

HOW TO SHOP FOR HEALTH INSURANCE

INTRODUCTION

In the past, many people had their insurance picked by their employers. These workers were limited to whatever their employers offered. Now, many employees are given a choice of plans, so they need to know how to choose between competing plans. Others may be shopping for health insurance coverage on their own (not part of a group plan). They may be confused by the myriad of different plans offered. Wise consumers need to examine their health care needs and learn how to compare policies, to make sure that the insurance they have is adequate and reasonably priced for the benefits offered.

WHAT TYPE OF INSURANCE DO I NEED?

First, you must consider what insurance you already have and what is available to you. What does your employer offer? What does your spouse's employer offer? If you can't get health insurance through your or your spouse's employer, can you get coverage through a trade association? Are you eligible for government-sponsored health insurance (such as VA benefits, Medicare for older adults and people with disabilities, Medicaid for certain low-income individuals, or NC Health Choice for uninsured children)?

Next, try to determine the gaps in coverage between what you currently have (or what is readily available to you) and what you think you need. If your circumstances suggest that you need additional health coverage, you will need to shop for insurance that meets your needs.

DO I NEED AN AGENT?

If your employer or trade association offers health insurance, you will probably not need an insurance agent. You may want to talk to your company's Human Resources Department, if any, if you have questions about different plans. However, you may want an agent if you are trying to buy individual (non-group) coverage, or if you are trying to supplement insurance coverage you already have.

If you decide you need an insurance agent, you will want a reputable insurance agent who can help you find a policy that is right for you. In North Carolina there are many different insurance companies licensed to offer health insurance policies. These companies offer a staggering number of different policies. Consumers may find it impossible to understand so many options or to choose among them without some assistance. Policies are not standardized, so it is difficult to comparison-shop

without help. A good insurance agent will be familiar with the range of options and can help you decide which company and policy will most closely match your needs.

There are a number of ways to choose a health insurance agent. One place to start is asking trusted family members and friends for a recommendation. Next, look for a professional designation — usually an abbreviation following the agent’s name in advertisements or literature. Agents with membership in the CLU (Charter Life Underwriters) or FLMI (Fellow of the Life Management Institute) must take extensive courses and examinations to qualify. Agents with RHU (Registered Health Underwriters) or LUTCF (Life Underwriters Training Council Fellow) membership also must take qualifying examinations, but these are less extensive than the requirements for the CLU and FLMI designations.

Insurance agents are listed in the Yellow Pages. Some agents are independent and can help you choose among policies offered by several different companies. Others are affiliated with a specific insurance company and will work only with that company’s policies. There are also professional organizations that can help you locate an agent. Their phone numbers are listed at the end of this chapter under “For

It is also wise to talk to more than one agent. Compare sales tactics. Ask questions. Evaluate your comfort level with the agent. Do you feel pressured? Are your questions answered in terms you can understand? Talking with more than one agent will help you understand all your options.

WHAT TYPES OF HEALTH INSURANCE POLICIES EXIST?

There are several different categories of health insurance policies sold in North Carolina. The most comprehensive are generally considered **major medical plans**. These may be offered through a traditional insurance company or by a health maintenance organization (HMO). In general, major medical plans offer comprehensive coverage of a wide range of medical services.

Insurance companies also offer plans that are not intended to be comprehensive. Some of the more common restricted policies are called “bare-bones” policies, catastrophic coverage, or “dread disease” coverage.

- ◆ **Bare-bones policies** may offer limited (or very limited) benefits.
- ◆ **Catastrophic plans** begin paying for health coverage only after you have incurred large medical bills (for example, a catastrophic policy may not cover the first \$5,000 of health care expenses that you incur). Catastrophic policies are generally most useful in covering hospital bills, but they do not provide much coverage of preventive services or general doctor’s visits.
- ◆ **Dread disease policies** cover care associated with only the disease named in the policy, such as cancer or heart disease.

Major medical plans do tend to be more expensive than these other types of policies, but they also offer far more coverage.

WHAT IS MANAGED CARE?

