## Health Insurance

**Fee-for-Service & Managed Care**

- Both surgical/hospital expenses, major medical/ outpatient services (lab work, rehab, maternity care, office visits, etc.), and prescriptions (Rx)
- Both require you to pay a premium
- The difference lies in the degree of freedom you have in choosing providers, and how the providers are paid.
- No plan will cover (pay for) all medical expenses

**Fee-for-Service:** (also known as **Indemnity Plan**)

***Costs:*** You will need to pay a premium, a deductible, and co-insurance

**Premium:** the policyholder's monthly contribution for insurance coverage. (This is like a gym membership payment.)

**Deductible**: the amount you pay on your medical bills each year before your insurance goes into effect/ will pay anything. Commonly range between $100 - $1000 for individuals and $500 - $3000 for families.

* The higher the deductible the lower the premium.

After you meet your deductible for the year, you and the insurance company will then share the remaining expenses. Usually the insurance company pays 80%, and you pay the other 20%. Your portion (20%) is called the coinsurance.

Stop Loss – After a specified maximum total out-of-pocket, the insurance company begins to pay 100% of the additional medical costs for the remainder of the year.

Maximum Coverage - The lifetime limit on the total amount your insurance company will pay.

***Example:*** Suppose your fee-for-service insurance policy carries a $500 deductible and the 80/20 coverage.

1. You just had an illness that costs $6000 in medical expenses.

- Your initial fee = $500 deductible
- You would now pay 20 % of the remaining bill
  ($5500 * .20 = $ 1100 )
- Your total is = $1600
- The insurance company will pay 80%
  ($5500 * .80 = $ 4400 )

2. Later in the year you break your arm. The bill totals $1200.

- You would pay 20 % of the bill
  ($1200 * .20 = $ 240 )
- The insurance company will pay 80%
  ($1200 * .80 = $ 960 )

**Managed Care Plans:**

***Costs:*** You will need to pay a premium, a co-pay, and a possibly/probably a deductible.

**Co-Insurance (co-pay):** The percentage of medical costs, or flat fee, the insured person must pay at the time of service.

The insurance company controls the cost of health care by negotiating fees with providers who want to participate in the plan. Often, you must choose doctors and hospitals that are in the plan, called **preferred providers** - **medical home,** or **primary care doctors** (or else you will have to pay a larger % of the costs). A provider not on the approved list is considered to be out-of-network.

Many pay doctors and hospitals a set amount each year for each insured patient, no matter what services they provide. The payment policy is called capitation.

- For example: If you are healthy and never see a doctor, your doctor still receives $350 a year just because they are listed as a provider. If you are sick and see the doctor many times, they still only get $350.

Another option: Your insurance company could pre-negotiate a set amount per visit and/or per procedure with the medical provider.

**Additional Coverage:**

*Dental Care:* not covered without an additional plan/ additional charge.

- Usually covers preventative services such as check-up, cleaning, and x-rays, and some portion of the expense of filings, crowns, dental surgery, and repair of teeth damage in an accident.

*Vision Care:* Most basic insurance plans cover eye injuries and diseases, but do not cover routine exams or eyewear – without an additional plan/ charge.

**What is not covered?**

Insurance is there to help cover cost for necessary medical services. Services not covered (**exemptions)** include cosmetic surgery, weight loss, infertility treatments, experimental drugs/surgeries, etc.

**MEDICAL SAVINGS ACCOUNTS**

- For people who are usually healthy
- Combination of high deductible and low premium
- Premiums go into a tax-free savings account, to be used when you have medical expenses
- Savings rollover from year to year (your unused $ accumulates)

**COBRA** (Consolidated Omnibus Budget Reconciliation Act) requires your employer to offer insurance coverage for 18 months after you leave.

- Must pay entire premium on your own
- Must notify employer you want continuing coverage within 60 days of leaving.

## Pre-Existing Conditions

- If you are changing jobs and changing health insurance plans it is important you maintain continuous coverage.
- Health Insurance Portability Act of 1997 protects you from the new insurance dropping coverage due to a pre-existing condition if you have been insured continuously the previous 12 months.
- Pre-existing Condition: is a medical condition diagnosed or treated before you joined a new insurance plan.
- If you had a previous condition, you might have a waiting period before the new insurance will cover any expenses. (Cannot be more than 12 months)

## SOCIAL SECURITY

Governmental Financial Program that provides payments to help replace income lost as a result of:

- Retirement
- Disability
- Unemployment
- Death

The Social Security Act was established in 1935 and included:

- Old age, disability, survivors, and health insurance
- Unemployment Compensation
- Worker's Compensation

You pay for Social Security through your payroll taxes (along with Medicare) and your employer pays an equal amount/matches your contribution

When you reach retirement age you will be entitled to some benefits, these benefits depend on:

1) The amount you have contributed into the system
2) Your age at retirement

Normal retirement age, to receive full social security benefits, used to be 65, but was increased to 67 for those who were born after 1960. You may retire and collect benefits as early as age 62, but your benefits will be reduced.

**UNEMPLOYMENT COMPENSATION**

- For people who lost their job through no fault of their own.
- If you quit your job, or are fired with reason, you might not qualify.
- Most of the funding comes from employers.
- Rules and benefits vary from state to state.
- If you are laid off you will receive about 1/2 of your former salary.
- Benefits usually last 26 weeks
- You must be actively seeking work.

**DISABILITY**

- Short-term vs. Long-term
- Physician documentation required
- Unable to work vs. unable to work at current job
- Often denied initially
- You might have to wait up to 5 months to begin receiving benefits.

**Government Sponsored Health Insurance**

**Medicare**

- Low-cost medical insurance for older Americans (Age 65 or older)

Medigap

- Americans can purchase a supplemental insurance to Medicare.
- Sold by insurance companies, not the gov't.
- Helps fill the gaps that Medicare misses

**Medicaid**

- For Americans who are low income or disabled, regardless of age.
- Supported by federal and state governments, but run by the state.
- In general, those who qualify for welfare qualify for Medicaid

**Workers Compensation**

- All states require employers to contribute to an insurance program to pay expenses for work-related injuries, illnesses, and death.
- Injured workers generally receive 2/3 of their salary while they are disabled.