Health Insurance

Health insurance provides protection against the expenses of health care. Everyone in the United States is required by law to have health insurance. If you do not have health insurance, you will pay a penalty every year. This is referred to as a *shared responsibility payment*. This mandate to have health insurance began in 2014.

The penalties for not having health insurance start out relatively low in 2014, but increase every year until 2016, where the percentage will level out, but the specific dollar amount will increase. In 2014, the penalty for not having health insurance is $95 per adult and $47.50 per child (maximum of $285 per family) or 1% of family annual income, whichever is greater. In 2015, the penalty increases to $325 per adult and $162.50 per child (maximum of $975 per family) or 2% of family annual income, whichever is greater. In 2016, the penalty increases again to $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. Medicaid is a joint federal-state program, where states provide health insurance for low-income individuals and families, paid for with a combination of federal and state tax dollars.

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. This means that those individuals and families will have some portion of their monthly premiums paid for by the federal government using federal tax dollars. The amount of subsidy received is based on a sliding scale. The closer your annual income gets to the 400% threshold, the lower your subsidy.

Characteristics of Policies

Covered Hazards. In your health insurance policies, it will state the covered hazards. In other words, it will state what routine medical care, illnesses, & injuries are covered, and what routine medical care, illnesses, & injuries aren't covered. For example, it may state that vision care is covered, but experimental procedures are not covered.

Co-Pay. Your policy may establish a co-pay, or specific dollar amount, you pay every time for a specific, routine service. This is generally a small amount, usually under $100. It is like a deductible, in that it is a specific dollar amount. An example of this is you having to pay a $10 co-pay for each prescription you get filled.

Co-Insurance. Your policy may have a co-insurance requirement, which is a percentage of the total bill you must pay for a specific treatment you have. For example, you may have a 20% co-insurance requirement on hospital stays. If the hospital stay cost $10,000, you would be required to pay $2,000 of the cost of that hospital stay; the insurance company would pay the other 80% ($8,000).

Deductible. Your policy may also establish a deductible, which is a specific dollar amount paid for medical expenses. The deductible may be a *per-year* deductible, which would be an initial amount you must pay before your insurance company starts paying for health care costs. It may be a *per-cause* deductible, which means for a specific procedure (like childbirth), you would pay an initial deductible for health care costs associated with giving birth before your insurance company starts paying for health care costs.

Cap. A ***cap*** is a maximum annual out-of-pocket expense that you would have to pay through co-insurance. It limits your out-of-pocket costs for major expenses. Your insurance policy may set a cap on your out-of-pocket expenses to $6,500. That means that you would not be required to pay more than $6,500 in combined deductible and co-insurance payments for any treatments you receive in a given year.

Maximum Limits. ***Maximum limits*** are limits of coverage to be paid by insurer. On some treatments, they set maximum limits on what they will pay. **Internal maximums** are maximums paid for specific health problems, like alcohol abuse treatment, drug abuse treatment, and some other treatments. The reason for internal maximums is to discourage the insured person for not taking the treatment seriously and getting the help intended by the treatment. If the insured person does not take the treatment seriously, and keeps having relapses requiring more treatment, the insurance company could be required to pay out significant amounts for the treatment, but the insured, through his/her own actions, is avoiding the benefits of the treatment.

Regular Medical Expense Insurance

Regular medical expense insurance covers normal health care and treatment costs. Common examples of regular, routine medical expenses are visits to physicians, treatments of minor illnesses and injuries, and prescription drugs.

Regular medical expense insurance pays for routine treatments like doctor's visits. You will normally pay a co-pay for the treatment; the insurance company pays the rest.
Image courtesy Microsoft Photo Gallery

Regular medical expense insurance normally has a co-pay requirement, requiring you to pay a specific amount every time you seek a specific treatment. For example, you may have a $30 co-pay you are responsible for paying every time you see your doctor.

Major Medical Insurance

Major medical insurance provides additional coverage for more critical illnesses or treatments that are particularly expensive. Examples include major hospital stays, major surgery, and extended care.

Surgery and other extensive medical treatments are covered by major medical insurance.
Image courtesy Microsoft Photo Gallery

Treatments covered by your major medical insurance normally have a co-insurance requirement, where you pay a percentage of the cost of the treatment you are being provided. It also often has a deductible associated with it that must be paid before the insurance company starts paying anything.