Managed care is a generic term that applies to different types of health care insurance arrangements. The goal of a managed care system is to provide patients with needed health care services at the least cost. Managed care systems typically combine the financing and delivery of health services. They do this by covering some or all of the costs of health care services while encouraging the enrollees to obtain services from the organization's network of providers. In some managed care arrangements, the patients must seek care from within the health plan's network of providers. In other arrangements, the patient can obtain services from any provider, but the health plan will pay more of the bill if the patient obtains care from a network provider.

Two of the primary components of a managed care system are "utilization reviews," which oversee the amount and type of health care services being used, and provider reimbursement methods that discourage unnecessary care. Managed care organizations often require patients to get prior approval before obtaining certain services. Some of the most common managed care arrangements are:

- ◆ **Preferred Provider Organizations (PPOs).** PPOs seek to manage medical costs by contracting with a network of providers who are willing to accept lower reimbursement rates. The providers must often meet other requirements of the insurer, such as quality assurance or utilization review. Patients can choose any health care provider, but must pay additional money if they use a provider who is not part of the PPO network. In addition, they may be subject to the same utilization review requirements if they use a non-network provider, such as requiring prior authorization before a nonemergency hospitalization. PPOs are usually offered by traditional insurance companies.
- ◆ **Health Maintenance Organizations (HMOs).** HMOs have exclusive provider networks. They may also use primary care providers as "gatekeepers." Gatekeepers are responsible for arranging the patient's referral to a specialist or a non-emergency admission to a hospital. While some HMOs use gatekeepers, many HMOs now have "open access" plans. These plans allow the patient to choose any primary care provider or specialist in the network without a referral. Many HMOs also use reimbursement systems to encourage providers to be more cost conscious. HMOs typically contract directly with physicians or a network of physicians in the community. This arrangement is called a network or IPA model HMO. Alternatively, HMOs may have their own doctors on salary or in an exclusive contractual arrangement. This is called a group- or staff-model HMO.
- ◆ **Point-of-Service (POS).** POS are HMO plans that give the patient the opportunity to see providers outside of the network. Patients who use the HMO network of providers pay less than patients who see providers outside the network. The HMO may require the use of a gatekeeper to authorize in- or out-of-network services; however, they cannot impose greater restrictions on the use of non-network providers than they impose on accessing network providers.

HMOs may still use the same utilization review requirements for out-of-network care—such as the need to obtain prior authorization before a nonemergency hospitalization.

- ◆ **Primary Care Case Management (PCCM).** Primary care case management programs operate only within the Medicaid program. In PCCM programs the Medicaid agency pays a primary care provider a small monthly management fee to manage the patient's care. However, the doctor is reimbursed for the services he or she provides on a fee-for-service basis. The primary care provider acts as the patient's gatekeeper and must authorize all nonemergency visits to the hospital and all referrals to specialists. *Carolina Access* is the name of North Carolina's PCCM program.

HOW DO MANAGED CARE PLANS DIFFER FROM TRADITIONAL INSURANCE COVERAGE?

In a traditional insurance system the insurance company pays the bills but the patient has freedom to choose the provider. In most managed care arrangements the company limits the network of providers. Managed care plans usually give patients a financial incentive to obtain care from within the network.

What Is the Difference between an HMO, POS, and PPO?

HMOs have exclusive networks of providers. An HMO will not usually pay any part of your bill if you choose a provider outside of your HMO's network without prior authorization. HMOs do not usually require their members to pay a deductible, although there may be a co-payment each time you receive services.

HMOs are the most different from traditional insurance plans. They offer both advantages and potential disadvantages over other forms of health insurance. For example, HMOs emphasize prevention and are more likely to cover annual physicals or well child check-ups than are other insurance products. In addition, the HMO industry has made greater efforts to measure the quality of care provided to its members. While HMOs offer advantages over traditional insurance plans, there are also potential disadvantages. HMO members must obtain care from health care providers who are in the HMO's network. Sometimes, HMO members must obtain approval from their primary care provider before receiving care from a specialist. In addition, HMOs sometimes give doctors or other health care providers financial incentives to be more efficient managers of care. While these payment mechanisms provide an incentive to reduce unnecessary care, some people worry that they also may provide incentives to withhold necessary care.

