CHOOSING AND USING A HEALTH INSURANCE PLAN

Introduction

Changes and choices with health care

Health care in America is changing rapidly. Twenty-five years ago, most people in the United States had indemnity insurance coverage. A person with indemnity insurance could go to any doctor, hospital, or other provider (which would bill for each service given), and the insurance and the patient would each pay part of the bill.

But today, more than half of all Americans who have health insurance are enrolled in some kind of managed care plan, an organized way of both providing services and paying for them. Different types of managed care plans work differently and include preferred provider organizations (PPOs), health maintenance organizations (HMOs), and point-of-service (POS) plans.

You've probably heard these terms before. But what do they mean, and what are the differences between them? And what do these differences mean to you?

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Overview of this section

This section can help you make sense of your choices for getting health care insurance:

- See the questions and answers on important things you should know when "Choosing a Plan."
- To get the most out of the plan you choose, see the tips in the section "Using Care."
- For more help, see "Sources of Additional Information."

Even if you don't get to choose the health plan yourself (for example, your employer may select the plan for your company), you still need to understand what kind of protection your health plan provides and what you will need to do to get the health care that you and your family need.

The more you learn, the more easily you'll be able to decide what fits your personal needs and budget.

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Choosing a Plan

What Are My Health Plan Choices?

Choosing between health plans is not as easy as it once was. Although there is no one "best" plan, there are some plans that will be better than others for you and your family's health needs. Plans differ, both in how much you have to pay and how easy it is to get the services you need. Although no plan will pay for all the costs associated with your medical care, some plans will cover more than others.

Almost all plans today have ways to reduce unnecessary use of health care—and keep down the costs of health care, too. This may affect how easily you get the care you *want*, but should not affect how easily you get the care you *need*.

Plans change from year to year, so you should carefully consider each plan, using the questions outlined in this booklet. If you get health insurance where you work, you should start with your employee benefits office. Its staff should be able to tell you what is covered under the plans available. You can also call plans directly to ask questions.

Health insurance plans are usually described as either indemnity (fee-for-service) or managed care. These types of plans differ in important ways that are described below. With any health plan, however, there is a basic premium, which is how much you or your employer pay, usually monthly, to buy health insurance coverage. In addition, there are often other payments you must make, which will vary by plan. In considering any plan, you should try to figure out its total cost to you and your family, especially if someone in the family has a chronic or serious health condition.

Indemnity and managed care plans differ in their basic approach. Put broadly, the major differences concern choice of providers, out-of-pocket costs for covered services, and how bills are paid. Usually, indemnity plans offer more choice of doctors (including specialists, such as cardiologists and surgeons), hospitals, and other health care providers than managed care plans. Indemnity plans pay their share of the costs of a service only after they receive a bill.

Managed care plans have agreements with certain doctors, hospitals, and health care providers to give a range of services to plan members at reduced cost. In general, you will have less paperwork and lower out-of-

pocket costs if you select a managed care type plan and a broader choice of health care providers if you select an indemnity-type plan.

Over time, the distinctions between these kinds of plans have begun to blur as health plans compete for your business. Some indemnity plans offer managed care-type options, and some managed care plans offer members the opportunity to use providers who are "outside" the plan. This makes it even more important for you to understand how your health plan works.

Besides indemnity plans, there are basically three types of managed care plans: PPOs, HMOs, and POS plans.

Indemnity Plan

With an indemnity plan (sometimes called fee-for-service), you can use any medical provider (such as a doctor and hospital). You or they send the bill to the insurance company, which pays part of it. Usually, you have a deductible—such as $200—to pay each year before the insurer starts paying.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the "Usual and Customary" charge for covered services. The insurer generally pays 80 percent of the Usual and Customary costs and you pay the other 20 percent, which is known as coinsurance. If the provider charges more than the Usual and Customary rates, you will have to pay both the coinsurance and the difference.

The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals. It may not pay for some preventive care, like checkups.

Managed Care

Preferred Provider Organization (PPO). A PPO is a form of managed care closest to an indemnity plan. A PPO has arrangements with doctors, hospitals, and other providers of care who have agreed to accept lower fees from the insurer for their services. As a result, your cost sharing should be lower than if you go outside the network. In addition to the PPO doctors making referrals, plan members can refer themselves to other doctors, including ones outside the plan.

