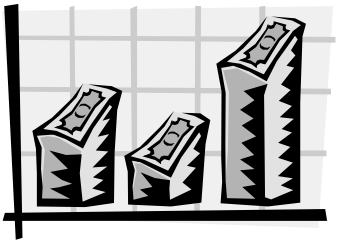
KOFA HIGH SCHOOL SOCIAL SCIENCES DEPARTMENT

ECONOMICS - PERSONAL FINANCE WORKSHOPS

 # 5 - HEALTH INSURANCE



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*Vocabulary Keys : Words that are in **bold** = are terms that appear in one of the chapters , Words that are underlined = supplemental vocabulary . Ask questions about these words if you are not familiar with them !*

Top Things To Know

1. Insurance costs a lot but having none costs more.

There are sensible ways to save money on insurance, but skipping coverage isn't one of them. Medical bills from even a minor car accident can deplete your savings -- a major illness can push you into bankruptcy.

2. If your employer offers insurance, grab it.

Group coverage, particularly when it's employer-subsidized, is almost always a better deal than anything you can get on your own, even if you're young and healthy. If you're NOT young and healthy, it's definitely a better deal.

3. Comparing plans is tough but necessary.

Unfortunately, there is no such thing as standard coverage. Benefits and costs vary widely from plan to plan. If you have choices, you'll have to examine each one closely to find the best deal.

4. The lowest premium isn't always the least expensive plan.

What your insurance covers is just as important as, and sometimes more important than, what you pay up front. Ultimately, the cheapest plan is the one with the best price for the benefits you're most likely to use.

5. Even good coverage can have big loopholes.

You can count on your health insurance to cover you for a hospital stay. Most policies cover doctor visits, but benefits for mental health, prescription drugs and dental care are strictly optional.

6. You'll pay more for freedom.

Plans with the most comprehensive coverage at the lowest out-of-pocket cost require you to use a specified network of hospitals, doctors, labs, and other providers. The more flexibility you demand, the more you'll pay, in either premiums or co-payments.

7. You can check out networks before signing up.

A growing number of public and private sources compile information on the track records of individual doctors, hospitals, and health plans.

8. You can keep your insurance if you lose your job.

State and federal regulations protect you from losing your health coverage just because you lose your job. Unfortunately, they offer little protection from high premium costs.

9. Working couples have more to think about.

If you and your spouse both get health insurance at work, you must sort out whether it makes more sense to have two policies or for one of you to cover the other. If you have kids, you need to decide who's going to cover them.

10. Tax breaks can help.

Ordinarily medical expenses, including insurance premiums, are not tax deductible until they exceed 7.5% of your income. However, if you're self-employed or your employer offers a flexible spending account, you can get a tax break without meeting the threshold.

The Basic Flavors

There are two types of plans, each of which has far-reaching consequences.

There are two basic types of insurance: indemnity plans and managed care.

Indemnity insurance -- also called "fee-for-service" -- generally gives you greater freedom and flexibility than managed care. However, you'll pay more out of pocket for the health care you get. With indemnity coverage, you can choose any doctor, hospital, laboratory, or other medical provider.

As long as your insurance contract includes the service performed, insurance will cover it, though it won't pay the entire charge. You'll have to satisfy an annual deductible -- generally a few hundred dollars -- before insurance even kicks in.

Then, you'll owe a portion of each bill, called a co-payment, normally 20 percent. If the provider you choose charges unusually high fees, your share may be considerably higher. That's because your insurer will base its 80 percent share on the "usual and customary" fee for the service in your area, not on the actual bill.

As a rule, indemnity insurance covers only illness or accidents; it doesn't pay for preventive care such as flu shots or birth control. Depending on your policy, it may or may not pay for prescription drugs or psychotherapy.

In its pure form, managed care flips indemnity coverage 180 degrees. With a health maintenance organization (HMO), there are no deductibles. Co-payments are fixed and low, and preventive care, drugs, and mental health treatment are usually covered.

