intended to provide coverage for a few months to a year). Temporary health programs are best suited for people who are very healthy, have no

Temporary health insurance plans may entice you with their low premiums. Be careful to understand the coverage provided and the renewal terms.

plans for visiting a doctor, but need coverage in case of an unexpected illness or injury. These health plans are designed to protect against catastrophic events, and will not provide the same level of coverage associated with traditional health plans. The coverage levels will vary by

plan, but may include hospital care, emergency services, prescription drugs, and diagnostic testing. Most temporary health plans will also have strict prior approval guidelines, giving the insurance company greater control over the services you receive. Because of the limited coverage, temporary plans are priced much more economically than traditional health plans. The other key reason why temporary plans are less expensive than traditional plans is that insurers providing temporary insurance have the right to refuse renewal of the policy. The major risk here is that if you develop a chronic medical condition while covered by the temporary insurance, it may be viewed as a pre-existing condition when you go to apply for traditional insurance in the future.

How to apply: Same as with traditional health insurance plans – call the companies directly, call a health insurance broker, or find an online insurance broker. Check out the [Smart Health Benefits](#) website to find a list of insurance brokers.

Non-Employer Group Plans

One alternative to individual insurance is private insurance that covers a group, such as labor unions, religious organizations, alumni groups, or professional associations.

Insurance companies view individuals as more risky to insure than a group of people, because with a group the

risks are (theoretically) more diversified. As discussed, individual health insurance may often be more costly than group insurance provided by an employer. Evaluating and applying for non-employer group insurance will be a similar process to applying for individual insurance, and may provide you valuable savings relative to COBRA or individual private insurance. Be sure to understand what happens to your coverage if you decide to leave the organization.

How to apply: Inquire with an administrator at your organization.

If you belong to a church, union, or trade organization, this group might offer a group health insurance plan.

High-Risk Pools

If you have a pre-existing medical condition and your COBRA coverage has expired, a high-risk pool may be your best option. As highlighted earlier, insurance companies that provide individual private health insurance have the option to deny coverage to people with pre-existing conditions or a medical history that includes a serious illness. In these situations, COBRA is the best option, because you will be guaranteed coverage under your former employer's health plan. If your COBRA coverage has expired and you are denied coverage under an individual plan, your state may provide a solution: high-risk pools. Thirty-four states offer these plans. High-risk pools are non-profit organizations that help procure health insurance for people who are otherwise uninsurable. The cost of coverage in a high risk pool is high, but it guarantees coverage. Note: High risk pools are referred to by different names, depending on your state. For example, California calls its high risk pool the Major Risk Medical Insurance Program, while Texas uses the term Health Insurance Risk Pool.

States with High-Risk Pools / Name of Program

Alabama	Alabama Health Insurance Plan
Alaska	Alaska Comprehensive Health Insurance Association
Arkansas	Arkansas Comprehensive Health Insurance Pool
California	California Major Risk Medical Insurance Program
Colorado	Cover Colorado
Connecticut	Connecticut Health Reinsurance Association
Idaho	Idaho Individual High Risk Reinsurance Pool
Illinois	Illinois Comprehensive Health Insurance Plan
Indiana	Indiana Comprehensive Health Association
Iowa	Iowa Comprehensive Health Association
Kansas	Kansas Health Insurance Association
Kentucky	Kentucky Access
Louisiana	Louisiana Health Insurance Association
Maryland	Maryland Health Insurance Plan
Minnesota	Minnesota Comprehensive Health Association
Mississippi	Mississippi Comprehensive Health Insurance Risk Pool
Missouri	Missouri Health Insurance Pool
Montana	Montana Comprehensive Health Insurance Association
Nebraska	Nebraska Comprehensive Health Association
New Hampshire	New Hampshire Health Plan
New Mexico	New Mexico Medical Insurance Pool
North Carolina	North Carolina Health Insurance Risk Pool
North Dakota	Comprehensive Health Association Of North Dakota
Oklahoma	Oklahoma Health Insurance High Risk Pool
Oregon	Oregon Medical Insurance Pool
South Carolina	South Carolina Health Insurance Pool
South Dakota	South Dakota Risk Pool
Tennessee	Cover Tennessee / Access TN
Texas	Texas Health Insurance Risk Pool
Utah	Utah Comprehensive Health Insurance Pool
Washington	Washington State Health Insurance Pool
West Virginia	Access WV
Wisconsin	Wisconsin Health Insurance Risk Sharing Plan
Wyoming	Wyoming Health Insurance Pool

Government Sponsored Healthcare Coverage

If your income is below a specified level (determined on a state by state basis), you may be able to receive health insurance from your state government. There are multiple government healthcare programs that have been established to help people who are unable to afford health insurance. Some of the prominent government sponsored healthcare programs include the following:

- **Medicaid:** Under the program, states fund health insurance programs that are intended to provide health insurance coverage to people considered to be below the poverty line. Eligibility varies by state, but is generally based on income level and your level of assets. For example, in New York, the 2008 thresholds for an individual with one dependant were: (i) income of less than \$10,070 per year (\$840 per month), and (ii) assets of less than \$19,200. Low income alone is not sufficient for eligibility. In most states, you must have a dependant child in order to qualify. In addition to medical care, many states also provide prescription drug assistance. To learn more about the program and the application process for Medicaid, contact your local Social Services office.
- **State Children's Health Insurance Program (SCHIP).** SCHIP is a program intended to provide health insurance to the children of people whose income is too high to qualify for Medicaid, but who still need financial assistance with healthcare costs.

Free Clinics

If you are not eligible for the government sponsored health programs, and you have decided not to purchase health insurance, a free clinic can be a great option. **There are over 3,600 non-profit free clinics throughout the country,**

providing healthcare to people who are uninsured. The scope of services available at a free clinic can include medical, dental, and pharmaceutical care, but will generally not include emergency or hospital care. With a focus on general healthcare, free clinics can be a good combination with temporary health insurance. If you decide to purchase temporary health insurance to cover medical emergencies, you can receive routine coverage at a free clinic. The primary challenge with free clinics is that the wait times can be extremely long. The wait may be long, but you can't beat the price! To find a list of free clinics near you check out www.needymeds.org/free_clinics.taf.

