What Types of Health Coverage Are Available?

Rising health-care costs have driven the demand for, and the price of, medical insurance sky-high. The availability of group coverage through employment has helped many Americans face such costs. However, people who are not currently covered by their employers have few affordable sources for group coverage currently. As a result of the Patient Protection and Affordable Care Act, state and/or regional insurance marketplaces offer coverage to individuals and some small businesses.

Individuals seeking medical coverage on their own can explore purchasing an individual health insurance policy. And those age 65 and older may qualify for Medicare coverage.

There are three general classifications of medical insurance plans: fee-for-service (indemnity), managed care (e.g., HMOs and PPOs), and high-deductible health plan (HDHP).

FEE FOR SERVICE

With a basic fee-for-service (indemnity) insurance plan, health-care providers (such as physicians, nurse practitioners, surgery centers, and hospitals) are paid a fee for each service provided to insured patients.

Indemnity plans normally cover hospitalization, outpatient care, and physician services in or out of the hospital. You select the health-care provider for consultation or treatment. You are then billed for the service and reimbursed by the insurance company, or you can “assign” direct payment to the provider from the insurance company. Indemnity plans typically require the payment of premiums, deductibles, and coinsurance. Limits on certain coverage or exclusions may apply. Lifetime limits on benefits are prohibited as are limits on annual benefits.

MANAGED CARE

Managed-care plans became popular in the 1990s as a way to help rein in rising medical costs. In managed-care plans, insurance companies contract with a network of health-care providers to provide cost-effective health care. Managed-care plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Health maintenance organization. A HMO operates as a prepaid health-care plan. You normally pay a monthly premium in addition to a small copayment for a visit to a physician, who may be on staff or contracted by the HMO. Copayments for visits to specialists may be higher. The insurance company typically covers the amount over the patient's copayment.
Each covered member chooses or is assigned a primary-care physician from doctors in the plan. This person acts as a gatekeeper for his or her patients and, if deemed necessary, can refer patients to specialists who are on the HMO's list of providers. Because HMOs contract with health-care providers, costs are typically lower than in indemnity plans.

Preferred provider organization. A PPO is a managed-care organization of physicians, hospitals, clinics, and other health-care providers who contract with an insurance company to provide health care at reduced rates to individuals insured in the plan. The insurance company uses actuarial tables to determine "reasonable and customary" fees for each type of service, and health-care providers accept the PPO's fee schedule and guidelines.
The insured can see any health-care provider within a preferred network of providers and pays a copayment for each visit. Insured individuals have to meet an annual deductible before the insurance company will start covering health-care services. Typically, the insurance company will pay a high percentage (often 80%) of the costs to the plan's health-care providers after the deductible has been met, and patients pay the balance.

Although insured individuals can choose providers outside the plan without permission, patient out-of-pocket costs will be higher; for example, the initial deductible for each visit is higher and the percentage of covered costs by the insurance company will be lower. Because PPOs provide more patient flexibility than HMOs, they may cost a little more.

Point-of-service plan. A POS health-care plan mixes aspects of a PPO and HMO to allow greater patient autonomy. POS plans also use a network of preferred providers. Patients turn to their preferred providers first and then receive referrals to other providers if deemed necessary. POS plans recommend that patients choose a personal physician from inside the network. The personal physician can refer patients to other physicians and specialists who are inside or outside the network. Insurance companies have a national network of approved providers, so insured individuals can receive services throughout the United States. Copays tend to be lower for a POS plan than for a PPO plan.

HIGH-DEDUCTIBLE HEALTH PLAN

An HDHP provides comprehensive coverage for high-cost medical bills and is usually combined with a health-reimbursement arrangement that enables participants to build savings to pay for future medical expenses. HDHPs generally cover preventive care in full with a small (or no)

deductible or copayment. However, these plans have higher annual deductibles and out-of-pocket limits than other insurance plans.

Participants enrolled in an HDHP can open a health savings account (HSA) to save money that can be used for current and future medical expenses. There are annual limits on how much can be invested in an HSA. The funds can be invested as the investor chooses, and any interest and earnings accumulate tax deferred. HSA funds can be withdrawn free of income tax and penalties provided the money is spent on qualified health-care expenses for the participant and his or her spouse and dependent children.

Remember that the cost and availability of an individual health insurance policy can depend on factors such as age, health (pre-existing conditions), and the type of insurance purchased. In addition, a physical examination may be required.

MEDICARE

Medicare is the U.S. government's health-care insurance program for the elderly. It is available to eligible people age 65 and older as well as certain disabled persons. Part A provides basic coverage for hospital care as well as limited skilled nursing care, home health care, and hospice care. Part B helps cover physician services, inpatient and outpatient medical services, and diagnostic tests. Part D prescription drug coverage is also available.

Medicare Advantage is a type of privately run insurance that includes Medicare-approved HMOs, PPOs, fee-for-service plans, and special needs plans. Some plans offer prescription drug coverage. To join a Medicare Advantage plan, you must have Medicare Part A and Part B and you have to pay the monthly Medicare Part B premium to Medicare, as well as the Medicare Advantage premium.

Medicare Supplement Insurance, or Medigap, supplements the benefits covered under Medicare. It also fills in some of the gaps left by Medicare, such as deductible and coinsurance or copayments. Medigap policies are sold by private insurance companies and must be clearly identified as "Medicare Supplemental Insurance." Currently, 10 standardized plans are available (Plans A-D, F and G, and K-N) except in Massachusetts, Minnesota, and Wisconsin, which have their own standardized plans. Each lettered plan corresponds with a certain level of coverage that is identical from insurer to insurer, prices may differ and not all plans are available in every state.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

Basically, under the Patient Protection and Affordable Care Act (ACA), most individuals who are not covered by employer-sponsored health insurance, Medicare, Medicaid, or another government program are required to have "minimum essential coverage" or pay an annual penalty. The penalty assessed is the greater of a flat dollar amount or a percentage of modified adjusted gross income. Taxpayers who claim dependents on their tax returns will be subject to the penalty for each dependent who does not have coverage, although college students and minors under age 18 would be subject to only 50% of the penalty.

However, individuals and families who are not covered by employer-sponsored health plans and who can't afford private health insurance may shop for coverage through health insurance

marketplaces created under ACA. A health insurance marketplace is essentially a one-stop health insurance outlet. Marketplaces are not issuers of health insurance. Rather, they contract with insurance companies that make their insurance coverage available for examination and purchase through the marketplace. In essence, marketplaces are designed to bring buyers and sellers of health insurance together, with the goal of increasing access to affordable coverage.

Since 2010, as a result of the health-reform act, adult children up to age 26 have been eligible for dependent coverage under their parents' health insurance plans provided they are not eligible for their own employer-based coverage. Insurance companies are no longer able to refuse coverage for children (under age 19) with pre-existing conditions nor can adults with pre-existing conditions be rejected or charged higher premiums.