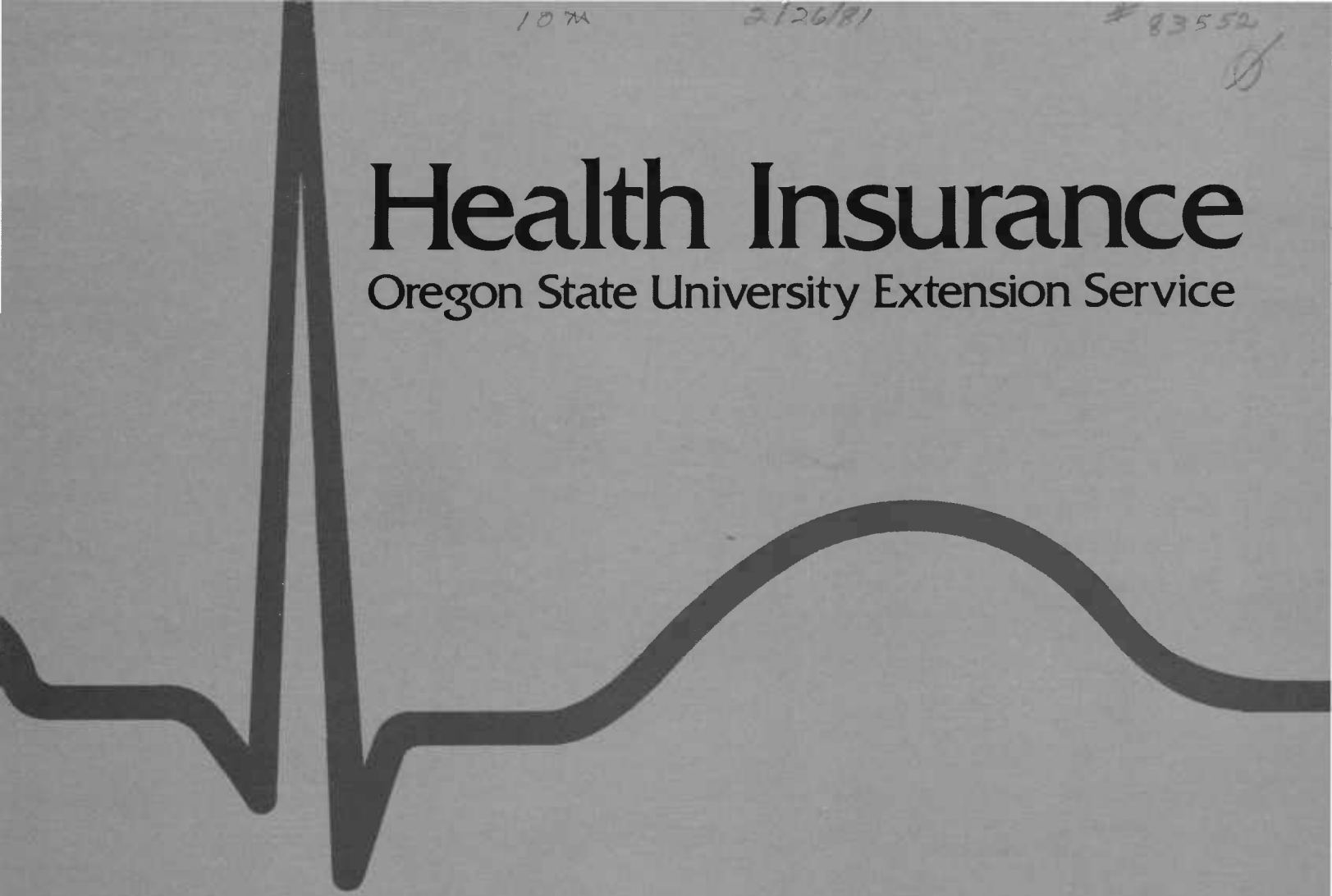
Health Insurance

Oregon State University Extension Service



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Health Insurance

Who Needs It?

As long as we enjoy good health, our lives and our plans continue to move along. But what happens if we become sick or disabled and cannot earn an income? Not only can illness and disability interrupt the flow of income, they can use up the financial resources of a family. Health insurance is designed to protect us against the rising costs of medical care. Only those individuals who have enough financial assets to be able to "self-insure" themselves are able to take on the risk of living without health insurance.

Why Does It Cost So Much?

Health care is expensive and, therefore, health insurance can be expensive, too. The reasons behind the increases in health care costs are explained by the inflationary trends in our economy, the increased costs of malpractice insurance, and by the improved care received by patients, that is, better medical training, more specialized equipment, increased services from doctors and hospitals, and new treatments for illnesses that previously could not be treated.

