

Questions and Answers About Health Insurance



A Consumer Guide



Agency for Healthcare Research and Quality
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America's Health
Insurance Plans

Note to reader:

This guide offers general information only. Do not rely solely on this guide in making health insurance decisions.

Health insurance plans vary widely, both in cost and in benefits. Before enrolling in a health insurance plan, you should consult the plan brochure and read the policy to get specific information about the benefits and costs and the way the plan works.

This guide was developed jointly by the Agency for Healthcare Research and Quality and America's Health Insurance Plans to provide consumers with general information about health insurance options.



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Introduction to the Guide

This guide briefly describes the different kinds of health insurance plans available today. These include network-based plans, non-network based coverage, and consumer-directed health plans. Also, you will find answers to many common questions you may have about health insurance. Resources are provided at the end of the booklet to help you find additional, more detailed information.

At the end of this guide, there is a glossary of health insurance terms. Terms included in the glossary are highlighted in bold type the first time they appear in the guide.

Changes and Choices

Today, there are many more kinds of health insurance to choose from than were available just a few years ago. Traditional differences between and among plans may no longer apply. Also, there is an increased emphasis on the role of consumers in managing their own health care and health care finances. There is a focus on providing information on the cost of care and health care quality—at the level of the physician, physician group, and hospital—to help consumers and employers choose among the many options available to them.

● ● ● ● A New Health Care Marketplace

Things have changed a lot since the 1970s, when most people in the United States who had health insurance had **indemnity insurance**. Indemnity insurance is often called **fee-for-service** or traditional health insurance. This type of coverage generally assumes that the medical provider (usually a doctor or hospital) will be paid a fee for

each service provided to the patient—that is, you or a family member covered under the policy.

With fee-for-service insurance, you go to the doctor of your choice, and you submit a claim to the insurance company for reimbursement. Often, your doctor or hospital will submit the claim for you. You will only be reimbursed for “covered” medical expenses; that is, the covered services listed in your plan’s benefits summary.

When a service is covered under your policy, you can expect to be reimbursed for some—but generally not all—of the cost. How much you will receive depends on your policy’s **coinsurance** and **deductibles**. You will be responsible for the portion of the bill not reimbursed by the insurance company. See the section on Indemnity Insurance (page 6 in this booklet) for more information on coinsurance and deductibles.

Today, many Americans who have health insurance are enrolled in a **managed care** plan, such as a **health maintenance organization** (HMO) or a **preferred provider organization** (PPO). For more information on HMOs and PPOs, see the section on managed care, which begins on page 7 of this booklet.

When we talk about health insurance, we usually mean the kind of insurance that pays medical bills, hospital bills, and typically, prescription drug costs. This type of coverage includes **Medicare** and **Medicaid**, two government programs that provide health insurance coverage for certain populations, such as seniors, people with disabilities, and individuals and families with low income. But there are other types of coverage as well, including **disability insurance**, **long-term care insurance**, and other coverage that can offer additional financial protection for you and your family. Information on these types of plans is provided later in this guide.

Frequently Asked Questions About Health Insurance

• • • • 1. Why do you need health insurance?

As medical care advances and treatments increase, health care costs also increase. The purpose of health insurance is to help you pay for care. It protects you and your family financially in the event of an unexpected serious illness or injury that could be very expensive. In addition, you are more likely to get routine and preventive care if you have health insurance.

You need health insurance because you cannot predict what your medical bills will be. In some years, your costs may be low. In other years, you may have very high medical expenses. If you have health insurance, you will have peace of mind in knowing that you are protected from most of these costs. You should not wait until you or a family member becomes seriously ill to try to purchase health insurance.

We also know that there is a link between having health insurance and getting better health care. Research shows that people with health insurance are more likely to have a regular doctor and to get care when they need it.

• • • • 2. How do you get health insurance?

Most people get health insurance through their employers or organizations to which they belong. This is called **group insurance**. Some people do not have access to group insurance. They may choose to purchase their own **individual health insurance** directly from an insurance company. Many Americans get health insurance through government programs that operate at the national, State, and local levels. Examples include Medicare, Medicaid, and programs run by the Department of Veterans Affairs and Department of Defense.

Group Insurance

Group health insurance is typically offered by employers. Or, if you are a member of a union, professional association, or other group, you may be able to get group coverage through that organization.

Some employers allow employees to choose between several plans, including both indemnity insurance and managed care. Other employers offer only one plan. Some group plans offer dental and/or vision benefits as well as medical benefits. So it is important to compare plans to find the one that offers the benefits you need most. Once you enroll in a health insurance plan, you usually cannot change to another plan until the next **open season**, usually set once a year.

When group health insurance is an employee benefit, your employer usually pays a portion or all of the **premiums**. This means your costs for health insurance premiums will be lower than they would be if you paid the entire premium alone.

When you get group insurance through membership in an organization, you usually will benefit from being a member of a large group. You may pay less for premiums than an individual would pay. However, the organization often does not pay a share of the premium, meaning you may be responsible for paying the entire premium yourself.

Individual Insurance

If you are self-employed or your employer does not offer health insurance, you may not have access to group insurance. You may, however, be able to purchase individual coverage directly from an insurance company. When you buy your own health insurance, you will be responsible for paying the entire premium rather than sharing the cost with an employer. You should shop around to find a plan that fits your needs at a price that you are willing to pay.

Most self-employed workers are able to deduct their health insurance premiums from their Federal taxable income, providing them with an important tax saving. Most States also offer similar tax preferences. If you are self-employed and buy individual health insurance, you should consult a tax advisor to find out if you are eligible for this deduction.