Many medical schools will have an associated clinic where you will be able to find excellent care for no charge.

Financial Factor Comparison

What to Compare

Now that you have determined the coverage best suited to your needs, it is time to make the best financial decision. To review, here are the steps you will take when choosing a health plan:

1. Compare plan structures
2. Compare levels of coverage
3. Compare financial factors

Preferred Provider Organizations are the most popular form of health coverage in the United States. They are also the most complex from a pricing perspective. As a result, once you understand the mechanics of a PPO health plan, all other plans will be easy to grasp. HMOs, which are the second most used form of health plan, have a simpler pricing structure, and lower premiums, deductibles, and co-payments. **(Many HMOs even have deductibles and co-payments of zero!)** When comparing health plans, it may be tempting to choose the plan with the lowest premium. While it is often true that lower premiums lead to lower costs, this isn't always the case. Your expected usage (i.e. doctors visits, hospital visits, and prescription drug purchases) can have a meaningful impact on the effective overall cost of the plan.

Q: How do insurance companies determine pricing?

A: Insurance companies use complicated statistical models to calculate premiums. These models derive a price by estimating the cost of providing you healthcare.

Real World Example

Below is an example of three recently unemployed people who are searching for healthcare coverage. All three are of similar age and have similar medical histories, but they each have different levels of medical requirements (and, hence expected usage). They are each evaluating three PPO plans with the objective of finding the best coverage for the lowest cost.

- **Albert:** Last year he had a recurring in-network physical therapy treatment once a month that will continue this year. In addition, he visited ten out-of-network doctors.
- **Jane:** Last year she saw three in-network doctors over the course of the year, and expects similar usage this year.
- **Rafael:** Last year he saw an in-network doctor for his annual physical. Rafael also experienced a medical emergency that sent him to the hospital for three days.

Albert, Jane, and Rafael each have the choice of three different PPO health plans. The plans offer the same healthcare coverage, but have different financial variables.

- **Plan 1:** A low-premium plan (\$125 per month) with a high deductible (\$5,000). The co-insurance rate for out-of-network visits is set at 75%.
- **Plan 2:** A higher premium plan (\$200 per month) than Plan 1, but a much lower deductible (\$1,000).
- **Plan 3:** A high premium (\$400 per month), low deductible plan (\$500).

The table on the next page summarizes each plan.

<u>Patient Profiles</u>	<u>Albert</u>	<u>Jane</u>	<u>Rafael</u>
Visits to In-Network Doctors	12	3	1
Visits to Out-of-Network Doctors	10	0	0
Hospital Stay	0	0	1
<u>Plan Profiles</u>	<u>Plan 1</u>	<u>Plan 2</u>	<u>Plan 3</u>
Premium (paid monthly)	\$125	\$200	\$400
Co-Payment (\$ per in-network doctor visit)	\$40	\$20	\$20
Cost of Out-of-Network Doctor Visit	\$200	\$200	\$200
Cost of Hospital Stay	\$5,000	\$5,000	\$5,000
Deductible	\$5,000	\$1,000	\$500
Co-Insurance (% of out-of-network doctor visit & hospital stay that you pay)	75%	30%	20%

How to Compare Plans

- **Albert** visits doctors frequently. The overall cost of his out-of-network visits is \$2,000 (the total of his monthly physical therapy and other doctor visits). Under Plan 1, he would be responsible for the entire cost, because the plan carries a \$5,000 deductible. With a lower deductible under Plan 2, Albert would end up paying \$1,300 for these visits (\$1,000 under the deductible, and 30% of the difference). Due to the lower deductible, Plan 2 is marginally more economical than Plan 1 for Albert. Plan 3 offers the benefit of a lower deductible and lower co-insurance rate, but these two benefits do not make up for the higher premium.
- **Jane** rarely goes to the doctor. She is in good health, and is considering going without insurance. A friend reminds her that health insurance is not something you buy with the hopes of using it, but rather protection in the case that you might need it. In addition, Jane remembers that a gap in coverage of more than 63 days will make it harder for her to find health insurance in the future. Jane is focused on finding the lowest premium, and she anticipates little usage of the medical services. For her, Plan 1 is an easy decision. While Plan 1 carries a higher deductible, it affords her low-cost protection from any expensive medical costs that would potentially arise.
- **Rafael** has a similar usage profile to Jane, but unfortunately had a motorcycle accident last year that required hospitalization. He again plans to visit the doctor only once, but wants to insure himself against the chance of another accident. Rafael is aiming to keep his deductible low, and is willing to pay a higher premium in order to do so. For him, Plan 2, with its combination of a relatively low premium and low deductible offers him the best value.
- **Note:** For both Rafael and Jane, in the case of an expensive procedure such as prolonged hospitalization or surgery, Plan 3 would be more economical than Plan 1. Plan 3's lower deductible, combined with the lower co-insurance rate, offsets the higher premium in a higher usage scenario.

Effective Monthly Cost

Albert, Jane, and Rafael each determined the best plan by computing their "effective monthly cost." The real cost of your healthcare plan is your "effective monthly cost." This figure incorporates not only the premium, but also co-payments, co-insurance, and the deductible. As shown below, Rafael saves nearly \$2,000 per year with his higher premium plan.

Note: The calculations for each scenario are described in detail on the following page.

<u>Annual Cost</u>	<u>Albert</u>	<u>Jane</u>	<u>Rafael</u>
Plan 1	\$3,980	\$1,620	\$6,540
Plan 2	\$3,940	\$2,460	\$4,620
Plan 3	\$5,840	\$4,860	\$6,220
<u>Effective Monthly Cost (Annual Cost / 12)</u>	<u>Albert</u>	<u>Jane</u>	<u>Rafael</u>
Plan 1	\$332	\$135	\$545
Plan 2	\$328	\$205	\$385
Plan 3	\$487	\$405	\$518

Smart Suggestion: All of this information is relevant whether you are choosing a company health plan or seeking health coverage on an individual basis. The only difference being that an employer will likely subsidize a portion of the premiums.

