

Health insurance basics

*By Nicholas Schidowka, President
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It's a fact of life, everyone needs health insurance — and the time to get it is *before* you have an accident, suffer a serious illness, or discover you're pregnant. Insurance doesn't cover health care for medical problems or conditions that start before the moment you have your policy. Finding adequate coverage might seem overwhelming, but knowing the basics can help make your search less stressful.

Your boss doesn't have to provide health insurance

The first reality of health insurance is you do not have a *right* to it. There are no state laws or federal laws requiring private employers to offer health benefits to their workers.

“For a number of valid reasons employers are not mandated to offer or provide health insurance for their employees,” explains Cleveland attorney, Oleh Mahlay. “It is common knowledge; however, that most employers though not mandated to do so offer insurance to their employees for a variety of reasons related to competition and smart business practice.”

If you have benefits through your employer, and you quit or lose your job, don't assume you will be able to pick up the identical coverage for the same price.

Similarly, don't expect your former employer to extend benefits beyond your last day at work. There is no "grace period" during which you are still covered.

If you do lose your employer-sponsored benefits, there is a federal plan called COBRA (Consolidated Omnibus Reconciliation Act) that could provide you with a short-term safety net.

Another federal law that offers some protection to workers experiencing a short-term lapse in coverage is HIPAA (Health Insurance Portability and Accountability Act).

Individual health insurance can be costly

If you need to purchase individual health insurance, it can be expensive. Unlike group plans, in which the costs and risks associated with health care are spread among many people, individual health policies are "medically underwritten" to take into account *your* personal health history. Any "pre-existing" condition such as heart disease, diabetes, and even pregnancy, can nix your chances of acceptance or boost your premiums. Some states require individual health insurers to offer everyone a plan, a mandate known as "guaranteed issue."

Individual and family health insurance plans are usually described as either "indemnity" or "managed-care" plans. Put broadly, the major differences concern choice of healthcare providers, out-of-pocket costs and how bills are paid. Typically, indemnity plans offer a

broader selection of healthcare providers than managed care plans. Indemnity plans pay their share of the costs for covered services only after they receive a bill, meaning the policy holder may have to pay up front and then obtain reimbursement from the health insurance company.

There are several different types of managed-care health insurance plans. These include HMO, PPO, and POS plans. Managed-care plans typically make use of healthcare provider networks. Healthcare providers within a network agree to perform services for managed-care plan patients at pre-negotiated rates and will usually submit the claim to the insurance company for you. In general, you'll have less paperwork and lower out-of-pocket costs with a managed-care health insurance plan and a broader choice of healthcare providers with an indemnity plan.

Expect to pay more and more

Once you have a health plan, don't expect your premiums to remain the same. Health insurance companies often seek permission to raise premiums. Additionally, some states allow health insurers to "file and use" rate increases, which means the insurers only have to submit their increases in writing and then they may immediately begin charging customers more money. Unless insurance regulators determine the rates are excessive, the insurers are allowed to keep charging the higher premiums.

Attorney Michael Dobronos says even if you have group health insurance, there's a good chance your rates will climb. "Even though you have not presented any claims, others that are insured by the same type policy have presented claims. Rates are directly affected by the claims experience of the group insured under a given plan or policy," Dobronos explains.

Help when you can't afford an individual plan

If you're a college student and are in need of coverage — perhaps you're being dropped from your parents' plan — your school might offer reasonable health insurance.

No matter what your age, there are several federally sponsored programs to help you if can't afford the premiums for individual health insurance, providing you meet their eligibility guidelines:

- Medicare, a health insurance program for people age 65 or older, certain younger people with disabilities, and people with end-stage renal disease.
- Medicaid, a program for the poorest individuals and low-income families with children.
- The Children's Health Insurance Program (CHIP), a plan that provides health care to children whose parents make too much to qualify for Medicaid, but earn too little to afford individual health insurance.

Many states offer health care plans for children of parents, who don't have health insurance through work and cannot afford individual plans. Some states have expanded the plans to cover the parents as well.