Insurance plans differ greatly from one company to another and, within an insurance company, from one plan or product to another. Some plans have multiple products (options) from which you can choose; read carefully through the “fine print” to be sure you understand the various choices.

● ● ● ● 3. Which type of health insurance is right for you?

Whether you are eligible for group insurance or choosing an individual plan, you should carefully compare costs and coverage. Be sure to compare:

1. Premiums.
2. Coverage/benefits.
3. Access to doctors, hospitals, and other providers.
4. Access to after hours and emergency care.
5. Out-of-pocket costs (coinsurance, **copays**, and deductibles).
6. **Exclusions** and limitations.

Even if you do not get to choose your health plan—for example, if your employer offers only one plan—you still need to understand your coverage. What kind of services are covered by the plan? What steps do you need to take to get the care you and your family members need? When do you need prior approval to ensure coverage for care (for example, elective hospitalization for scheduled surgery)? How are benefits paid; do you have to submit a claim?

Make sure you understand how your plan works. Don't wait until you need emergency care to ask questions.

If you are choosing between indemnity and managed care plans, remember that they may differ in several important ways, including:

- How you access services.
- How you obtain specialty care.
- How much and sometimes how you pay for care.

Despite these differences, indemnity and managed care plans share some features. For example, both types of plans cover a wide array of medical, surgical, and hospital services. Most plans offer some coverage for prescription drugs. Some plans also have at least partial coverage for dentists and other providers.

The major difference between indemnity (non-network based coverage) and managed care plans (network-based coverage) concerns choice of doctors, hospitals, and other providers; out-of-pocket costs for covered services; and how bills are paid.

Be sure to check on the physicians and hospitals that are included in the plan.

Remember, plans vary in what they pay. No plan will pay 100 percent of your medical expenses, but some plans will pay more than others.

Indemnity Insurance

This type of coverage offers more flexibility in choosing doctors and hospitals. Usually, you can choose any doctor you wish, and you can change doctors at any time. Although you usually will not need a referral to see a specialist or go for x-rays or tests, you may need paperwork, such as your medical records, from your **primary care physician**. Be sure to ask your doctor if there's any paperwork that you will need to take with you.

If you have indemnity insurance, your plan only pays part of your medical bills. You are responsible for the rest. Your out-of-pocket costs are likely to be higher for certain services than with some managed care plans. Usually, you will need to spend a certain amount each year before your plan begins to pay benefits. This amount is called a deductible.

Deductibles are the amount of the covered expenses you must pay each year before your plan starts to reimburse you. Deductibles might range from \$100 to \$300 per year per covered person or \$500 or more per year for a family.

If you have an indemnity plan, you may have more paperwork to do. Some doctors will submit the claim for you. Once the doctor receives payment from the insurance company, he or she will bill you for the difference. With other doctors, you will have to pay the entire bill and file a claim with your insurance company to be reimbursed.

Indemnity insurance pays a portion of the bill—usually 80 percent, after the deductible has been met, although this may vary. You pay the remainder, usually 20 percent of the total bill. This is called coinsurance.

Indemnity policies typically have an out-of-pocket maximum. This means that once your expenses reach a certain amount in a given calendar year, the fee for covered benefits typically will be paid in full by your insurance plan. If your doctor bills you for more than the reasonable and customary charge, you possibly may have to pay a portion of the bill. If you have Medicare coverage, there are limits on how much a physician may charge you above the usual amount.

There also may be lifetime limits on benefits paid under the policy. Most experts recommend that you look for a policy with a lifetime limit of at least \$1 million. Anything less may not be sufficient.

Managed Care

More than half of all Americans who have health insurance are enrolled in a managed care plan. Managed care plans usually cover a wide range of health services. With these plans, costs are lower when patients use the doctors and other providers who participate in the plan (network providers).

In most cases, you will not have to fill out any insurance forms or submit any claims to the insurance company when you use

in-network providers. Usually, you will pay a copay (typically \$10 to \$20 for an office visit) each time you go to the doctor or hospital or fill a prescription. Your copay may vary depending on whether you see your primary care doctor or a specialist and whether you receive a generic or brand name prescription drug.

Most managed care plans have a list of drugs that they cover, called a **formulary**. Your copay for prescription drugs will probably depend on whether you are getting a generic drug, a brand name formulary drug, or a brand name drug not on the plan's formulary. For example, the copay might be \$10 for a generic drug, \$25 for a formulary drug, and \$40 for a brand name non-formulary drug. Be sure to check the formulary of the plan you are considering to make sure it will cover any routine prescription drugs that you and your family members take.

Some managed care plans have a mail-order pharmacy option. This means that you send your doctor's prescription for routine maintenance drugs (for example, blood pressure medicine, drugs to control blood sugar, and other drugs used on a regular basis) to the mail order pharmacy. In most cases, you will receive a 3-month supply of your medication by return mail. You still pay a copay, but your cost may be lower than it would be at a local retail pharmacy.

If you choose to enroll in a managed care plan instead of an indemnity plan, you may have lower out-of-pocket expenses for health care, as long as you see doctors who are part of the plan (in-network providers).

There are three main types of managed care plans:

- Health maintenance organizations (HMOs).
- Preferred provider organizations (PPOs).
- **Point-of-service plans** (POS).

All three types of managed care plans have contracts with doctors, hospitals, and other providers. They have agreed on certain fees with these providers. As long as you get your care from a plan

provider, you typically will be responsible only for any cost-sharing your plan requires.

