



## Insurance Coverage

Everything You Need to Know to Become a Smarter Healthcare Consumer



# Choose a Health Plan

Comparing health plans can be overwhelming and time consuming. With so many three-letter acronyms like PPO, HMO, and POS flying around, no wonder it gets confusing. To simplify the process, understand your options and think about these options in the context of your own personal health priorities. Whether you are purchasing an individual policy or choosing a plan through your employer, assess your expected situation for the coming year and select accordingly.

Obviously, you cannot predict unexpected health events. However, it is best to be sure you will have coverage even if the unexpected happens. Remember, there are always trade-offs when choosing a plan. Lower premiums equal less coverage and/or more limited choice of providers. Higher premiums equal more coverage and/or greater choice of providers. If you decide to choose a plan with a higher deductible, recognize that you will need funds to supply those higher upfront out-of-pocket costs.

So, let's get started. First, we will go over the types of healthcare plans out there. Then, after you understand your options, you can begin to determine which plan best meets your health coverage requirements.



## The Big 3: HMOs, PPOs, POS

Here are the three most common types of health plans from which you will be able to choose. The plans vary in terms of the provider selection flexibility and the amount of out-of-pocket costs.

Plan	Description	Provider Selection	Out-of-pocket costs
<b>Health Management Organization (HMOs)</b>	Coverage that is fulfilled through hospitals, doctors, and other providers with which the HMO has a contract; generally require that insured individuals select a primary care physician to coordinate preventative care	Typically more restrictive; often require referrals	Lowest out-of-pocket costs
<b>Preferred Provider Organization (PPOs)</b>	Managed care organization of medical doctors, hospitals, and other health care providers who have contracted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients	Moderate level of provider selection	Higher initial out-of-pocket costs
<b>Point of Service (POS)</b>	Plan that allows enrollees to seek care from a physician affiliated with the service provider at a fixed co-payment or to choose a nonaffiliated physician and pay a larger share of the cost	Largest amount of provider selection	Typically higher out-of-pocket costs when you choose an out of network provider

Looking at these three plan types, you see that each encompasses different healthcare needs. If you want greater flexibility, a PPO could be best for you. However, if you want lower out-of-pocket costs and are not concerned with the need for referrals, then you may want to look

further at HMO options. Although POS plans are less well-known, they often provide the most flexibility in terms of provider selection. Therefore, it is a good option to keep in mind if that is a priority for you.

## Changing Up the Game: Consumer Directed Health Plans (CDHPs)

In recent years, a new type of health plan has been thrown into the mix. This option is the Consumer Directed Health Plan. You may have heard even more three-letter acronyms that relate to this type of plan (HSAs, HRAs or FSAs). Oh, and don't forget their four letter friend, HDHPs (High Deductible Health Plans). So, what is this new type of coverage and how is it different? Unlike traditional health plans, CDHPs shift most of the initial costs to the individual through high deductibles or a high percentage co-insurance. The minimum deductible for a consumer directed policy is roughly \$1,100 for an individual plan and \$2,200 for a family plan. This high deductible helps to reduce premiums and prompts plan participants to be engaged in the cost of their healthcare, by asking them to spend money from their own wallet first. Below is a breakdown of all of the products related to CDHPs.

### Glossary of Consumer-Directed Products

Plans	Descriptions	Employee Tax Benefits
<b>Flexible Spending Accounts (FSAs)</b>	An employer bookkeeping account for medical expenses generally funded by employee pre-tax contributions care expenses)	Unspent balances may not be rolled over from year to year or cashed out (i.e., "use-it-or-lose-it")
<b>Health Reimbursement Arrangements (HRAs)</b>	Medical plan funded entirely by the employer that reimburses the employee for qualified medical expenses. Cannot be offered through a cafeteria plan	Unspent balances may be rolled over from year to year but there is only limited portability and unused amounts cannot be cashed out
<b>Medical Savings Accounts (MSAs)</b>	Available to persons who work for a small employer and who are covered by a HDHP  No new accounts may be opened after 2005	Requires a trust or custodian account. Contributions are excludable or deductible and may be rolled over from year to year if unused for qualified medical expenses
<b>High Deductible Health Plan (HDHP)</b> <i>* For 2009, the minimum deductible to qualify as an HDHP was \$1150 for self-only and \$2300 for family coverage.</i>	A health insurance plan with a deductible requirement of typically at least \$1,000 for health plan coverage  The HDHP must meet certain legislative and regulatory requirements in order for plan participants to become eligible to contribute to MSAs and HSAs	Tax benefits are the same as other employer plans - tax deductions for employers and generally not taxable to employees
<b>Health Savings Accounts (HSAs)</b>	A portable, personal, and untaxed account for the payment of qualified medical expenses; employer or employee funded  Individuals must be covered by a HDHP to contribute to an HSA  Not available to individuals covered by Medicare, persons who can be claimed as a tax dependent, and those covered by a health plan that is not a HDHP	Requires a trust or custodian account. Contributions are excludable or deductible and may be rolled over from year to year if unused for qualified medical expenses

\*Source "Take Care of Yourself: Employers Embrace Consumerism to Control Healthcare Costs," PricewaterhouseCoopers Health Research Institute, 2005. Table 1: Glossary of Consumer-Directed Products, p 7.

## Steps on How to Choose

First, it is important to understand what you are looking for when comparing plans. For example, if you rarely visit the doctor, a higher deductible/higher co-pay or percentage co-insurance with a lower premium may create cost savings for you and your family. However, if you frequent the doctor multiple times a month or need surgery, having a lower co-pay or lower deductible with a higher premium may make more sense. Assess your situation for the coming year and select accordingly.