Calculations for each of the scenarios above:

Albert

Plan 1	Premiums: \$125 x 12 months = \$1,500 In-Network co-pays: \$40 x 12 visits = \$480 Out-of-Network Doctor Visits: \$200 x 10 visits = \$2,000 Total: \$3,980
Plan 2	Premiums: \$200 x 12 months = \$2,400 In-Network co-pays: \$20 x 12 visits = \$240 Out-of-Network Doctor Visits: \$200 x 10 visits = \$2,000 (Albert has gone over the \$1,000 deductible, so he'll just pay \$1,000 plus 30% of the costs over \$1,000 because 30% is the co-insurance rate for Plan 2 = \$1,300) Total: \$3,940
Plan 3	Premiums: \$400 x 12 months = \$4,800 In-Network co-pays: \$20 x 12 visits = \$240 Out-of-Network Doctor Visits: \$200 x 10 visits = \$2,000 (Albert has gone over the \$500 deductible, so he'll just pay \$500 plus 20% of the costs over \$500 because 20% is the co-insurance rate for Plan 3 = \$800) Total: \$5,840

Jane

Plan 1	Premiums: \$125 x 12 months = \$1,500 In-Network co-pays: \$40 x 3 visits = \$120 Out-of-Network Doctor Visits: \$0 Total: \$1,620
Plan 2	Premiums: \$200 x 12 months = \$2,400 In-Network co-pays: \$20 x 3 visits = \$60 Out-of-Network Doctor Visits: \$0 Total: \$2,460
Plan 3	Premiums: \$400 x 12 months = \$4,800 In-Network co-pays: \$20 x 3 visits = \$60 Out-of-Network Doctor Visits: \$0 Total: \$4,860

Rafael

Plan 1	Premiums: \$125 x 12 months = \$1,500 In-Network co-pays: \$40 x 1 visit = \$40 Out-of-Network Doctor Visits: \$0 Hospital Stay: \$5,000 Total: \$6,540
Plan 2	Premiums: \$200 x 12 months = \$2,400 In-Network co-pays: \$20 x 1 visit = \$20 Out-of-Network Doctor Visits: \$0 Hospital Stay: \$5,000 (Rafael has gone over the \$1,000 deductible, so he'll just pay \$1,000 plus 30% of the costs over \$1,000 because 30% is the co-insurance rate for Plan 2 = \$2,200) Total: \$4,620
Plan 3	Premiums: \$400 x 12 months = \$4,800 In-Network co-pays: \$20 x 1 visit = \$20 Out-of-Network Doctor Visits: \$0 Hospital Stay: \$5,000 (Rafael has gone over the \$500 deductible, so he'll just pay \$500 plus 20% of the costs over \$500 because 20% is the co-insurance rate for Plan 3 = \$1,400) Total: \$6,220

Choosing a Health Plan

Each of your healthcare options has a variety of issues, each of which present choices. Using three key categories serves as a helpful framework for evaluating these choices:

The Three Categories

CATEGORY	VARIABLES
<p>Personal Factors</p>	<ul style="list-style-type: none"> ▪ medical history ▪ age ▪ current medical condition ▪ individual or family ▪ expected usage ▪ medicine
<p>Healthcare Coverage Factors</p>	<ul style="list-style-type: none"> ▪ doctors in the network ▪ hospitals in the network ▪ proximity to doctors and hospitals ▪ hospital stays ▪ emergency room coverage ▪ prior approvals ▪ maximum doctor visits ▪ preventive care ▪ prescription drug coverage ▪ mental health coverage ▪ vision coverage ▪ dental coverage
<p>Financial Factors</p>	<ul style="list-style-type: none"> ▪ premium (monthly) ▪ co-payments (\$ per visit) ▪ deductible (annual) ▪ co-insurance (% per visit) ▪ out of pocket maximum (annual) ▪ lifetime limit

Each category warrants discussion, and each variable can have an impact on the health plan that is right for you. Carefully consider each of the questions asked. Note that the variables considered are relevant to all health plans, but the specific features discussed pertain primarily to managed care plans.

Personal Factors

PERSONAL FACTOR: Medical History

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ What medical conditions have you experienced in the past? ▪ Does the new plan cover the expenses associated with these medical conditions? 	<ul style="list-style-type: none"> ▪ Your medical history provides an indication of the type of medical coverage you may require. ▪ Insurance companies will ask about your medical history. You must tell them the truth, but remember there is no need to expand upon your answers.

PERSONAL FACTOR: Age

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ How old are you? 	<ul style="list-style-type: none"> ▪ Health insurance is priced according to your age (unless you live in a <i>guaranteed issue</i> state). All else equal, the younger you are, the less you pay. ▪ Young people have an opportunity to find individual health insurance at competitive rates. ▪ If you are between the ages of 50 and 65, COBRA is often the best option. ▪ Note: At age 65, you will qualify for Medicare, the government-sponsored health insurance program.

PERSONAL FACTOR: Current Medical Condition

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ How is your current health? ▪ Do you anticipate the need for a particular type of healthcare over the next year or two? ▪ Do you have any chronic medical conditions that might preclude you from coverage? 	<ul style="list-style-type: none"> ▪ Similar to your medical history, insurance companies will attempt to gauge the risk of providing you with insurance based on your current level of health. ▪ Recall that insurance companies are looking to make a profit. Their goal is to provide coverage to people who are not going to need to use it very much.

PERSONAL FACTOR: Individual or Family

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Is this plan just for you, or do you need coverage for a spouse and children? 	<ul style="list-style-type: none"> ▪ If you will be insuring your family in addition to yourself, think about the medical history, age, and current medical condition of each of your family members.

