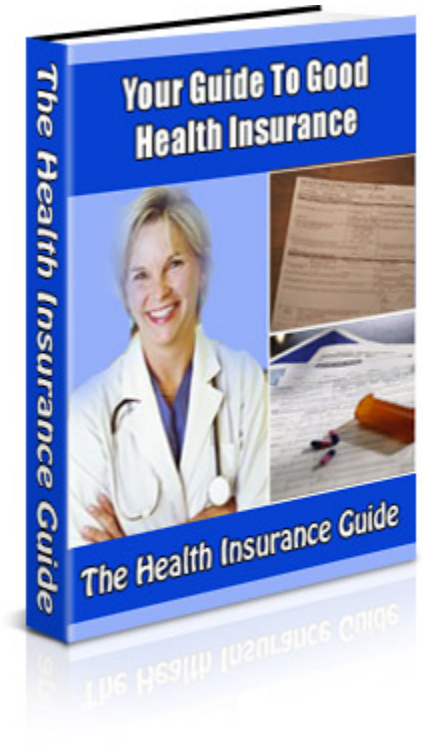
YOUR GUIDE TO GOOD HEALTH INSURANCE



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INTRODUCTION

If you want to spark a spirited debate at your next social gathering, just try bringing up the subject of health insurance. You will undoubtedly set off a firestorm of opinions.

Years ago, acquiring your first health coverage was almost a right of passage. You began your career and you were automatically enrolled in your employers health plan after your first 90 days of employment.

That still takes place today but the health care industry has metamorphosed into a gigantic monster gobbling up resources everywhere it travels. Rates keep going up at an astounding pace and more employers are cutting back on their plans or doing away with their health benefit packages entirely.

Naturally, no one document will tell you everything you ever wanted to know about health insurance. When it comes to health insurance there is no “one size fits all.”

However, what will do is provide with enough knowledge to weigh the options and make informed decisions regarding your own circumstances.

The most important tool you can have when looking for good health insurance is knowledge. Unfortunately there aren’t too many places where you can obtain that knowledge without having to spend

months wading through the small print.

So, before discussing the various plans that are available, we must first grasp an understanding of the complex nature of health insurance. Therefore, our first chapters are written specifically to help you understand the terminology and different components involved so that you can make those informed decisions and present it in plain English. Let's get to it!

DIFFERENT TYPES OF HEALTH INSURANCE POLICIES

Health insurance is a legal contract between two or more parties that promises certain performance in exchange for considerations. A health insurance policy is considered a unilateral contract. This is because only one party (the insurer) is required to fulfill their obligation. While a policy owner may decide to terminate premium payments, as long as the payments are paid the insurer must meet their responsibility under the contract.

A health insurance policy can provide just one or any combination of certain benefits:

- Hospital, medical and surgical expenses resulting from sickness or an accident
- Accidental death or dismemberment

- Disability resulting from accident or sickness (sometimes this can also be referred to as “loss of income” or “loss of time”

An accident is an injury that occurs accidentally. A sickness is an illness or disease that is **not** the result of an accident. Knowing the difference is important because policies may have different provisions that apply to accidents or sickness. Also, there are some companies that sell a separate accident policy that does not include sickness.

The terms accident and sickness are widely used and often interchangeable in any discussion of health insurance. They are often abbreviated as A&H and A&S. Health insurance is also referred to as medical insurance.

As we discussed above, health insurance is designed to protect again two types of economic loss. Loss of income and expenses for medical care which places them in either of two broad policy categories:

- Disability income policies
- Medical expense policies

Disability income policies can also be referred to as loss of income, loss of time or replacement income. This type of policy will pay benefits to an insured who is disabled and can no longer work to earn a regular income. Payments can be weekly or monthly depending

on the policy.

Medical expense policies are represented by a wide range of coverage from very minimal to comprehensive packages with multiple coverage. Some include both accidents and illnesses, various hospital expenses and other costs pertaining to medical care such as:

- Accident and sickness policies
- Hospital policies
- Basic medical expense policies
- Major medical expense policies
- Comprehensive medical expense policies

Any of these policies might cover various combinations of the above and may be paid in a lump sum.

Accident Policies. Some policies cover only accidents and not illness. As you might imagine, policies like this are very specific about what is considered an accident.

It is important to understand what is defined as an accident as it pertains to the health insurance industry. . .an accident is an event that is unforeseen and unintended.

Keep in mind that any discussion of this type of policy also applies to any type of policy that includes accidental coverage not just accident specific policies.

Accident benefits are most commonly paid for accidental loss of

life (also called accidental death), accidental loss of limb or sigh (dismemberment), loss of time and/or income, hospital expenses, surgical expenses, and medical expenses like visits to the doctor.

Let's expand a bit on dismemberment. As we said, this would be loss of limb or sight, however, different states have statutes that define dismemberment and they can vary from state to state. This is a subject that you need to discuss with your insurance agent to determine what actually constitutes dismemberment in your state.

Accidental Death Benefit can also be referred to as "principal sum." This type of coverage should not be confused with life insurance. There is a world of difference between the two. Life insurance policies will generally regardless of the cause of death. An accidental benefit is paid ONLY if the death is accidental as opposed to a death by natural causes or illness.

The person who received the death benefit is called the beneficiary. The policy owner has the right and responsibility of naming beneficiaries. Usually there is a primary beneficiary however he/she can assign a second and even a third beneficiary.

