Health Insurance

Affordable Healthcare Act Video

Health Insurance

- Provides protection against the expenses of health care
- Required by law to have health insurance
  - You will pay a penalty every year if you do not have health insurance
    - Called a ***shared responsibility payment***

– Penalties for not having health insurance:
  - 2014: $95 per adult and $47.50 per child (maximum of $285 per family) or 1% of family annual income, whichever is greater
  - 2015: $325 per adult and $162.50 per child (maximum of $975 per family) or 2% of family annual income, whichever is greater
  - 2016: $695 per adult and $347.50 per child (maximum of $2,085 per family) or 2.5% of family annual income, whichever is greater

- Individuals and families whose incomes are below certain income thresholds are eligible for Medicaid or government subsidies
  - Individuals & families whose annual income is below 138% of the federal poverty level qualify for Medicaid
  - Individuals & families whose annual income is below 400% of the federal poverty level will qualify for a subsidy to help offset the cost of their health insurance premium
    - Sliding scale
    - The closer your annual income gets to the 400% threshold, the lower your subsidy

Characteristics of Policies

- Covered hazards
  - What routine medical care, illnesses & injuries are covered
  - What routine medical care, illnesses & injuries aren't covered
- Co-pay
  - Specific dollar amount you pay every time for a specific, routine service
    - Generally small amount (under $100)
  - Like a deductible

- Co-insurance
  - Percentage of total bill you must pay
- Deductible
  - Specific dollar amount paid for medical expenses:
    - Per year
    - Per cause
- Cap
  - Maximum annual out-of-pocket expense paid through co-insurance
  - Limits maximum out-of-pocket costs for major expenses

- Maximum Limits
  - Limits of coverage to be paid by insurer
  - Internal maximums
    - Maximum paid for specific health problems
      - Alcohol abuse treatment
      - Drug abuse treatment
      - Other

Regular Medical Expense Insurance

- Covers normal health care and treatment costs:
  - Visits to physicians
  - Treatments of minor illnesses and injuries
  - Prescription drugs
- Normally has a co-pay
  - Example: you may have a $30 co-pay you are responsible for paying every time you see your doctor

Major Medical Insurance

- Provides additional coverage for more critical illnesses or treatments that are particularly expensive
  - Major stays
  - Major surgery
  - Extended care
- Normally have co-insurance requirement
  - Often also has deductible
- Normally require pre-approval of non-emergency services

- Example:
  - Your policy states you have a $1,000 deductible and 20% co-insurance requirement for knee surgery
  - The knee surgery, and all related treatment associated with the surgery (hospital stay, physical therapy, etc.) totals $10,000
  - You pay:
    - $1,000 deductible
    - 20% x $9,000 = $1,800
    - Total = $2,800 out-of-pocket for your surgery
    - Insurance pays the other $7,200

John Green on HealthCare Video

Assignment:

Health Insurance Cost Calculation Worksheet

Methods of Obtaining Insurance

- Individual insurance policy
  - Obtained by individual directly from insurer
  - Individual risk factors of insured are considered when setting premium
  - You pay premium
  - Can be relatively expensive
  - Done through an insurance “marketplace” that was mandated to be established by the health care law passed in 2010

- Group insurance policy
  - Employers offer health insurance to all employees at a “reasonable” cost
    - Employer may pay all of premium
    - Employer may only pay some of premium; employee pays rest
  - All employees charged same amount for chosen plan (if not paid by employer)
  - Individual risk factors of each insured employee not considered
  - Can be cheaper than individual policy

Types of Health Insurers

Health Maintenance Organization (HMO)

- Sometimes referred to as ***network*** insurance plans
- Provides members with comprehensive set of services to members within well-defined geographic area
- Members pay set premium per month
- Coverage tends to be broader than provided by other insurers
- Tend to emphasize prevention of health problems

- HMO has own facilities
  - Clinics
  - Hospitals
- HMO has own medical professionals
  - Doctors
    - General practitioners (primary care physician)
    - Specialists
  - Nurses
  - Anesthesiologists
  - X-ray techs
  - Etc.

