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Affordable Healthcare: Can It Happen To You?

By Irina

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Let's face it – an apple a day is no longer an adequate substitute for the professional healthcare services. And after the doctor leaves, someone has to reach for a wallet. Accept this undeniable fact of life and make necessary arrangements BEFORE you get into a car accident, suffer intolerable toothache, or become pregnant.

The cold reality of healthcare in this country is that you do not have any legal right to it. There are no state or federal laws mandating employer-paid or –subsidized health benefits. So if you (or your spouse) have a complete and reasonably priced health coverage through your employer – BE GRATEFUL... and find some better use for your time than reading this article. (I would still suggest saving it – just in case...)

For those who keep on reading, health insurance is available on an individual or group basis, but don't be fooled by the terms! INDIVIDUAL insurance usually covers A GROUP of people (entire family), and many GROUP health plans will cover "a group" of ONE. In both cases you are the only one paying (individually!) for the coverage. So, what's the difference? From a consumer's point of view, the big advantage of group health insurance plans over individual is that they can't turn you down because of health problems.

Of course, the ABILITY to get into a health insurance plan is one thing. The AFFORDABILITY is quite another! Let's

begin with some basic terminology (or should we call it deceptive lingo?) used in the health insurance industry. Here are major plans with unique features to consider while making your choice:

HMO – Health Maintenance Organizations

The least expensive, but also the least flexible of all the health insurance plans.

Advantage:

- Low co-payments, minimal paperwork, and coverage for some preventive-care and health-improvement programs.

Disadvantages:

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

POS – Point Of Service plans

More flexible than HMOs, but they also require you to select a PCP.

Advantages:

- You may visit a doctor outside the network and still receive coverage; but substantially less than if you stayed within your network.
- Offer more preventive care and well-being services, such as workshops on smoking cessation and discounts to health clubs.

Disadvantages:

- You must choose a PCP.
- 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 – Preferred Provider Organizations

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

Advantages:

- The standard co-payment is \$10 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.

Disadvantages:

- If you see an out-of-network doctor, you may have to pay

the entire bill yourself, then submit it for reimbursement.

- You may have to pay a deductible if you choose to go outside the network, or pay the difference between what network doctors charge vs. out-of-network doctor's charge.

FFS – Fee-For-Service plans, also called Traditional Indemnity

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

Advantages:

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

Disadvantages:

- There's a deductible (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 may have to pay up front for medical services, 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.

Depending on what you choose, you might end up with either EXPENSIVE or VERY EXPENSIVE plan. Here are some practical ways to reduce the high (and constantly rising!) cost of health care if you are unemployed, self-employed or work for an employer that doesn't offer health benefits:

– If you feel comfortable buying online, you can often save on broker and agent fees. Sometimes, this will translate into premium savings for policies purchased over the Internet.

– If you can afford to do so, pay your premiums annually rather than monthly or quarterly to avoid service fees and to take advantage of prepayment discounts where available.

– Take advantage of the group buying power. Check out your local chamber of commerce, trade and professional groups and small and home business associations relevant to your particular profession. Many of them offer access to discounted health insurance. Here are some links:
National Association for the Self-Employed

http://www.nase.org/nase_benefits/health_benefits.asp

American Association of Home-Based Businesses

<http://www.aahbb.org/benefits.htm>

Home Office Association of America

<http://www.hoaa.com/allbenefitsnew.htm>

National Business Association

http://www.nationalbusiness.org/NBAWEB/Directory/Internal_Pages/Member_Benefits/Health.htm

– Increase your deductible. This obviously depends on your risk tolerance. The general rule of thumb is that by increasing your deductible from \$100 to \$2,000 you can cut your premium payment in half.

– Use new tax laws. The self-employed can write off 70% of their health insurance premiums in 2002. This increases to 100% in 2003.

– Use Medical Savings Accounts or MSA. Under the Health Insurance Portability and Accountability Act (HIPAA), self-employed individuals are eligible for a medical savings account. MSA works nicely in conjunction with higher

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deductible health insurance policy to reduce premiums and allow you to use pre-tax dollars to pay for your medical expenses. Basically, you reduce your premium by increasing deductible and use the savings to make fully tax-deductible contributions to your MSA. You can contribute up to 65% of the deductible each year into your MSA (75% for families). The money goes into a tax-deferred account or trust and you pay your medical expenses by drawing from the account. Once you hit the deductible, of course, the insurance policy kicks in.

All the above is helpful if you're able to get health insurance in the first place. What if a pre-existing condition disqualifies you from getting insurance at any price? There are still some options to consider.