The primary beneficiary is the first person in line to receive the benefit in the event of the death of the policy holder. They can also name a second beneficiary who would receive the benefit in the event the primary beneficiary dies before the insured. Some policies can

include a third beneficiary who would be in line after the first two.

There is much more to be learned about accidental death policies, but we would like to mention one important element before we move on. An accidental death may not be instant. A person can die as a result of an accidental injury months after the accident occurrence. Read your policy carefully because most stipulate that the accidental death benefit will only be paid if death occurs within three months of the accident.

DISABILITY INCOME INSURANCE

When a person becomes disabled and unable to work, at some point their income will stop. It might be sooner or later, but unfortunately, life goes on and daily living expenses continue to mount.

Disability income insurance is available to continue at least a portion of ones income while unable to work. It's sad, but most people give more attention to life insurance than they do about income replacement should they become disabled.

Disability income insurance is available individually or sometimes as a portion of a group benefit provided by an employer in their group package.

Individual policies are most often sold to self-employed and

professional people. The amount of the benefit relates to earnings and is matched as close to after tax income as possible. Generally it is up to 60% of monthly net income and there is usually a cap on the amount.

When included as part of a employee group benefit package, disability income policies are usually more liberal than individual plans as far as limitations and exclusions. It is also much easier to acquire coverage. As a general rule, group plans are much less costly to all parties.

Disability income protection should be an element of your entire financial planning. The importance cannot be overestimated because it relates to your overall family finances. Whatever you situation may be, disability is one of the most important factors when you consider you inability to work and produce income.

Some things to consider when determining disability income needs are:

- Establish the bare minimum required if income stops.
- Determine your retirement needs if work ceases and the ability to pay into the retirement ends.
- Allow for any benefit that might be offset by social security and workers compensation.

Some thought needs to be afforded to the possibility of “total

disability." That definition is important as it is always defined in a policy and different companies may use different definitions.

Interpretation is important as it pertains to the insured's own occupation and any occupation the insured may be qualified to perform.

The first method used to determine total disability concerns the occupation that the insured is normally engaged in. In this case total disability might be defined as "the insured's inability to perform any or all of the duties or his or her own occupation." This is determined by the insured's occupation at the time that disability begins.

The second method is more restrictive defined as "the insured's inability to perform the duties of any occupation for which he or she is reasonably qualified by education, training or experience."

In other words, while you may no longer be able to conduct the duties of your current occupation you may be able to perform activities in a related field.

There are some disability income policies that use another criterion to classify total disability. This is called presumptive disability and automatically qualifies the insured for total disability classification. These conditions are:

- Loss of use of any two limbs
- Total and permanent blindness

- Loss of speech and hearing

Presumptive disability may also be decided by using a loss of income test. If the earnings after disability significantly drop below pre-disability earnings by a given percentage the insured may be considered totally disabled.

Usually short-term policies cover non-occupational disability but most long-term policies cover both occupational and non-occupational sickness and accidents. Bear in mind, however, that occupational benefits are usually reduced by benefits received form workers compensation and social security.

Other considerations are the probationary period, elimination period and the benefit period.

Some disability policies use a probationary period that begins when a policy goes into effect and no benefits are paid during this period. It varies but is often 15 or 30 days and sometimes up to 60 days for long-term policies.

In addition to the probationary period some policies also include an elimination period. It begins when the policy goes into effect and can last for any length of time even up to a full year. This is usually left to the insured to decide as it is based on how long the insured can go without income after becoming disabled.

The primary advantage to a long probationary period is a low

premium and allows the insured to use premium dollars to purchase a benefit that best suits their needs.

The benefit period, which is the length of time, can vary depending on the needs of the insured. They can be as short-term as 13 weeks up to long-term as long as age 65.

As a general rule the longer the benefit period, the higher the premium. Same as everything in life, we get what we pay for.

Benefit amounts for both short-term and long-term policies range from 50% to 66 2/3% of earnings with a cap on the maximum amount to be paid.

Other disability categories are confining vs. non-confining, partial, residual, recurrent, delayed, combined accident and sickness and non-disabling.

We won't cover definitions of each category here, but do be aware of their existence and check your policy for a definition of coverage for these types of disability.

Most companies offer optional short-term benefits for an additional cost. A typical disability income policy might include all, some or none of the items below so it is important to discuss these with your agent. These options are:

Supplemental income – sometimes called an additional monthly benefit rider, provides additional income during the first several

months of a long-term disability.

Hospital income – pays a stipulated amount per day when hospitalized extending for a certain period and can be up to 12 months.

Elective benefits or indemnities – provides lump-sum payments for certain injuries like fractures, dislocations, sprains or amputations of toes or fingers and is elected by the insured in lieu of weekly or monthly benefits stated in a contract.

MEDICAL INSURANCE

If you recall, we explained that there are two broad categories of health insurance policies: disability and medical expense. Thus far we have covered disability. Now we'll take a look at basic medical expense insurance.

Basic medical expense policies provide for medical expenses that result from accidents and sickness. This is a loose term that refers to various medical, hospital and surgical benefits.

The broad category of medical expense coverage provides a wide range of benefits for hospital, surgical and medical care. Other benefits may apply as well, such as private nurses, convalescent care, and more.

Policies may be written as such that they may be limited to only

one or two types of coverage like hospital or miscellaneous medical costs or surgical expenses. These are known as basic plans.

Other, more broadly written, policies may cover all expenses resulting from accident or illness using some specific exceptions.

Medical plans include fee-for-service wherein doctors and other providers receive a payment that does not exceed their billed charge for service provided.