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
*Amount remaining for treatment: **$9,000***

20% x $9,000 = **$1,800 co-insurance requirement**

Your total = **$2,800** out-of-pocket for your surgery

The insurance company pays the other $7,200

Treatments covered by your major medical insurance normally require pre-approval by the insurance compnay for any non-emergency services. A knee injury is not life-threatening, and surgery on the injury usually does not need to be performed on an emergency basis. Therefore, your health care provider (or you) will need to get approval from your insurance company to perform the surgery; if you do not get the approval, the insurance company may refuse to pay for the surgery. This requirement for prior approval is usually written into the policy.

Methods of Obtaining Insurance

There are two methods you can use to obtain a health insurance policy. You can get an individual insurance policy or be a part of a group policy.

Individual Insurance

This type of policy is obtained by an individual directly from an insurer. When getting an individual insurance policy, the individual risk factors of the insured persons are considered when setting the premium. If you are older, in poor health, or have other risk factors that make the likelihood that the insurance company will have to pay for health care, you will have to pay more for your health insurance.

With an individual insurance policy, you pay the premium directly to the insurance company. This type of policy can be relatively expensive compared to the cost of being a part of a group policy.

Individual insurance policies are purchased through an insurance "marketplace" that was mandated to be established by the health care law passed in 2010. Individuals purchase their policy from this marketplace. The marketplace is based around an online "exchange" (web site) on which insurers list the various policies they offer, and the individual shops for and chooses the policy he/she wants to purchase.

Group Insurance

A group insurance policy is one in which employers offer health insurance to all employees at a "reasonable" cost. With group insurance, the employer may pay all of the premium. The employer may, however, only pay some of premium, and the employee pays the rest of the cost of the insurance policy. For example, the employer may pay for the employee, and the employee pay for his/her family members.

With a group insurance policy, all employees are charged the same amount for a chosen plan (if the premium is not paid entirely by the employer). With a group insurance policy, the individual risk factors of each insured employee are not considered when setting the premium. The insurance company is offering the insurance to a large enough risk pool that allows it to use the Law of Large Numbers to determine how much it will have to pay out on that risk pool. This can be cheaper for you than an individual policy, especially if you have risk factors that would drive your premium on an individual insurance policy up.

Types of Health Insurers

Health Maintenance Organization (HMO)

Health Maintenance Organizations (HMOs) are sometimes referred to as network insurance plans. HMOs provide members with comprehensive set of services to members within a well-defined geographic area. With an HMO, members pay a set premium per month. In an HMO, the coverage tends to be broader than what is provided by other insurers. They also tend to emphasize prevention of health problems. HMOs are usually found in major metropolitan areas like Northern Virginia or San Diego, where there is a large concentration of businesses and the employees for which they provide coverage.

One of the key characteristics of an HMO is that it has its own facilities. HMOs have their own clinics and hospitals. HMOs also have their own medical professionals on staff in those clinics and hospitals. They have their own doctors, both general practitioners (primary care physicians) and specialists, like eye doctors and neurosurgeons, nurses, anesthesiologists, X-ray techs, etc. Almost every health care need a member might have can be provided by medical professionals on the staff of the HMO.

In an HMO, the member chooses his/her own primary care physician from the available primary care physicians on staff at the HMO clinic of his/her choice. This primary care physician decides which specialists member will see if needed. The member has no choice in selection of specialist. If the member needs a specialized treatment, like heart surgery, he/she can only see heart surgeons who are on the staff of the HMO; the member cannot choose any heart surgeon he/she wants.

A member of an HMO normally pays only premiums and relatively low co-pays (usually under $100) for any doctor visits or other medical treatment. Since the member is usually only seeing the HMO's health care providers, he/she normally won't have any additional costs beyond the co-pay. If the HMO does not provide a specific service, it usually has a specified list of approved medical professionals to provide that service. Should a member need to see a health care professional who is not part of the HMO, his/her primary care physician will need to refer him/her. The member will only pay any stated co-pays, deductibles, and/or co-insurance requirement for seeing that non-HMO health care professional.

Health Maintenance Organizations (HMOs) own their own treatment facilities and have their own health care professionals on the staffs of those treatment facilities. If you have insurance through an HMO, you must seek treatment from their treatment facilities; you do not get to choose your physician or treatment facility.
Images courtesy Microsoft Photo Gallery

Preferred Provider Organization (PPO)

A **Preferred Provider Organization (PPO)** is another type of "network" health insurance plan. The PPO negotiates set prices for specific services with private hospitals and/or clinics, and private doctors, like general practitioners and other specialists. These hospitals, clinics, doctors, and specialists become part of a list of "preferred providers". The PPO, however, does not own the clinics or hospitals, nor do the medical professionals work for the PPO, as is the case with an HMO. Those are all private practices owned and operated by those medical professionals.

