

What Types of Health Coverage Are Available?



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Rising health-care costs have driven the demand for, and the price of, medical insurance sky-high. The availability of

group coverage through employment has helped many Americans face such costs. However, people who are not currently covered by their employers have few affordable sources for group coverage. If you are not covered at work, inquire about coverage through your religious affiliation, professional organizations, or alumni association.

Individuals seeking medical coverage on their own can explore purchasing an individual health insurance policy. And those aged 65 and older may qualify for Medicare coverage.

There are three general classifications of medical insurance plans: fee-for-service (indemnity), managed care (e.g., HMOs and PPOs), and high-deductible health plan (HDHP). Older persons may be eligible for Medicare coverage.

Fee for Service

With a basic fee-for-service (indemnity) insurance plan, doctors and hospitals are paid a fee for each service provided to insured patients.

Indemnity plans normally cover hospitalization, outpatient care, and physician services in or out of the hospital. You select the service provider (physician) for consultation or treatment. You are then billed for the service and reimbursed by the insurance company, or you can “assign” direct payment to the provider from the insurance company. Indemnity plans typically require the payment of premiums, deductibles, and coinsurance. Limits on certain coverage or exclusions may apply. Because many policies have lifetime limits on benefits that the insurance company will pay, you should look for a policy with a lifetime limit of at least \$1 million.

Managed Care

Managed-care plans became popular in the 1990s as a way to help rein in rising medical costs. In managed-care plans, insurance companies contract with a network of doctors and hospitals to provide cost-effective health care. Managed-care plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Health Maintenance Organization. An HMO operates as a prepaid health-care plan. You normally pay a monthly premium in addition to a small co-payment for a visit to a physician, who may be on staff or contracted by the HMO. Co-payments for visits to specialists may be higher. The insurance company typically covers the amount over the patient co-payment amount.

Each covered member chooses or is assigned a primary-care physician from doctors in the plan. This person acts as a gatekeeper for his or her patients and, if deemed necessary, can refer patients to specialists who are on the HMO’s list of providers. Because HMOs contract with

doctors and physicians, costs are typically lower than in indemnity plans.

Preferred Provider Organization. A PPO is a managed-care organization of physicians, hospitals, clinics, and other health-care providers who contract with an insurance company to provide health care at reduced rates to individuals insured in the plan. The insurance company uses actuarial tables to determine “reasonable and customary” fees for each type of service, and health-care providers accept the PPO’s fee schedule and guidelines.

The insured can see any doctor or hospital within a preferred network of the providers and pays a co-payment for each visit. Insured individuals have to meet an annual deductible before the insurance company will start covering health-care services. Typically, the insurance company will pay a high percentage (often 80%) of the costs to the plan’s health-care providers after the deductible has been met, and the patients pay the balance.

Although insured individuals can choose physicians or providers outside the plan without permission, patient out-of-pocket costs will be higher; for example, the initial deductible for each visit is higher and the percentage of covered costs by the insurance company will be lower. Because PPOs provide more patient flexibility than HMOs, they may cost a little more.

Point-Of-Service Plan. A POS health-care plan mixes aspects of an HMO and a PPO to allow greater patient autonomy. POS plans also use a network of preferred providers whom patients must turn to first and from whom patients receive referrals to other providers if deemed necessary. POS plans recommend that patients choose a personal physician from inside the network. The

personal physician can refer patients to other physicians and specialists who are inside or outside the network. Insurance companies have a national network of approved providers, so insured individuals can receive services throughout the United States. Co pays tend to be lower for a POS plan than for a PPO plan.

High-Deductible Health Plan

An HDHP provides comprehensive coverage for high-cost medical bills and is usually combined with a health-reimbursement arrangement that enables participants to build savings to pay for future medical expenses. HDHP plans generally cover preventative care in full with a small (or no) deductible or co-payment. However, these plans have higher annual deductibles and out-of-pocket limits than other insurance plans.

Participants enrolled in an HDHP can open a health savings account (HAS) to save money that can be used for current and future medical expenses. There are annual limits on how much can be invested in an HAS. The funds can be invested as you choose, and any interest and earnings accumulate tax deferred. HAS funds can be withdrawn free of income tax and penalties provided the money is spent on qualified health-care expenses for the participant and his or her spouse and dependent children.

Remember that the cost and availability of an individual health insurance policy can depend on factors such as age, health (pre-existing conditions), and the type of insurance purchased. In addition, a physical examination may be required.

Medicare

Medicare is the U.S. government’s health-care insurance program for the elderly. It is available to eligible people aged 65 or older

as well as certain disabled persons. Part A provides basic coverage for hospital care as well as limited skilled nursing care, home health care, and hospice care. Part B covers physicians' services, inpatient and outpatient medical services, and diagnostic tests. Part D prescription drug coverage is also available.

Medicare Advantage is a type of privately run insurance plan that includes Medicare-approved HMOs, PPOs, fee-for-service plans, and special needs plans. Some plans offer prescription drug coverage. To join a Medicare Advantage plan, you must have Medicare Part A and Part B and you have to pay a monthly Medicare Part B premium to Medicare, as well as the Medicare Advantage premium.

Medicare Supplement Insurance, or Medigap, is sold by private insurance companies and is designed to cover the deductibles and co-payments that Medicare doesn't cover. There are 10 standard packages of coverage, designated by the letters A through J, plus two newer policies (K and L) that offer different benefits and lower premiums. Only Medigap insurers are able to offer these plans, but not all plans are available in every state.