Prepaid plans provide medical or hospital benefits in the form of service rather than dollars. Many things need to be considered when selecting a medical expense plan such as:

Specified coverage versus comprehensive care. In other words does the plan feature only specific benefits or is the coverage comprehensive?

Any provider versus a limited number of providers. Are you required to choose from a specific list of providers?

National versus regional operation. Is the plan limited to a specific geographical region or operate nationwide?

Insured versus subscribers. Are participants considered insureds (the person who receives the benefit) or subscribers (the person who is paying the premium)?

We are going to take a look at the limited coverage for hospital, medical and surgical expenses. Discussing this separately first, will

help you to understand how the components are combined in major medical and comprehensive policies.

The broad definition of basic medical expense insurance in most states includes hospital, medical and surgical expenses. The purpose of this type of insurance is to cover a broad range of medical, hospital and surgical expenses as well as separate categories of medical expenses.

Let's explore individual versus group coverage.

No matter how a policy is written, narrowly or broadly, medical expense insurance is designed to reimburse for the cost of care whether it results from injury or illness.

Both individual and group policies are available to consumers. Normally individual policies are more costly along with having limited benefits but generally speaking, both types cover the same medical services.

Hospital expense benefits provide for expenses incurred during hospitalization. Indemnities usually fall under two broad groups:

- Room and board – including nursing care and special dietary requirements
- Miscellaneous medical expenses – including x-rays, lab work, medications, medical supplies and operating and special treatment rooms

In some cases, benefits might be included for certain surgeries and related costs like pain killers given during a hospital stay.

Room and board benefits may be paid based on indemnity or reimbursement depending upon the particular policy. When paid on an indemnity basis, the insurer pays a specified rate per day that has been pre-determined and is laid out in a schedule within the policy.

The schedule will spell out the details of the benefit coverage as it pertains to length of stay. Once the length of stay has been exhausted, no more benefits are available. These are sometimes called dollar amount plans and typically the number of days is from 90 up to 365.

More commonly used is a reimbursement basis, also known as an expenses-incurred basis. With this type of coverage the policy will pay in one of two ways – the actual charges for a semi-private room or a percentage of the actual charges. There are no specific dollar amounts but a maximum number of days will still be specified.

Surgical Expense Benefits fall under two plans, scheduled and non-scheduled.

In the scheduled plan, surgical expense policies pay the fees incurred from the surgeons services and related costs incurred when the insured has an operation. Typical related costs include fees for an assistant surgeon, anesthesiologist and can even include the operating

room when it is not covered as a miscellaneous item.

Basic surgical coverage can be included in the same policy as basic hospital and medical expense and are normally included in a schedule listing major commonly performed operations and the benefits payable for each.

This gets a bit tricky and you need to be aware of how the insurance company determines the benefit. Just because a specific surgery is not listed in the schedule does not necessarily mean that there is no benefit for it available. It might mean that the insurer indemnifies that surgery based on absolute value and the relative value of each procedure.

In other words, let's say that the insurer determines that a certain surgical procedure has a prevailing value of $1500 and indicates that in the schedule included in your policy. That is considered the absolute value. Now, let's say that there is another procedure not listed in the schedule that is say 50% less complicated as the $1500 procedure. In this case, the relative value would be $750 and that is the benefit amount that will be paid for the less complicated procedure.

Using a non-scheduled scenario, when surgical benefits are not listed by a specific dollar amount in a schedule, the policy will pay based on what is considered usual, customary and reasonable in a

certain geographical area and is also known as UCR.

This non-scheduled type of indemnity is found most often in major medical and comprehensive policies which we will discuss further along.

As you might imagine, under this type of arrangement the UCR is determined by the amount that physicians in the local area usually charge for the same procedure.

Regular medical expense benefit is another category that is sometimes known as physician's non-surgical expense. This coverage is for non-surgical services a physician provides and can sometimes be narrowly applied to physician visits while the patient is in the hospital.

If this is the case the benefit will most likely pay for a specified maximum number of visits per day, a specified maximum dollar amount per visit and a specified number of days coverage applies.

In other policies this benefit could be for non-surgical services performed by a physician whether the patient is in or out of the hospital. Once again there are limits such as $100 per visit up to 50 visits per year depending on the policy.

Other medical expense benefits fall into a category in addition to the hospital, surgical and medical benefits previously discussed. These optional benefits vary from insurer to insurer and may or may not include as part of their standard policies. Separate policies can

sometimes be written to include these benefits. Some of them are:

- Maternity
- Convalescent – Nursing home
- Emergency first-aid
- Home health care
- Mental infirmity
- Hospice care
- Prescription drugs
- Dread disease
- Outpatient treatment
- Dental
- Private duty nursing
- Vision

We will not cover all of these options, but will let's take a look at the most common.

Maternity benefits are sometimes included in policies subject to certain conditions and limitations. The most usual limitation is a 10 month waiting period designed to prevent the purchase of health insurance just to cover pregnancy and childbirth expenses. Interesting to note, however, group policies for employee groups of 15 or more are required by law to provide maternity benefits on the same basis as non-maternity benefits. This means that in a case such as this, the

waiting period would not apply unless non-maternity benefits also required a 10 month waiting period.

Aside from the group scenario above, many policies just exclude maternity benefits totally but make them available at extra cost. Where maternity benefits do apply, the benefit usually includes newborn care while the mother is in the hospital.

Other benefits that are sometimes available under the same maternity coverage might include cesarean deliveries, natural abortions and elective abortions.

