

Health Insurance - Don't Bet Your Life On It

Unless you live in a cave, you know that healthcare costs have accelerated in recent years. According to a recent study, more than 15% of the United States' total gross domestic product (GDP) was spent on health care, and by 2014, this figure is expected to represent nearly one in every five dollars we spend!¹

What's more, a growing number of Americans - more than 40 million, by latest count - don't have any health insurance coverage at all.² Without health insurance, a single illness can cause serious, and often irreversible, 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.

Health Insurance Categories

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

Fee-For-Service - A primary difference between fee-for-service and managed health plans in the amount of control you enjoy in choosing doctors and hospitals. Fee-for-service plans give you the greatest amount of choice, allowing you to select doctors and hospitals based on your needs and preferences. This greater amount of choice comes at a cost; however, as 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 generally see any doctor you wish. You will most likely be responsible for a percentage of every expense, typically 20% but sometimes higher or lower.

Fee-for-service plans also have an annual deductible; these generally start at \$100 for individuals and \$500 for families. Typically, the higher the deductible, the lower your premiums. You'll have to meet the deductible amount before receiving any reimbursement,

If your doctor charges more than is "reasonable" as defined by your policy, 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.

Fee-for-service plans usually limit 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 with serious accidents or illnesses that this number is met.

Managed Care

There are three major types of managed care health plans -- HMOs, PPOs, and POSs - which generally charge a co-payment of \$10 or \$20 a visit. One limitation 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 care physician (PCP) who will be responsible for coordinating your care. You will need to be approved by the PCP 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 you can choose between the organization's network of providers but can see physicians outside the network if you desire.

Other Considerations

If you choose not to utilize the coverage offered at work, or if no coverage is available through your employer, you could get your own personal policy or go through a group. Group policies have lower premiums. Also, some group policies do not ask questions about your health. Nevertheless, some policies will not cover pre-existing conditions for up to 12 months. You will want to understand all the pre-existing limitations that your coverage includes. If you have had health coverage for at least two years and change employment, you won't be affected by the exclusion.

If you are terminated from or leave a job in which 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. Created by the Consolidated Omnibus Budget Reconciliation Act, this so-called COBRA program gives workers and their families who lose their health benefits the right to choose to continue health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

Decoding MSAs and HSAs

For small businesses and the self-employed, a Medical Savings Account, or MSA, is a tax-exempt account established for the purpose of paying medical expenses in conjunction with a high-deductible health plan. Like an IRA, an MSA is established for the benefit of the individual, and is "portable." Thus, if the individual is an employee who later changes employers or leaves the work force, the MSA does not stay behind with the former employer, but remains with the individual.

Introduced in 2004, Health Savings Accounts, or HSAs, are similar to MSAs. However, MSA eligibility is restricted to employees of small businesses and self-employed individuals, while HSAs are open to everyone with a high-deductible health insurance plan. The interest and investment earnings generated by the account are also not taxable while in the HSA. Amounts distributed are not taxable as long as they are used to pay for qualified medical expenses. Amounts distributed that are not used to pay for qualified medical expenses will be taxable, plus an additional 10% penalty is applied to prevent the use of the HSA for nonmedical purposes.

Given the bills you could face for an unanticipated illness or injury, health insurance is probably the most important coverage you can have. Although you might be in fine health now and think you'll never need it, don't bet your life on it - or your financial future.

1) "Health Tracking," Office of the Actuary, Centers for Medicare and Medicaid Services, February 23, 2005

2) National Coalition on Health Care, based in 2003 statistics

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