If you go to a doctor within the PPO network, you will pay a copayment (a set amount you pay for certain services—say $10 for a doctor or $5 for a prescription). Your coinsurance will be based on lower charges for PPO members.

If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. In addition, you may have to pay the difference between what the provider charges and what the plan will pay.

Health Maintenance Organization (HMO). HMOs are the oldest form of managed care plan. HMOs offer members a range of health benefits, including preventive care, for a set monthly fee. There are many kinds of HMOs. If doctors are employees of the health plan and you visit them at central medical offices or clinics, it is a staff or group model HMO. Other HMOs contract with physician groups or individual doctors who have private offices. These are called individual practice associations (IPAs) or networks.

HMOs will give you a list of doctors from which to choose a primary care doctor. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist.

With some HMOs, you will pay nothing when you visit doctors. With other HMOs there may be a copayment, like $5 or $10, for various services.

If you belong to an HMO, the plan only covers the cost of charges for doctors in that HMO. If you go outside the HMO, you will pay the bill. This is not the case with point-of-service plans.

Point-of-Service (POS) Plan. Many HMOs offer an indemnity-type option known as a POS plan. The primary care doctors in a POS plan usually make referrals to other providers in the plan. But in a POS plan, members can refer themselves outside the plan and still get some coverage.

If the doctor makes a referral out of the network, the plan pays all or most of the bill. If you refer yourself to a provider outside the network and the service is covered by the plan, you will have to pay coinsurance.

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Where Do I Get These Health Plans?

Group Policies

You may be able to get group health coverage—either indemnity or managed care—through your job or the job of a family member.

Many employers allow you to join or change health plans once a year during open enrollment. But once you choose a plan, you must keep it for a year. Discuss choices and limits with your employee benefits office.

Individual Policies

If you are self-employed or if your company does not offer group policies, you may need to buy individual health insurance. Individual policies cost more than group policies.

Some organizations—such as unions, professional associations, or social or civic groups—offer health plans for members. You may want to talk to an insurance broker, who can tell you more about the indemnity and managed care plans that are available for individuals. Some States also provide insurance for very small groups or the self-employed.

Medicare

Americans age 65 or older and people with certain disabilities can be covered under Medicare, a Federal health insurance program.

In many parts of the country, people covered under Medicare now have a choice between managed care and indemnity plans. They also can switch their plans for any reason. However, they must officially tell the plan or the local Social Security Office, and the change may not take effect for up to 30 days. Call your local Social Security office or the State office on aging to find out what is available in your area.

Medicaid

Medicaid covers some low-income people (especially children and pregnant women), and disabled people. Medicaid is a joint Federal-State health insurance program that is run by the States.

In some cases, States require people covered under Medicaid to join managed care plans. Insurance plans and State regulations differ, so check with your State Medicaid office to learn more.

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What Plan Benefits Are Offered?

Most plans provide basic medical coverage, but the details are what counts. The best plan for someone else may not be the best plan for you. For each plan you are considering, find out how it handles:

- Physical exams and health screenings.
- Care by specialists.
- Hospitalization and emergency care.
- Prescription drugs.
- Vision care.
- Dental services.
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Also ask about:

- Care and counseling for mental health.
- Services for drug and alcohol abuse.
- Obstetrical-gynecological care and family planning services.
- Ongoing care for chronic (long-term) diseases, conditions, or disabilities.
- Physical therapy and other rehabilitative care.
- Home health, nursing home, and hospice care.
- Chiropractic or alternative health care, such as acupuncture.
- Experimental treatments.

Some plans offer members health education and preventive care, but services differ. Ask questions such as:

- What preventive care is offered, such as shots for children?
- What health screenings are given, such as breast exams and Pap smears for women?
- Does the plan help people who want to quit smoking?

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What Is Most Important to Me in a Plan?

In choosing a plan, you have to decide what is most important to you. All plans have tradeoffs. Ask yourself these questions:

- How comprehensive do I want coverage of health care services to be?
- How do I feel about limits on my choice of doctors or hospitals?
- How do I feel about a primary care doctor referring me to specialists for additional care?
- How convenient does my care need to be?
- How important is the cost of services?