Emergency First Aid Coverage applies to an accident that may call for immediate first-aid on the scene. This applies when a medical professional who just happens on the scene provides first-aid service he/she might bill the insured. Sometimes treatment like this must be performed without the knowledge or assent of the insured. Some policies offer coverage for such contingencies and normally must incur within a very short time after an accident.

Mental Infirmity historically has been excluded from most policies. However, in recent years more and more policies include this type of coverage but with limitations. The benefits are usually much lower than physical ailments and a stated percentage of the benefit paid for other types of medical care is included.

Common exclusions and limitations. Both disability income and

medical expense policies limit or exclude coverage for certain types of injuries or illness. There is a difference between limitations and exclusions. The mental infirmity policy limitations we discussed above is an example, whereas an exclusion is completely omitted from any coverage.

It is important that you deal with a knowledgeable agent because state laws and policies may differ on specific items. Some items that fall into the common exclusions and limitations might be:

- Pre-existing conditions as defined by your policy and dictated by state law.
- Hernia however the growing trend is to cover the condition.
- Self-inflicted injuries
- Suicide
- War and/or acts of ware that result in injury or death
- Military duty
- Non-commercial air travel
- Injury while committing a felony
- Injury, illness or death incurred while under the influence of alcohol or narcotics
- Cosmetic surgery unless for surgery required as a result of an accidental injury or a congenital defect

- Dental expense, unless resulting from accidental injury
- Vision correction such as eye exams, eyeglasses and contact lenses
- Care provided by governmental facility which is normally covered by the Veterans Administration or by workers compensation
- Sexually transmitted diseases
- Experimental procedures
- Organ transplant
- Infertility treatment and services
- Alcohol and drug abuse treatment

Up to this point we have discussed “basic” benefits that are designed to cover some hospital, medical and surgical costs that are primarily considered to be minor. When purchased individually, these benefits can be substantially less than actual costs incurred.

Here is where Major Medical coverage enters the picture. Major Medical covers a broader range of medical expenses providing more complete coverage. Generally speaking, these more extensive types of policies fall into two categories:

1. Comprehensive. This is the more traditional basic coverage and any other type of medical expenses are combined into a single policy.

2. Supplemental. This coverage usually begins with a traditional basic policy. That coverage pays first and the major medical coverage is added to include expenses that are not covered by the basic policy.

The primary distinction between supplemental and comprehensive major medical coverage is that supplemental plans distinguish between basic and major medical for reimbursement purposes. Comprehensive plans combine the two types to cover essentially all types of medical expenses.

Let's take a more in depth look at comprehensive major medical benefits. There are two types of comprehensive major medical plans, one with first dollar coverage and the other without.

Just as the first term implies, first dollar coverage begins as soon as covered medical expenses are incurred. Without first dollar coverage, the insured must pay specified "deductible" amounts first. When that amount of expenses incurred has been paid by the insured, the policy begins reimbursing.

Major medical coverage has another feature, coinsurance. This means that the insurer and the insured share in any expensive above the deductible amount. The insurer will always carry the bulk of expenses and normally pays 80% and the insured pays 20%. Other proportions may be used so it is important that you read your policy

thoroughly.

Some policies dictate that certain types of medical expenses are not subjected to the deductible while other types are. For example it is non uncommon for no deductible to apply to initial hospital and/or surgical expenses up to a specified amount. In a case like this, the insured would pay no deductible in expenses but would first pay the deductible before major medical covered any additional expenses. The insurer and insured would then share in the remaining expenses at 80% and 20% or whatever the percentage is in their applied policy.

It is becoming more common for major medical polices to include a “stop-loss limit.” This limit would be a dollar amount that, when reached, the insured no longer participates in any further payment.

This is generally referred to as a stated maximum benefit. The lifetime maximum limits on health insurance might range from $100,000 to $1,000,000. Some policies can even have unlimited benefits. Just as the maximum benefit can vary, so can the amount of the stop-loss limit depending upon the insurer.

Supplemental major medical benefits supplement a basic policy that includes hospital, surgical and medical with an additional policy that covers the broader range of medical expenses.

Usually the basic plan will pay covered expenses with no

deductible up to the policy limit. Beyond that limit, the supplemental policy operates the same as a comprehensive policy that provides no other first dollar coverage.

This means that after the basic policy limits are exhausted, a deductible kicks in followed by the major medical coverage.

Just as the comprehensive major medical policy, a supplemental plan will more than likely include stop-loss limit as well as a maximum benefit limit.

What expenses are covered under major medical policies? No matter whether they are supplemental or comprehensive both will generally cover the following even if they vary slightly from policy to policy:

- Hospital inpatient room and board including intensive and cardiac care
- Nursing services including private duty outside a hospital
- Hospital medical and surgical services and supplies
- Physicians' diagnostic, medical and surgical services
- Anesthesia and anesthetist services
- Other medical practitioners' services
- Outpatient services
- Ambulance service to and from a hospital
- xRays and other diagnostic and lab tests

- Radiologic and other types of therapy
- Prescription drugs
- Blood and blood plasma
- Oxygen including administering
- Dental services that are a result of injury to natural teeth
- Convalescent nursing home care
- Home health care services
- Prosthetic devices when initially purchased
- Casts, splints, trusses, braces and crutches
- Rental of durable equipment like hospital style beds and wheelchairs

Let's review some of the other major medical concepts such as deductible features, benefit periods and restoration of benefits.

