Why Do You Need Health Insurance?
Today, health care costs are high, and getting higher. Who will pay your bills if you have a serious accident or a major illness? You buy health insurance for the same reason you buy other kinds of insurance, to protect yourself financially. With health insurance, you protect yourself and your family in case you need medical care that could be very expensive. You can't predict what your medical bills will be. In a good year, your costs may be low. But if you become ill, your bills could be very high. If you have insurance, many of your costs are covered by a third-party payer, not by you. A third-party payer can be an insurance company or, in some cases, it can be your employer.

Where Do People Get Health Insurance Coverage?
Most Americans get health insurance through their jobs or are covered because a family member has insurance at work. This is called group insurance. Group insurance is generally the least expensive kind. In many cases, the employer pays part or all of the cost. Some employers offer only one health insurance plan. Some offer a choice of plans: a fee-for-service plan, a health maintenance organization (HMO), or a preferred provider organization (PPO), for example. Employers with 25 or more workers are required by Federal law to offer employees the chance to enroll in an HMO. Explanations of fee-for-service plans, HMOs, and PPOs are provided in the section called Types of Insurance.

What happens if you or your family member leaves the job?
You will lose your employer- supported group coverage. It may be possible to keep the same policy, but you will have to pay for it yourself. This will certainly cost you more than group coverage for the same, or less, protection. A Federal law makes it possible for most people to continue their group health coverage for a period of time. Called COBRA (for the Consolidated Omnibus Budget Reconciliation Act of 1985), the law requires that if you work for a business of 20 or more employees and leave your job or are laid off, you can continue to get health coverage for at least 18 months. You will be charged a higher premium than when you were working. You also will be able to get insurance under COBRA if your spouse was covered but now you are widowed or divorced. If you were covered under your parents' group plan while you were in school, you also can continue in the plan for up to 18 months under COBRA until you find a job that offers you your own health insurance. Not all employers offer health insurance. You might find this to be the case with your job, especially if you work for a small business or work part-time. If your employer does not offer health insurance, you might be able to get group insurance through membership in a labor union, professional association, club, or other organization. Many organizations offer health insurance plans to members.

If your employer does not offer group insurance, or if the insurance offered is very limited, you can buy an individual policy. You can get fee-for-service, HMO, or PPO protection. But you should compare your options and shop carefully because coverage and costs vary from company to company. Individual plans may not offer benefits as broad as those in group plans. If you get a noncancellable policy (also called a guaranteed renewable policy), then you will receive individual insurance under that policy as long as you keep paying the monthly premium. The insurance company can raise the cost, but cannot cancel your coverage. Many companies now offer a conditionally renewable policy. This means that the insurance company can cancel all policies like yours, not just yours. This protects you from being singled out. But it doesn't protect

you from losing coverage. Before you buy any health insurance policy, make sure you know what it will pay for...and what it won't. To find out about individual health insurance plans, you can call insurance companies, HMOs, and PPOs in your community, or speak to the agent who handles your car or house insurance.

Tips when shopping for individual insurance:

- Shop carefully. Policies differ widely in coverage and cost. Contact different insurance companies, or ask your agent to show you policies from several insurers so you can compare them.
- Make sure the policy protects you from large medical costs.
- Read and understand the policy. Make sure it provides the kind of coverage that's right for you. You don't want unpleasant surprises when you're sick or in the hospital.
- Check to see that the policy states: the date that the policy will begin paying (some have a waiting period before coverage begins), and what is covered or excluded from coverage.
- Make sure there is a "free look" clause. Most companies give you at least 10 days to look over your policy after you receive it. If you decide it is not for you, you can return it and have your premium refunded.
- Beware of single disease insurance policies. There are some polices that offer protection for only one disease, such as cancer. If you already have health insurance, your regular plan probably already provides all the coverage you need. Check to see what protection you have before buying any more insurance.

What Are Your Choices?