How does health insurance work

Imagine you have a \$100,000 heart surgery, which is a covered medical expense under your health insurance plan, and let's say this health insurance plan has a \$1,000 annual **deductible**, 20% **coinsurance** after deductible, \$2,000 **out-of-pocket limit** per year and \$5 Million **lifetime maximum**. (*Not all health insurance plans feature deductible or coinsurance.)

What is a Deductible? Typically, a deductible is the amount of money you must pay each year before your health insurance plan starts to pay for covered medical expenses. So with a \$100,000 heart surgery bill, you are responsible for paying the first \$1,000. After this \$1,000 **deductible** is met, the insurance company will pay a percentage of the bill in what is called the **coinsurance**.

What is Coinsurance? Typically, coinsurance is a cost-sharing requirement where you are responsible for paying a certain percentage and the insurance company will pay the remaining percentage of the covered medical expenses after your deductible is met. For a health insurance plan with 20% **coinsurance**, once the deductible is met, the insurance company will pay 80% of the covered expenses while you pay the remaining 20% until your **out-of-pocket limit** is reached for the year.

What is Out-of-Pocket Limit? Typically, the out-of-pocket limit is the maximum amount you will pay out of your own pocket for covered medical expenses in a given year. For a plan with a \$2,000 **out-of-pocket limit**, you will pay a \$1,000 deductible and \$1,000 coinsurance while the insurance company covers the remaining \$98,000 of the heart surgery bill. Even if you are hospitalized again in the same year, the insurance company will pay 100% of your covered expenses within the limit of the **lifetime maximum**.

What is a Lifetime Maximum? Typically, a lifetime maximum is the amount your insurance plan will pay for covered medical expenses in the course of your lifetime. If a health insurance plan has a **lifetime maximum** of \$5 million and you continue to pay your deductible, coinsurance and out-of-pocket limit each year, the insurance company will pay for all remaining covered medical bills up to a maximum of \$5,000,000 in your lifetime.

Here's one more concept... Some health insurance plans offer co-payment. **What is Co-payment?** Typically, a **co-payment** or **co-pay** is a specific flat fee you pay for each medical service, such as \$30 for an office visit, after which the insurance company often pays the remainder of the covered medical charges. Let's say you are not feeling well and went to see your doctor who charges \$200 for the office visit. If your insurance plan has an office visit **co-payment** of \$30, then you will only be responsible for the \$30 and the insurance company will cover the remaining \$170.

Making sense of alphabet soup

Before you visit a country where the population speaks a foreign language, it helps to know a few key words and phrases. The same holds true when you're trying to decipher the lingo of health insurance. Whether you're buying individual or group health insurance, know there are several health plan varieties, including traditional indemnity fee-for-service plans (FFS), health maintenance organizations (HMOs), point of service plans (POS), and preferred provider organizations (PPO). Each plan has its own features to consider before making your choice.

FFS, also called traditional indemnity

FFS coverage offers flexibility in exchange for higher out-of-pocket expenses, more paperwork, and higher premiums.

FFS advantages

- You may choose your own doctors and hospitals.
- You may visit any specialist without getting permission from a primary care physician.

FFS disadvantages

- There's typically a deductible (anywhere from \$500 to \$1,500) before the insurance company starts paying claims, and then doctors are reimbursed about 80 percent of the bill while you pick up the remaining 20 percent.
- You might have to pay up front for medical services, and then submit the bill for reimbursement.
- FFS plans pay only for "reasonable and customary" medical expenses. If your doctor charges more than the average for your area, you will have to pay the difference.

HMO

HMOs are the least expensive, but also the least flexible of all the health insurance plans. They are geared more toward members of a group seeking health insurance.

HMO advantages

- They offer their customers low co-payments, minimal paperwork, and coverage for many preventive-care and health-improvement programs.

HMO disadvantages

- You *must* choose a primary care physician, also known as a PCP.
- HMOs require you to see only network doctors, or they won't pay.
- You *must* get a referral from your PCP to see a specialist.