Deductibles can be handled in several different ways depending on your policy. One method might be on a per-cause deductible which applies to sickness or injury. Other policies may have a deductible known as all-cause which is sometimes called cumulative or calendar-year deductible.

If your policy is per-cause you will pay a single deductible for all expenses you incur for the same injury or illness. Your benefit period for each cause begins when deductible has been meant for that injury or illness. This can sometime run as long as one or two years.

It is important to understand the per-cause stipulation. Let's look at an example. If you are ill in May and then are injured in an accident in July those are two separate causes and deductible must be met for each of them separately.

However, if your policy is based on an all-cause deductible, the expenses for various injuries or illnesses are accumulated to meet your deductible in one calendar year. Once that is met, the rest of your charges are paid for that calendar year.

Additionally, using the all-cause method there is usually carryover provision that allows you to carry over expenses from the last three months of one calendar year to the next.

If your policy covers the entire family, then a family deductible will apply rather than individual deductibles. In other words if a policy's individual deductible is $200 a family deductible might be $400. This can be very advantageous because a six member family would only have to meet $400 rather than $1200 individually.

One other type of deductible could also be beneficial to a family and that is the common injury or illness provision. What this means is that if two or more family members are injured in a common accident or become sick from the same illness, only one deductible amount will be required.

The time during which benefits are paid is called a benefit

period. These times are generally linked to the deductible as well as any inside or internal limits in the major medical policy.

Determining when a benefit must be paid can be one of two different ways. The benefit period might begin either on the first day of an injury or illness or on the date that the insured meets the deductible and can extend up to two years. Or, the benefit period may cease at the end of a calendar year and begin with a new deductible.

Benefit limitations placed on certain of the various coverages in a major medical policy are considered inside or internal limits. In other words, the policy may limit both room and board and number of days that will be paid. In this case, the period for hospital room and board will be whatever number of days that are specified. Other internal limits might be restrictions for convalescent are days, mental health, x-rays and similar items.

Your restoration of benefits is the time at which you can expect your benefits to resume after policy limits have been met. For instance, a lifetime level might be as much as $500,000 and an insured might use up half or more of that in a single year. This leaves only $250,000 left for the remainder of his life.

Some policies allow the maximum to be restored if the insured can prove that he is once again insurable. Other policies may have an automatic reset provision restoring a specified amount every January

1st.

HEALTH INSURANCE PROVIDERS

In this chapter we will take a look at all the different "types" of insurers and how they are structured. The following are the different types of insurers:

- Traditional Insurers
- Domestic, Foreign and Alien Companies
- Blue Cross/Blue Shield
- Health Maintenance Organizations (HMO)
- Preferred Provider Organizations (PPO)

Traditional Insurers

This type of company is one that has evolved over time into a 'branded" image in the eyes of the public. This is the opposite of what we have come to know in today's world as Health Maintenance (HMO) and Preferred Provider Organizations (PPO).

A traditional insurer selling health coverage may specialize in just health coverage. The types of insurance they sell may be referred to as accident and health (A&H) or accident and sickness (A&S) companies. Most states require a separate license to write life, health and property casualty.

Stock and Mutual. Not only can an insurance company be

categorized by the type of insurance, they can also be considered in terms of its ownership as either a stock or mutual company.

At the time of organization, a stock company sells stock to raise the money necessary to operate a business. The stockholders are not necessarily insured by the company nor do policyholders necessarily own stock in the company. It is in business solely for the purpose of selling insurance to policyholders.

On the other hand, with a mutual company the policyholders are also owners of the company and as such, can vote to elect the company management. Any monies beyond the operating costs of the company may be returned to the policyholders as dividends or reductions in future premiums.

Consumer Cooperatives. There are two different types of cooperatives. They are consumer cooperatives and producer cooperatives. Producer cooperatives include companies like Blue Cross/Blue shield and some Health Maintenance Organizations which we will discuss further on.

Additionally, there are two types of consumer cooperatives. One is the mutual insurance model discussed previously and the other less common and unincorporated type is a reciprocal company.

A reciprocal company is based on the model of give and take. Members agree to share insurance responsibilities among all members.

All members insure one another and share in the losses and no member can buy insurance without committing to providing insurance in return. This type of consumer cooperative is managed by an attorney-in-fact who handles all matters of business for the cooperative.

Participating and Non-participating Policies. These terms indicate that the policyholder of a traditional type of insurance, either does or does not participate in, or receive, a share of any surplus that results from an insurers business operations. These terms are also known as par and non-par.

The surplus from which participating policyholders might receive a return are excess reserves for claims, interest on investments and savings on expenses. This represents amounts not ear marked for any particular purpose and are therefore available to participating policy owners.

Domestic, Foreign and Alien Companies

Here in the United States, companies are usually organized and chartered under the laws of one particular state and it is common for them to do business in many states. A company that operates its home office in the state where it is organized is known in that state as a domestic company. In any other states where they do business the

company is considered a foreign company. If the home office of a company is located outside the United States, it is considered an alien company. No matter whether it is domestic, foreign or alien a company must be registered in every state in which they operate.

Blue Cross/Blue Shield

These service organizations represent producers cooperatives. Hospitals and physicians who sponsor Blue Cross/Blue Shield plans are providing the insurance, therefore they are considered to be the producers of the cooperative.

Originally Blue Cross and Blue shield were separate voluntary and tax-exempt associations. Blue Cross provided payments to hospitals and Blue Shield covered physicians, medical and surgical fees. People originally covered under these plans were traditionally known as subscribers since Blue Cross and Blue shield differ from traditional insurance companies.