- Member chooses own primary care physician
  - Primary care physician decides which specialists member will see if needed
  - Member has no choice in selection of specialist
- Member normally pays only premiums and relatively low co-pays
  - Since member is usually only seeing the HMO's health care providers, they normally won't have any additional costs beyond the co-pay
- If HMO does not provide a specific service, it usually has a specified list of approved medical professionals to provide that service
  - Member will only pay stated co-pays, deductibles, and/or co-insurance requirement

Preferred Provider Organization (PPO)

- PPO negotiates set prices for specific services with:
  - Private hospitals and/or clinics
  - Private doctors
    - General practitioners
    - Specialists
- Hospitals/clinics/doctors become part of a list of “preferred providers”

- Member of PPO chooses doctor/clinic/hospital he/she wants to use
  - Member pays co-pay, deductible, and/or co-insurance as agreed to in policy
  - Member can go to different geographic area to seek services from doctor/clinic/hospital of his/her choosing
- Member can choose to go outside of PPO network for care
  - Insurance will only pay what it would pay for a “preferred provider”
  - Member will have to pay for any cost above the “preferred provider” rate

- Doctor may not accept your insurance and refuse to treat you unless you pay 100% of the cost (won't let your insurance pay part)
- Doctors/clinics/hospitals can be part of multiple PPOs
  - Allows individual doctor/clinic/hospital to see patients from different PPOs that all live in same geographic area served by that individual doctor/clinic/hospital
- More effective for non-metropolitan area that is not large enough to support HMO

Differences Between HMO & PPO

Characteristic	HMO	PPO
Hospitals, clinics, pharmacies, etc.	• Owned by HMO • You must use HMO facilities unless injury is emergency & life-threatening	• Privately owned, but contracted with PPO as a “preferred provider” • You pick which you want to use
Doctors	• Work for HMO, paid by HMO	• Work for hospital or have private practice, not PPO
Primary Care Physician	• Required • You must use one that is on staff at HMO	• Optional • You pick your doctor from anyone in PPO network
Treatment by Specialists	• Must be referred by primary care physician • Also on staff at HMO	• No referral needed • You pick which specialist you want to see

Differences Between HMO & PPO (continued)

Characteristic	HMO	PPO
Routine medical care (doctor visits, prescriptions, etc.)	• Low co-pay paid at time of service	• Low co-pay paid at time of service
Major Medical Treatment	• Low co-pay paid at time of service	• May have only co-pay • May have to pay initial deductible • May have co-insurance requirement
Out-of-Network Care	• Paid by HMO only if they did not offer service • HMO pays $0 for out-of-network care for treatments it could perform	• You will pay normal costs plus all costs that exceed what PPO would pay in-network provider • If provider refuses to work with your PPO, you will pay 100% of costs

Government-Mandated Health Insurance Policies

- 2010 health care law mandated "tiers" of health care plans based on percent of health care costs to be paid by insurer
  - Bronze: intended to pay **60%** of anticipated annual health care costs
  - Silver: intended to pay **70%** of anticipated annual health care costs
  - Gold: intended to pay **80%** of anticipated annual health care costs
  - Platinum: intended to pay **90%** of anticipated annual health care costs

- Plans which cover a larger percentage of costs have higher premiums
- Plan specifics can vary from state to state
  - Some follow the traditional co-pay and deductible/co-insurance model for a health care plan
  - Others require payment of the entire deductible before insurance pays anything
    - Can be quite high, depending on which “tier” plan you purchase (Bronze, Silver, Gold, Platinum)
    - Average Bronze-level plan is over $5,000

Disability Income Insurance

- A type of health insurance
- Pays insured specified amount of money while he/she is unable to work due to illness or injury
  - May be short-term
    - Up to a year
  - May be long-term
    - Several years, up to specified age, or for life

Risk Management for Health Insurance

- Risk Reduction
  - Maintain healthy lifestyle (weight, diet, don't smoke, avoid dangerous activities)
  - Preventative care (physicals, check-ups, early diagnosis & treatment)
- Risk Transfer
  - Obtain health insurance
    - You choose which hazards will be covered & not covered
    - You choose limits of coverage (co-pays, deductibles, co-insurance)
- Risk Retention
  - Co-pays
  - Deductibles
  - Co-insurance
  - Out-of-network costs
  - Hazards not covered by policy

Assignment

Two Sisters, Two Plans