Health Maintenance Organizations

HMOs have long been known for a focus on prevention and wellness. Traditionally, HMOs required that you receive most of your care from one primary care physician who is aware of your total health picture. If you belong to an HMO, usually you must receive all of your medical care from network providers, except in emergencies. HMOs usually have flat copayments rather than deductibles and co-insurance and no lifetime limits on coverage.

After you enroll in an HMO, you typically will need to select a primary care physician who will be responsible for coordinating all of your care. Primary care physicians may be family practice doctors, internists, pediatricians, obstetricians-gynecologists, or general practitioners.

If you become ill, your primary care doctor will see you first, unless it is an emergency. Your primary care doctor will give you a referral if he or she thinks you need to see a specialist. Usually, your HMO will not provide coverage for a specialist unless you have this referral.

In most cases, you must see a specialist who participates in your HMO. Sometimes, in special circumstances, HMO patients may be referred to providers outside the HMO network and still receive coverage.

If you need to be admitted to the hospital and it is not an emergency, you may have to obtain precertification from your plan. In most cases, your physician or hospital will take care of this for you. Non-emergency hospital care may not be covered without precertification. In case of an emergency admission, you or a family member, your doctor, or your hospital will need to contact your plan within a certain timeframe (usually within 48 hours of admission) to obtain written confirmation of coverage for the hospital stay.

Today, some HMOs do not follow this “primary care model.” So, if you are considering a traditional HMO, it is important to compare the features and requirements among the various HMO plans that are available to you.

Preferred Provider Organizations and Point-of-Service Plans

PPOs and POS plans combine features from both fee-for-service and HMOs. PPOs and POS plans offer more flexibility than HMOs in choosing physicians and other providers. POS plans have primary care physicians who coordinate patient care, but in most cases, PPOs do not. Premiums tend to be somewhat higher in PPOs and POS plans than in traditional HMOs.

Generally, the greater the emphasis on in-network care, the lower the premiums and the more comprehensive the benefits will be. Consumers and employers make tradeoffs, deciding which is more important: a greater choice of providers or a lower premium.

If you are enrolled in a PPO or POS plan, your out-of-pocket expenses will be less if you use a provider who is part of the plan (a network provider). However, you will still get some reimbursement if you receive a covered service from a provider who is not in the network. In this case, your reimbursement will be at a lower level than if you used an in-network provider.

If you choose to go out of network for your care, you may have to meet a deductible before your plan begins to pay benefits. Also, you may have to pay the bill yourself and submit paperwork to the plan for reimbursement of covered expenses.

If you are in a PPO, you will not need a referral to see a specialist or get other types of care, but you may need to take some paperwork with you. Be sure to ask your doctor if you will need a written order or other documentation when you are referred to a specialist, laboratory, or other provider.

When you go out of the plan’s network for care, PPOs and POS plans work like fee-for-service plans and charge you coinsurance.

For PPOs, this coinsurance may be different than the coinsurance charged for in-network providers. Also, you may have to pay the total cost of care right away and then file a claim with your insurance company to get the allowable reimbursement for out-of-plan care.

● ● ● ● 4. What is consumer-directed coverage?

Consumer-directed health plans allow individuals and families to have greater control over their health care, including when and how they access care, what types of care they receive, and how much they spend on health care services. The major types of consumer-directed coverage are:

- **Health savings accounts**, usually coupled with **high-deductible health plans**.
- **Health reimbursement arrangements**.
- **Flexible spending arrangements**.
- **Archer Medical Savings Accounts**.

Health Savings Accounts

A health savings account is a type of medical savings account that allows you to save money to pay for current and future medical expenses on a tax-free basis. In order to be eligible for a health savings account, you must be covered by a high-deductible plan, not have any other health insurance (including Medicare), and not be claimed as a dependent on someone else's tax return.

You can use this account to pay for your qualified health expenses, including expenses that the plan ordinarily doesn't cover, such as eyeglasses and hearing aids. Expenses paid out of the HSA that are eligible expenses under your high-deductible health plan will count toward the plan's deductible.

During the year, you can make voluntary contributions to your health savings account using before-tax dollars. In some cases, employers may set up and help fund health savings accounts for

their employees. A health savings account earns interest. If you have a balance in your health savings account at the end of the year, it will “roll over,” allowing you to build up a cushion against future health expenses. A health savings account allows you to accumulate funds and retain them when you change plans or retire.

High-deductible Health Plans

High-deductible health plans that can be used with health savings accounts are now being offered by many insurers. As of 2007, individuals contributing to a health savings account must be covered by a health plan with an annual deductible of not less than \$1,100 for self-only coverage and \$2,200 for family coverage. The deductible generally applies to all expenses, including prescriptions and doctor office visits, but in some cases, preventive care does not count toward meeting the deductible. However, most plans will cover preventive services, such as routine office visits, before you have met your deductible.

Under a high-deductible plan, out-of-pocket expenses in 2007 cannot exceed \$5,500 for self-only coverage and \$11,000 for family coverage. These dollar amounts are adjusted annually to account for inflation, and they include deductibles, copays, and other amounts, but not premiums.

After the deductible has been met, some plans will have a coinsurance of 10 to 15 percent of expenses but only up to the out-of-pocket limit in the plan. After you meet the out-of-pocket limit, the plan will pay 100 percent of expenses. Other plans will pay 100 percent after the deductible has been met.

Some insurers have negotiated discounted prices with participating physicians and hospitals, resulting in substantial savings to consumers who purchase high-deductible health plans. If you are considering this type of coverage, be sure to inquire about discounted prices.