If you have a point-of-service plan (POS), you can see providers outside the HMO network. The HMO will help pay part of the bill but will not pay as much as if you go to a provider within the network. For example, if you see a doctor inside the network, the HMO may pay all of the costs except any required co-payment. If you choose to see a doctor outside the network, the HMO may pay only 70-80% of the costs. You would be responsible for paying the remaining 20-30% of the costs. In

addition, you may also have to meet a deductible for out-of-network services, and may have to pay a higher premium. Under state law, HMOs can exclude coverage for preventive services if you obtain care from a non-network provider.

PPOs are more like traditional insurance companies. Once you meet the deductible, the insurance company will pay a certain percentage of the health care bill. However, you must go to one of the network providers to get the highest level of coverage. A PPO will pay a smaller percentage of the bill if you go to a provider outside the network. For example, the insurance company may pay 80% of the costs if you seek care from an in-network provider, but only 50-60% of the costs if you seek care from a non-network provider. Patients are allowed to make the decision themselves about which doctor to use.

WHAT SERVICES WILL BE COVERED?

It's important to figure out what health services will be covered by a given plan. Most major medical plans cover health services such as hospitalization and doctor's visits. However, not all insurance plans cover preventive services (such as immunizations or annual physicals). In addition, many plans limit the amount of services that are covered. For example, the company may limit the number of physical or occupational therapy visits that will be covered, or put dollar limits on certain services. It is very important to examine the list of covered services and exclusions, particularly if you have a special health care need. Ask to see a copy of the policy contract or evidence of coverage—these provide much more comprehensive descriptions of the services that are covered and excluded.

HOW MUCH DOES HEALTH INSURANCE COST?

There are very few restrictions on how much an insurance policy can cost. Wise shopping for health care coverage is difficult because of the wide variation in the cost of policies and in what the policies cover. When looking for health care coverage, you should be prepared to pay close attention to details and keep looking until you find a plan that meets your needs and is reasonably priced for the benefits it offers.

Be sure to find out the annual cost of the premium and consider this in relation to your annual income. Don't be afraid to reject the first quote that an agent gives you. Ask for another quote from another insurance company for the same or similar coverage. Premium charges can vary widely. An independent agent may very well be able to find you comparable coverage for a lower price with another insurance company. Also, ask your agent if there are any group plans that you may be able to join (such as an association or church plans). Depending on your age and health status, group plans may be more affordable than non-group, individual plans.

Note: if it sounds too good to be true, it probably is! Comprehensive coverage from a reliable insurance company will almost never be cheap. Paying a few more dollars to get the

coverage you want from the insurance company you trust may well be the best buy in the long run.

ARE THERE ANY “HIDDEN” COSTS?

Policies have varying deductibles and levels of co-payments or coinsurance. A “*deductible*” is the amount you must spend on medical services out of pocket, usually in the space of one year, before the insurance policy begins to pay benefits. A “co-payment” or “coinsurance” is what the insurance company requires you to pay when you use medical services. A *co-payment* is usually a fixed amount (for example, \$20 for a doctor’s visit). *Coinsurance* is generally a percentage of the allowable charges (for example, the insurer may pay 70% of the allowable charges, leaving you 30% of the bill to pay).

Some policies have a deductible of \$500 for an individual or \$1,500 for a family. With this kind of policy you would have to pay \$500 in medical costs out of your own pocket before the insurance company would begin to pay claims. Once the combined uncovered bills for all of your family members reaches \$1,500, then the insurer will pay the remainder of allowable claims for all of the family members. Other policies have larger annual deductibles—in the \$1000-\$2000 range (some are even larger).

Plans also have varying levels of co-payments and coinsurance. Certain services, such as inpatient hospitalization or certain preventive health services, may be 100% covered. Other services are not fully covered. You may be required to pay a percentage of the provider’s bills (coinsurance) or a fixed payment per visit (co-payment). Some policies have both co-payment and coinsurance requirements, depending on the service. Read your policy for the schedule of benefits or plan summary, which will, among other things, list the co-payments, coinsurance and deductibles.

