

13. Insurance 3: Protecting Health through Health, Long-term Care, and Disability Insurance

Introduction

Having adequate health insurance is crucial; health insurance ensures that you and your loved ones will receive necessary medical treatment throughout the course of your lives. Because of the importance of health insurance, it is extremely important for you to learn how this type of insurance fits into your Personal Financial Plan.

Health insurance is costly, largely because there is a lack of incentive to reduce costs. Rising insurance costs have gotten the attention of corporate managements. Companies are passing on a greater percentage of insurance costs to their employees. This shift is affecting many individuals' financial situations; as medical costs rise, individuals become less able to pay for medical care costs out of their own pockets. Therefore, the number of people who are uninsured and underinsured continues to rise. Health insurance is important and could be a major detraction from attaining your goals if health-related problems arise and you do not have appropriate health insurance to cover your costs.

Objectives

When you have completed this chapter, you should be able to do the following:

1. Understand how health insurance relates to your Personal Financial Plan
2. Understand Obamacare and basic health insurance coverage and health insurance plans
3. Understand the key areas of disability insurance
4. Understand the key areas of long-term care insurance
5. Understand how to control your health-care costs
6. Understand some strategies for health insurance for different stages of your life

Understand How Health Insurance Relates to Your Personal Financial Plan

Health insurance protects you and your dependents from suffering a financial catastrophe caused by high medical expenses. Paying out of pocket for a hospital stay, even if short, can be very expensive. Health insurance offers peace of mind and eliminates the financial risk of having to make large payments to health-care providers for injury or illness.

Concerning the need for adequate insurance, N. Eldon Tanner remarked:

Nothing seems so certain as the unexpected in our lives. With rising medical costs, health

insurance is the only way most families can meet serious accident, illness, or maternity costs, particularly those for premature births . . . Every family should make provision for proper health and life insurance.¹

Understand Obamacare and Basic Health Insurance Coverage and Provisions

Obamacare (the Affordable Health Care Act) brought many changes to the health care industry. However, in the current Congress, there are likely changes coming. The main changes due to Obamacare were:

- Obamacare doesn't create health insurance; rather, it regulates the industry.
- Many people who have health insurance can keep their coverage, but not all people.
- Young adults can stay on their parents' health insurance plan till age 26.
- If you don't have coverage, you can use the Health Insurance Marketplace during the open period.

Other features of Obamacare include:

- You can obtain private health insurance during each year's annual enrollment period.
- If you don't have insurance, you are taxed.
- The cost of your insurance is on a sliding scale.
- You cannot be denied coverage based on health status, and there are no pre-existing coverage limitations and no lifetime coverage limits on your policy.

Getting healthcare through Obamacare, you have many options. You can continue to get health insurance through your work if it is provided. You can obtain healthcare coverage outside or inside of the marketplace during open enrollment. During open enrollment, you can purchase federally regulated and subsidized health insurance through private providers. You can also purchase private health plans through a broker or directly from the provider.

Major Types of Health Insurance Coverage

There are four major types of health insurance coverage:

- Basic health insurance
- Major medical expense insurance
- Dental and eye insurance
- Dread disease and accident insurance

Basic health insurance describes most health insurance policies that cover hospital, surgical, and physician expenses. Hospital insurance covers hospitalization expenses, including room, board, nursing, and prescription fees. Surgical insurance covers only the direct costs of surgery, including the equipment costs and surgeon fees. Finally, physician expense insurance covers physicians' fees, including fees for office visits, lab tests, X-rays, and other necessary tests.

Major medical expense insurance covers medical costs that are in excess of those covered by basic health insurance. This type of insurance normally requires you to pay a co-payment and/or a deductible and has an overall limit.

A co-payment is an amount of money you pay to help cover medical costs. A co-payment may be a flat amount, such as a \$15 payment each time you visit a doctor's office, or it may be a percentage of the total cost of a surgical procedure, such as a payment that covers 20 percent of the surgical fee. The insurance company pays the remaining balance of the medical cost—for example, the insurance company pays \$50 for the office visit to supplement your \$15 co-payment and 80 percent of the surgical fee to supplement your 20 percent co-payment.

A deductible is the amount you pay in full before you receive any benefits from an insurance company. For example, if your medical bill were \$1,000, and you had to pay a \$200 deductible on your insurance plan, then you would pay the first \$200 and your insurance company would pay the remaining \$800 of the bill.

Major medical insurance usually includes both a stop-loss provision and a lifetime cap. The stop-loss provision limits your total out-of-pocket expenses to a specific dollar amount. The lifetime cap limits the total amount the insurance company is required to pay over the life of a policy.