Health Reimbursement Arrangements

Health reimbursement arrangements may be established by employers to pay employees' medical expenses. A health reimbursement arrangement must be set up by an employer on behalf of its employees, and only the employer can contribute to it. The employer decides how much money to put in a health reimbursement arrangement, and the employee can withdraw funds from the account to cover allowed expenses. Health reimbursement arrangements often are established in conjunction with a high-deductible health plan, but they can be paired with any type of health plan or used as a stand-alone account.

Federal law allows employers to determine whether employees can carry over all or a portion of unspent funds from year to year. Also, employers can decide whether account balances will be forfeited if an employee leaves the job or changes health plans.

Flexible Spending Arrangements

Flexible spending arrangements are set up by employers to allow employees to set aside pre-tax money to pay for qualified medical expenses during the year. Only employers may set up an account, and employers may or may not contribute to the account. Also, there may be a limit on the amount that employers and employees can contribute to a health flexible spending arrangement.

Health flexible spending arrangements can be offered in conjunction with any type of health insurance plan, or they can be offered on a stand-alone basis. In the past, health flexible spending arrangements were subject to a use-it-or-lose-it rule. Now, employers may give employees a 2-1/2 month grace period at the end of the plan year to use up funds in the account. After that time, remaining funds from the previous plan year are forfeited. If you have a flexible health spending arrangement, you should try to anticipate your health care expenses for the coming year to avoid losing any money that you contribute and don't spend.

Archer Medical Savings Accounts

Archer Medical Savings Accounts are individual accounts that may be set up by self-employed individuals and those who work for small businesses (less than 50 employees). To set up an Archer medical savings account, you must be covered by a high-deductible health plan. Either the employee or the employer may contribute to an Archer account, but both cannot contribute to the account in the same year.

Individuals control the use of funds in Archer medical savings accounts and can withdraw funds for qualified medical expenses. You can roll over funds from year to year, and balances in Archer medical savings accounts are portable. This means you can take them with you when you change jobs or retire.

● ● ● ● 5. How does Medicare coverage work?

Medicare is the Federal health insurance program for Americans age 65 and older, some disabled Americans, and individuals who have end-stage renal disease (ESRD). The Original Medicare Plan, which is available nationwide, is a fee-for-service plan that is managed by the Federal Government. It pays for many health care services and supplies, but it won't pay all of your health care costs.

Generally, you should enroll in Medicare when you first become eligible. If you choose to enroll at a later time, you will pay a late-enrollment penalty.

If you already have health insurance from an employer or another source, talk to your benefits administrator about whether you should join Medicare or not while still covered.

Medicare has four parts: hospital insurance, known as Part A; medical insurance, known as Part B, which provides payments for doctors and related services; and prescription drug coverage, known as Part D. Medicare Part C gives you the choice of receiving the benefits of Medicare A, B, and D through a private health plan, like

an HMO or PPO. This coverage is called Medicare Advantage and is described on page 16 of this booklet.

Most people don't pay a premium for Part A, since they already paid for it through payroll taxes while they were working. There is a monthly premium for Medicare Part B (\$93.50 per month in 2007, but people with incomes over \$80,000 pay more).

Usually, you will pay a premium if you decide to enroll in Medicare's prescription drug plan. If you don't enroll as soon as you are eligible, your premium will be higher if you decide to enroll at a later time. Also, once you are past your first eligibility, you will have to wait for the annual enrollment period (generally November 15-December 31 of each year) in order to enroll in Medicare's prescription drug coverage.

Medicare Prescription Drug Benefits

In January 2006, prescription drug coverage (Part D) became available to Medicare beneficiaries for the first time. Through this new benefit, Medicare now pays for a portion of your prescription drug costs. Both brand-name and generic prescription drugs are covered at participating pharmacies across the country. Everyone with Medicare is eligible to enroll in this coverage, regardless of income and resources, health status, or current prescription expenses.

Do you have limited income and resources?

If so, you may be eligible for extra help with your prescription drug coverage.

If you choose to have this coverage, you will be able to get your drugs in one of two ways. You can buy an individual drug plan, or you can sign up with a Medicare Advantage plan, like an HMO or PPO. Either way, you will pay a monthly premium, which varies by plan, coinsurance or copays for your drugs, and in some cases, a yearly deductible (no more than \$265 in 2007).

There are many plans participating in the Medicare prescription drug program. This broad competition among plans should have a

positive effect on consumers' out-of-pocket costs. Nevertheless, deductibles, out-of-pocket costs, and covered drugs vary widely across the plans. Some plans may offer more coverage and additional drugs for a higher monthly premium.

If you have limited income and resources and you qualify for extra help, you may not have to pay a premium or deductible. If you are eligible, you will get help paying for your drug plan's monthly premium, yearly deductible, and prescription copayments. The amount of help you get will depend on your income and resources.

To find out if you qualify for extra help, contact Social Security at 1-800-772-1213 or online at www.socialsecurity.gov. Or, you may contact your State medical assistance office. Call Medicare at 1-800-Medicare or go to www.medicare.gov to get a phone number for the medical assistance office in your State.

If you already have prescription drug coverage from an employer, former employer, or other source, you may be better off keeping that coverage. You should contact your benefits administrator to find out how your existing coverage works with Medicare drug coverage before you make a decision. You may decide to keep the drug coverage you have, or you may want to join a Medicare drug plan instead of, or in addition to, your current plan.