Some policies also have pre-certification requirements. For instance, your policy may require you to call a special phone number at the insurance company before your doctor performs surgery. Failure to get pre-certification may mean that the insurance company will refuse to pay for the services, or that they will pay only a portion of the charges. Be sure to follow the pre-certification rules to the best of your ability. Your policy will specify these requirements, so read the policy carefully.

Some policies have additional charges that you should ask about before purchasing. For example, some companies charge a one-time fee to cover the cost of the application process and/or administrative charges. The average amount for a one-time application fee may be in the \$50 range. If it is significantly higher, you may want to ask why.

ARE THERE OTHER LIMITATIONS THAT I SHOULD KNOW ABOUT?

Most policies include some limitations in coverage. Two of the most common limitations are waiting periods and coverage maximums.

A waiting period could be the 60- or 90-day period that applies to most employment-based coverage. Under this type of waiting period, a new employee must wait a specified time before coverage begins. Another type of waiting period is a “pre-existing condition exclusion waiting period.” (See following section for more information about exclusionary waiting periods.)

Coverage maximums define the maximum amount the policy will pay, either annually or over your lifetime. “Lifetime maximums” set the total amount the insurance company will pay for all covered medical services over the course of your lifetime. A lifetime maximum might be \$1,000,000 or \$2,000,000. A lifetime maximum may also be imposed on specific services. For instance, a policy might impose a lifetime maximum of a certain dollar amount for organ transplants.

“Annual maximums” define the total amount the insurance company will pay for covered medical services in a year. Annual maximums may apply to all services or just to certain services. It is not unusual for a policy to impose annual maximums on treatment of chemical dependency or durable medical equipment.

Many policies also exclude injury or illness that results from participation in a felony or illegal occupation; injury or illness related to alcohol abuse; acts of war; court-ordered examinations or care; custodial or maintenance care (such as care in adult care homes) or services provided solely for personal comfort, hygiene or convenience. Insurance companies may also exclude coverage for injuries or illnesses that are covered by another insurance plan, such as work-related injuries (which may be covered by workers compensation), or for services covered by Medicare or the Veterans Administration.

WHAT IF I HAVE A PRE-EXISTING CONDITION?

Under certain circumstances, health plans are allowed to limit coverage to people with pre-existing conditions. Pre-existing conditions are mental or physical conditions for which you sought medical advice, care or treatment within six months prior to your enrollment. Health plans, both HMOs and insurance companies, can limit coverage for up to 12 months for individuals who enroll in a health plan during a normal enrollment period. With certain exceptions, a person who enrolls late—after the normal enrollment period—can be excluded from coverage for pre-existing conditions for up to 18 months. However, individuals who enroll late because they lost other health insurance coverage are generally not considered “late” enrollees. Therefore, they can only be subject to a maximum of 12 months pre-existing condition limitation.

A patient who has a pre-existing condition may be excluded from coverage for the services needed to treat that condition. The health plan will cover other services that are unrelated to the pre-existing condition. For example, if a person has cancer or a heart condition, the health plan can exclude coverage for those conditions, but will still be required to pay for other health services unrelated to the heart condition or cancer. The reason that health plans are allowed to limit coverage for pre-existing conditions is to discourage individuals from waiting until they are sick before purchasing health insurance coverage.

Once you meet the 12- or 18-month pre-existing condition limitation period or are enrolled in a health plan for at least 12 months, you are given additional protections. You cannot be subject to a pre-existing coverage limitation if you later develop health problems. In addition, you will not be subject to a pre-existing coverage limitation if you change health plans and enroll in your new plan within 63 days of ending your prior health insurance coverage. If you met part of an exclusionary period, you must be given credit for that time when enrolling in a new health plan. For example, if you received health insurance through ABC insurance company, and met six months of a 12-month exclusionary period, you must be given credit for those six months if you enroll in XYZ insurance company within 63 days of leaving ABC.

Under certain circumstances, insurers that sell individual (non-group) policies may refuse to cover certain conditions at all. This is most likely to happen if a person has a pre-existing condition. This kind of exclusion is usually called a “rider.” A rider may exclude coverage for exactly the medical condition that you need coverage for the most. If you are shopping in the non-group market, be sure to check to see whether certain health conditions are excluded from coverage.