There are many different types of health insurance. Each has pros and cons. There is no one "best" plan. The plan that's right for a single person may not be best for a family with small children. And a plan that works for one family may not be right for another. For example, if your family includes just two adults, it may be less expensive for each of you to have individual coverage than for just one of you to have a family plan. If you have children, or if you might have children soon, you need a family plan. Because your situation may change, review your health insurance regularly to make sure you have the protection you need. Choosing a health insurance plan is like making any other major purchase: You choose the plan that meets both your needs and your budget. For most people, this means deciding which plan is worth the cost. For example, plans that allow you the most choices in doctors and hospitals also tend to cost more than plans that limit choices. Plans that help to manage the care you receive usually cost you less, but you give up some freedom of choice. Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You need to compare plans carefully for both cost and coverage.

Although there are many names for health insurance plans, the information here groups them as three main types:

- Fee-For-Service (or Traditional Health Insurance)
- Health Maintenance Organizations (or HMOs)
- Preferred Provider Organizations (or PPOs)

Which Type Is Right for You?
For each group, choose the statement 1 or 2 that best describes how you feel:

1-Having complete freedom to choose doctors and hospitals is the most important thing to me in a health plan, even if it costs more.
2-Holding down my costs is the most important thing to me, even if it means limiting some of my choices.

1-I travel a lot or have children that live away from me and we may need to see doctors in other parts of the country.
2-I do not travel a lot and almost all care for my family will be needed in our local area.

1-I don't mind a health insurance plan that includes filling out forms or keeping receipts and sending them in for payment.
2-I prefer not to fill out forms or keep receipts. I want most of my care covered without a lot of paperwork.

1-In addition to my premiums, I am willing to pay for the cost of routine and preventive care, such as office visits, checkups, and shots. I also like knowing that I can get an appointment for these services when I want one.
2-I want a health plan that includes routine and preventive care. I don't mind if I have to wait for these services to be scheduled for an available appointment with my doctor.

1-If I need to see a specialist, I probably will ask my doctor for a recommendation, but I want to decide whom to go to and when. I don't want to have to see my primary care doctor each time before I can see a specialist.
2-I don't mind if my primary care doctor must refer me to specialists. If my doctor doesn't think I need special services, that is fine with me.

If your answers are mostly 1: You want to make your own health care choices, even if it costs you more and takes more paperwork. Fee-for-service may be the best plan for you.

If your answers are mostly 2: You are willing to give up some choices to hold down your medical costs. You also want help in managing your care. Consider a health maintenance organization.

If your answers are some 1's and some 2's: You might want to look for a plan such as a preferred provider organization that combines some of the features of fee-for-service and a health maintenance organization. The differences among fee-for-service plans, HMOs, and PPOs are not as clear-cut as they once were. Fee-for-service plans have adopted some activities used by HMOs and PPOs to control the use of medical services. And HMOs and PPOs are offering more freedom to choose doctors, the way fee-for-service plans do. By studying your health insurance options carefully, you will be able to pick the one that provides you with the coverage you need, no matter what it is called. Managed Care: A Way to Control Costs Managed care influences how much health care you use. Almost all plans have some sort of managed care program to help control costs. For example, if you need to go to the hospital, one form of managed care requires

that you receive approval from your insurance company before you are admitted to make sure that the hospitalization is needed. If you go to the hospital without this approval, you may not be covered for the hospital bill.

Types of Insurance

Fee-for-Service
This is the traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured people covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. You can choose any doctor you wish and change doctors any time. You can go to any hospital in any part of the country. With fee-for-service, the insurer only pays for part of your doctor and hospital bills.
This is what you pay:

- A monthly fee, called a premium.
- A certain amount of money each year, known as the deductible, before the insurance payments begin. In a typical plan, the deductible might be $250 for each person in your family, with a family deductible of $500 when at least two people in the family have reached the individual deductible. The deductible requirement applies each year of the policy. Also, not all health expenses you have count toward your deductible. Only those covered by the policy do. You need to check the insurance policy to find out which ones are covered.
- After you have paid your deductible amount for the year, you share the bill with the insurance company. For example, you might pay 20 percent while the insurer pays 80 percent. Your portion is called coinsurance. To receive payment for fee-for-service claims, you may have to fill out forms and send them to your insurer. Sometimes your doctor's office will do this for you. You also need to keep receipts for drugs and other medical costs. You are responsible for keeping track of your medical expenses. There are limits as to how much an insurance company will pay for your claim if both you and your spouse file for it under two different group insurance plans. A coordination of benefit clause usually limits benefits under two plans to no more than 100 percent of the claim. Most fee-for-service plans have a "cap," the most you will have to pay for medical bills in any one year. You reach the cap when your out-of-pocket expenses (for your deductible and your coinsurance) total a certain amount. It may be as low as $1,000 or as high as $5,000. Then the insurance company pays the full amount in excess of the cap for the items your policy says it will cover. The cap does not include what you pay for your monthly premium. Some services are limited or not covered at all. You need to check on preventive health care coverage such as immunizations and well-child care. There are two kinds of fee-for-service coverage: basic and major medical. Basic protection pays toward the costs of a hospital room and care while you are in the hospital. It covers some hospital services and supplies, such as x-rays and prescribed medicine. Basic coverage also pays toward the cost of surgery, whether it is performed in or out of the hospital, and for some doctor visits. Major medical insurance takes over where your basic coverage leaves off. It covers the cost of long, high-cost illnesses or injuries. Some policies combine basic and major medical coverage into one plan. This is sometimes called a

"comprehensive plan." Check your policy to make sure you have both kinds of protection.

What Is a "Customary" Fee?
Most insurance plans will pay only what they call a reasonable and customary fee for a particular service. If your doctor charges $1,000 for a hernia repair while most doctors in your area charge only $600, you will be billed for the $400 difference. This is in addition to the deductible and coinsurance you would be expected to pay. To avoid this additional cost, ask your doctor to accept your insurance company's payment as full payment. Or shop around to find a doctor who will. Otherwise you will have to pay the rest yourself.

Questions to Ask About Fee-for-Service Insurance

- How much is the monthly premium? What will your total cost be each year? There are individual rates and family rates.
- What does the policy cover? Does it cover prescription drugs, out-of-hospital care, or home care? Are there limits on the amount or the number of days the company will pay for these services? The best plans cover a broad range of services.
- Are you currently being treated for a medical condition that may not be covered under your new plan? Are there limitations or a waiting period involved in the coverage?
- What is the deductible? Often, you can lower your monthly health insurance premium by buying a policy with a higher yearly deductible amount.
- What is the coinsurance rate? What percent of your bills for allowable services will you have to pay?
- What is the maximum you would pay out of pocket per year? How much would it cost you directly before the insurance company would pay everything else?
- Is there a lifetime maximum cap the insurer will pay? The cap is an amount after which the insurance company won't pay anymore. This is important to know if you or someone in your family has an illness that requires expensive treatments.

Health Maintenance Organizations (HMOs)
Health maintenance organizations are prepaid health plans. As an HMO member, you pay a monthly premium. In exchange, the HMO provides comprehensive care for you and your family, including doctors' visits, hospital stays, emergency care, surgery, lab tests, x-rays, and therapy. The HMO arranges for this care either directly in its own group practice and/or through doctors and other health care professionals under contract. Usually, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care. However, exceptions are made in emergencies or when medically necessary. There may be a small copayment for each office visit, such as $5 for a doctor's visit or $25 for hospital emergency room treatment. Your total medical costs will likely be lower and more predictable in an HMO than with fee-for-service insurance. Because HMOs receive a fixed fee for your covered medical care, it is in their interest to make sure you get basic health care for problems before they become serious. HMOs typically provide preventive care, such as office visits, immunizations, well-baby checkups, mammograms, and physicals. The range of services covered vary in HMOs, so it is important to compare available plans. Some services, such as outpatient mental health care, often are provided only on a limited basis. Many people like HMOs because they do not require claim forms for