PERSONAL FACTOR: Expected Usage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ How often do you expect to visit the doctor? ▪ Will you need to see specialists? 	<ul style="list-style-type: none"> ▪ Think about the frequency of your doctor visits over the last year. This should provide some indication as to how much you might use the plan. ▪ Recall that you are buying insurance to protect against “catastrophic” events. Even if you rarely expect to use the services provided by your healthcare plan, it is there to protect you (financially) from the unexpected costs.

PERSONAL FACTOR: Medicine

Questions to Answer

- What, if any, prescription drugs do you currently take?
- Are these available in generic form?



What You Need to Know

- Make sure that the drugs that you and your family need are covered by the plans you are evaluating.
- Sometimes insurance for medicine is sold separately as “prescription drug coverage.”
- You will save money with a health plan that covers only generic drugs.

Coverage Factors


COVERAGE FACTOR: Doctors in the Network

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Are the doctors you visit regularly part of the health plan? 	<ul style="list-style-type: none"> ▪ The health insurance company should be able to provide you with a list of all of the providers in the network. ▪ Call your current physicians and ask which healthcare networks they belong to. Most doctors belong to multiple plans.

COVERAGE FACTOR: Hospitals in the Network

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ What hospitals can you go to? 	<ul style="list-style-type: none"> ▪ The same thing that applies to doctors applies to hospitals. ▪ Check to see if the hospitals near you are approved by the health plan you are considering. ▪ You can of course receive treatment at any hospital you choose, but an out of network hospital will be expensive.

COVERAGE FACTOR: Proximity to Doctors and Hospitals

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Are the doctors and hospitals in the network geographically desirable? ▪ What happens to your coverage if you travel out of state? 	<ul style="list-style-type: none"> ▪ It's great if a health plan has a lot of doctors and hospitals in its network, but if they aren't within driving distance, it doesn't matter much. ▪ Out of state coverage is particularly important if you plan to be in other parts of the country. Emergency services are nearly always covered when out of state, but many health plans do not have nationwide coverage for non-emergency care. ▪ If you travel internationally and experience a medical emergency, you can submit a claim and will most often have the ability to receive some coverage from your insurance company. Also, many countries (particularly in Western Europe) have government provided healthcare systems. If you are in need of medical care while visiting one of these countries, you likely will not be charged.

COVERAGE FACTOR: Hospital Stays

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ How does the plan treat inpatient vs. outpatient procedures? ▪ Is there are limitation on the maximum number of days you can stay in the hospital? 	<ul style="list-style-type: none"> ▪ Insurance companies want to encourage outpatient care (because it is cheaper than having you stay overnight at a hospital). ▪ Pay attention to the plan’s coverage of inpatient care; this is where hospital costs can really add up. ▪ Also note the additional options associated with hospital care. For example, private vs. shared rooms, meals, 24 hour nursing care.

COVERAGE FACTOR: Emergency Room Coverage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Who pays for the ambulance, paramedics, and emergency room doctor? 	<ul style="list-style-type: none"> ▪ The ambulance, paramedics, and emergency room doctor may all bill separately! ▪ An ambulance trip alone can cost upwards of \$500. ▪ While emergency rooms are generally incorporated into hospitals, they are sometimes operated independently. ▪ See if there are any freestanding emergency medical care facilities covered under the health plan.

COVERAGE FACTOR: Prior Approvals

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> What procedures require prior approval from the insurance company? 	<ul style="list-style-type: none"> Prior approval is another way for managed care companies to limit costs. Effectively they are signing off before you undergo an expensive treatment (e.g. an MRI). The managed care company will often request an explanation from your doctor. If you are not approved for a procedure that you need, you can petition the managed care company. You will need to demonstrate why the treatment is required. Having a doctor on your side can help make the case.

COVERAGE FACTOR: Maximum Doctor Visits

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> Does the plan limit the number of doctor visits per year? If so, what is the cap? 	<ul style="list-style-type: none"> Most plans will not limit the number of doctor visits, but some will. If you are insuring a family, or will have the need for recurring visits (e.g. immunizations or physical therapy), make sure that the cap is well above your expected usage.

COVERAGE FACTOR: Preventive Care

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> Does the plan cover preventive care such as immunizations, annual physicals, and screenings (e.g. pap smears or prostate exams)? 	<ul style="list-style-type: none"> Most managed care plans encourage preventive care. Remember, they want you to stay healthy, so that you'll have less need for medical care, and will cost them less money. Some plans offer discounts for wellness, for example discounts for gym memberships.

COVERAGE FACTOR: Prescription Drug Coverage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ How does the plan treat generic drugs vs. branded drugs? ▪ Is there a limitation on how long this drug coverage will last? ▪ Is there a difference in cost for purchasing from pharmacies vs. mail order services? 	<ul style="list-style-type: none"> ▪ When you are prescribed medicine, ask your doctor if a generic version of the drug is available. Generic drugs are chemically identical to the branded drugs, and are much less expensive. ▪ If the doctor is unaware of an equivalent generic drug, ask your pharmacist. ▪ Some health plans will add a third category, referred to as “formulary drugs.” The insurance companies partner with pharmaceutical companies to purchase these drugs at a discount. Where these relationships exist, the drugs are “approved” by the plan (similar to a doctor who is a member of the network), and will save you money.

COVERAGE FACTOR: Mental Health Coverage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Does the plan cover treatment for mental health and substance abuse? 	<ul style="list-style-type: none"> ▪ If you or anyone in your family could be at risk for substance abuse or depression, for example, you’ll want to take a look at the type of mental health coverage that the plan provides. ▪ Certain plans are willing to spend more on treatments for these conditions.

COVERAGE FACTOR: Vision Coverage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Does the plan include coverage of vision care? 	<ul style="list-style-type: none"> ▪ Most health plans do not cover routine vision health, such as the cost of eye exams or glasses. ▪ Insurance to cover vision care can be purchased separately. ▪ Some plans cover corrective laser surgery, but most consider it to be an elective procedure, and therefore will not offer coverage for this procedure.