WHEN WILL MY COVERAGE END?

Health insurance coverage may end as a result of an action that you take, or by an action of the insurance company. You may cause the insurance policy to end by:

- ◆ Requesting to drop coverage, usually in writing
- ◆ Failing to pay the premium
- ◆ Reaching a certain age (some policies specify that when you reach a certain age, your coverage automatically ends)
- ◆ Making fraudulent misstatements. If you intentionally provide false information on an insurance application and subsequently file a claim for benefits, the insurance company may uncover the truth in the course of processing your claim. Under such circumstances, your policy may be canceled as if the coverage was never in force, you may be subject to a pre-existing condition exclusion, or your coverage may be reduced.

The insurance company may also cancel the policy in certain circumstances. For example, the company may decide to terminate the entire line of business. As a

general rule, the company cannot cancel your policy if you continue to pay premiums, if the company continues to offer the same type of policy to others in North Carolina.

WHAT HAPPENS IF I CANCEL MY CURRENT POLICY AND BUY A NEW ONE?

Depending on your type of coverage, new conditions of coverage may be applied to you. For example, if you are shopping in the individual (non-group) market, you may need to give information about your health status. Coverage may be more difficult to obtain if your health declined after you bought the original policy. In some instances, you may be subject to a new pre-existing condition waiting period. In general, it is not wise to cancel one policy before obtaining coverage from another company.

WHAT SHOULD I REPORT ON MY APPLICATION?

You should try to answer all of the insurance questions completely and honestly. Omissions could be interpreted as fraudulent misstatements, which can result in significant penalties or even in the cancellation of your policy. Fraudulent misstatements (that is, statements made with the intent to deceive) that are discovered within the first two years of the policy's life will almost always result in the insurance company rescinding your coverage and refunding your premiums.

HOW SHOULD I COMPARE POLICIES?

Not everyone has a choice of health plans. However, if you are offered a choice of different health plans, you may want to consider the following factors:

Health Care Providers: If you are considering a managed care product (HMO, POS, or PPO), find out if your doctor is part of the managed care network. You should also check to see what specialists, hospitals, specialized treatment centers, and other practitioners are included in the network. This is especially important if you have chronic or special health problems. For example, if you have a child with special health needs you may be interested in finding what pediatricians are included in the network. You may also want to know whether the provider network includes pediatric specialists that can address your child's health condition. If you want to continue your care with a provider who is not in the network, you may want to consider enrolling in a preferred provider organization (PPO) or a point-of-service plan (POS) if given that choice.

Services: Check to see what services are covered or excluded under the plan. You will be given a Summary of Benefits or Plan Summary that summarizes the covered services. If you have a special health need, ask to see the Evidence of Coverage that lists the covered and excluded services in more detail. It also lists any limitations in services. For example, many plans limit the number of physical or occupational therapy sessions, or how often a patient can have durable medical equipment replaced. Check the Evidence of Coverage for more specific information about the

limitations in covered services. Also check to see where the services are offered and whether they are available in your area of the state. If you have a choice of plans, you may want to talk with your provider to determine which service package best meets your needs.

Treatment of Certain Health Conditions: If you have special health needs, you may want to find out how the insurance company or HMO typically treats other people with the same health condition. New state laws give you a right to request certain information from an insurer before you choose to join. You can ask the insurer or other managed care company for:

- ◆ An explanation of the *criteria* or *clinical treatment protocols* that the health plan uses in deciding what types of services or treatments are appropriate. For example, you might want to find out what services the insurer would authorize to treat patients with sickle cell anemia, inflammatory bowel disease, infertility, autism or severe mental illness.
- ◆ Information about the *health plan's referral process*. You should check the insurer's prior authorization and referral process, especially if you have a health condition that requires you to see your specialist frequently.
- ◆ Information about *Centers of Excellence*. Some health plans contract with "Centers of Excellence" for certain services such as transplant care. You may be required to travel to other cities or states to obtain those services. It is important to find out where the services are provided, as well as whether the health plan will pay for transportation and lodging costs if the service is outside your immediate area. Check whether the plan will also pay the transportation and lodging costs of a parent if a child is required to travel outside the service area for care.
- ◆ *Case management protocol*. You may want to see if the insurer has someone who can help you or your family member coordinate all the needed health care services. It is important to realize that a health plan's case manager is not necessarily the same as a patient advocate. A case manager who is employed by the health plan may help you obtain and coordinate health care services, but may also have a responsibility to the insurer to try to reduce health care costs.
- ◆ *The drug formulary*, a listing of medications that the insurer will cover. Health plans often have different medications to treat hypertension, depression, ulcers, or schizophrenia. Find out if your specific medication is covered on the health plan's formulary. If it is not, you may be able to get an exception to the formulary, but that might require more work.

Quality: The NC Department of Insurance collects significant information to use in comparing HMOs and sometimes PPOs. However, it is difficult to determine the quality of a traditional insurance company. Some of the factors to consider include:

- ◆ Whether the health plan has been accredited by a national accreditation organization. (Note: managed care organizations are more likely to be accredited than traditional insurance companies.)

- ◆ How the plan compares to other plans on certain performance data (such as the percentage of women who receive recommended mammograms or pap smears, or diabetics who receive yearly eye examinations).
- ◆ Whether large numbers of enrollees or groups are leaving the plan, or whether doctors are withdrawing in large numbers.
- ◆ Information about member satisfaction with the plan. This information is gathered as a result of yearly HMO consumer satisfaction surveys.
- ◆ How often the plan reviews requests for medical services (“utilization review”) and how often these reviews are denied and appealed.
- ◆ Other complaints that members have with the plan (grievance reports).

Most of these measures are limited to managed care arrangements (either HMOs, PPOs, or POS). However, the Department of Insurance also keeps a record of complaints that it receives from consumers against health insurers or managed care organizations. This information can be obtained from the Department of Insurance, Consumer Services Division.

Costs: Find out the costs of the different health plans, including monthly premiums and out-of-pocket costs in the form of deductibles, coinsurance or co-payments and annual or lifetime limits. An HMO with a higher monthly premium may cost less money on a yearly basis after considering deductibles and coinsurance.

Example: Mary Jones is given a choice to enroll in Insurance Company A or HMO B. Insurance Company A charges \$185 a month in premiums. The plan has a \$250 deductible, after which it will pay 80 percent of all other health care services. HMO B charges \$200 a month in premiums, but only requires a \$10 co-payment per visit to the doctor. Mary’s annual health care costs will depend on her use of health services and the costs incurred. Even though Insurance Company A’s premiums are less expensive, Mary may spend more money on a yearly basis if she has multiple visits to the doctor. For example, it would be less expensive for Mary to join the HMO, if she sees the doctor three times a year, assuming an average cost of \$100 a visit. She would have to pay \$2,480 for Insurance Company A (\$2,220 premium costs, plus a \$250 deductible, plus \$10 for the 20 percent coinsurance). It would cost \$2,430 for HMO B (\$2,400 premium costs, plus \$10 co-payments).

Remember, your best protection is being an alert consumer. It is important to read the insurance or HMO policy cover to cover before you purchase. Don’t be afraid to question your agent, the insurance company, or the Department of Insurance before purchasing insurance.

FOR MORE INFORMATION

Consumer Services Division

N.C. Department of Insurance

(800) JIM LONG (546-5664) outside the Raleigh area
(919) 733-2032

The Consumer Services Division can answer questions about your insurance policy either before purchase or after you have obtained coverage.

Independent Insurance Agents, N.C. Chapter

Bob Byrd, Executive Vice President
PO Box 1165
Cary, NC 27512
Phone: (919) 828-4371

North Carolina Association of Health Underwriters

Carol Matznick, Executive Director
P.O. Box 38905
Greensboro, NC 27438
Carol4ncahu@aol.com
Phone: (336) 605-9108
Fax: (336) 605-9103

NC Association of Insurance Financial Advisors

Cletis Wooton, President
P.O. Box 827
Statesville, NC 28687
Phone: (704) 838-0837
Fax: (704) 873-0215