How To Shop For a Health Insurance Plan

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Before shopping for a health insurance plan, ask yourself these two questions:

1. What are my health care needs?

For example, do you get ill often? Do you require several prescription drugs? Do you have a condition that requires ongoing treatment? Are preventive care benefits, such as immunizations and annual physical exams, important to you? Do you need to see specialists regularly?

2. How much can I afford to spend on health insurance?

How much are you able to pay for monthly premiums, office visit co-payments and/or deductibles? What is the best combination of deductible and monthly payments to make health insurance most affordable while getting good service?

Your answers to these two questions will help you decide which type of health insurance plan is best for you. The three basic types are Traditional Plans, Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs).

Traditional Plans

Also called indemnity or fee-for-service plans, traditional plans are the least restrictive ones. You, the insured, can choose any doctor or hospital. Typically, the less restrictive the plan is in terms of your choice of health providers, the more costly the premium.The disadvantages are high premiums and not receiving any benefits until the deductible is met. In addition, preventive care, prescription drugs, and dental and vision benefits are often excluded.

Here's how a fee-for-service plan works. You pay the medical bills until you reach the plan's deductible. Most deductibles are annual, which means the required deductible starts again at the beginning of the next year. When you reach the deductible, the insurance benefits kick in at a specified rate, typically 80/20. In this example, the insurance company pays 80 percent of the covered medical expenses up to a certain out-of-pocket amount or cap, and then 100 percent thereafter. You are responsible for the remaining 20 percent until the cap is met. To be reimbursed, you must submit claim forms.

A range of deductibles are available. The higher the deductible is, the lower the premium. The two primary types of traditional plans are major medical and catastrophic plans. Major medial plans offer wide coverage for medical costs in and out of the hospital. Catastrophic plans cover only the costs of hospitalization and surgery.

To determine the cost for a year's coverage, add the cost of the premium, the deductible amount and your coinsurance up to the out-of-pocket limit. It would be good to have your previous years medical invoices to figure this out.

Health Maintenance Organizations (HMOs)

HMOs are the most restrictive regarding providers because medical treatment must be provided by the HMO's defined network of doctors and medical facilities. In addition, many HMOs also require you to get a referral from your primary care physician before you can see a specialist.

Coverage is not provided outside of the HMO network except for emergencies that threaten life or limb.

Most HMOs include preventive health care benefits, such as physical exams, well-baby care, immunizations, mammograms and blood tests. Some offer prescription drug, dental and vision options.

Here's how HMOs typically work: You, the insured, pay a monthly premium and a small co-payment for each visit to a doctor or hospital. The higher the premium is, the lower the co-payment. Some HMOs also offer plans with deductibles.

Compared to traditional plans and PPOs, the insured usually has lower premium payments and lower out-of-pocket costs for the medical treatment received.

To calculate the yearly cost, add the premiums and estimate how much you are likely to pay in co-payments for doctor visits. If you have chosen a deductible HMO plan, also include the deductible in your calculation.

Preferred Provider Organizations (PPOs)

PPOs typically have a large, extensive network of physicians and hospitals from which to choose. You can also see physicians outside of the PPO network. Generally it costs less to see doctors within the network because they have agreed to charge the insurance company a discounted fee.

Here's how PPOs work. After you have met your deductible, you pay a specified percentage, such has 10 percent, of the cost of seeing a network doctor. If you choose to see a doctor who is not a member of the PPO network, your payment will be higher, for example, 20 percent of the cost of the visit. Typically, you will have to submit claim forms. Preventive benefits may or may not be covered.

To estimate the cost of your annual coverage, total the premiums, the deductible and estimated co-payments for doctor visits.

Health Savings Accounts (HSA's)

This plan allows eligible individuals to buy a high deductible medical insurance policy and open a tax-deductible health savings account alongside. The concept is that the individual will make tax-deductible contributions into the HSA and withdraw the funds to pay for small medical bills. Large, catastrophic expenses would be covered by the underlying insurance policy. The appeal to the consumer is the tax deductibility of the HSA deposits, and more control over the use of the funds by the individual. For example, if a family did not use much medical care during the year they could allocate the HSA funds to cover dental or optical bills. The individual, not the insurance company, retains any unused HSA deposits.

Underwriting

Individual medical plans require full medical underwriting by the insurance policy and contain a two year contestability clause for misstatements. The policy can be accepted as quoted by the insurance company, rejected, or it can be issued with a modification such as a rate up (higher

premium) or and exclusion rider for a pre-existing condition. Underwriting criteria vary widely among insurers so it pays to shop medical conditions around with multiple carriers.

Conclusion

While shopping for a health insurance plan, take a close look at your health care needs and your health care budget. Estimate what each type of plan would cost you. Evaluate each plan's ability to meet your health care needs. After you have done this, you are ready for the next step -- exploring the options within the type of plan you have chosen.

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