COVERAGE FACTOR: Dental Coverage

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Does the plan include dental treatment? 	<ul style="list-style-type: none"> ▪ Similar to vision coverage, dental insurance is often sold separately. ▪ For most individuals it is cheaper to pay for dental care out of pocket than to pay the insurance premiums. ▪ Insurance coverage for dental care may make sense if you have a large family that has regular dental visits.

COVERAGE FACTOR: Other Coverage Variables

<i>Questions</i>	<i>Commentary</i>
<ul style="list-style-type: none"> ▪ Does your plan cover any of these other forms of medical treatment? <ul style="list-style-type: none"> ○ home healthcare ○ medical equipment ○ family planning ○ pregnancy and maternity care ○ rehabilitation services (e.g. physical therapy) ○ chiropractic services ○ acupuncture 	<ul style="list-style-type: none"> ▪ While you may not have used any of these forms of treatment in the past, having access to them under your healthcare plan can be extremely helpful.

Financial Factors

FINANCIAL FACTOR: Premium

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ What is the plan’s premium? ▪ How does this amount impact your financial situation? ▪ How would the premium change if you looked at a different type of plan (i.e. HMO vs. PPO)? ▪ How would the premium change if you looked at different types of coverage (e.g. a smaller network)? ▪ How would the premium change if you looked at different financial terms (e.g. a higher deductible or higher co-insurance percentage)? 	<ul style="list-style-type: none"> ▪ The premium is the monthly price you pay to receive insurance coverage under the health plan. ▪ Premiums can range from under \$100 per month to thousands of dollars per month. ▪ Nearly all other variables discussed impact the amount of your premium. ▪ Premiums are the most readily apparent portion of healthcare costs. But don’t be fooled; remember that the premium is only one part of a much larger equation. ▪ A higher premium may actually represent a better value. For example, assuming comparable coverage under two plans, a higher premium may compensate for lower co-payments or a higher deductible. ▪ Premiums are discussed in detail in the Financial Factor Comparison section.

FINANCIAL FACTOR: Co-Payments

Questions	Commentary
<ul style="list-style-type: none"> ▪ What is the co-payment? ▪ Are there different levels of co-payments for different types of procedures? 	<ul style="list-style-type: none"> ▪ Co-payments represent the dollar amount you will be asked to pay when receiving medical care. ▪ Ranging from \$10 - \$50 per visit, co-payments can add up if you see doctors regularly. This is especially true for people who have families with young children. ▪ Co-payments also apply to prescription drugs, and will vary based on the type of drug (i.e. branded vs. generic) and where they are purchased. ▪ <i>A higher co-payment amount will result in a lower premium.</i>

FINANCIAL FACTOR: Deductible

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ What is the deductible amount? ▪ What payments count toward the deductible? ▪ How much would your premiums go down if you accept a higher deductible? ▪ How much would your premiums go up if you accept a lower deductible? 	<ul style="list-style-type: none"> ▪ The deductible represents the cost that you will incur before the insurance company begins paying for coverage. As an example, if you have a \$500 deductible and are undergoing surgery that will cost \$10,000, when the bill for the surgery arrives, you will pay \$500, and your insurance company will pay \$9,500. ▪ Deductibles can range from \$500 to multiple thousands of dollars. ▪ The amount of co-insurance that you pay when seeing out-of-network doctors may count towards your deductible. ▪ <i>A higher deductible will result in a lower premium.</i> ▪ When evaluating a health insurance plan, changing the level of the deductible will have the greatest impact on your premium.

FINANCIAL FACTOR: Co-Insurance

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ What is the co-insurance percentage? ▪ Where do co-insurance payments apply? I.e. Does co-insurance only pertain to costs associated with out of network doctors, or are other procedures like hospitalization subject to co-insurance as well? 	<ul style="list-style-type: none"> ▪ Co-insurance is stated as a percentage. For example, if your co-insurance is 30%, you will pay 30% of the medical bill, and your insurance company will be responsible for remaining 70%. ▪ Many managed care plans will have both co-payments and co-insurance, with the co-insurance applying to out-of-network medical procedures, hospital services, and emergency care. ▪ Co-insurance can also apply to certain prescription drug coverage. ▪ <i>A higher co-insurance percentage will result in a lower premium.</i>

FINANCIAL FACTOR: Out of Pocket Maximum

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Is there an out of pocket maximum, or limit on how much you would pay in a given year? ▪ If so, what is the limit? 	<ul style="list-style-type: none"> ▪ An out of pocket maximum is the upper limit of what you would be expected to pay in any one year. This amount includes the deductible. ▪ Example: Let's say you have a deductible of \$1,000 and an out-of-pocket maximum of \$3,000. After you have paid \$3,000 in costs for the year, the insurance company will cover 100% of the costs above this amount. ▪ An out of pocket maximum is a great feature. It limits your total financial exposure in a given year. ▪ <i>A higher out of pocket maximum will result in a lower premium.</i>

FINANCIAL FACTOR: Lifetime Limit

<i>Questions to Answer</i>	<i>What You Need to Know</i>
<ul style="list-style-type: none"> ▪ Does the plan have a lifetime limit? If so, what is the limit? 	<ul style="list-style-type: none"> ▪ A lifetime limit is the maximum amount that the insurance company will pay over the course of your life. ▪ The lifetime limit is relevant when considering your potential chronic conditions, long-term medications, prolonged hospitalization, or other situations that require ongoing medical costs. ▪ Some plans are unlimited. In other words, they do not have a lifetime limit. ▪ You may be able to achieve a lower premium by accepting a lower lifetime limit. ▪ <i>A lower lifetime limit will result in a lower premium.</i>

Applying the framework of Personal, Coverage, and Financial factors will optimize and accelerate your healthcare decision process.

Use the Medical Plan Comparison Worksheet on the following page to perform a side-by-side comparison of three medical plans and isolate the topics that are most important to you.