If you think you might be better off changing out of your employer-based drug plan, be sure to consult with your employer first. If you leave your employer coverage and later change your mind, you probably will not be able to return to it for health or prescription drug coverage.

Your employer, union, or other group is your best source of information about your current drug coverage. If you need more help in deciding what to do, you can call your State Health Insurance Assistance program to get personalized counseling about your choices. To get their telephone number, visit www.medicare.gov online and select "Helpful Telephone Numbers and Web Sites."

Medicare Advantage Plans

Another type of Medicare coverage, known as Medicare Advantage Plans, is available in many areas of the country. These Medicare plans include HMOs, PPO's, private fee-for-services plans, and special needs plans.

In comparison to the Original Medicare Plan, Medicare Advantage Plans often give you more choices and sometimes extra benefits, like coverage for more days in the hospital. Many include Part D drug coverage. To join a Medicare Advantage Plan, you must have Medicare Part A and Part B coverage. You will pay the monthly premium for Medicare Part B, and you may also have to pay a premium to your Medicare Advantage Plan for the extra benefits it offers.

Medigap Supplemental Insurance

Since Medicare doesn't cover all medical expenses, people who don't have other health insurance and choose not to enroll in a Medicare Advantage plan may decide to purchase a Medigap policy. Medigap is private insurance that helps to cover some of the gaps in Medicare benefits.

Since 1992, there have been 10 standard Medicare supplemental policies. These Medigap policies are designated by the letters A through J. In 2005, two new Medigap policies—designated by the letters K and L—were added. Medigap policies K and L have higher out-of-pocket amounts and lower premiums than policies A through J. Although all 12 standard policies may not be available to you where you live, supplemental Plan A is available to Medicare beneficiaries everywhere.

For more information on Medicare, Medigap policies, and Medicare prescription drug coverage, contact the Centers for Medicare & Medicaid Services. Log onto their Web site at www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227).

• • • • 6. What other government programs are available?

Other government-sponsored programs for specific groups—such as Medicaid and the State Children’s Health Insurance Program (SCHIP) for low-income individuals and families—and plans that meet a specific need, such as long-term care, supplemental coverage, and disability insurance, are also available.

Medicaid

Medicaid provides health care coverage for certain people with limited income who are eligible to participate in the program. Medicaid is a Federal-State program that is operated by the States. Each State sets its own rules about eligibility and covered services.

Many groups of people are eligible for Medicaid coverage. Some of the factors affecting eligibility include age; whether you are pregnant, blind, or disabled; your income and resources; and whether you are a U.S. citizen or legal immigrant. Your child may be eligible for coverage even if you are not. Eligibility for children is based on the child’s status, not the parent’s status.

If your income is limited and you can’t afford the care you need, you should apply for Medicaid whether or not you think you qualify. A qualified caseworker in your State will evaluate your situation to see if you are eligible for Medicaid.

For more information about the Medicaid program, go to www.cms.hhs.gov/MedicaidGenInfo.

State Children’s Health Insurance Program

Congress created the State Children’s Health Insurance Program (SCHIP) in 1997. SCHIP is a Federal/State partnership similar to Medicaid. SCHIP expanded health insurance to children whose families earn too much money to be eligible for Medicaid but not enough to purchase private insurance.

Like Medicaid, SCHIP eligibility and covered services vary from State to State. In some States, Medicaid and SCHIP are combined. In other States, they operate as separate programs. Although health benefits covered by SCHIP vary, all States must provide coverage for well-baby and well-child care, immunizations, and emergency services.

You can get more information about SCHIP online at www.insurekidsnow.gov. This site provides a link where you can access specific information about SCHIP in your State. Or, to get information by phone, call 1-877-KidsNow (1-877-543-7669) toll-free.

High-Risk Pools

A **high-risk pool** is a State-operated program that offers health insurance to individuals who don't have access to coverage through an employer or other group and have a serious medical condition that prevents them from purchasing private health insurance. It is similar to risk pools for automobile insurance to ensure coverage for people who can't get it elsewhere. In most States, the risk pool is funded through premiums, supplemented by tax revenues or by an annual assessment on health insurance companies operating in the State.

More than 30 States have established high-risk pools that provide access to comprehensive health coverage for more than 180,000 people across the country. An estimated 1 million people who are eligible for coverage in high-risk pools don't participate. In a few cases, States don't have adequate funding for the pools and are unable to enroll all eligible individuals.

To find out if coverage through a high-risk pool is an option in your State, contact your State Insurance Commissioner. Check the blue pages of your local phone book for contact information.

● ● ● ● 7. Are there other types of health-related coverage?

Other types of health-related coverage include long-term care insurance, disability insurance, and supplemental insurance.

Long-Term Care Insurance

The purpose of long-term care is to provide the help you need to perform activities of daily living—such as bathing and dressing yourself. Or, you may need supervision because of dementia or another form of cognitive impairment. In addition to this custodial care, some people also need skilled nursing services due to serious illness.

You can receive long-term care in a nursing home, assisted living facility, or in your own home. The need for long-term care can arise at any time, regardless of your age. Older people use the most long-term care, but younger and middle-aged people sometimes need long-term care as well. You may need long-term care because of a chronic illness or disability that leaves you unable to care for yourself for an extended period of time.

Long-term care can be very expensive. On average, a year in a semi-private room in a nursing home costs about \$58,000 (estimated annual cost in 2005). In some parts of the country, it may cost much more.