The member of PPO chooses the doctor, specialist, clinic, and/or hospital he/she wants to use. The member will usually choose to see someone on the list of preferred providers, since he/she will know that the provider accepts his/her insurance. The member's policy will establish a co-pay, deductible, and/or co-insurance requirement for when he/she seeks care from one of the "preferred providers."

When the member sees one of those preferred providers, he/she pays whatever co-pay, deductible, and/or co-insurance requirement he/she agreed to in the insurance policy. If the member has agreed to a $30 co-pay for doctor visits, he/she pays the $30 to the doctor's office at the time of the visit. If the member has agreed to paying a deductible and/or co-insurance percentage for a treatment, he/she will be responsible for paying that directly to the medical professional. The PPO will reimburse the medical professional for its agreed-upon portion of the overall cost.

A member of a PPO can go to different geographic area to seek services from any doctor, clinic, or hospital of his/her choosing. If that medical professional is part of the PPO network, the cost structure would be the same is if it was in the same geographic area. For example, if you are part of a PPO, and you decide that you want to see a heart surgeon on the opposite side of the country from you, you can do so. Your cost for those services would be the same as if you chose to see a local surgeon.

A member of a PPO can choose to go outside of the PPO network for care. However, the insurance company will only pay what it would pay for a "preferred provider". If the actual cost of the services is more than the amount normally paid for that service by the PPO, the member will have to pay for any cost above the "preferred provider" rate.

If the doctor is not in your PPO network, he/she may not accept your insurance and refuse to treat you unless you pay 100% of the cost. Doctors have the option of refusing to treat patients from a PPO with which they do not want to work, and they won't let your insurance company pay its part because it does not want to have to try to work with the PPO. If a medical professional is not in your PPO network, you need to see if you can still see him/her and still have your insurer pay their normal portion for your treatment; if not, and you still want to see that doctor, you will need to pay the entire amount charged for the treatment.

Doctors, clinics, hospitals, etc., can be part of multiple PPO networks. This allows an individual medical professional to see patients from different PPOs that all live in the same geographic area served by that individual medical professional. This form of health insurance plan is more effective for a non-metropolitan area that is not large enough to support an HMO.

Government-Mandated Health Insurance Policies

The 2010 health care law mandated that insurers provide "tiers" of health care plans based on percent of health care costs to be paid by the insurer. The different tiers, and the coverage levels, are:

- **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. However, those plans will also have smaller deductibles and/or co-insurance requirements than the less expensive plans.

Plan specifics can vary from state to state, as well as within a state. Some plans follow the traditional co-pay and deductible/co-insurance model for a health care plan. For these plans, you might have a specified deductible and a co-payment percentage after the deductible is paid for a specific treatment. Other plans require payment of the entire deductible before insurance pays anything. The deductible can be quite high, depending on which "tier" plan you purchase (Bronze, Silver, Gold, Platinum). For example, the average deductible for Bronze-level plans is over $5,000 per year. This means that, if you had this plan, you would be required to pay $5,000 out of pocket for any medical care you receive in a year before your insurance starts paying for anything.

HMO vs. 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
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

Disability Income Insurance

Disability income insurance is a type of health insurance. However, it does not pay for medical care. Instead, it pays the insured a specified amount of money per day while he/she is unable to work due to illness or injury. If you have this type of policy, you will specify the dollar amount you want to receive per day, and the maximum number of days you want to receive the pay-out.

The length of time you receive disability income insurance payments may be short-term, up to a year. It may be long-term, lasting several years, up to specified age, or for life. This long-term disability income insurance is normally something you receive either through worker's compensation (for disability due to illnesses or injuries as a result of employment) or a government program, like Social Security Disability Income (SSDI); a private insurance company normally will not provide long-term disability insurance.

Risk Management for Health Insurance

Risk Reduction	Risk Transfer	Risk Retention
Maintain a healthy lifestyle (weight, diet, don't smoke, avoid dangerous activities) Get preventative care (physicals, check-ups, early diagnosis & treatment) to reduce the likelihood and severity of a major illness	Obtain health insurance: • Routine Medical Expense • Major Medical Expense • You choose which hazards will be covered & not covered • You choose limits of coverage (co-pays, deductibles, co-insurance)	Co-Pays Deductibles Co-insurance requirements Out-of-Network Costs Hazards not covered by policy