Medical Plan Comparison Worksheet

Plan 1

Plan 2

Plan 3

Coverage Factors

What is the plan structure (e.g. HMO, PPO, POS)?			
Do my doctors belong to the network? (Yes / No)			
Are the hospitals near me part of the network? (Yes / No)			
Cost for an outpatient hospital visit? (\$ or %)			
Cost for a 3-day hospital stay? (\$ or %)			
Cost for emergency room services? (\$ or %)			
Cost for emergency room doctor visits? (\$ or %)			
Cost for ambulance services? (\$ or %)			
What procedures require prior approval? (list)			
What will I pay for generic drugs? (\$)			
What will I pay for branded drugs? (\$)			
What will I pay for formulary (approved) drugs? (\$)			
Cost of drugs purchased through pharmacy? (\$)			
Cost of drugs purchased through mail order? (\$)			
What is the maximum number of annual doctor visits? (#)			
Does the plan cover preventive care? (Yes / No)			
Any discounts for preventive care (e.g. gym membership)? (Yes / No)			
Does the plan cover mental health services? (Yes / No)			
Does the plan cover vision? (Yes / No)			
Does the plan cover dental? (Yes / No)			
Other areas of coverage (e.g. home healthcare, medical equipment, family planning, pregnancy and maternity care, rehabilitation services, chiropractic services, acupuncture) (list)			

Financial Factors

What is the monthly premium?			
What is the deductible? (\$)			
What is the co-payment for in-network doctor's visits? (\$)			
What payments apply to the deductible (e.g. out-of-network doctor's visits, emergency car, outpatient surgery)? (list)			
What is the co-insurance for out-of-network doctor's visits? (%)			
What is the out-of-pocket maximum for the year? (\$)			
What is the lifetime limit that the insurance company will pay? (\$)			

Key Terms

When choosing a healthcare plan, it's helpful to speak the language of healthcare coverage. The folks who run the healthcare system enjoy making things confusing. This way, they keep the power. Now it's your chance to take control!

Coverage Alternatives

- **COBRA:** It's not a snake, but its high cost can make it feel like one! COBRA stands for the Consolidated Omnibus Budget Reconciliation Act. It's a policy that gives you the option to continue your current healthcare plan (i.e. the health insurance plan provided by your former employer). Here's the catch: You now pay for 100% of the cost! You have 60 days after your departure to "elect" COBRA coverage. COBRA coverage lasts for up to 18 months. (See the [Healthcare Options](#) chapter for more detail on COBRA.)
- **Fee for Service:** A health insurance plan where you pay a fixed percentage of the cost for any service received. As an example, you pay 25% of the cost for any doctor's visit, hospital stay, or prescription, and the insurance company pays the remaining 75%. Fee for service health insurance plans have largely been replaced by *managed care* plans in the United States. Fee for service health insurance is also referred to as *indemnity health insurance plans*.
- **High-Risk Pools:** Health insurance provided by states that cover individuals who have been denied health insurance because of a *pre-existing medical condition*. High-risk pools generally take the form of an *HMO* or *PPO*, and premiums are capped at a certain level. Over 30 states offer high risk pools. High-risk pools can be tricky, because many states offering these programs use different names to describe them.
- **Managed Care:** Managed care plans (also referred to as managed care "organizations," managed care "insurance," or managed care "companies") include *Health Maintenance Organizations (HMOs)*, *Preferred Provider Organizations (PPOs)*, and *Point of Service (POS)* plans. Managed care plans employ the concept of a *network*, which refers to a group of doctors, hospitals, and other healthcare providers. When insured under a managed care plan you'll be referred to as a "member" of the plan. As a member, you are entitled to seek medical service with doctors and facilities that are part of the managed care *network*. If you require care outside of the *network*, you will pay a

premium for this service. In addition, managed care companies may require *prior approval* for certain types of medical care (e.g. seeing a specialist or undergoing expensive procedures). In doing so, these groups are able to “manage” the care that patients receive, thereby reducing overall costs. Collectively, managed care plans currently account for the vast majority of private health insurance in the United States.

- **Health Maintenance Organization (HMO):** A type of *managed care* insurance plan. Services are provided by doctors who are employed by, or “contracted with,” the HMO. In contrast with other managed care plans, HMOs require that you seek a referral from a *primary care physician* prior to seeing a *specialist*. In addition, HMOs do not provide insurance coverage for you to see *out-of-network* doctors, meaning that if you need to see a doctor who is not contracted with the HMO, you will have to pay 100% of the cost. The HMO network of doctors will likely be large enough to have a doctor that meets your needs. Because of these limitations, HMOs are typically the most affordable healthcare option.
- **Point of Service (POS):** A type of *managed care* insurance plan that combines some the features of an *HMO* and a *PPO*. A point of service plan enables you to see *out-of-network* doctors and receive some insurance coverage. Think of a point of service plan as having more flexibility than an *HMO*, but less than a *PPO*.
- **Preferred Provider Organization (PPO):** A type of *managed care* insurance plan offering the most flexibility. As a member of a PPO, you can see *in-network* and *out-of-network* doctors, and may seek the care of a *specialist* without the referral of a *primary care physician*.
- **Self Insurance:** Going without health insurance. Technically, self insurance refers to setting aside an appropriate amount of money to pay for both expected and unexpected medical care.
- **Temporary Health Insurance:** Short-term health insurance plans that last anywhere from one month to twelve months in duration. Temporary health insurance plans offer limited healthcare coverage relative to traditional health insurance plans, and the insurance companies that provide these policies have the option to prevent you from renewing the plan at expiration. Because of their limited scope and unfavorable renewal provisions, temporary plans are typically priced at a discount compared to traditional healthcare plans. Temporary health insurance plans are also referred to as “short-term policies.”