Home care is less expensive than nursing home care, but it is still costly. Home care can include part-time skilled nursing care, speech therapy, physical or occupational therapy, home health aides, and homemakers. Having the services of an aide in your home just three times a week—to help with dressing, bathing, preparing meals, and similar household chores—can easily cost \$1,000 or more a month. If you add in the cost of skilled help, such as physical therapy, the costs can be much higher.

Long-term care—whether in a nursing home, assisted living facility, or your own home—usually is not covered by health insurance except in a very limited way. Medicare generally doesn't cover long-term care.

Long-term care insurance can help protect you from the high costs associated with this type of care. Most long-term care policies pay a fixed dollar amount, which can vary quite a bit—from as little as \$40 a day to more than \$200 a day. The daily benefit for at-home care usually is about half of the benefit for nursing home care.

In order to get the lowest rates, you should apply sooner rather than later for long-term care insurance. Your age and any medical conditions you may have will affect your eligibility for coverage and how much it will cost (the premium). Recent changes in Federal law may allow you to take certain income tax deductions for some long-term care expenses and insurance premiums. In addition, some States may give a partial deduction or credit toward State income taxes for these costs.

Traditionally, the annual rate of increase in the cost of long-term care services has risen more quickly than it has for other consumer services. This means the benefit you buy today may not be enough to cover higher costs in the future. You can choose a plan with an inflation adjustment feature so that you can be protected against the rise in long-term care costs over time until services are needed.

Long-term care insurance may be offered where you work, or you may be eligible through a union, fraternal group, or other organization to which you belong. In addition, many life insurance companies offer long-term care insurance directly to the consumer.

Disability Insurance

Disability insurance replaces income you lose if you have a long-term illness or injury and cannot work. This is an important type of coverage for working-age people to consider.

Disability insurance is not usually considered a form of health insurance, and it doesn't cover the costs associated with rehabilitation following an injury or illness. Often, these costs are covered under the major medical part of your health insurance plan. Benefits paid under a disability plan can be used for expenses at the discretion of the insured, for example, rent, utilities, or groceries.

Some employers offer group disability insurance. Check with your employer to find out if this coverage is available. Disability insurance will be less expensive if your employer contributes toward the cost. Many different kinds of individual policies are also available. Contact your insurance company to find out if it offers disability insurance coverage.

Supplemental Insurance

Different types of coverage are available to you that pay benefits when specific types of events occur, such as hospitalization or critical illness. This coverage usually will pay a cash benefit that can be used to cover additional expenses that you incur due to the event. This type of coverage may be available from your employer or directly from an insurance company.

● ● ● ● 8. What happens if you have a preexisting condition?

Before passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1997, people had to worry about health insurance coverage for preexisting conditions like diabetes, heart disease, or cancer. If you changed jobs and had to change insurers, you might not have been able to get some of your care covered because of the preexisting condition exclusion.

Today, HIPAA helps to assure continued coverage for employees and their dependents, regardless of preexisting conditions. Insurers can impose only a 12-month waiting period for any preexisting condition that has been diagnosed or treated within the preceding 6 months. As

long as you have maintained continuous coverage without a break of more than 63 days, your prior health insurance coverage will be credited toward the preexisting condition exclusion period.

If you have had group health coverage for at least 1 year and you change jobs and health plans, your new plan can't impose another preexisting condition exclusion period. If you have never been covered by an employer's group plan and you start a new job that offers such a plan, you may be subject to a 12-month preexisting condition waiting period. Federal law also makes it easier for you to get individual insurance under certain situations. You may, however, have to pay a higher premium for individual insurance if you have a preexisting condition.

If you have not had coverage previously and you are unable to get insurance on your own, you should check with your State insurance commissioner to see if your State has a high-risk pool (described previously in this booklet). You can find the phone number for your State insurance commissioner in the blue pages of your local phone book.

● ● ● ● 9. What happens if you have health insurance through your employer and you leave your job?

If you leave a job where you have had employer-sponsored health insurance, you will want to ensure that you have continued protection against the high costs of health care. Whether you leave the job on your own or you are forced to leave, there is a Federal law that may help you to maintain coverage.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as COBRA), group health plans sponsored by employers with 20 or more employees are required to offer continued coverage for you and your family for 18 months after you leave the job. In some cases, the COBRA period may be extended past 18 months. In order to continue your coverage under

COBRA, you must notify your employer that you intend to do so within 60 days of losing your employer's health coverage. You also must pay the entire premium for the cost of the coverage.

Some States have laws similar to COBRA that apply to employers with fewer than 20 employees. To find out if this applies in your State, contact your State Insurance Commissioner. Check the blue pages of your local phone book for contact information.

If COBRA doesn't apply in your case, you may be able to convert your group policy to individual coverage. Or, you may decide to purchase a short-term policy if you plan to take another job in the near future. If you open your own business and become self-employed, you may be able to obtain health insurance through a trade or professional association.

In Closing

Having health insurance helps to protect us from high health care costs that most people could not meet in any other way. It helps us pay for health care, and it ensures that we have access to care when we need it. Research has shown that having health insurance is closely tied to the quality and timeliness of care.

This booklet is intended to help you sort through your health insurance options. However, it presents general information about health insurance. Before you make a decision, be sure to consult the brochures and policies of the plans you are considering for more specific information. The time you invest in researching your health insurance choices will make a big difference, not only in how much you pay out-of-pocket, but also in how easy it is for you to get care and how satisfied you are with the health care services that are available to you.

If you can enroll in health insurance at work or through a group or organization to which you belong, you almost certainly have access to group coverage. Sometimes, there is only one plan, but in many cases, there are several plans from which you can choose.