Efforts are being made by the medical profession and by individuals to lower the cost of health care. Among the cost-lowering practices are reducing the length of hospital stays, increasing out-patient treatment, increasing services performed by paramedics, shopping around for health services from less expensive sources, self-insuring through the use of deductibles and co-insurance, and

decreasing the number of laboratory tests upon admittance to the hospital.

The best advice for avoiding medical expenses is to stay well by practicing good health habits such as ample rest, proper exercise, eating a well-balanced diet, and having regular medical check-ups. Even then, there is no guarantee of perfect health.

What Kind Do I Need?

There are a number of basic forms of medical insurance and these will be discussed here. Probably the insurance you will need will be a combination of two or more kinds. Insurance policies are written with many variations so that coverage more nearly matches the particular needs of one or more clients.

What Are the Basic Forms?

Hospital expense

Hospital expense insurance is the most common kind of insurance issued to policyholders. This policy usually covers in-hospital services such as room and board, routine nursing care, and minor medical supplies. The amount of coverage for benefits may be stated as a maximum amount allowed for each day in the hospital, up to a maximum number of days. It provides benefits which generally range from 21 to 365 days or longer.

Q. **Is it likely that the amount allowed for room and board per day will be adequate?**

A. This is a very important point to check in the particular policy you are considering. Some policies may cover the daily charge, whatever it may be, but it is far more likely that a limit will be set for the amount allowed. In the first part of 1980 the average hospital claim was $310 for members in Blue Cross programs. This amount included room and board plus the routine nursing

care and minor medical supplies mentioned earlier. There are often limits such as the "daily charge for a semi-private room." Learn what the current charge is for the hospital in your area and compare this amount with the amount allowed in your policy. If the difference is large, plan to add insurance to cover the difference or to self-insure.

Q. **Does this kind of policy apply only to in-hospital expenses?**

A. In the past this was true. However, more recently some hospital expense insurance policies are being written to include out-patient or out-of-hospital expenses such as home care, pre-admission testing, nursing home care, dental and vision care, prescription drugs, and a variety of diagnostic and preventative services.

Surgical expense

Surgical expense insurance is the second most popular kind of health insurance coverage and will pay part or all of the surgical cost of an operation. The policy may also cover the cost of a second surgeon or an anesthesiologist. The amount allowed is generally specified in a schedule listing which operations are covered and the dollar limits for each operation. Some policies are more general and indicate they will allow what is "usual, customary, and reasonable."

Q. **Are all surgical operations covered by this kind of policy?**

A. No. It is more likely that a policy will list the operations which are covered and any not listed will not be covered. It is important to read a policy to learn what procedures are covered, and if the definition is not clear, to ask questions to determine the company policy.

Physicians' expense

Physicians' expense insurance is generally combined with hospital and surgical expense insurance to form "basic" coverage. Physicians' expense insurance may be called "medical" insurance when described in various policies. This insurance is intended to help pay the cost of a physician's services not involving surgery, and maximum benefits allowed will be stated. The coverage will generally be for a stated number of in-hospital visits and may also include office and home visits.

This coverage seldom pays for routine physical examinations. Moreover, for any one illness, coverage may not begin until after a stated number of office visits. Many times the initial office visit is covered in the event of an injury, but not for an illness.

Major medical

Major medical insurance covers nearly all types of expenditures for medical care and equipment. Rather than issue a schedule of the amount of coverage which is allowed for specific kinds of health care, most policies will pay a share of all covered expenses after

the policyholder has paid an initial amount, called a deductible; the deductible may be as low as $25 or as high as $200 or more, depending on the particular plan.

After the deductible is paid by the policy-holder, the insurance company will pay a share of the remaining covered expenses, usually 80 to 90 percent with the policyholder paying the remaining 10 to 20 percent. This second feature is called co-insurance. The maximum dollar amount allowed by an insurance policy will vary with the plan and can range from a figure as low as $5,000 to a high of $250,000 or more. Of course, the cost of the policy will vary in accordance with the benefits allowed.

Q. **What is the primary purpose of major medical insurance?**

A. Major medical insurance is intended to help defray the cost of serious illnesses and/or accidents. Medical costs for serious injury and long illness quickly exceed the amount allowed by the three basic kinds of coverage. Major medical is intended to begin where basic coverage ends. However, some major medical policies are written with a low deductible and they are offered as a comprehensive major medical plan without any separate basic plan.

Q. **If a family has major medical insurance, who must pay the deductible?**

A. The particular policy will indicate who must pay the deductible. Generally, in a family plan, the deductible must be paid for each person making a claim up to three persons. The expenses of additional family members will be paid without requiring a deductible.