Financial Terms

- **Claim:** A request for payment from an insurance company or managed care plan. A claim may be filed either by you as the patient or by your healthcare provider (e.g. doctor's office or hospital) after service has been provided.
- **Co-insurance:** The portion of a medical bill that you have to pay (i.e. the amount not covered by the insurance company). Co-insurance is stated as a percentage. For example, if your co-insurance is 30%, you will pay 30% of the medical bill, and your insurance company will be responsible for remaining 70%. With a *fee for service* plan co-insurance works as described in the previous example for all healthcare costs. In *managed care* plans, co-insurance generally refers to the percentage that you are responsible for when visiting *out-of-network* doctors or when receiving specialized medical procedures.
- **Co-payment:** The fee you pay when visiting a doctor. Generally ranges from \$10 to \$50. Depending on your plan, co-payments may apply toward your *deductible*. Co-payment is also referred to as "co-pay."
- **Deductible:** Costs you will have to cover on your own before your insurance begins paying. For example, if you have a \$500 deductible and are undergoing surgery that will cost \$10,000, when the bill for the surgery arrives, you will pay \$500, and your insurance company will pay \$9,500. The deductible will reset annually. Depending on your insurance plan, the deductible will only apply to certain types of procedures.
- **Lifetime Limit:** The maximum amount that the insurance company will pay over the course of your life. The lifetime limit is relevant when considering potential chronic conditions, long-term medications, prolonged hospitalization, or other situations that require ongoing medical costs.
- **Out of Pocket Maximum:** The maximum amount that the health plan will require you to contribute during any one year. After you have met the *deductible* amount, your *co-*

Q. Why don't health insurance companies cover 100% of your healthcare costs?

A. With co-insurance, co-payments, and deductibles, the insurers attempt to prevent "moral hazard". By requiring that people share in the cost of their medical care, the insurance companies prevent people from abusing the system. Were this cost sharing not in place, some people would visit doctors and have procedures done unnecessarily, raising the overall cost to everyone else who belongs to that insurance program.

payments will count toward the out of pocket maximum. As an example, if your out of pocket maximum is \$3,000, after you have paid this much in a given year, the insurance company will cover 100% of the costs beyond \$3,000. In practice, some insurance plans structure out of pocket maximums for specific services (e.g. hospital stays or surgeries).

- **Premium:** The monthly price you pay for your healthcare coverage. **Nearly all other variables discussed impact the amount of your premium.** Think of your premium as the answer that you get when solving a long, complicated math problem.

Other Terms

- **Allowable Amount:** The dollar amount that a *managed care* company assigns to a particular medical service. Doctors that are part of a *managed care* organization agree to accept this amount, even if the doctor would normally charge a higher rate. For example, you visit a dermatologist. You are told that the checkup is \$150, but your *managed care* insurance

Q. Why would doctors accept payment of the allowable amount if it is lower than their full price?

A: As a member of a *managed care network*, the doctors benefit by receiving access to a much larger pool of potential patients than they would have access to on their own.

company says the *allowable amount* is \$125. As a member of the *managed care network*, the doctor accepts \$125 less your *co-payment* from the *managed care* company. The doctor does not collect the \$25 difference. *Managed care* organizations determine the *allowable amount* for various levels of medical care based on what they deem to be reasonable, what comparable care would cost in the marketplace, and how much doctors are willing to accept.

- **Benefits:** Services and payments you receive as part of a health plan.
- **Explanation of Benefits:** A document prepared by your insurance company indicating the cost of service, benefits received (i.e. the amount the insurance company will pay), and your *co-insurance* or *co-payment* amount. For example, let's say you visit a doctor who charges \$100 for the visit. You submit your insurance information and make a \$20 *co-payment* upon leaving the doctor's office. About 30 days later, you will receive an *explanation of benefits* from the insurance company informing you of the total amount billed, the *allowable amount*, your *co-payment*, and an additional payment required. The Explanation of Benefits is often abbreviated as "EOB".

Generic drugs account for 63% of prescriptions in the United States.

- **Generic Drug:** As described by the Food and Drug Administration, a generic drug is identical in dosage, form, safety, strength, route of administration, quality, performance characteristics, and intended use to its brand name equivalent prescription drug.
- **Group Plan:** A health insurance plan that provides insurance to a group of people (e.g. employees of a company or members of an organization). Buying insurance as part of a group is theoretically cheaper than buying insurance individually. Insurance companies are able to charge lower rates to groups because they view the group as diversifying risk. Note: COBRA is a form of group insurance.
- **Guaranteed Issue:** State provisions where health insurance companies operating in the state are required to provide health insurance to all applicants, regardless of medical history, age, or current medical condition. Insurance companies operating in the state

The states that have guaranteed issue policies are Maine, Massachusetts, New Jersey, New York, and Vermont.

must charge the same rates to all members of a given health insurance plan without differentiating based on the personal factors mentioned. As a result of these requirements, *guaranteed issue* policies benefit older people with medical conditions at a cost to younger people without any health issues.

- **HIPAA:** The Health Insurance Portability and Accountability Act is a law that was passed in 1996 to protect your right to qualify for health insurance in situations where you have experienced a change in employer, employment status, or relationship (e.g. divorce). HIPAA is important because under the law health insurance companies are required to renew health plans.

- **Insurance Broker:** An independent company that represents a variety of insurance companies. Insurance brokers can provide you multiple health insurance alternatives for comparison purposes.

Insurance “brokers” differ from insurance “agents”. Brokers are independent and represent multiple insurance companies, while agents work on behalf of an individual insurance company.

- **Network:** A group of doctors, hospitals, and other healthcare providers who belong to a managed care organization. A healthcare provider who is part of the managed care organization is considered to be “in-network,” while a provider who does not contract with the managed care organization is described as “out-of-network.” Doctors may belong to more than one managed care organization. When applying for a health plan, you will have access to a list of all of the providers in the network.

- **Open Enrollment:** A 30 day window occurring once per year, during which you can join a managed care plan, regardless of your medical history. Not all states require that insurance companies have an *open enrollment period*. The benefit of an *open enrollment period* is that you will be able to qualify for coverage even if you have a *pre-existing condition*. States that do not require insurance companies to offer open enrollment will likely have a *high-risk pool*, which provides another alternative for people who would otherwise not qualify for health insurance.