However, you can choose only among doctors, hospitals, and other providers who have contracts with your HMO, and you can receive only medical services authorized by the plan. If you use non-authorized providers or receive non-authorized care, your HMO will not pay any portion of the bills.

Because many people are uncomfortable with these restrictions, managed care has evolved to include hybrid plans that blend HMOs with some of the features of indemnity coverage.

With a point-of-service plan (POS), for instance, you can keep your costs low by using a network of doctors and hospitals that have contracts with your insurer. If you choose to do so, you can go outside the network, but you'll pay a deductible and higher co-payments.

Competitive marketing has produced other permutations, such as the "open access" HMO that allows you to see a network specialist without a referral. The only way to know for certain what your options and costs are is to carefully read the descriptive materials and question anything that's not clear.

For general help in understanding health insurance, check the federal Agency for Health Care Policy and Research. Your state insurance department may also offer online help. Also check the guide from the Food and Drug Administration to find your state health agency's Web site. Websites like Insure.com can help you to understand different types of health insurance.

Once you grasp the basics, you're ready to make informed choices. The next section tells you how to find the coverage that best suits your needs.

Which Plan Is Right For You?

Which plan gives you the services you're most likely to need at the lowest out-of-pocket cost.

If you get coverage through your job, your employer picks your insurance and you may or may not have very many choices about it. If you buy your own, you're in charge, but your choices are limited by the plans available to individual purchasers, as well as by how much you can afford to spend.

Unfortunately, there's no such thing as standard coverage. Details vary enormously from one plan to another. The best value is not necessarily the plan with the cheapest premium or the one with the most benefits. It's the plan that covers the health services you want and need for the lowest out-of-pocket expense (see "types of insurance"). In essence, differences among plans come down to three intertwined elements: benefits, costs, and restrictions.

Benefits: Every insurance plan will cover you for doctor and hospital bills, with various limits, discussed below under "costs." Virtually everything else, including prescription drugs, glasses, psychotherapy and preventive care, such as immunizations and screenings, may or may not be covered, depending on the specific plan.

To figure out how well a plan suits your needs, first make a list of the health services you and your family normally use. For each plan, note the amount of coverage for each of those services -- for instance, "100 percent," "80 percent," "not covered." Once you've got a handle on how fully each plan covers your health needs, you can evaluate cost differences.

Costs: If you don't use many medical services, your primary cost for indemnity coverage will be the premium. If you do use a lot of services, it will be hard to gauge your actual costs, since you must factor in the deductible, co-payments, and any excess charges or uncovered services.

In contrast, cost is easy to gauge with a true HMO -- a managed-care plan with no out-of-network option. Once you've paid your premium, nearly everything will be covered and you'll be liable only for small co-payments.

Estimating the cost of a managed-care plan with an out-of-network option is tricky, because your ultimate cost depends on whether or not you actually go out-of-network. If cost considerations make you lean toward a managed-care plan, read its literature thoroughly to decide whether you can live with the restrictions it imposes.

Restrictions: Generally speaking, a managed-care plan will limit your choice of providers and require you to get pre-approval for services. If your pediatrician shuns HMOs or you have a difficult health problem, you may decide that you can't abide limits like these.

Keep in mind, though, that indemnity insurance also comes with limitations in the form of deductibles, co-payments and uncovered services. These financial roadblocks can inhibit freedom of choice as much as any managed-care bureaucracy.

Another worry is that many consumers equate freedom of choice with medical quality. They're not entirely wrong. If you receive poor treatment in a managed-care plan, it's hard to vote with your feet.

But they're not completely right, either. The quality of medical care varies considerably both in and out of managed care. In fact, the best managed-care plans offer quality advantages you won't get outside managed care, such as outreach for preventive services, heath-risk screening, and coordination of care.

Know your provider

Whether you choose indemnity insurance or managed care, it's wise to check up on your providers in advance. One way is via state insurance department Web sites.

Florida, Maryland, Massachusetts, New York, and Rhode Island, for instance, post lists of local doctors who have been disciplined for poor patient care or, in some cases, criminal conduct. New York and New Jersey rate local hospitals and doctors on how well they care for cardiac patients. Florida, New Jersey, New York, Maryland, Texas, and Utah rate local managed-care plans.