office visits or hospital stays. Instead, members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with a fee-for-service plan. In some HMOs, doctors are salaried and they all have offices in an HMO building at one or more locations in your community as part of a prepaid group practice. In others, ndependent groups of doctors contract with the HMO to take care of patients. These are called individual practice associations (IPAs) and they are made up of private physicians in private offices who agree to care for HMO members. You select a doctor from a list of participating physicians that make up the IPA network. If you are thinking of switching into an IPA-type of HMO, ask your doctor if he or she participates in the plan. In almost all HMOs, you either are assigned or you choose one doctor to serve as your primary care doctor. This doctor monitors your health and provides most of your medical care, referring you to specialists and other health care professionals as needed. You usually cannot see a specialist without a referral from your primary care doctor who is expected to manage the care you receive. This is one way that HMOs can limit your choice. Before choosing an HMO, it is a good idea to talk to people you know who are enrolled in it. Ask them how they like the services and care given.

Questions to Ask About an HMO

- Are there many doctors to choose from? Do you select from a list of contract physicians or from the available staff of a group practice? Which doctors are accepting new patients? How hard is it to change doctors if you decide you want someone else? How are referrals to specialists handled?
- Is it easy to get appointments? How far in advance must routine visits be scheduled? What arrangements does the HMO have for handling emergency care?
- Does the HMO offer the services I want? What preventive services are provided? Are there limits on medical tests, surgery, mental health care, home care, or other support offered? What if you need a special service not provided by the HMO?
- What is the service area of the HMO? Where are the facilities located in your community that serve HMO members? How convenient to your home and workplace are the doctors, hospitals, and emergency care centers that make up the HMO network? What happens if you or a family member are out of town and need medical treatment?
- What will the HMO plan cost? What is the yearly total for monthly fees? In addition, are there copayments for office visits, emergency care, prescribed drugs, or other services? How much?

Preferred Provider Organizations (PPOs)

The preferred provider organization is a combination of traditional fee-for-service and an HMO. Like an HMO, there are a limited number of doctors and hospitals to choose from. When you use those providers (sometimes called "preferred" providers, other times called "network" providers), most of your medical bills are covered. When you go to doctors in the PPO, you present a card and do not have to fill out forms. Usually there is a small copayment for each visit. For some services, you may have to pay a deductible and coinsurance. As with an HMO, a PPO requires that you choose a primary care doctor to monitor your health care. Most PPOs cover preventive care. This usually includes visits to the doctor, well-baby care, immunizations, and mammograms. In a PPO, you can use doctors who are not part of the plan and still receive some

coverage. At these times, you will pay a larger portion of the bill yourself (and also fill out the claims forms). Some people like this option because even if their doctor is not a part of the network, it means they don't have to change doctors to join a PPO.

Questions to Ask About a PPO

- Are there many doctors to choose from? Who are the doctors in the PPO network? Where are they located? Which ones are accepting new patients? How are referrals to specialists handled?
- What hospitals are available through the PPO? Where is the nearest hospital in the PPO network? What arrangements does the PPO have for handling emergency care?
- What services are covered? What preventive services are offered? Are there limits on medical tests, out-of-hospital care, mental health care, prescription drugs, or other services that are important to you?
- What will the PPO plan cost? How much is the premium? Is there a per-visit cost for seeing PPO doctors or other types of copayments for services? What is the difference in cost between using doctors in the PPO network and those outside it? What is the deductible and coinsurance rate for care outside of the PPO? Is there a limit to the maximum you would pay out of pocket?

