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What are my health insurance choices?

There are essentially two types of health insurance plans: **indemnity** plans (fee-for services) or **managed care** plans. The differences include the choice of providers, out-of-pocket costs for covered services and how bills are paid. There is no one ?best? plan for everyone. Some plans are better than others for your or your family?s health care needs, but no one plan will pay for all the costs associated with your medical care.

Here is a brief description of the types of available health insurance plans: Indemnity Plans; Managed Care Options; and Government-sponsored Health Insurance

A. Indemnity Plans

Cafeteria/Flexible Spending Plans are employer-sponsored plans that allow the employee to design his or her own employee benefit package, choosing between one or more employee benefits and cash. Several types of Flexible Benefits or Cafeteria Plans are used by employers, including a pre-tax conversion plan, multiple option pre-tax conversion plan, medical plans plus flexible spending accounts, and employer credit cafeteria plans. For more information about these choices, contact your employee benefits department.

Indemnity Health Plans allow you to choose your health care providers. You can go to any doctor, hospital or other provider for a set monthly premium. The plan reimburses you or your health care provider on the basis of services rendered. You may be required to meet a deductible and pay a percentage of each bill. However, there is also often an annual limit on out-of-pocket expenses, so that once an individual or family reaches the limit, the insurance covers the remaining eligible medical expenses in full. Indemnity plans sometimes impose restrictions on covered services and may require prior authorization for hospital care or other expensive services.

?Basic and Essential? Health Plans provide limited health insurance benefits at a considerably lower cost. When buying such a plan, it is extremely important to read the policy description carefully because these plans don?t cover some basic treatments, such as chemotherapy, certain prescriptions and maternity care. Furthermore, rates vary considerably because, unlike indemnity plans or a managed care option, premiums are community rated and are based on age, gender, health status, occupation or geographic location.

Health Savings Accounts (HSA) are a recent alternative to traditional health insurance plans. HSAs are basically a savings product designed to offer individuals a different way to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. Instead of paying a premium, you establish a tax-free savings account that covers your out-of-pocket medical expenses. This means that you own and control the money in your HSA. You make all decisions about how to spend the money without relying on a third party or a health insurer. You also decide what types of investments to make with the money in the account in order to make it grow. However, if you sign up for an HSA, you are generally required to buy a High Deductible Health Plan as well.

High-Deductible Health Plans (HDHP) are sometimes referred to as catastrophic health insurance coverage. An HDHP is an inexpensive health insurance plan that kicks in only after a high deductible is met of at least $1,000 for an individual or $2,000 for a family.

B. Managed Care Options

Health Maintenance Organizations (HMOs) offer access to an extensive network of participating physicians, hospitals and other health care professionals and facilities. You choose a primary care doctor from a list provided by the HMO and this doctor coordinates your health care. You must contact your primary care doctor to be referred to a specialist. Generally, you pay fewer out-of-pocket expenses with an HMO, but you are often charged a fee or co-payment for services such as doctor visits or prescriptions.

Point-of-Service (POS) plans are an indemnity-type option in which the primary care doctors in the POS plan usually make referrals to other providers within the plan. If a doctor makes a referral out of the plan, the plan pays all or most of the bill. However, if you refer yourself to an outside provider, the service is covered by the plan, but you will be required to pay co-insurance.

Preferred Provider Organizations (PPO) charge on a fee-for-service basis. The participating doctors, hospitals and health care providers are paid by the insurer on a negotiated, discounted fee schedule. Costs are lower if you use in-network healthcare services, but you have the option of going out-of-network. If you choose an out-of-network provider, you are generally required to pay the difference between what the provider charges and what the plan pays.

C. Government-sponsored Health Insurance

Medicaid is a federal/state public assistance program created in 1965. It is administered by the states for people whose income and resources are insufficient to pay for health care or private insurance. All states have Medicaid programs, though eligibility levels and coverage benefits vary.

Medicare is a federal government program for people 65 and older, or those with certain disabilities, that pays part of the costs associated with hospitalization, surgery, doctors? bills, home health care and skilled-nursing care.

State Children?s Health Insurance Program (SCHIP) is administered at the state level and provides health care to low-income children whose parents do not qualify for Medicaid. SCHIP may be known by different names in different states.

Military Health Care includes TRICARE/CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs) as well as care provided by the Department of Veterans Affairs (VA).

State-specific Plans are available for low-income uninsured individuals. These plans are known by different names in different states.

Indian Health Service (IHS) is a Department of Health and Human Services program offering medical

assistance to eligible American Indians at HIS facilities. In addition, the HIS helps pay the cost of selected health care services provided at non-HIS facilities.

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