Q. **If a family has a limited number of dollars to spend for health insurance, how could they get the most insurance for their money?**

A. Generally, the best advice is to buy insurance for the large unexpected expenses and to self-insure for the small, expected expenses. Buying a policy with as

large a deductible and as great a co-insurance feature as the buyer can afford to pay will allow the buyer to get more insurance for the dollar. As for other types of insurance, the consumer should compare prices for similar policies from different companies and should compare premium costs for different levels of deductibles and co-insurance.

Disability income

Disability income insurance is designed to replace income which is lost because the wage earner is unable to perform usual work due to illness or injury. How much disability income insurance is needed or can be afforded will depend on several factors.

When the wage earner is ill or injured, how long will a paycheck continue? What amount of money or liquid assets does a family or individual have on hand to help meet an emergency? Can another member of the family find work and support the family?

What amount of income is necessary for a family to maintain its present standard of living or an adjusted lifestyle? How much sick leave does the worker have accumulated? Will the disabled worker be eligible for Social Security disability payments? How long will the family income be dependent on the insurance proceeds?

A disability income insurance policy should be planned to complement the other resources a family or individual has at hand. A policy needed by one family may require benefits to begin immediately or at the third or tenth day of illness or injury with benefits extending for a length of six months. At that time, Social Security benefits may be available or a second wage earner may have found employment and be able to support the household. However, for another family, a policy may be needed which will begin to make payments at the end of three months and continue until age 65.

Q. Is it possible to buy disability income insurance which will replace the full amount of current income?

A. No. The maximum payment is normally 66 percent of the disabled person's salary but may be less, depending on a particular policy and how it is written.

Q. If I have some money saved in an emergency fund, should I plan to keep it intact and buy disability insurance beginning as soon as my "sick leave benefits" end?

A. The best answer to that question will depend on the amount of assets and other resources you have access to but, in general, the waiting period before benefits begin acts as a deductible. This deductible for disability insurance is measured in time, (a waiting period) whereas the deductible for other types of health insurance is measured in dollars. The longer you can wait for benefits to begin, the lower the premium you will pay and the greater your protection can be, per dollar spent.

Q. Is the definition of "disability" the same for all insurance companies?

A. No. Disability can be defined in a broad sense to mean that the wage earner is unable to perform any or all functions of his/her occupation. Under a strict interpretation of disability, income loss benefits begin only if the policyholder is unable to perform any form of gainful employment. This disability definition is of critical importance to the person buying an income insurance policy.

Other

There are a number of government health programs which may cover some of your health needs. These include Workman's Compensation (which varies from state to state), Social Security (which has a waiting period of five months and a strict definition of what is a disability), and Medicare.

Nursing home custodial care is expensive and is seldom included in medical insurance. Nursing homes with patients who qualify for welfare support will receive only a partial payment for services provided.

Health Maintenance Organizations (HMO's) exist in some communities and are available to some people. In general, they provide a broad variety of health care services for a fixed amount of payment. Routine doctor's visits, dental and vision care may be included as well as hospitalization.

Q. **How does an HMO differ from a comprehensive health care policy?**

A. The difference is that participating members are encouraged to follow preventative health care practices. Costs are kept as low as possible as part of the incentive.

How Do I Buy Health Insurance?

Group and/or individual

Group insurance or individual insurance policies are two options available to most people who are shopping for health care insurance. Many individuals are eligible for group insurance through their place of work, a union, or a fraternal organization. Whenever group insurance is available, it is generally 15 to 40 percent less than the cost of the same insurance through an individual plan. There may be other advantages such as

no requirement of a physical examination to qualify for coverage, a pre-existing condition may not disqualify an applicant, and a policy may not be cancelled unless the policyholder leaves the group.

Because a group policy is written for a large number of people, its coverage may not fit your particular needs. In this situation, you may want to purchase an individual health insurance policy to supplement the group plan.

Q. **If I leave one place of employment where I have group health insurance, will my policy terminate with the last day of employment?**

A. Often a group policy carries the provision that an employee may convert the group policy into an individual policy with the same coverage but at a higher premium with the same company. Or, the policy may contain the option of a grace period of a specified number of days, allowing the policyholder to continue benefits until a new group health plan takes effect. Read the policy to determine what options, if any, are available.

Q. **Is it possible to modify the group health plan in any way?**

A. Generally not. However, a given employer or group offering health insurance may have several plans from which to choose.

Amount of coverage needed

The amount of coverage you need, as stated before, will depend upon your emergency fund and the other resources you have. A general rule of thumb to follow is to purchase basic benefits which would cover at least 75 percent of your anticipated expenses from any illness or injury.