In this guide, you have received general information about the various types of health insurance. You have also learned about things you should consider when choosing a health insurance plan.

It is very important to compare plans carefully to find the one that is best for your situation. Read and compare policies. You should contact each plan you are considering and ask them for a summary of their benefits. Be sure to ask questions if something is unclear. Also, ask whether your doctor or a doctor you may be considering participates in the plan. To be safe, you should also contact the doctor's office to confirm that they will accept the plan.

At the back of this guide you will find a list of resources where you can get more detailed information on many of the topics discussed here.

Glossary

Archer Medical Savings Accounts – Individual accounts that may be set up by self-employed individuals and those who work for small companies. Funds in the accounts are used to pay medical expenses.

Coinsurance – The amount you must pay for medical care after you have met your deductible. Typically, your plan will pay 80 percent of an approved amount, and your coinsurance will be 20 percent, but this may vary from plan to plan.

Copay – The flat fee you pay each time you receive medical care. For example, you may pay \$10 each time you visit the doctor. Your plan pays the rest.

Deductible – The amount you must pay each year before your plan begins paying.

Disability insurance – Pays benefits if you are injured or become seriously ill and are no longer able to work.

Exclusions – Services that are not covered by a plan. Sometimes called limitations. These exclusions and limitations must be clearly spelled out in plan literature.

Fee-for-service insurance – Traditional (indemnity) health insurance where you and your plan each pay a portion of your health expenses, usually after you meet a yearly deductible. In most cases, you can choose any physician, hospital, or other provider (non-network based coverage).

Flexible spending arrangements – Employees use pre-tax dollars to set up these accounts and draw down on them to pay qualified medical expenses during the year. Unused amounts are forfeited at the end of the year.

Formulary – An insurance company's list of covered drugs.

Group insurance – Health plans offered to a group of individuals by an employer, association, union, or other entity.

Health maintenance organization (HMO) – A form of managed care in which you receive all of your care from participating providers. You usually must obtain a referral from your primary care physician before you can see a specialist.

Health reimbursement arrangement – An account established by an employer to pay an employee’s medical expenses. Only the employer can contribute to a health reimbursement account.

Health savings account – An account established by an employer or an individual to save money toward medical expenses on a tax-free basis. Any balance remaining at the end of the year “rolls over” to the next year.

High-deductible health plan – A plan that provides comprehensive coverage for high-cost medical events. It features a high deductible and a limit on annual out-of-pocket expenses. This type of plan is usually coupled with a health savings account or a health spending account.

High-risk pool – A State-operated program that offers coverage for individuals who cannot get health insurance from another source due to serious illness.

Indemnity insurance – Traditional, fee-for-service health insurance that does not limit where a covered individual can get care.

Individual health insurance – Coverage purchased independently (not as part of a group), usually directly from an insurance company.

Long-term care insurance – Coverage that pays for all or part of the cost of home health care services or care in a nursing home or assisted living facility.

Managed care – An organized way of getting health care services and paying for care. Managed care plans feature a network of physicians, hospitals, and other providers who participate in the plan. In some plans, covered individuals must see an in-network provider; in other plans, covered individuals may go outside of the network, but they will pay a larger share of the cost.

Medicaid – A Federal program administered by the States to provide health care for certain poor and low-income individuals and families. Eligibility and other features vary from State to State.

Medicare – A Federal insurance program that provides health care coverage to individuals aged 65 and older and certain disabled people, such as those with end-stage renal disease.

Network — A group of physicians, hospitals, and other providers who participate in a particular managed care plan.

Open enrollment – A set time of year when you can enroll in health insurance or change from one plan to another without benefit of a qualifying event (e.g., marriage, divorce, birth of a child/adoption, or death of a spouse). Open enrollment usually occurs late in the calendar year, although this may differ from one plan to another.

Point-of-service plan – A form of managed care plan in which primary care physicians coordinate patient care but there is more flexibility in choosing doctors and hospitals than in an HMO.

Preferred provider organization – A form of managed care in which you have more flexibility in choosing physicians and other providers than in an HMO. You can see both participating and nonparticipating providers, but your out-of-pocket expenses will be lower if you see only plan providers.

Premium – The amount you pay to belong to a health plan. If you have employer-sponsored health insurance, your share of premiums usually are deducted from your pay.

Primary care physician – Usually a family practice doctor, internist, obstetrician-gynecologist, or pediatrician. He or she is your first point of contact with the health care system, particularly if you are in a managed care plan.

Reasonable and customary charge – The prevailing cost of a medical service in a given geographic area.

Resources

AARP – an advocacy organization comprising 35 million members. AARP focuses on issues affecting men and women aged 50 and older. Go to www.aarp.org to find many publications and other resources on health topics, including Medicare and other health insurance. Contact AARP by phone at 1-888-687-2277, or write to AARP, 601 E Street, N.W., Washington, DC 20049.

Agency for Healthcare Research and Quality (AHRQ) – an agency of the Federal Government. Go to the Agency’s Web site at www.ahrq.gov to find more information and tools to help you evaluate health plans, as well as many consumer publications on various health topics. Most of the consumer materials are available in English and Spanish. Call the AHRQ Clearinghouse at 1-800-358-9295 to order free copies of publications.

America’s Health Insurance Plans (AHIP) – a national association that represents health insurance plans providing medical, long-term care, disability income, dental, supplemental, stop-loss, and reinsurance to more than 200 million Americans. Go to www.ahip.org and select “Consumer Information,” where you can access many consumer guides on health insurance and link directly to companies that provide health insurance coverage. Or, contact AHIP by phone at 1-202-778-3200, or write to AHIP, 601 Pennsylvania Avenue, N.W., Washington, DC 20004.