POS

POS plans are more flexible than HMOs, but they also require you to select a primary care physician (PCP).

POS advantages

- Depending on your insurance company's rules, you may choose to visit a doctor outside the network and still receive coverage — but the amount covered will be substantially less than if you went to a physician within your network.
- These plans tend to offer more preventive care and well-being services, such as workshops on smoking cessation and discounts to health clubs.

POS disadvantages

- You *must* choose a PCP.
- While you may choose to see a physician outside the network, if you don't receive permission from your PCP, you're likely to wind up submitting the bills yourself and receiving only a nominal reimbursement — if any.

PPO

PPOs give policyholders a financial incentive — reasonable co-payments (also called co-pays) — to stay within the group's network of practitioners.

PPO advantages

- The standard co-payment is \$15 for a routine office visit during regular hours.
- You may go to any specialist without permission, as long as the doctor participates in the network.

PPO disadvantages

- If you see an out-of-network doctor, you might have to pay the entire bill yourself, and then submit it for reimbursement.
- You might have to pay a deductible if you choose to go outside the network, or pay the difference between what network doctors and out-of-network doctors charge.

How to find an individual health plan

Your first step in getting health coverage is to contact an insurance agent in your area, or an insurance company. An agent should be familiar with the insurance companies that do business in your state, especially those able to provide the coverage you need.

You might do business with either a "captive" agent who works for one insurance company or an independent agent or broker who sells policies for a variety of companies. A list of agents can be found in your phone book or by contacting your state department of insurance.

You should discuss with your agent your own particular health insurance needs. Think carefully about what coverage you must have. Do you need health insurance for your whole family, or just yourself? Do you want to choose your providers? If you're over 65, do you need insurance to fill the gaps in Medicare? Do you need — and can you afford — long-term disability and/or long term care coverage?

When you've found the right coverage, you need to fill out an application or give information to your agent to complete the necessary forms. Be honest. It's important to

disclose your medical history thoroughly and accurately. Report all of your health problems to your agent. If any of your health information is misstated or incomplete, the company might refuse to pay your claims and could cancel your policy.

*The above article is meant to give a general overview of insurance policies; exact coverage and terminology could vary by insurance company. **Please refer to your policy for exact coverage details and terminology.***

About the Author

Nicholas Schidowka began his work in the insurance and financial services industry in 1997. In 2001 he obtained Ohio licenses in Property and Casualty insurance and Life and Health insurance. Since then, he has worked hard to provide various insurance services to his customers including auto, business, health, home, and life. His professional and courteous approach to the insurance field has cultivated a diverse and loyal clientele in the Cleveland (Parma), Ohio area.

In 2007, Insurance Cleveland Agency LLC was formed. As an independent agency, Insurance Cleveland Agency has access to several different insurance carriers including Aetna, Encompass (owned by Allstate), Golden Rule, The Hartford, Medical Mutual, Ohio Casualty, Progressive Drive, Safeco, The Providence Association, Travelers, Victoria (owned by Nationwide), Dairyland/Viking etc.

Insurance Cleveland Agency is pleased to announce the addition of Ivan Voytovych, Evelina Iablonskaya and Yosyf Ciszkewycz to their team! Mr. Voytovych is a highly qualified and valuable addition to the ICA team and helps the agency cater to the company's English, Ukrainian and Russian speaking customers. Ms. Iablonskaya speaks English, Polish and Russian while Mr. Ciszkewycz speaks English and Ukrainian.

Insurance Cleveland Agency is conveniently located off of Pearl Road and Highway 71 in the Islander Office complex. Office hours are Monday – Friday 9:00 am to 12:30 pm and 1:30 pm to 5:00 pm. Please call ahead for an appointment. We look forward to hearing from you in the near future!

Please give us a call at 440.866.0155 or visit us on the web at insurancecleveland.com, your free quote is waiting for you without any obligations. Many insurance policies are needlessly expensive and often out of date. We will work hard to give you the best service and there is a very good chance you can save money and improve your insurance at the same time.