Things to look for in the policy

What does the policy say about pre-existing conditions or illness? If a company rejects your application, send a written request for further explanation. A computer may reject applications based on

standards which, upon further questioning, may be revised.

How many days in the hospital will a policy cover? Often a large number of days of hospital coverage will be used as a selling point for an individual policy while the actual number of days of hospital care will be very small. Government statistics show the average length of stay to be just under 8 days with only 3 percent of all hospital confinements more than 31 days.

Is a policy non-cancellable, guaranteed renewable, or optionally renewable? In the case of non-cancellable, the company must renew the policy and it cannot raise the schedule of premiums. If a policy is guaranteed renewable, a company must renew the policy, but the premium can be raised on the renewable date if it is increased for all policyholders of a given class. With the optionally renewable policy, the company can refuse to renew the policy on the renewable date, often leaving a person with no insurance when it is most needed. The latter is the least expensive but provides limited protection and security.

Be sure to check the current rates for hospital care against the coverage provided by the policy. Does the policy pay a specified amount per day or does it pay a percentage of the cost? The latter would keep pace with inflation if the allowed percentage is of current rates.

What is excluded from the policy? Often knowing what the policy will not cover is as important as knowing what it will cover. You would be better prepared to buy supplemental insurance if it is needed or, at the least, be prepared mentally for paying the full cost of excluded illnesses yourself.

If you consider buying insurance by mail, investigate if the company is licensed to do business in the state. If a company is not, then the business of receiving benefits and following up on disputed claims becomes more difficult and costly. A phone call or a letter to the State Insurance Commission, 158 12th Street N.E., Salem, Oreg. 97310, phone 378-4271, will provide this information. Read all advertised claims very carefully to detect misleading information.

Comparison Chart

Benefits	Policy A (major medical)	Policy B (Health maintenance)
Deductible requirements	Subscriber must pay first $50 per family member per year with a maximum of three.	No deductible requirement for maintenance health care by participating doctors and other providers approved by plan.
Room and board	Semi-private room—no limit on days. 80 percent of reasonable charges.	Semi-private room paid in full.
Hospital outpatient	80 percent of reasonable charges.	10 percent of emergency room charge; balance paid in full.
Hospital doctor calls	80 percent of reasonable charges.	Paid in full to participating physicians.
Surgery	80 percent of reasonable charges.	Paid in full to participating physicians.
X-Ray and laboratory	80 percent of reasonable charges.	Paid in full to participating physicians.
Renewal benefits	Reinstatement up to $25,000 each calendar year.	Renew each year.
Preventive care	Routine physical, well baby care excluded.	Covers periodic routine physicals, eye exams, well child care, immunications according to frequency schedule.
Prescription drugs	80 percent after deductible satisfied.	In hospital or doctor's office—paid in full. Outpatient prescriptions—50 percent paid.
Employee cost to cover self, spouse and children	$0.	$45.58 per month.

This chart compares a major medical policy and a health maintenance policy, both of which may be available to an employee. In the examples, the employer pays part of the cost of policy B and all of the cost of policy A as a job-related benefit.

A family covered by policy A considering a change to policy B needs to compare out-of-pocket costs under plan A with the premium cost of policy B. If their costs under policy A average $21 per month, then policy B at $45 per month represents a higher cost.

If the family has young children needing frequent routine check-ups, and their preferred doctor participates in policy B, then the monthly premium cost of policy B may be offset by having insurance which pays for routine care.

Take a close look at the complete policy to see what is covered and what is excluded. Policy B does not cover the cost of eye glasses, but does cover the examination. Policy A does not cover either. Policy A pays 80 percent of prescription costs while policy B pays 50 percent.

Policy A can be used for medical expenses worldwide; policy B health care must be provided by participating physicians with 80 percent coverage allowed, by prior arrangement, for medically necessary care not provided by a participating physician. Chronic mental conditions can be excluded by policy B.

Glossary

Comprehensive medical—a single policy that includes basic hospital, surgical, and medical expense coverage (such as office calls) with major medical protection.

Co-insurance—the policy holder shares the cost of medical services with the insurance company. For example, the insurance company may pay 80 percent of the cost with the policy holder paying 20 percent.

Hospital expense—insurance that provides benefits toward full or partial payment of room, board, and services received while hospitalized.

Major medical—insurance that covers virtually all types of medical care, except for specified exceptions, in connection with a major accident or illness. It is designed to take over where basic health plans leave off.

Self-insured—the individual with resources available to pay for medical services.

Surgical expense—insurance that pays for the services of a surgeon generally according to a fee schedule which sets maximum amounts.