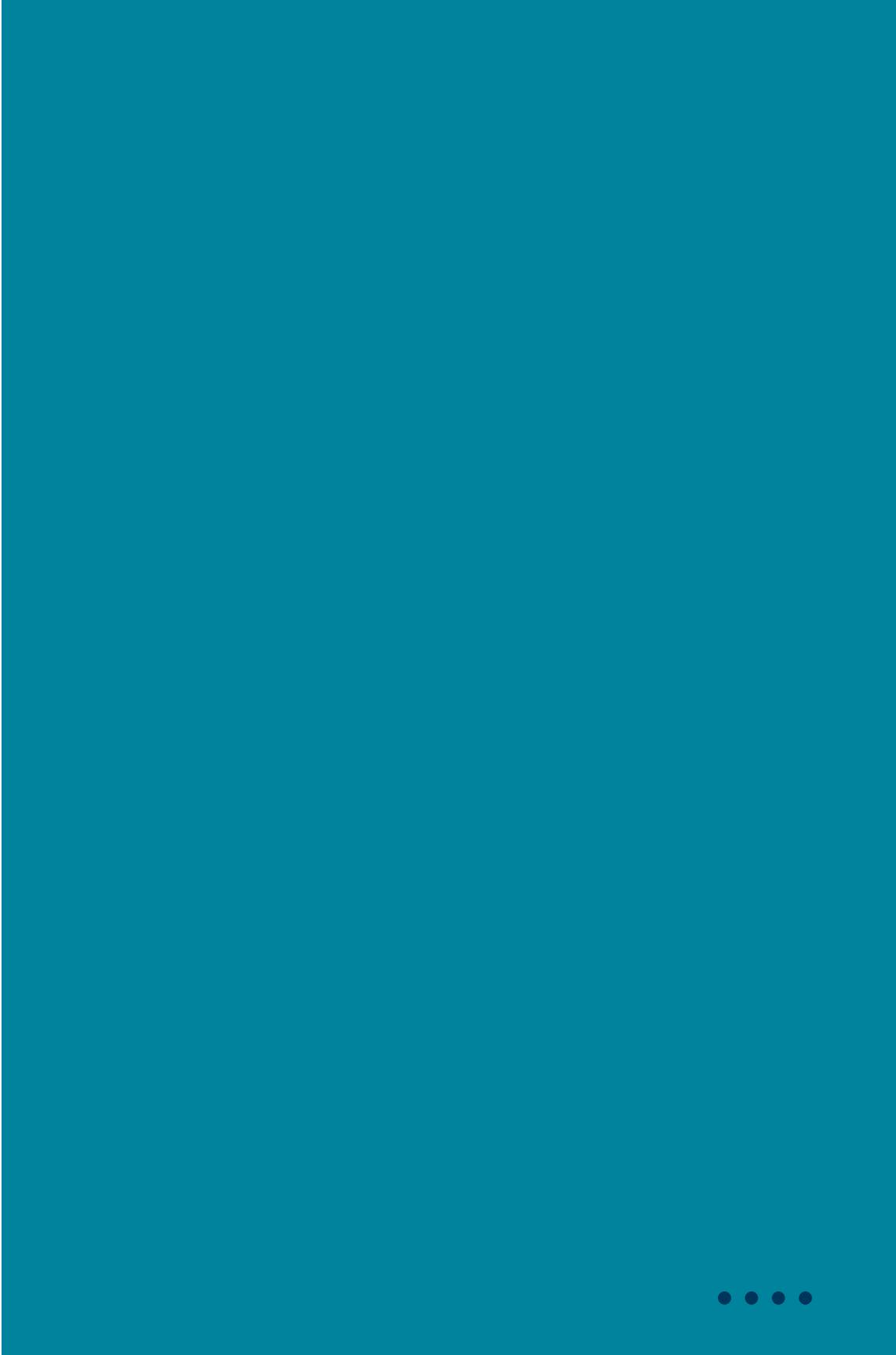
Joint Commission on Accreditation of Healthcare Organizations (JCAHO) – Evaluates and accredits health care organizations and programs, including hospitals, long-term care facilities, and other health care facilities, as well as health plans, managed care entities, and other insurers. Go to the JCAHO Web site at www.jointcommission.org, call them at 630-792-5000, or write to JCAHO, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

Medicaid – General information about the Medicaid program is available online at www.cms.hhs.gov/MedicaidGenInfo/. Medicaid is a State administered program; eligibility and covered services vary from State to State. For information specific to the Medicaid program in your State, contact your State Insurance Commissioner; see the blue pages of your local phone book for contact information.

Medicare – Go to the Medicare Web site at www.medicare.gov where you can search by category, keyword, or phrases to find information about Medicare. Telephone help is also available; you may call 1-800-MEDICARE 24 hours a day, 7 days a week. Assistance is available in English or Spanish. You will be able to get general information about Medicare, view Medicare booklets, and find out about plans that are available in your area.

National Committee for Quality Assurance – a group that develops quality standards, performance measures, and recognition programs for organizations and individuals, including health plans, medical groups, physician networks, and individual physicians. Visit their Web site at www.ncqa.org or call 202-955-3500.

Utilization Review Accreditation Commission – a group that accredits PPOs and other managed care networks. Visit their Web site at www.urac.org, call 202-216-9010, or write them at URAC, 1220 L Street, N.W., Washington, DC 20005.





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