

Types Of Health Insurance Plans

Traditional health insurance

Up until about 30 years ago, most people had traditional indemnity coverage. These days, it's

often known as "fee-for-service." Indemnity plans are a bit like auto insurance: you pay a certain amount of your medical expenses up front -- in the form of a deductible -- and afterward the insurance company pays the majority of the bill.

Advances in modern medicine increased the cost of providing health care and made it possible for people to live longer. Those advances caused many insurance companies to look for ways to reduce their costs of doing business, giving managed care the boost it enjoys today.

Fee-for-service

For years, indemnity or fee-for-service coverage was the norm. Under this type of health coverage, you have complete autonomy when it comes to choosing doctors, hospitals and other health care providers. You can refer yourself to any specialist without getting permission, and the insurance company doesn't get to decide whether the visit was necessary.

You don't, however, have complete autonomy. Most fee-for-service medicine is managed to a

certain extent. For instance, if you're not already incapacitated, you may need to get clearance for a visit to the emergency room.

On the down side, fee-for-service plans usually involve more out-of-pocket expenses. Often there is a deductible, usually of about \$200, before the insurance company starts paying.

Once you've paid the deductible, the insurer will kick in about 80 percent of any doctor bills. You may have to pay up front and then submit the bill for reimbursement, or your provider may bill your insurer directly.

Under fee-for-service plans, insurers will usually only pay for "reasonable and customary" medical expenses, taking into account what other practitioners in the area charge for similar services. If your doctor happens to charge more than what the insurance company considers

"reasonable and customary," you'll probably have to make up the difference yourself.

Traditionally, preventive care services like annual check-ups and pelvic exams haven't been covered under fee-for-service plans. But as the evidence mounts that preventive care can prevent more costly illnesses down the road, some insurers are including them.

Fee-for-service plans often include a ceiling for out-of-pocket expenses, after which the insurance company will pay 100 percent of any costs. Needless to say, the ceiling is usually pretty high.

Traditional Fee-for-service

Preferred Provider Organizations (PPOs)

Point-of-Service (POS)

Exclusive Provider Organizations (EPO)

Health Maintenance Organizations (HMOs)

In a nutshell, fee-for-service coverage offers flexibility in exchange for higher out-of-pocket expenses, more paperwork and higher premiums.

Managed care

Managed care has been around in one form or another since the 1930s, but it really took off in the last 10 years. As it grew, it evolved, leaving us with three basic types of managed care

plans. Today, the majority of people with private health insurance have some type of managed care.

Although there are important differences among the different types of managed care plans, there are some similarities. All managed care plans involve an arrangement between the insurer and a selected network of health care providers, and they offer policyholders significant financial incentives to use the providers in that network. There are usually explicit standards for selecting providers and a formal procedure to assure quality care.

Preferred Provider Organizations (PPOs)

One step over the managed care border is the Preferred Provider Organization. PPOs have made arrangements for lower fees with a network of health care providers. PPOs give their policyholders a financial incentive to stay within that network.

For example, a visit to an in-network doctor might mean you'd have a \$10 co-pay. If you wanted see an out-of-network doctor, you'd have to pay the entire bill up front and then submit the bill to your insurance company for an 80 percent reimbursement. In addition, you

might have to pay a deductible if you choose to go outside the network, or pay the difference

between what the in-network and out-of-network doctors charge.

With a PPO, you can refer yourself to a specialist without getting approval and, as long as it's

an in-network provider, enjoy the same co-pay. Staying within the network means less money coming out of your pocket and less paperwork. Preventive care services may not be covered under a PPO.

Exclusive Provider Organizations (EPO)

Exclusive Provider Organizations are PPOs that look like HMOs. EPOs raise the financial stakes for staying in the network. If you choose a provider outside the network, you're responsible for the entire cost of the visit.

Point-of-Service (POS)

Point-of-service plans are similar to PPOs, but they introduce the gatekeeper, or Primary Care Physician. You'll need to choose your PCP from among the plan's network of doctors. As with the PPO, you can choose to go out of network and still get some kind of coverage.

In

order to get a referral to a specialist, though, you usually must go through your PCP. You can

still choose to refer yourself, but it'll mean more hassles and more money coming out of your pocket.

If your PCP refers you to a doctor who is out of the network, the plan should pick up most of the cost. But if you refer yourself out, then you'll probably have to deal with more paperwork

and a smaller reimbursement. You may also have to pay a deductible if you go outside the network.

POS plans may also cover more preventive care services, and may even offer health improvement programs like workshops on nutrition and smoking cessation, and discounts at health clubs.

Health Maintenance Organizations (HMOs)

Most of the time, when you talk about HMOs, you're really talking about closed-panel HMOs

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- the least expensive, but least flexible type of health plan. They also tend to be geared more

toward members of group plans than individuals.

In exchange for a low co-payment (or sometimes no co-pay at all), low premiums and minimal paperwork, an HMO requires that you only see its doctors, and that you get a referral from your primary care physician before you see a specialist. If you can still pick up the phone, you'll probably need to get clearance before you can visit the emergency room.

An HMO may have central medical offices or clinics (such as those used by Kaiser Permanente), or it may consist of a network of individual practices. In general, you must see

HMO-approved physicians or pay the entire cost of the visit yourself. HMOs have the best reputation for covering preventive care services and health improvement programs.