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OKLAHOMA COOPERATIVE EXTENSION SERVICE

Health Insurance: Sources and Understanding Policy Terms

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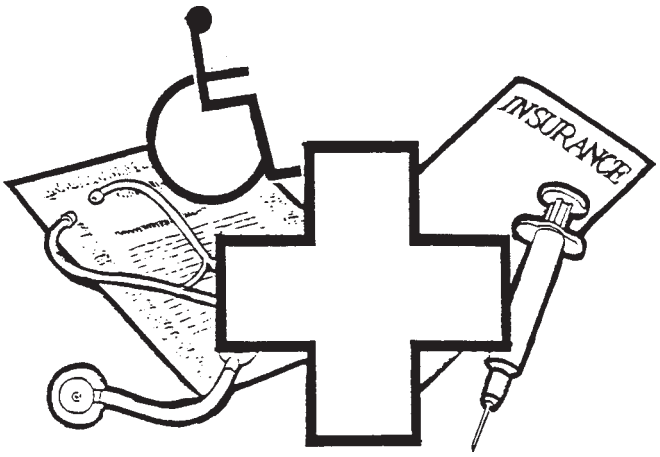
This publication will provide you with a basic understanding of health insurance, help you to get full value for your money, and introduce you to key health insurance terms. The publication has two sections. The first section discusses sources of health insurance. The second section explains health insurance terms in nontechnical language.



Sources of Health Insurance

Health insurance is available from a variety of sources, both private and public.

Private Insurance Companies offer a variety of health policies available on an individual or group member basis. When shopping for coverage, ask two or three agents to present several policies for you to compare. To get the best value for your dollar, compare the premium costs, coinsurance payments, and benefit coverage of several companies.

Blue Cross/Blue Shield. These nonprofit organizations provide insurance to members. Blue Cross plans provide hospital care benefits, while Blue Shield plans provide surgical and medical services. You have the option to join either plan on a group or individual basis. Since the Blues are nonprofit organizations, premiums cover only claims and administrative expenses. There are many plans to choose from and benefits can differ with each plan.

Health Maintenance Organizations (HMOs) are health care providers that operate on a prepaid basis. HMOs directly employ or contract with selected physicians to provide you with health care services. HMO members pay a monthly fee for total health care services. Services of HMOs range from periodic checkups to major surgery. Some provide vision and hearing care for an additional fee. The philosophy behind HMOs is that preventive care will lessen future medical problems.

Some advantages of HMOs include reducing health care costs and dropping the filing of claim forms. Disadvantages include the removal of personal choice in selecting a physician and sometimes inconvenient locations.

Two other forms of HMOs are Preferred Provider Organizations and Independent Practice Associations. A Preferred Provider Organization (PPO) is a group of medical care providers. PPOs contract with a health insurance company to provide services at a discount to policyholders. An Independent Practice Association (IPA) provides care through independent physicians who are under contract with the HMO. Any of the HMOs will provide or arrange for health care through hospitals, physicians, and medical specialists.

Government Health Care Insurance. Medicare is a federal health insurance program for people 65 or over, people of any age with permanent kidney failure, and certain disabled persons under 65. You must meet certain requirements to be eligible for Medicare at 65. Medicare consists of Part A and Part B.

Medicare Part A is a hospital insurance plan that pays some of the costs of inpatient hospital care, skilled nursing, home health and hospice care.

Medicare Part B is a voluntary medical insurance program. Part B helps pay physicians' services and some medical services and supplies not covered by the hospital part of Medicare. To be eligible, individuals must enroll and pay the premium for Part B.

For more information on Medicare, the Home Economics Cooperative Extension Service has Alert Fact Sheets called "Medicare Roundup" to further explain the benefits offered in Medicare Parts A and B. The local Social Security office has a free booklet entitled *The Medicare Handbook*. The booklet gives detailed explanation of requirements for Medicare eligibility and benefits paid by the federal program. Medicare deductibles, beneficiary coinsurance costs, and benefit coverage change on January 1 of each year.

Medicare Supplemental Insurance or Medigap should complement Medicare coverage - not duplicate it. Insurers suggest purchasing one comprehensive supplemental policy that you can afford rather than several limited coverage policies.

Shopping for a supplemental policy is now easier. Recent federal legislation requires Medicare supplemental insurance policies be standardized. The National Association of Insurance Commissioners developed 10 model policies (Models A through J) covering a range of benefits. The regulations specify exactly what benefits each plan must contain. The new law also protects consumers by restricting certain sales practices used by insurance agents and companies selling Medicare supplemental insurance. The law requires all states to comply with the standards.