Nationally, the Joint Commission on Accreditation of Health Organizations is the major rating group for hospitals, the National Committee for Quality Assurance rates managed-care plans, and thehealthpages.com lists surveys and other data on selected health plans and health services.

Money-saving Srategies

It's hard if you're young, harder if you're old or infirm

If you are young and healthy, saving on health-insurance premiums is tough enough. Older people not in the best of health will have great difficulty getting an affordable plan.

If you're buying your own insurance, you've got to shop around for the best price. As long as you're healthy and under 50, insurers want your business. To avoid attracting applicants they don't want, though, many keep a low profile, so you'll have to seek them out by phoning agents, checking with your state insurance department, or going online. For instance, Quotesmith, a nationwide insurance broker, has a national online database of carriers you can search for policies that might be available to you.

Older people or those with health problems will have a tougher time finding insurance. Government protections offer some help (see "Your Legal Rights") but insurers are not always quick to advise you of your options, so you may have to take the initiative to get the coverage you're entitled to.

Make the most of spousal coverage :

Working couples with insurance from two employers may be able to get more or pay less than one-income couples. Depending on the premiums and benefits of each available plan, the best deal may be separate coverage for each, double coverage for both, or forgoing one spouse's coverage in favor of the other's. If you have kids, you'll need to compare your options for family coverage. Be warned: The calculations can be mind-boggling and, even with double coverage, a couple can't collect more than 100% on the same claim.

Use available tax-breaks :

If you're self-employed, you may be able to deduct 45% of your insurance premium from your gross income. If your employer offers a flexible spending account, sign up. You can pay your premium as well as expenses not covered by insurance with money that's not subject to income tax or Social Security taxes.

Take prudent risks :

If you are generally healthy and use few medical services, you can cut premium costs substantially by buying "catastrophic" coverage. This is an indemnity policy with a very high deductible, perhaps as much as $2,500. Assuming this much financial risk can slash your premium by 50% or more, depending on your age. Don't try to trim your premium by reducing coverage on the other end, though. Make sure your insurance has a high maximum payout, at least $100,000, preferably $500,000. Also take care to understand the definition of "catastrophic."

*Look for a **subsidy** :*

If your income is very low, if you're permanently disabled or if your medical expenses are extremely high, you may qualify for federal or state-subsidized insurance, such as Medicare or Medicaid (check your state Medicaid office). Regardless of your ability to pay, you may be qualified to receive free primary care through public health clinics. To find a site near you, check the Bureau of Primary Healthcare web site.

If you lose your job or have health problems, federal and state laws give you certain rights to health insurance, which are described in the next section.

Your Legal Rights

If you work for a company with 20 or more employees and you lose your job, a federal law called COBRA (for Consolidated Omnibus Budget Reconciliation Act) requires your ex-employer to let you stay on the group policy for at least 18 months, at your own expense. If you have generous coverage paid mostly by your employer, the full premium (plus 2% for administrative costs) could be quite a shock. Still, it's wise to hang on to your old coverage until you're covered at a new job or find more affordable insurance elsewhere.

The Health Insurance Portability and Affordability Act (HIPAA) goes COBRA one better. It says that as long as you've been covered under a group policy within the previous 63 days, no insurer can turn you down for coverage, even if you're seriously ill. Unfortunately, HIPAA doesn't regulate premium costs so there's no guarantee that you can afford the insurance you're legally entitled to.

As the number of uninsured continues to rise, states have become increasingly active in helping individuals get insurance, though price continues to be a problem. Thirty states have so-called "high-risk pools," which guarantee insurance to applicants whose health histories make them undesirable to insurers.

Some states have other ways of making coverage more accessible. New York, for instance, requires insurers to use a modified "community rating" when pricing coverage, so they can't charge disproportionately high premiums to applicants in poor health. For a state-by-state analysis of your rights to health insurance, check out Georgetown University's Institute for Health Care Research and Policy.