HEALTH INSURANCE- HMOS, PPOS & POS ⋙

Health insurance becomes more complicated and confusing every day. With new terms like managed care, free-for-service, premium, co-payment, the industry has developed a language of its own. When dealing with a health condition like hepatitis, you must understand the health insurance world.

All health care policies are not created equal. To make a smart choice about which plan is best, you must first understand the differences. Health insurance plans can be broken into two basic categories; the traditional fee-for-service plan, and the managed-care plan. While the fee-for-service or indemnity options usually offer full freedom of choice of service provider, these plans are typically more expensive. Managed care options limit the choice of service provider in different ways but are generally more economical.

- With the least freedom and cost, the Health Maintenance Organization (HMO) normally restricts you to a primary care physician who coordinates your care and must refer you to a specialist. Two other managed care options give more choice with more expense than an HMO.
- The Preferred Provider Organization (PPO) gives patients the choice of staying within the network or seeking care outside the group. If you stay within the network, 90–100% of the cost is normally covered while if you go outside the network you submit the claims, similar to an indemnity policy, and typically get 70% of the cost covered.
- Less expensive than PPOs, Point-of-Service plans (POS) still provide more freedom than HMOs. For basic care, you can stay within the network but if you choose to see a specialist outside of the HMO you simply pay a percentage of his charges.

When choosing a health care plan, consider the access it gives you to specialists. Typically in HMOs, a patient's care is managed by a primary care physician, a family practitioner or internist. This physician, the gatekeeper, provides the majority of care and controls access to specialists, tests, and procedures. Their goal is to keep costs down which may mean limiting specialists and certain tests. Some plans may not even have hepatologists or gastroenterologists familiar with hepatitis within their network, so it is essential to select a plan that gives you the experts you need.

Managed care plans may limit accessibility to emergency rooms. Know what type of restrictions exist before you can go to an emergency room. Do you need approval from the gatekeeper? And, what if you are out of town? Will the managed care plan cover you to see someone out of the network? Do you need approval first?

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Also, consider the access to treatments, medications, and tests it gives you, particularly experimental treatments. There are not a lot of medications to treat hepatitis and it is a long process before medications receive "official" approval. Will your plan allow you to access the experimental treatments? Check to see if your plan covers medications and ask to see the list of covered drugs (the formulary). Find out if medications like interferon are covered and for what conditions. In addition, a limit may exist on the lifetime amount they will pay towards drugs.

If you decide to buy indemnity insurance, stick with a major medical policy which covers both hospital stays and physician services in and out of the hospital. There are cheaper plans, which offer a fixed rate per day in the hospital or dread-disease policies, which pay only if you contract a specific disease, like cancer. These policies give you very limited coverage.

Premium costs vary depending on the type of plan, location, benefits offered, deductible, and age and sex of person. Generally, the fee-for-service plan is the most expensive followed in decreasing order by PPOs, POS plans, and HMOs.

Your true cost cannot just be judged by the premium alone. There is also the amount that you are expected to pay for out-of-pocket-costs. These charges include the deductible; the annual dollar amount you must spend on health care before the insurance company picks up the costs. Normally, the higher the deductible, the lower the premium. The portion of the bill you are expected to pay after your premium is met is known as the co-payment. With managed care plans this is usually a nominal fee. In indemnity plans, the co-payment is usually 20% of the fees. However, the insurance company pays 80% of what they feel is the reasonable and customary charge for a service even if your doctor charges a larger amount, leaving you to pay the difference.

Many insurance companies specify a lifetime cap or maximum dollar amount they will spend for each insured person. Most set a cap at a $1 million, which many experts argue is too low for people with chronic conditions. Others may set a cap on a condition or even a yearly cap.

Patients need to know how these important details affect their health care policies. You ought to know how medical care is determined, how “medically necessary” treatment is determined. If necessary, patients should know how to appeal these decisions. You also need to know what provider restrictions exist and how they may affect treatment decisions. Does the doctor charge a discount rate based on volume of patients or does he receive a certain amount per patient per month or year, known as a capitation? If the patient’s care exceeds this amount the doctor must cover the expense. This may cause a doctor to limit care.

What to do when your insurance company denies payment. Contact your local State Department of Insurance and/or Attorney General’s office. These agencies do not charge to investigate and negotiate patient claims of unfair treatment or that have tried to deny payment on claims they should have paid.

Good News! No longer can insurance companies deny you coverage due to a pre-existing condition. The Kassebaum-Kennedy Health Insurance Reform Bill prohibits this practice, as well as allowing employees to transfer insurance policies between employers. The bill, however, does not stop insurance companies from charging higher premiums for people with previous conditions.

You must ask questions and investigate carefully before making any decision concerning health care insurance. Several organizations other than HFI off information to help:

- The Agency for Health Care Policy and Research offers “Checkup on Health Insurance Choices” which describes and compares various options. To get a copy call 800-358-9295 or write AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907-8547.
- The National Committee for Quality Assurance, a non-profit organization which evaluates managed care health plans offers “Choosing Quality: Finding the Health Plan That’s Right for You.”

For a copy call 800-839-6487 or write to

NCQA Publications Center, P.O. Box 533, Annapolis Junction, MD 20701

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