Qualified Medicare Beneficiary (QMB). Government financial assistance is available through Medicaid for paying Medicare monthly premiums, deductibles, and coinsurance amounts for certain low-income elderly and disabled beneficiaries. If you qualify for Medicaid and the QMB program, you do not need to purchase Medicare supplemental insurance because you have complete health care coverage. For further information, contact your local Social Security office and ask about the "Qualified Medicare Beneficiary" program.

Social Security Disability provides eligible workers and their dependents with income during a period of disability. The disability must be total and there is a five full calendar months waiting period before collecting benefits.

Medicaid is a government assistance health care program for persons of all ages with limited income. If your annual household income is below the poverty level and you do not have access to many financial resources, you qualify for government assistance with health care expenses. For more information or to apply for Medicaid, contact your local Department of Human Services office.

Workers' Compensation Insurance provides insurance to employers for coverage of employee injury or disease caused by work activities.

Veterans Administration Hospitals provide health care services exclusively to veterans. Individuals with military experience should inquire about qualifications for medical care.

Community Health Services offered within a community can save on health care expenses for both you and your family. Often, the local health department will provide free or low-fee services for immunizations or TB testing. Other services include blood pressure checks, blood cholesterol checks, and other medical services.

Policy Provisions

The health insurance policy is the most important source of information about your health insurance benefits. The **policy** outlines the benefits and includes the limitations and conditions. If you are a group plan member, you will receive a certificate of insurance instead of the actual policy. **A certificate of insurance** is a document outlining benefits and policy provisions for individuals covered by group insurance. Only benefits appearing on the insuring agreement are available. This information is your first sign about whether the policy meets your needs.

When purchasing health insurance, keep three features in mind. One is to compare the provisions of the health insurance policy with your family's health needs. The second is to keep the family budget in mind. The last is to comparison shop before buying a policy. Policies differ widely as to coverage and cost, and companies differ as to service rendered to policyholders. Contact at least three companies and compare the coverage and premiums before you buy a policy. Also check the claims/loss ratios of different policies.

The **claims/loss ratio** represents the percentage of premiums collected by the insurance company that are paid out to reimburse claims of the insured. Avoid purchasing a policy with a claims/loss ratio of less than 75 percent. Most major medical plans pay 75 to 80 percent of eligible medical costs above the deductible. You are responsible to pay the remaining amount. The lower the claim/loss ratio, the lower the return on the premium dollar paid. There are many companies that have a ratio of less than 50 percent. These policies should not be purchased.

Application. When completing the application, you are providing specific information about yourself that determines the premium cost. The application becomes a part of your policy. Questions frequently asked on the application concern health status, age, and occupation. Errors in an application or withholding information can result in denial of claims or cancellation of the policy.

Coinsurance represents the portion of medical costs shared by you and the insurance company after you pay the deductible. Usually you pay 10 percent to 30 percent and the insurance pays 70 percent to 90 percent of the covered service. Some policies set a maximum amount for you to pay. After you pay the maximum amount, the insurer pays all of the covered services beyond that amount.

An excellent policy is one without coinsurance; however, such a policy is expensive. When choosing a policy with coinsurance, select one with a low percentage paid by you. Be sure to choose a policy with a maximum dollar amount you must pay. Once you reach this amount, the insurer pays 100 percent of the covered expenses. This reduces the chances of you paying large out-of-pocket expenses.

Continuation Provision. Health insurance policies expire and you will need to renew or change the policy. The four types of continuation provisions are cancelable, optionally renewable, guaranteed renewable, and noncancelable.

With *cancelable* policies, the insurance company has the option to cancel or change the policy at any time. It is a good idea to avoid these policies whenever possible.

In *optionally renewable* policies, the insurance company can cancel or change the policy only at the time of expiration.

Guaranteed renewable policies must continue in force as long as the insured pays the required premium. This is the most common and desirable policy.

Noncancelable policies continue in force without the premium changing as long as the insured pays the required premiums. These types of policies may continue until age 65 or for life. Most noncancelable policies are expensive.

Coordination of Benefits. This clause prevents you from collecting more than 100 percent of a loss and designates which policies pay benefits if several policies apply to the illness or injury. The primary policy is the first insurance policy to pay on the claim when more than one policy provides coverage. If the primary policy fails to pay 100 percent of the claim, the secondary policies will pay until the claim is paid in full or benefit provisions are consumed.