Dental and eye insurance pays for the costs of dental work, dentures, eye exams, glasses, and contact lenses. You should know which expenses your plan covers before you go to the dentist or eye doctor. Normally, this type of insurance covers only a portion of the costs and requires you to pay the rest. Dental and eye care insurance plans are often expensive unless they are provided as part of an employee insurance plan.

Dread disease and accident insurance is a unique type of insurance that covers specific diseases and accidents. If your illness is not on the list given by the insurance company, it won't be covered. This type of insurance provides a set dollar amount that is available for reimbursement. If your expenses exceed this amount, you must pay the difference. It is generally best to avoid dread disease and accident insurance unless it is included in your company's total health plan. Instead, you should concentrate on finding health insurance coverage that is as comprehensive as possible so that you will be protected against the widest variety of diseases and accidents that could occur.

Health-Care Plans

The three major types of health-care plans are as follows:

- Private health-care
- Non-group coverage
- Government-sponsored health-care

Health-Care Plans

Private health-care plans are sold by private insurance companies to individuals and employers as part of a benefits package. These plans include two types: fee-for-service plans and plans provided by managed health-care providers.

Fee-for-service plans, also called traditional indemnity plans, are private health-care plans in which doctors bill patients directly; the insurance company then reimburses a specific percentage or set amount of the bill to the patient. The advantages of these plans are that they provide patients with the greatest flexibility in choosing doctors and hospitals, and that individuals can go to whatever doctor or hospital they choose and still be reimbursed. Another advantage of these plans is that they define what percentage of each claim the policy will cover and what percentage the patient must cover. Finally, these plans clearly define how much the patient must pay before a claim is eligible for reimbursement. The disadvantages to these plans include that they are usually expensive for those insured and providers, and they require more paperwork than other types of insurance plans.

Plans provided by managed health-care providers offer prepaid health-care plans for employers and individuals. There are four main types of managed health-care providers: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service plans (POSs), and exclusive provider organizations (EPOs). One of the advantages of managed health-care providers is that these organizations pay for and provide health-care services to policyholders, including preventive health-care. Also, managed health-care providers generally pay bills more efficiently than other providers because they do not require you to pay your doctor's bills and hospital bills first (with the exception of the nominal co-payment for visiting a doctor's office).

However, one disadvantage of working with managed health-care providers is that they limit the number of doctors and hospitals that participate in their program, thereby limiting your choices. Like fee-for-service plans, plans provided by managed health-care providers require you to pay a monthly premium and to share the cost of care; however, these costs are traditionally less than the costs of fee-for-service health care.

HMOs provide prepaid insurance plans that entitle individuals to the services of specific doctors, hospitals, and clinics. These plans are the most popular form of managed health care because of their low costs, which are roughly 60-percent less than the costs of fee-for-service plans. HMOs provide a system of doctors and hospitals for a flat fee, and they emphasize preventive medicine and efficiency, which are advantages. The disadvantage of HMOs is that they provide limited choices of doctors and hospitals. Because of these limited choices, the quality of service may suffer, and referrals to other specialist doctors are sometimes difficult to get.

Preferred provider organizations (PPOs) provide insurance plans that are essentially a cross between traditional fee-for-service plans and HMO plans. PPOs negotiate with a group of doctors and hospitals, and these doctors and hospitals provide care to PPO participants at

reduced rates. PPOs then give individuals the option of choosing either “plan” or “non-plan” doctors. One advantage of PPOs is that they provide health care for less than the cost of fee-for-service plans while still allowing members to choose their doctor or hospital. Because PPOs provide a group of doctors who work at reduced rates for PPO participants, PPOs assess an additional fee if the participant uses a non-plan doctor or medical center. PPOs are generally more expensive than HMOs.

Point-of-service plans (POSs) have many of the attributes of HMOs, PPOs, and fee-for-service plans. For example, these plans generally have a network of contracted doctors, hospitals, and clinics. If you use these preferred providers, the fees are less. But you also have the option to go outside the network for other medical specialists if you are willing to pay a larger out-of-pocket fee. These plans may have a gatekeeper (a physician or other authority) that must be notified before participants are allowed to receive services.

Exclusive provider organizations (EPOs) are similar to HMOs, but they operate through an insurance company. These organizations are funded through an insurance company, and health care is provided by contracted providers. Only care received from contracted providers is covered, unless there is an emergency situation.