In most states, the two have merged, but each group still covers the expenses for which they were initially created. Over the years the tax advantages they originally enjoyed have deteriorated and many states have removed their exempt status. Additionally the federal Tax Reform Act of 1986 now makes them taxable as insurance companies.

Health Maintenance Organizations (HMO)

The number of Health Maintenance Organizations (HMOs) is growing by leaps and bounds and is in direct correlation with increasing health care costs.

The purpose of HMOs is to manage health care by using a prepaid model that emphasizes early treatment and prevention. This prepayment is referred to as a service-incurred basis and is paid by the consumer.

This emphasis on prevention such as routine physicals, diagnostic screening is paid for in advance. The model is a direct contrast to health insurance plans that historically did not pay for preventive programs but only paid after the fact for injury and illness.

In theory, the HMOs focus on prevention is ultimately supposed to reduce health care costs. At the same time, HMOs provide medical treatment, hospital and surgical when needed.

There is another way that HMOs differ from the traditional health insurance providers. HMOs have two step system that is not shared by insurance companies. Under the traditional method, consumers receive the health care itself from the medical profession and the financial coverage from the insurance company.

In sharp contrast, the HMO provides both the health care services AND the health care coverage.

These are combined because the HMO is made up of medical practitioners who provide specific services to HMO members at prices that are pre-set and the HMO member agrees to pay the HMO a specified amount in advance to cover necessary services. Therefore, the HMO is furnishing health services as well as making the financial arrangements.

As we have stated, the emphasis on prevention and the effort to containing cost is the major factor for developing HMOs. However, federal law also encourages the development of HMOS. They may receive government grants as well as requiring certain employers who offer health benefits, to offer HMO enrollment as an option by meeting certain criteria.

The basic structure of HMOs includes contractual agreements with a variety of facilities and health care providers to provide services to HMO subscribers. Within this structure are four different types, Group, Staff, Network and Individual Practice Association.

Group model – Early on this was the predominant scenario. With this arrangement the HMO contracts with an independent medical group that specializes in a variety of medical services and the HMO in turn provides these services to members. Additionally, the HMO is paying another entity as a whole rather than individuals.

Staff model – This arrangement is pretty self-explanatory

wherein the physicians are paid employees working on the staff of an HMO in a clinical setting at the HMO physical facilities. The HMO often owns the hospital as well. In this model the HMO is taking all the financial risk as opposed to the group model.

Network model – This arrangement works like the Group model with the difference being that the HMO will contract with more than one group to provide the services. The primary purpose for this model is to provide convenience and increase accessibility for the members.

Individual Practice Association Model – This structure is designed to give maximum flexibility to the HMO members wherein they contract individually for all services. There are no separate HMO facilities and all services operate out of their own facilities.

There are several types of groups that may sponsor HMOs, some of which are:

- Medical schools or associations
- Labor unions
- Physicians
- Hospitals
- Insurance companies
- Labor groups
- Consumer groups
- Service organizations (Blue Cross/Blue Shield)

- Government entities

Most HMOs restrict membership to a narrowly defined group. For instance, a labor union might limit enrollment to active members of their union.

HMOs are required to provide the following basic health care services:

- Physicians' services
- Hospital inpatient services
- Outpatient medical services
- Emergency services
- Preventive services
- Diagnostic laboratory services
- Diagnostic and therapeutic radiology services

Many HMOs may also provide the following, but are not required to do so:

- Prescription drugs
- Vision care
- Dental care
- Home health care
- Nursing services
- Long-term care
- Mental health care

- Substance abuse services

Those who would like supplemental services may purchase them from the HMO only as an addition to the basic health care services that the HMO provides.

Co-payments. HMO members may be charged only nominal amounts for basic services in additional to the original monthly payments. In some cases there may be no additional payments for services. All details are spelled out in a descriptive document which is known as either the certificate of coverage or evidence of coverage.

Gatekeeper. HMOs most often have this type of system wherein a primary care physician must be selected who in turn will authorize all care for a member including referrals to specialists.

Twenty four hour access. Normally members have 24 hour access to the HMO.

Open Enrollment. This term can apply in one of two different ways. An employee sponsored group has a set time period each year when employees may choose to enroll or remain enrolled or change plans. The second meaning is a period each year when an HMO must advertise to the general public on an individual basis.

Nondiscrimination. When HMO services are offered to a group, the HMO may not refuse to cover an individual member of the group due to pre-existing health conditions. This practice is much different

from traditional insurers where adverse conditions may preclude enrollment.

Complaints. HMOs must be set up to handle coverage complaints and care complaints. HMO members must receive a document that spells out how complaints can be registered.

Prohibitive practices. In addition to non-discrimination against group members based on their health status during enrollment, HMOs are not allowed to cancel or dis-enroll members because of their current health status or the amount of usage of health services. HMOs are also not allowed to use words that may imply that the HMO provides insurance in the traditional manner.

Preferred Provider Organizations (PPO)

Preferred Provider Organizations are another attempt to reduce medical costs. This is an arrangement whereby a selected group of independent hospitals and medical practitioners in a certain area agree to provide certain services at a prearranged rate.

The organizers and providers agree upon medical service charges that are generally less than the provider would charge patients not associated with the PPO.