Coverage. Health insurance policies cover only you or members of your family. Understanding a policy designed for a family is more complex than for an individual. You will need to find out how the policy defines a family. Usually, policies define a family as a husband, wife and dependent children. Ask the following questions: At what age are children no longer covered by the policy? Are children born while the policy is in affect automatically covered from moment of birth? Each policy answers questions differently.

Remember, if you are a new policyholder, there may be a waiting period before certain coverage goes into effect.

Coverage Limitations. Policies can have provisions limiting the types of expenses it will cover. A preexisting condition is an illness that received treatment before the purchase of the insurance policy. Insurance policies may contain specific waiting periods before coverage can pay for specific claims. Some policies require a one year or more wait before paying any benefits for a particular condition. Policies with no or short waiting periods for preexisting conditions are the best.

Convertibility. This provision allows a policyholder to convert group coverage to an individual policy without proving insurability. The policy premium is usually higher but waiting periods and preexisting conditions do not apply.

Deductible. This is the amount you must pay before the insurance company pays any benefits. Deductibles may apply to each episode of illness or injury. Some deductibles may also apply to the time period, usually one year. Be sure to check the time period allowed to accumulate the deductible. Time periods will vary from three months to a year or more. Insurance companies require a deductible clause to cut down on small claims. Deductibles start at $100 and go up. Policies with a high deductible will be less expensive than those with low deductible amount.

Family policies require special attention, since you may pay a deductible for each family member.

Select a policy applying the same deductible to the whole family unit.

Exclusions. This refers to illness and injuries the policy does not cover. Policies vary in the number and types of exclusions. Some common exclusions include injuries resulting from war, riot, and civil disturbance. Additional exclusions are dental care, hearing aids, intentional self-inflicted injuries, eyeglasses, custodial or convalescent care, and cosmetic surgery. A good way to determine whether the policy will pay for an illness or injury is to check the exclusions list.

Grace Period. This provision prevents the policy from expiring when the payment is late. The grace period is usually 30-31 days. If the premium is paid before the end of the grace period, the policy will remain in force.

Major Medical. This insurance plan covers the expense of major illness or injury. The plan is characterized by large benefit maximums ranging up to $250,000 or with no limit. The policy has a deductible - an amount you must pay before benefits begin. Most major medical plans will pay 75 to 80 percent of eligible medical costs above the deductible. You pay the remaining amount.

Policy Limits. Insurance policies have the maximum amounts they will pay for a covered illness or injury. The four types of policy limits are item limits, episode limits, time period limits, and aggregate limits.

Item limits specify the maximum reimbursement for a particular health-care procedure. For example, you may have a policy that pays $200 for x-rays. If you had a hospital charge for x-rays totaling $300, your insurance would pay $200 and you would pay the difference of $100.

Episode limits specify the maximum payment for health care expenses arising from a single episode of illness or injury. Each episode is considered separately. For example, Ben Smith has an episode limit of $10,000. In January, he was hospitalized for a skiing accident and his hospital bill was $11,000. His insurance paid $10,000 and he paid a $1,000. Five months later, Mr. Smith had a car accident. His hospital bill was $2,000. The policy paid these expenses in full, since it was a separate episode.

Time period limits specify the maximum payment for covered expenses occurring within a specified period, usually one year. Let's take Ben Smith's example and apply it to the time period limit. His time period limit is $10,000 per year. Under this policy, he would pay $1,000 for his first hospital stay. He would pay the full amount of $2,000 for the second incident since he had exceeded the time period limit.

Aggregate limits place an overall maximum on the total amount of payment for all health care expenses allowed under the policy.

When reviewing policy limits, consider each limit separately to determine if it allows for enough protection. A policy with high aggregate limits appears attractive. However, if the episode limits are too low, the policy may not be a good buy.

Time Period. Most health insurance policies are written on an annual basis. Health care services are covered when they occur during the covered time period.

Waiver of Premium. The provision allows the insured to stop making premium payments while an insured is totally disabled during the life of the policy.

To receive adequate health insurance coverage, study the policy. Base the decision to purchase a policy on the consideration of covered benefits, policy limitations, the premium to be paid, company reputation, and the claims procedures. A good health insurance program provides protection from major losses and smaller losses that you and your family may find unaffordable. Having no coverage, too little coverage, or the wrong kind of coverage can be a costly mistake.

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