Non-Group Coverage Plans

Non-group coverage plans (also called individual health-care plans) insure individuals independently. These plans are often used by people who are self-employed or between jobs; they are also used by people whose companies do not offer group insurance. An advantage of these plans is that they provide a custom insurance policy. There are also several disadvantages to non-group coverage plans. These plans are expensive—they are usually 15 to 60 percent more expensive than group plans. Non-group coverage plans may also require subscribers to pass a medical exam prior to enrolling in the program; at a minimum, they require subscribers to submit a personal health history.

Before you sign up for a non-group coverage plan, check the insurance company’s ratings and its claim service. It is best to avoid a company that raises premiums when claims are made or reserves the right to cancel policies at any time.

Instead of using a non-group coverage plan when you are between jobs, use COBRA, if possible. COBRA, which stands for the Consolidated Omnibus Reconciliation Act, requires companies with more than 20 employees to continue providing group health care to former employees, retirees, spouses, and dependents for a specific length of time. This length of time is based on the employee’s reason for leaving the company and is usually about 18 months. If COBRA is used, the former employer must provide the insurance, but the discharged employee must cover the entire cost of the health insurance.

Government-Sponsored Health-Care Plans

Government-sponsored health-care plans are sponsored by either the state or the federal government. These plans fall under four headings: (1) workers' compensation, (2) Medicare, (3) Medigap, and (4) Medicaid.

Workers' compensation is a state-sponsored insurance program that insures employees who have suffered work-related accidents or illness. An advantage of workers' compensation is that it provides insurance for workers injured on the job whether they have health insurance or not. A disadvantage is that it covers only work-related accidents and illnesses. Moreover, coverage is determined by state law and varies from state to state.

Medicare provides medical benefits to people who are disabled or are of age 65 and older and covered by Social Security. The costs of this federally sponsored program are covered by Social Security taxes.

The cost of private insurance for people who are disabled or are over age 65 is often unaffordable. Medicare provides a way for these individuals to get affordable health care. A disadvantage of Medicare is that it does not cover all the costs of care and treatment.

Medicare is divided into Part A and Part B. Medicare Part A is compulsory and covers all hospital-related expenses, including costs for hospitalization, skilled nursing-care facilities, home health care, hospice care, and prescription drugs furnished by the hospital.

Medicare Part B is voluntary and carries a monthly fee for services. Part B covers doctors' fees and other medical services, including clinical lab services, health care provided in the home, and outpatient hospital treatment.

Medicare does not cover the total costs of all services. Those insured by Medicare must still pay a portion of their medical costs in order to receive coverage. There are also limitations; for example, out-of-hospital prescription drugs are not covered, and the number of days a person can spend in a skilled nursing-care facility are limited.

Medigap is sold by private companies and covers the gaps between the two parts of Medicare. In all but three states, federal law has limited Medigap insurance provided by private companies to 10 set or standardized contracts, each with different options and costs. Another advantage of Medigap is that a person can't be rejected for health reasons if he or she enrolls in Medigap within six months of enrolling in Medicare Part B. A disadvantage of Medigap is that this type of insurance is expensive; however, consumers should shop around—costs can vary.

Medicaid is a medical assistance program that is jointly operated by states and the federal government through the Social Security program. It provides health-care coverage to persons who have a low income, to those who are blind or aged, and to needy families with dependent children. An advantage of Medicaid is that an individual's payments can be used to offset the

monthly premiums, deductibles, and co-payments incurred with Medicare. A disadvantage is that there is no guarantee Medicaid will still exist in its present form in the future.

Understand the Key Areas of Disability Insurance

Disability insurance provides payments to insured individuals in the event that regular income is interrupted by illness or an accident. Disability is similar to life insurance but is really earning-power insurance. An advantage of disability insurance is that it may provide you with between 50 and 80 percent of your after-tax income if you are disabled by a long-term illness or injury. Anyone who depends on earned income should at least look into disability coverage. The risk of disability is even higher than the risk of premature death.

Table 1. Different Types of Disability Insurance

Individual Disability Income	For personal protection, to provide income to individuals in the event of a disability.
Group Disability Income	For businesses to provide the owners and employees short-term and/or long-term benefits in the event of a disability.
Social Security Disability Income	Provides benefits to individuals covered under the Social Security system.
Workers' Compensation	Provides benefits to employees who incurred a job-related disability.
Disability Overhead Expense	Provides a monthly benefit for covered overhead expenses when a business owner is totally or partially disabled.
Key-Person Disability	Provides a benefit to the business in the event the key person is disabled.

The major sources of disability insurance are employers, the government, and private providers. Workers' compensation coverage is determined by individual states, with wide variability between states. Social Security benefits vary depending on your salary, how many years you have paid into the system, and how long the disability is expected to last.