HIPAA may offer some protections. For more information visit
<http://www.hcfa.gov/medicaid/hipaa/content/hipsteps.asp>

State-funded high-risk health insurance plans, also known as Risk Pools, are an important safety net for individuals denied health insurance because of a medical condition. They're available only in 29 states though. For more information on risk pools in your state, contact your state health insurance department, the national association "Communicating for Agriculture and the Self-Employed" (1-800-432-3276) or visit

<http://www.selfemployedcountry.org>

Last but not least, consider possible NON-INSURANCE solutions to minimize your out-of-pocket healthcare expenses. Through the various Healthcare Savings Programs you can access the same networks of healthcare providers (for the same negotiated rates!) that large insurance companies use. No long-term commitment is required on your part and the service is available for a modest monthly fee that is only a fraction of a health insurance premium. To make them even more attractive, these programs accept all pre-existing conditions. For example and details see
<http://www.careentree.com/310559>

Finding adequate healthcare coverage might seem overwhelmingly elusive like hitting a moving target, but

learning the basics and knowing where to start can make the process less painful and even save you money. No matter which (if any) of my suggestions you decide to follow, please eat at least one apple a day! Not for the alleged ability of the fruit to keep a doctor away – just because it tastes good!

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The ABC's Of Health Insurance Plans

By JM Bauer

In today's health insurance marketplace, three primary types of healthcare coverage are available. They are the Indemnity plan, the Preferred Provider Organization (PPO), and the Health Maintenance Organization (HMO). Each approach offers consumers the opportunity to choose between flexibility and control in their healthcare choices vs. the expense of their healthcare coverage. Almost universally, healthcare plans that offer more consumer flexibility and control are also more expensive, while plans allowing the insurance company to control healthcare delivery choices are usually more affordable. Let's look at each of these plans.

The Indemnity plan approach represents healthcare as it was offered in the days before managed care. In an Indemnity plan, the policyholder is free to go to any doctor, specialist, hospital or laboratory to pursue the medical care they believe they need. These healthcare services are billed to the insurance company at the individual rate set by the healthcare provider. The insurance company pays a fixed proportion of the fees (usually 80%) and the consumer pays the remaining percentage (usually 20%) of the billed medical fees. Each healthcare provider is free to set their fees at a level they choose, and the consumer has little incentive to consider overall medical expenses. While Indemnity plans are still available today, they are not widely utilized since they are too expensive for the average consumer. The monthly premium for an Indemnity plan is generally 50% to 100% higher than premium for a PPO or HMO plan.

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On the opposite end of the spectrum, Health Maintenance Organizations or HMOs were introduced by insurance companies as a way to combat the rising costs of healthcare being experienced by employers providing health benefits to their employees. In an HMO, the policyholder selects or is assigned to a Primary Care Provider (PCP) such as a family practitioner, internist or pediatrician. The PCP is responsible for coordinating all healthcare services delivered to the policyholder (except for emergency care). The policyholder can only see a specialist, use a lab service or check into a hospital if they are referred for such services by the PCP. Any services that are not referred by the consumer's PCP are not reimbursable under the health insurance policy. Within the HMO network, healthcare providers agree with the insurance company on negotiated rates for specific services. Once approved, these healthcare providers become part of the network available to the PCP for referring patients when additional care is required. Based on the insurance company's strict control of the healthcare providers used and the rates they will charge, an HMO is usually the least expensive alternative for a healthcare plan.

In the middle between the wide–open Indemnity plan and the strictly–controlled HMO, insurance companies also offer a third alternative called a Preferred Provider Organization or PPO. In a PPO plan, a policyholder is free to go to almost any healthcare provider they choose, including doctors, specialists, labs and hospitals, and usually without a medical referral. However, the amount reimbursed by the insurance company for the delivered medical services will vary depending on whether the healthcare provider is within their negotiated network or not. As with an HMO, the insurance company negotiates fees in advance with selected healthcare providers and approves them for inclusion in the plan's preferred provider network. Healthcare services delivered by these in–network providers are generally reimbursed to the consumer at high rates of 70% or more. On the other hand, when the consumer uses a non–network healthcare provider, the reimbursement will be much lower, ranging from 0% to 50% of the incurred medical expenses. Since the vast majority of PPO policyholders use

in–network providers to reduce their out–of–pocket expenses, PPOs are very cost–effective for insurance companies. As a result, PPOs are somewhat more expensive than HMOs, but are still very reasonably priced for the average person.

JM Bauer offers unbiased consumer information on today's healthcare choices. For more information visit the



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