Insurance

Health Insurance - How It Works

Without health insurance, a single illness can cause serious, and often irrevocable, financial hardship. Insurance of any kind is intended to transfer financial risk to an insurance company in exchange for a reasonable insurance premium. Where most insurance coverages pay once a loss has occurred, health insurance has the added benefit of paying to keep your loss from getting worse. Health insurance is probably your most important coverage since it can be the difference between life and death. Fortunately, most employers offer some form of health insurance. Often you will have to select from several different alternative plans with differing coverages and premiums.

There are two broad categories of health insurance coverage. One is fee-for-service and the other is managed health care. Under managed health care there are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) plans.

Fee For Service

Fee-for-service and managed health plans have distinct differences in the amount of control the policyholder has in choosing doctors and hospitals. Fee for service plans offer you the greatest amount of choices, allowing you to select doctors and hospitals based on your needs and preferences. This greater amount of choice comes at a cost, fee for service plans are usually more expensive than managed care plans. Under a fee for service plan, your doctor will submit a bill to your insurance provider, or, if he or she does not have a relationship with your provider, you may have to pay the bill directly and get reimbursed by your provider. Under this plan you can see any doctor you wish. You will most likely be responsible for a percentage of every expense, often 20%.

Fee-for-service plans also have an annual deductible; these generally start at $100 for individuals and $500 for families. Generally speaking, the higher the deductible, the lower your premiums. Before receiving the reimbursement you'll have to pay the deductible amount. If your doctor charges more than is "reasonable," you will have to pay the difference. You can appeal this if you feel the doctor is charging the same as the other doctors around your area.

Under fee for service plans there is usually a limit to how much you will have to pay before the plan reimburses you at 100%. Some plans also have a lifetime limit on benefits, usually at least $1,000,000. This seems very high but it is not uncommon in serious situations that this number is met.

Managed Care

There are three major types of managed care health plans: HMOs, PPOs, and POSs. Many of these plans charge a co-payment of $10 or $20 a visit. The disadvantage of an HMO is that you must use the doctor and hospitals that participate in the plan. The premiums are generally lower than fee-for-service plans.

With a managed care plan you will have to select a primary physician who will be responsible for coordinating your care. You will need to be approved by him to seek care by a specialist. You must also get authorization for any hospitalization you may require. As you can see, the lower premiums associated with managed care are the result of allowing the managed care provider to make many of your health care decisions for you.

PPOs and POSs differ from HMOs in that not only do they have a network of providers, but you are also allowed to use physicians outside the network.

Other Considerations

If you are terminated from or leave a job where health insurance was provided for you, the government has established guidelines for maintaining your old coverage at your own expense until you can find new coverage.