- How much am I willing to spend on premiums and other health care costs?
- How do I feel about keeping receipts and filing claims?
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You might also want to think about whether the services a plan offers meet your needs. Call the plan for details about coverage if you have questions. Consider:

- Life changes you may be thinking about, such as starting a family or retiring.
- Chronic health conditions or disabilities that you or family members have.
- If you or anyone in your family will need care for the elderly.
- Care for family members who travel a lot, attend college, or spend time at two homes.
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How Do I Compare Health Plans?

After you review what benefits are available and decide what is important to you, you can compare plans. Many things should be considered. These include services offered, choice of providers, location, and costs. The quality of care is also a factor to think about (see How Do I Find Out About Quality?).

Services

Look at the services offered by each plan. What services are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the plan provide the medicines and equipment you may need?

Find out what types of care or services the plan won't pay for. These usually are called exclusions.

Few indemnity and managed care plans cover treatments that are experimental. Ask how the plan decides what is or is not experimental. Find out what you can do if you disagree with a plan's decision on medical care or coverage.

Choice

What doctors, hospitals, and other medical providers are part of the plan? Are there enough of the kinds of doctors you want to see? Do you need to choose a primary care doctor? If you want to see a specialist, can you refer yourself or must your primary care doctor refer you? Do you need approval from the plan before going into the hospital or getting specialty care?

Location

Where will you go for care? Are these places near where you work or live? How does the plan handle care when you are away from home?

Costs

No health insurance plan will cover every expense. To get a true idea of what your costs will be under each plan, you need to look at how much you will pay for your premium and other costs.

- Are there deductibles you must pay before the insurance begins to help cover your costs?
- After you have met your deductible, what part of your costs are paid by the plan?
- Does this amount vary by the type of service, doctor, or health facility used?
- Are there copayments you must pay for certain services, such as doctor visits?
- If you use doctors outside a plan's network, how much more will you pay to get care?
- If a plan does not cover certain services or care that you think you will need, how much will you have to pay?
- Are there any limits to how much you must pay in case of major illness?
- Is there a limit on how much the plan will pay for your care in a year or over a lifetime? A single hospital stay for a serious condition could cost hundreds of thousands of dollars.

You can't know in advance what your health care needs for the coming year will be. But you can guess what services you and your family might need. Figure out what the total costs to your family would be for these services under each plan.

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How Do I Find Out About Quality?

Quality is hard to measure, but more and more information is becoming available. There are certain things you can look for and questions you can ask. Whatever kind of plan you are considering, you can check out individual doctors and hospitals. For doctors, see "Tips on Choosing a Doctor."

Many managed care plans are regulated by Federal and State agencies. Indemnity plans are regulated by State insurance commissions. Your State Department of Health or insurance commission can tell you about any plan you are interested in.

You can also find out if the managed care plan you are interested in has been "accredited," meaning that it meets certain standards of independent organizations. Some States require accreditation if plans serve special groups, such as people in Medicaid. Some employers will only contract with plans that are accredited.

Several national organizations review and accredit plans and institutions (see "Sources of Additional Information"). You can contact these organizations to see if a plan you are considering, or an institution in the plan, is accredited.

Another approach is to ask the plan how it ensures good medical care. Does the plan review the qualifications of doctors before they are added to the plan? Plans are supposed to review the care that is given by their doctors and hospitals. How does the plan review its own services, and has it made changes to correct problems? How does the plan resolve member complaints?

Some managed care plans survey members about their health care experiences. Ask the plan for a report of the survey results.

Some plans and independent organizations are also beginning to produce "report cards." These reports often include satisfaction survey results and other information on quality, such as if a plan provides preventive care (for example, shots for children and Pap smears for women) or if the plan follows up on test results. Report cards may also include information on how many members stay in or leave the plan, how many of the plan's doctors are board certified, or how long you may have to wait for an appointment.

Report cards can only give you an idea of how a plan works and may not give a full picture of a plan's quality. Ask plans if their activities have

been reported in report cards developed by outside groups (business or consumer organizations).

Also keep any eye out for magazine articles that rate health plans.

Finally, you can talk to current members of the plan. Ask how they feel about their experiences, such as waiting times for appointments, the helpfulness of medical staff, the services offered, and the care received. If there are programs for your particular condition, how are the patients in it doing?

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