These differ from HMOs in that the providers are paid on a fee for service basis rather than receiving a flat monthly amount and the organizer or contracting agency might be:

- Traditional insurance companies
- Blue Cross/Blue Shield
- Local groups of hospitals
- Local groups of physicians
- An existing HMO
- Large employers
- Trade unions

Those people who will receive services select a preferred provider from a list that the PPO distributes. Usually the choices are more extensive with a PPO than a HMO.

Sometimes PPOs and HMOs are lumped together and called a managed care system. One characteristic still exists concerning regulation, however. HMOs increasingly have to meet state requirements as well as standard established by federal government. PPOs are less stringently regulated since any group that can agree on the arrangements can call itself a PPO.

GROUP HEALTH INSURANCE

Most people have a general idea of the nature of 'group' coverage. The most common type of group coverage is provided via employment. Many employers provide group health coverage as a benefit to their employees, either by paying the entire premium or

sharing in the premium.

In a group situation, a single policy covers a specific group of people as opposed to a single person as individual policies do. Because of this special nature, insurance companies have to make certain that the number of people covered by a group policy stays at or above a certain level.

Some states also have their own regulations that control the minimum number of people required under a group plan. The number can differ from state to state so check local regulations.

In order to be considered a group, the entity must have the same employer or other commonality. As we discussed above, there are many different types of groups that may be considered, but for our purposes we will consider an employer/employee group.

A single master policy is issued to an individual or entity representing the group of people. As we stated, for our purposes we will call this the employer. It is the employers responsibility to apply for coverage for the group, own and hold the master policy and collect and make premium payments to the insurer when due.

Eligibility and eligibility period. In an individual policy situation where each person is evaluated separately in terms of risk, the normal practice in a group situation is to include all eligible employees regardless of physical condition or age.

On condition must be met, however, for all people regardless of their physical condition before they may be included in a group plan. That condition is that they must apply for coverage during a specified eligibility period. Failing to enroll in that time period will result in a requirement to take a physical examination and they will be selected on an individual basis just as if the policy were an individual policy. An initial 90 day employment period is typical for group coverage, after which the employee has a 31 day eligibility period. If the employee fails to apply during that eligibility period, then the employee will be required to take a physical examination and must qualify as if on an individual basis.

This is how an insurer can afford to cover a group of people without individual selection. Otherwise some people might choose not to enroll until they discover they have an illness or they become disabled, and requiring a physical exam after the eligibility period helps to preclude this event.

This same concept also applies to determining who receives specific benefits. For example, an employer may choose to offer certain groups of people within the total employee group, a different set of benefits.

For instance, this can award certain benefits for those employed less than 5 years and a different set of benefits for those employed

over 5 years. This arrangement can be differentiated in many other ways as well using salary level, position within the company and so on. The only stipulation is that such divisions may not have an adverse effect on the insurer.

Further, any such special benefit provision must apply to everyone within that specified group who meet the selected criteria. All who are designated must automatically become eligible as soon as they qualify.

How premiums are paid depends on which of two different types of plans a group selects. The two types are contributory and non-contributory. In the case of non-contributory, the employer pays the full cost of the premium, while the contributory type requires a shared cost between the employer and employee.

When applying for a contributory group plan, the employer needs to solicit enough employees to demonstrate to the insurer that a sufficient percentage want the coverage and are willing to pay a share of the premium. For a non-contributory plan, 100% of the eligible employees must be included.

There are several considerations that the insurer has when determining the group premiums. Average age of the group is an important consideration. The higher the average age of the group, the more instance of potential claims resulting in a higher premium.

Another consideration is the maximum indemnity period for loss of time benefits. The longer an insurer pays disability benefits, the higher the rate will be.

If a group policy covers occupational illness and/or injury, the degree of occupational hazard becomes an important factor. Again, the higher the occupational hazard, the higher the rate.

Group policy types. Group health plans may include any of several types of insurance discussed earlier. With no intention of becoming repetitive, let's review some of those individual coverages. A group health plan doesn't have to include all coverages although most will include at least two or more. In addition, disability income coverage may be offered in a group arrangement but it is usually separate from hospital, medical and surgical coverage.

Therefore, the first possible group coverage pays benefits for lost earnings resulting from accident or sickness and is commonly called disability insurance.

Accidental loss of life and accidental loss of one or more limbs or eyesight is another common type.

Hospital expense is another type of potential group coverage. These policies can pay for hospital expenses whether inpatient or outpatient. Fees of an attending physician during hospital treatment may be covered. Some types of group policies may only cover surgical

expenses.

Further, there are a number of provisions that apply only or primarily to group policies. These provisions:

- Describe who is eligible for the group plan
- Describe when individuals become eligible for the plan
- Specify minimum number of participants and minimum participation by eligible people necessary to sustain the plan
- Specify amount of insurance that individual group members are entitled
- Describe the responsibilities of the master policy owner

We discussed earlier that not all members of a group are necessarily eligible under a group plan. Also, the employer may set certain eligibility requirements.

Often working couples both qualify for group health insurance through their employment whereby the spouse is covered by each plan. To prevent possible abuse, special provisions are required by law in most states. This is referred to as a Coordination of Benefits Provision and allows insureds as much coverage as possible while doing away with over insurance. Receiving dual benefits constitutes fraud and is punishable by law.

Businesses that offer group coverage are subject to certain

provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Terminated employees of companies that regularly employ more than 20 people may be eligible for extended group health insurance coverage after they leave their jobs.

COBRA requires that some group health plans offer a continuation of coverage at group rates or slightly higher to departing employees for up to 18 months. For dependents of deceased employees and in some other special cases, continuation of coverage can last for up to 36 months.