### Before you choose a plan:

1. Make sure you know what type of organization you are dealing with. **Is it an HMO, PPO, or POS plan?** (Refer to the table on the previous page to clarify questions surrounding out-of-pocket costs, provider flexibility, etc.)

2. **Look at the plan options.** Upon deciding what is most important to you, a plan may stand out among the options. Are you most concerned with yearly out-of-pocket costs? Or are you worried about your deductible and premium amounts?

3. **Now look at the network.** Do you have a wide selection of providers? It's a good idea to see if your important providers are in-network for your preferred plan option if keeping your current providers is important to you.

4. **See how the pharmacy plans compare.** Some will have a standard co-payment on name brand drugs. Others may have lower co-payments on "preferred" brand name drugs or generics.

5. Always read over **dental, vision, and behavioral health coverage** within the policy if no supplemental coverage is offered.

### Once you select your plan:

1. **Make sure to disclose your pre-existing conditions during enrollment.** If you do not disclose your current medical conditions, you could be denied coverage later. While there may be a waiting period for

care after disclosure, it is still better than no coverage at all.

2. **Read your policy!** Know what your plan does and doesn't cover to get the most value from your coverage. If questions arise, call and ask your insurance provider. It is better to be safe than sorry because sorry could mean extra medical expenses you are not prepared to handle.

3. **Know and understand your appeals process.** If you have a denied medical claim, make sure you know how the appeals process for your specific insurance provider works. For help, check out our "How to: Handle a Denied Medical Claim" Field Guide. health and medical services are covered by the insurer

## TERMS TO KNOW

**Behavioral coverage:** usually falls under its own heading. Insurers typically cap behavioral health benefits at a few thousand dollars when offered. For that reason, along with the stigma associated with behavioral health, many facilities are self-pay and many people opt to pay out of their own pocket to avoid the risk that their employer or co-workers will be made aware of their condition.

**CDHP:** is a healthcare plan in which the consumer directs and is responsible for payment up to the generally higher deductible amount. The insurer accepts payment responsibility only after that obligation has been reached by the consumer.

**Co-insurance:** represents the percentage split of the healthcare cost responsibility between the insurer and insured in relation to insurance coverage after the deductible has been met. For example, on an 80/20 co-insurance plan, the insurance company will cover 80% of the cost and the patient will be responsible for the remaining 20%.

**Co-pay:** (also co-payment) is a fixed amount that an insured patient is expected to pay out-of-pocket at the time of service.

**Deductible:** is the amount that you have to pay out of your own pocket toward healthcare services before your insurer starts to pay for covered services.

**Dental coverage:** similar to medical insurance coverage but related to the teeth and gums. Dental coverage is less common than medical insurance and typically provides different coverage rates for preventative care (i.e. cleanings and x-rays) than for dental procedures (fillings, crowns, etc.).

**Flexible Spending Account (FSA):** is an account provided by an employer through the benefits plan and is funded by the employee with pre-tax dollars. It can be used for multiple expenses as long as they are tax-deductible (for example, childcare and healthcare).

**High Deductible Health Plan (HDHP):** is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. It is sometimes referred to as a consumer directed health plan. Participating in a “qualified” HDHP is a requirement for Health Savings Accounts and other tax-advantaged programs.

**Health Plan:** refers to the type of insurance chosen for healthcare coverage to meet the medical needs of the insured individual; types of plans include HMOs, PPOs, HDHPs, and so on.

**Health Maintenance Organization (HMO):** is a type of Managed Care Organization (MCO) that provides a form of health insurance coverage fulfilled through hospitals, doctors and other providers with which the HMO has a contract.

**Health Reimbursement Account (HRA):** are IRS-approved arrangements between the employer and employee where healthcare expenses are reimbursed to the employee after initial payment. Only pre-approved healthcare expenses are reimbursed by the employer.

**Health Spending Account (HSA):** is a savings account associated with a high deductible health plan (HDHP) that receives pre-tax dollars, from which the consumer pays their deductible and other related health expenses.

**Point-of-Service (POS):** offers an approved network of medical care facilities and physicians for their policy holders to choose from just like an HMO or a PPO. A major difference is that point-of-service plans allow for their policy holders to receive their medical care outside of the network, though use of facilities and physicians within the network is encouraged.

**Preferred Provider Organization (PPO):** is a managed care organization of medical doctors, hospitals and other healthcare providers who have contracted with an insurer or a third-party administrator to provide healthcare at reduced rates to the insurer’s or administrator’s clients.

**Pre-existing condition:** a health condition, injury or sickness that you have already been diagnosed with or received treatment for prior to enrollment in a new health plan.

**Premium:** is the amount paid for an insurance coverage. Premiums are usually paid on a pay period or monthly basis.

**Primary Care Physician:** (or PCP or “gatekeeper”) is a physician selected within an HMO plan as the professional who will act as the coordinator for patient care and be responsible for approving or denying referral requests. PCPs are usually indicated by titles such as Internal Medicine, General Practitioners, Family Practice or Pediatricians.

**Vision coverage:** refers to portions of a policy that cover basic eye care including regular checkups and a regular stipend for the purchase of corrective lenses or contacts.

## Additional Resources:

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If you still need clarification relating to the content in this guide, try browsing through our Healthcare FAQs at [help.changehealthcare.com](http://help.changehealthcare.com). Hopefully this will help clarify any questions you may have.