Other Types of Insurance

Medicare
Medicare is the Federal health insurance program for Americans age 65 and older and for certain disabled Americans. If you are eligible for Social Security or Railroad Retirement benefits and are age 65, you and your spouse automatically qualify for Medicare. Medicare has two parts: hospital insurance, known as Part A, and supplementary medical insurance, known as Part B, which provides payments for doctors and related services and supplies ordered by the doctor. If you are eligible for Medicare, Part A is free, but you must pay a premium for Part B. Medicare will pay for many of your health care expenses, but not all of them. In particular, Medicare does not cover most nursing home care, long-term care services in the home, or prescription drugs. There are also special rules on when Medicare pays your bills that apply if you have employer group health insurance coverage through your own job or the employment of a spouse. Medicare usually operates on a fee-for-service basis. HMOs and similar forms of prepaid health care plans are now available to Medicare enrollees in some locations. The best source of information on the Medicare program is the Medicare Handbook. This booklet explains how the Medicare program works and what your benefits are. To order a free copy, write to:

Health Care Financing Administration, Publications,
N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850. You also can contact your local Social Security office for information.

Some people who are covered by Medicare buy private insurance, called "Medigap" policies, to pay the medical bills that Medicare doesn't cover. Some Medigap policies cover Medicare's deductibles; most pay the coinsurance amount. Some also pay for health services not covered by Medicare. There are 10 standard plans from which you can choose. (Some States may have

fewer than 10.) If you buy a Medigap policy, make sure you do not purchase more than one. You need to shop carefully before deciding on the best policy to fit your needs. You may get another booklet, Guide to Health Insurance for People with Medicare, to help you in making the right choice. To order a free copy, write to:

Health Care Financing Administration, Publications, N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850.

Another good source of information on the same topic is The Consumer's Guide to Medicare Supplement Insurance. To order a free copy, write to: Health Insurance Association of America, 555 13th St., N.W., Suite 600 East, Washington, D.C.20004.

Medicaid

Medicaid provides health care coverage for some low-income people who cannot afford it. This includes people who are eligible because they are aged, blind, or disabled or certain people in families with dependent children. Medicaid is a Federal program that is operated by the States, and each State decides who is eligible and the scope of health services offered. General information on the Medicaid program is given in the Medicaid Fact Sheet.
For a free copy, write to: Health Care Financing Administration, Publications, N1- 26-27, 7500 Security Blvd., Baltimore, MD 21244-1850. For specifics on Medicaid eligibility and the health services offered, contact your State Medicaid Program Office.

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 does not cover the cost of rehabilitation if you are injured. Check your major medical insurance to see if it is covered there. Some employers offer group disability insurance and this may be one of the benefits where you work. Or you might be eligible for some government-sponsored programs that provide disability benefits. Many different kinds of individual policies are also available. The Consumer's Guide to Disability Insurance explains disability insurance and sources of disability income to help you decide if you need this coverage. It will also help you compare your choices of policies. For a free copy, write to: Health Insurance Association of America, 555 13th St., N.W., Suite 600 East, Washington,D.C. 20004.

Hospital Indemnity Insurance

This insurance offers limited coverage. It pays a fixed amount for each day, up to a maximum number of days. You may use it for medical or other expenses. Usually, the amount you receive will be less than the cost of a hospital stay. Some hospital indemnity policies will pay the specified daily amount even if you have other health insurance. Others may coordinate benefits, so that the money you receive does not equal more than 100 percent of the hospital bill.

Long-Term Care Insurance

Long-term care insurance is designed to cover the costs of nursing home care, which can be several thousand dollars each month. Long-term care is usually not covered by health insurance except in a very limited way. Medicare covers very few long-term care expenses. There are many plans and they vary in costs and services covered, each with its own limits. More detailed

information is given in A Shopper's Guide to Long-Term Care Insurance. Contact your State Insurance Department or write:
National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105.

Another good source of information is The Consumer's Guide to Long-Term Care Insurance. For a free copy, write to: Health Insurance Association of America, 555 13th St., N.W., Suite 600 East, Washington, D.C. 20004.

A Final Thought
There's no doubt that choosing among health insurance plans takes time and effort. Now that you have read this information, you know what questions to ask so you will be able to carefully compare various plans and find the one that best fits your needs.

Understanding Health Insurance 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.
Copayment: 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.
Noncancellable 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.
Preexisting 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 Doctor: 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.