In most cases, if an employer discontinues group insurance, employees must be given the opportunity to convert to individual insurance without a medical exam.

Self-insurance is a situation where an employer provides health benefits to its employees by depositing money in a special self insured fund which pays for reimbursement of medical expenses from the fund. This is not a viable option for most employers which must be large enough to have a base from which to predict expected expenses.

FINDING THE BEST VALUE FOR YOUR NEEDS

We mentioned early on that when it comes to health care, there is no “one size fits all.”

Ideally, working for an employer who offers non-contributory health insurance is what most of us would aspire to. However, that is not a realistic scenario.

Finding affordable, adequate health care coverage is a huge problem in our country right now. If you are in a situation where you require certain medications and have no access to reduced rates on prescriptions you can almost bet the farm that you will be paying top dollar for the medications you need.

When considering a change in employment, scrutinizing the potential employers health care plan is a given. Sadly, many people look at everything about a new job except the health care plan, just lumping it together with a "benefit package." This could be a huge mistake. Contracting a debilitating illness or becoming an unwilling participant in an accident is not something that anyone can foresee.

This is particularly true with young singles. Life situations change and a health care plan that was adequate for a single person may not apply should he/she marry and even have children while employed. If their policy has no provisions for the addition of dependents in the future you can find your health care woefully inadequate. Take the time to project what your future situation might be and plan accordingly.

One of the most overlooked segments of our society are the self-

employed. Depending on age and dependent requirements, the cost for individual coverage can be astronomical.

If you are self-employed or a very small business owner, consider joining a local association like a chamber of commerce, better business bureau or some other type of business organization.

Many of these organizations offer access to health care that might otherwise be prohibitive on an individual basis. They often charge a membership fee to the organization. Sometimes even when you factor in several hundred dollars a year for membership dues, that small cost far outweighs the potential savings in premiums. Health care packages are often one of the most lucrative options these organizations have to assist in recruitment of new members.

If you do not fall into either of the categories above, you might investigate other potential group options. Fraternal organizations, unions and clubs may offer access to group rates. The important thing is to pursue every possible avenue with an eye toward obtaining access to group health insurance.

Unless you are in a category considered as “low income” that would afford you access to social health care you can plan on paying hefty premiums. If you have a pre-existing condition, your chances of obtaining affordable rates are statistically very low. But, there are some things you can do. Some tips to bear in mind are:

- Shop very carefully. You now understand what some of the options are and how widely diversified policies can be.
- Make certain you are looking at insurance that is appropriate and adequate for your needs.
- Read the fine print so you understand what is included and what is excluded.
- Never buy a policy that covers a single disease.
- Are there deductibles and if so, how much?
- Does the coverage include major medical?
- What is the maximum out of pocket expense you can expect to incur?
- When does coverage begin?
- Does the coverage include prescriptions?
- Are lab fees and x-rays included?
- Can you choose your own physician or select from a list of providers?
- What is most important to you?
- Does the coverage include dental, vision, maternity, well-baby care, etc.

If you are in that “no mans land” where you do not yet qualify for Medicare, Medicaid or any of the other social programs yet are too

old for individual coverage you might take a look at AARP. It can provide a stop gap for that period of time while you are waiting to qualify for assistance.

If you are a young single parent, investigate any subsidized programs that might be available in your state. Many states have programs that will provide care for your children if not for yourself. These social programs are generally based on a sliding scale based on your income level and in many cases visits and prescriptions for your children might be free of charge.

With the skyrocketing costs of health care, no one should ever feel embarrassed or sacrifice the health of themselves or their loved ones by applying for any type of assistance that might be available to meet their needs. Until something happens to curb this upward spiral we must all take special steps to see that the most vulnerable members of our society receive the health care they need. . .namely, our children and our elderly.

GLOSSARY OF TERMS

Coinsurance: The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if

the insurance company pays 80 percent of the claim, you pay 20 percent.

Coordination of Benefits: A system to eliminate duplication of benefits when you are covered under more than one group plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Co-payment: Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, $5 for every visit to the doctor). The insurance company pays the rest.

Covered Expenses: Most insurance plans, whether they are fee-for-service, HMOs, or PPOs, do not pay for all services. Some may not pay for prescription drugs. Others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy.

Deductible: The amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying.

Exclusions: Specific conditions or circumstances for which the policy will not provide benefits.

HMO (Health Maintenance Organization): Prepaid health plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays, and therapy. You must use the doctors and hospitals designated by

the HMO.

Managed Care: Ways to manage costs, use, and quality of the health care system. All HMOs and PPOs, and many fee-for-service plans, have managed care.

Maximum Out-of-Pocket: The most money you will be required pay a year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

Non-cancellable Policy: A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

PPO (Preferred Provider Organization): A combination of traditional fee-for-service and an HMO. When you use the doctors and hospitals that are part of the PPO, you can have a larger part of your medical bills covered. You can use other doctors, but at a higher cost.

Pre-existing Condition: A health problem that existed before the date your insurance became effective.

Premium: The amount you or your employer pays in exchange for insurance coverage.

Primary Care Physician: Usually your first contact for health care. This is often a family physician or internist, but some women use their gynecologist. A primary care doctor monitors your health and diagnoses and treats minor health problems, and refers you to

specialists if another level of care is needed.

Provider: Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care.

Third-Party Payer: Any payer for health care services other than you. This can be an insurance company, an HMO, a PPO, or the Federal Government.