Does the doctor “accept my insurance”? When people talk about whether or not a doctor accepts their insurance they are asking if the doctor is “in-network”.

- **Policy:** The document from your insurance company that provides the details of your coverage, fee schedules, and contact information. Insurance companies also refer to a policy as “evidence of coverage.”
- **Pre-Existing Condition:** A medical condition that may limit the health coverage that an insurance company is willing to provide. For example, if you have a chronic medical condition, a health insurance company may qualify this as a *pre-existing condition*, meaning they may do the following:
 - refuse to provide you any health coverage
 - provide you health coverage, but exclude treatment of this condition
 - provide you full coverage

For an insurance company or managed care organization to discriminate based on your medical history or current medical condition may not sound fair, but this is the way the system is structured throughout most of the United States.

Exceptions exist in states that have *guaranteed issue* laws and *open enrollment* periods. In addition, *high-risk pools* are another option for people who experience difficulty finding health insurance because of a pre-existing medical condition.



- **Preferred Provider:** A physician, hospital, or other medical provider who is a member of a *managed care network*. Visits to these “in-network” medical providers are covered by your *managed care* plan, meaning that you will generally only pay the *co-payment* portion of the medical bill.
- **Primary Care Physician:** A doctor who provides general overall care (e.g. annual physicals), and is responsible for providing recommendations to *specialist* doctors. In an

HMO, your selection of a primary care physician is very important, as he or she is the gatekeeper, determining which specialists you are able to see.

- **Prior Approval:** Requirement that doctors receive permission from the insurance company before going forward with a certain procedure (typically expensive procedures). Such procedures include imaging services (e.g. MRIs), clinical trials, and certain types of surgeries. Prescriptions (e.g. brand name pharmaceuticals) may also be subject to prior approval. *Managed care* insurance companies incorporate prior approval procedures to help manage costs. Prior approval is also referred to as “prior authorization.”
- **Qualifying Event:** An occurrence that would cause a change in your eligibility for health coverage. Qualifying events include the following: change in employment status (e.g. a layoff or a reduction in work hours), change in marital status, or change in number of dependants (e.g. a new child). A qualifying event enables you to make changes to your health plan within a given timeframe (usually 30 days). This is particularly relevant as it pertains to joining your spouse’s health plan (discussed in the [Healthcare Options](#) section).
- **Specialist:** A doctor who specializes in a certain field of medicine. Many insurance plans allow you to see specialists directly, while *HMOs* require a referral from your *primary care physician* prior to seeing a specialist.

Time and Money Saving Tips

Saving Time

- Invest the time to read your policy.
- Stay inquisitive. If you are unable to get answers to the factors that are most important to you, keep asking questions.
- Create a file to keep track of your medical records.

Saving Money

- Premiums are the most obvious cost of your healthcare, but they are not the only cost. Think about the levels of coverage, deductible, co-payment, and co-insurance as they factor into your effective monthly cost.
- Examine your medical bills. Medical billing can be a somewhat messy process, with multiple parties having input on the bill. Statistics indicate that over 80% of hospital bills contain mistakes. Finding these mistakes can be like finding money.
- Be wary of discount health cards. These are not insurance or healthcare coverage. Instead, they offer discounts with doctors and pharmacies that honor the card.
- Carefully consider your expected dental and vision care needs. Most health insurance plans will not cover routine or preventive dental and vision care, but may cover medical emergencies involving your teeth or eyes. The premiums associated with dental and vision care coverage may appear low, but these costs can add up over the course of a year. Compare the total premiums (and other financial factors) to what you would pay out of pocket for your anticipated level of care.
- Reach out to non-profit health organizations. These groups (e.g. American Cancer Society and American Diabetes Association) have tremendous resources to help. Check out the “Membership Directory” at www.nationalhealthcouncil.org for a good list.
- For non-emergency procedures, make an appointment with a doctor instead of seeking treatment in the emergency room. Emergency rooms are expensive, and insurance companies will try to pass on 100% of this cost to you if you are seeking non-emergency care.

- When going for a procedure at a hospital, verify that the doctor you will be seeing is also part of the network. Even if the hospital is part of the network, seeing an out-of-network doctor at an in-network hospital could result in you footing a larger portion of the bill.

Smart Summary and Checklist



You now have knowledge of the healthcare coverage options available to you, a framework to evaluate your alternatives, and the confidence to decide on the health plan that is right for you.

Remember, there is not a “perfect healthcare plan” out there, but investing the time to understand your options now will save you hours of time when you put your health plan to use.

Use the [Medical Plan Comparison Worksheet](#) provided earlier, combined with the checklist below, as your roadmaps for securing healthcare coverage for yourself and your family.

Smart Health Benefits Checklist



Choosing a Health Plan

Determine Personal Factors	
Understand Coverage Factors (Refer to Medical Plan Comparison Worksheet)	

Evaluate Healthcare Options

Self Insurance	
COBRA	
Individual Health Insurance	
Coverage Under Spouse's Plan	
Coverage Under Parent's Plan	
Temporary Health Insurance	
Non-Employer Group Plans	
Government Sponsored Health Plans	
Free Clinics	

Compare Financial Factors

Estimate Usage Based on Medical History	
Think About Deductible Affordability	
Calculate Plan Costs Under Various Scenarios	

Concluding Remarks

“An investment in knowledge always pays the best interest.”

-- Benjamin Franklin

Thank you for taking the time to read Smart Health Benefits. By investing in this knowledge, and absorbing the information provided, you have gained the resources to address your healthcare needs with clarity.

By following the steps provided, you will know *what* questions to ask, *where* to look for the answers, and *how* to make the smart decisions that will produce results. Your next opportunity comes in applying the knowledge you now possess. Take action by making informed decisions to achieve the results you desire.

To your health and your wealth!