

HEALTH INSURANCE SIMPLIFIED-A short tutorial

There are five basic types of health insurance. There are also a few variations of the basics, however, if you understand the five, the variations will be easily understood.

First, let's start with the names of the five types.

HMO-Health Maintenance Organization

Open Access HMO- Health Maintenance Organization with no referral requirement to see a specialist

POS-Point of Service

Open Access POS – Point of Service with no referral requirement to see a specialist

PPO-Preferred Provider Organization

Indemnity-A health plan with no preferred physician/hospital network

HSA-Health Savings Account

All plans have certain things in common. It would be helpful to understand what they are so you can see how they apply to each type of insurance.

Deductible-This is the portion of any health charges that you pay before the insurance company pays anything (many plans waive the deductible for physician office visits, instead using an office visit co-pay). **ALL** plans have a deductible. It may vary from \$0 to \$10,000, but it's always included in the plan benefits.

Coinsurance- After the deductible is met, you enter into a period of coinsurance. It's just what the name says. Two entities are paying the health costs during the coinsurance period. When you see the term 80/60 it means that if you stay in network, you pay 20% and the insurance company pays 80% of the charges. Out of network, you pay 40% and the insurance company pays 60%. There is normally a stop loss of \$1000 or more that the insured has to pay. In other words, if your plan reads 80/20 through \$5000, you would be responsible for 20% of \$5000. Then the insured's liability would stop and the insurance company would pay the rest.

Not all plans have coinsurance. Often, you won't find coinsurance in an HMO plan, and often it won't be in an HSA eligible plan.

After the deductible and coinsurance have been met, the insurance company has the liability of any other covered health charges during the plan year.

There is one more term you should be familiar with and that is the network.

NETWORK - A group of providers, doctors, hospitals, labs, etc. that have a relationship with the insurance company and have established specific pricing for services. This is the way that insurance companies manage their costs.

The next section includes information of each new plan.

HMO - An HMO is the broadest type of health coverage available. The deductible is often \$0 and many companies offer plans with no coinsurance.

Normally, an HMO has a co pay for most services. The reason we say this is the most comprehensive coverage is that the co pay covers all the service that the physician or lab charges. When you go for an office visit, it's all-inclusive. There is normally a co pay for a hospital stay or outpatient surgery. If you encounter coinsurance on an HMO, it usually will be in conjunction with a co pay or sometimes a deductible for the hospital stay. HMO's usually fully cover the cost of physicals, where the other plans normally have a limit to what they will pay for a physical.

Advantages-The HMO offers the broader coverage with less out of pocket costs during the plan year.

Disadvantages-Primarily less choice in doctors and hospitals. Many of the doctors in an HMO will be employees of the HMO and not in private practice. Treatment is often in a clinical environment.

Open Access HMO's operate the same as a regular HMO, but add the convenience of being able to see different providers within the network without a referral.

POS- A POS plan is simply an HMO that also includes an indemnity plan that allows you to go out of network if you choose. All the info on the HMO applies to the POS plus the benefits of out of network treatment with the indemnity plan (see below).

Open Access POS plans operate primarily in the same manner as the POS plans listed above, except that you have the added convenience of being able to see physicians and specialists in the network without having to first obtain a referral. These plans are currently the most popular of the managed care plans due to the flexibility and cost saving advantages over a PPO plan.

PPO-A PPO almost always has a deductible, and coinsurance. If you stay within the network, there are also co pays for certain services where the deductible and coinsurance do not come into play. For example, an office visit might be a \$15-\$40 co pay without regard to a deductible or coinsurance. For a hospital stay, you would be responsible for the deductible and your portion of the coinsurance. A word of caution, the co pays are often not all inclusive. For example, an office visit co pay may mean just covers the physician's portion of the visit. Any lab or x-ray charges, might go towards your deductible and you would have to pay the charges.

There is **always** an indemnity plan included in the PPO which allows you to see any doctor you wish, however, the out of pocket charge to you will be greater.

Advantages-A PPO provides a great deal of choice of doctors and hospitals. Because of this, the PPO's are the most popular plans at this time.

Disadvantages-Coverage not as comprehensive as an HMO and you would experience greater out of pocket expense.

Indemnity-An indemnity plan was the first type of health insurance. There is no network of providers (you can go to any doctor or hospital) and there are no copays. As an insured with a \$500 deductible, you would pay the first \$500 of any charges. Then you would go into the coinsurance period where both you and the insurance company are paying, i.e. 80/20 for typically \$5000 to \$10,000, costing you another \$1000 to \$2000. After that, the insurance company pays everything up to the limit of the policy. There is always an indemnity plan attached to every POS and PPO plan.

HSA-The health savings account, formerly MSA, was established by Congress in an effort to make people more responsible for their health care costs. Normally, it is some type of indemnity plan with a high deductible.

As an incentive for a person to manage their health care costs, Congress allowed an insured to pay into a special H S A account an amount equal to their chosen deductible. This payment would be taken from the insured's income on a before tax basis. The insured would then be allowed to use this account to pay for medical and related expenses. The money could even be used to cover medical charges not covered by their health plan.

To further simplify, the H S A comes in two parts. One is a high deductible health plan for which you would pay a reduced premium. The second is a medical saving account, where you could pay into the account an amount annually, up to the amount of your deductible. **This account is your money.** If you use the money to pay medical expenses, it is never taxed. If you do not use the money in this account, it will remain your money and essentially becomes like an IRA. The difference is between an I R A and an H S A is the H S A funds can be withdrawn at any time to pay medical expenses without penalty. Also, any excess funds must remain in the H S A account until age 65 in order to be withdrawn without penalty. Any monies withdrawn after age 65 will be subject to regular income tax at the time of withdrawal.

We hope this information is helpful to you. If you would like further information or have questions, please feel free to contact us at Insurance Now and we will spend whatever time is needed to help you make sure that you select the right plan for you.