The key question is how much coverage you should have. Generally, you should have enough coverage to maintain your living standard should you no longer be able to work. Your investment income will not stop with a disability, but your income from working will stop. If you have sufficient savings, you may not need much insurance, perhaps only 30 percent of after-tax income, depending on your investment portfolio. If you have little savings, you may need more,

perhaps 80 percent. Once a person has accumulated sufficient assets, it may be possible to self-insure fully or partially. If a person could stop receiving earned income and live comfortably for the rest of his or her life, then there would be no need for that person to insure his or her income.

Providers of Disability Insurance

Common providers of income in the event of a disability are the government, employers, and private providers.

Government

Disability income benefits may be provided by the government through the Social Security program. Benefits from this program are dependent upon income and time paid into the Social Security system. The Social Security website states:²

The definition of disability under Social Security is different than other programs. Social Security pays only for total disability. **No benefits are payable for partial disability or for short-term disability.**

“Disability” under Social Security is based on your inability to work. We consider you disabled under Social Security rules if:

- You cannot do work that you did before;
- We decide that you cannot adjust to other work because of your medical condition(s);
and
- Your disability has lasted or is expected to last for at least one year or to result in death.

This is a strict definition of disability. Social Security program rules assume that working families have access to other resources to provide support during periods of short-term disabilities, including workers’ compensation, insurance, savings and investments.

Employers

Employers may offer two types of protection: workers’ compensation and group disability insurance. The former is mandatory, and the latter is optional. Workers’ compensation is state-specific and provides benefits only for job-related injuries or illnesses, while group disability insurance provides benefits for injuries or illnesses wherever or whenever they occur.

Group disability insurance is an optional benefit an employer may offer to its employees. The employer may implement or retract this benefit at any time for any reason. Typically a group disability plan will cover 50 to 70 percent of income, and most plans only cover base salary and do not cover bonuses or retirement contributions. The benefits are taxable when the insurance policy is paid for by the employer; sometimes the policy or a portion of the policy may be paid

for by the employee on an after-tax basis, which can result in tax-free benefits. Short-term disability and long-term disability benefits may be offered by group plans. Short-term disability can pay for the first few months of a disability, while long-term disability will start at the expiration of the short-term disability and typically pays out until normal Social Security retirement age. Frequently the definition of disability is constructed to change after 24 months of benefits and goes from an “own occupation” to an “any occupation” definition. An “own occupation” definition states that a person is disabled if he or she cannot perform the material duties of his or her current occupation. An “any occupation” definition requires the worker not be able to perform the material duties of any occupation that he or she may be physically, mentally, or educationally qualified to perform. Most group plans are also offset by any benefits received by Social Security, and group benefits typically do not increase with inflation.

Private Providers

Disability income insurance can be obtained most comprehensively through private providers. Individual disability income insurance policies are typically paid for with after-tax dollars, and the benefits are tax-free. The policies can stand alone or be used to supplement a group disability plan. Unlike group plans, individual plans typically do not change the definition of disability, are not offset by Social Security benefits, and may have benefits that increase with inflation. Individual disability income plans have many choices and factors. It is very important to choose wisely when selecting a company and a policy, as not all disability insurances are equal

Key Areas of Disability Insurance

There are eight key areas of disability insurance:

1. Definition of Disability.

Needs differ, which is why there are many different definitions of disability. It is important to understand the various ways disability is defined. What exactly does the policy consider a disability? Stick with a policy that defines disability as an inability to perform your normal job. A combination definition may include, “if you can’t perform your normal job for the first two years, and afterward any occupation for which you are reasonably suited” and may be acceptable. The latter definition will have lower cost.

2. Partial Disability Benefits

Some policies offer partial disability payments that allow workers to return to work part-time. These payments make up the difference in earnings between part-time and full-time work.

3. Benefit Duration

Policies state how long the benefits will continue. Most policies provide benefits for a maximum period or until the disability ends (or the disabled reaches age 65 or 70). Short-term disability

policies, which are more expensive, generally provide benefits from six months to two years.

4. Waiting or Elimination Period

Policies determine the waiting period before the benefits begin. Short-term disability policies, which are more expensive, have a waiting or elimination period of 8 to 20 days. Longer-term policies have waiting periods of between one and six months. Generally the longer the waiting period, the less expensive the policy. Generally, a long-term policy makes more sense as your emergency fund protects you in the short-term.

5. Waiver of Premium

This option waives the premium payments if you become disabled.

6. Non-Cancelable Option

A policy may be purchased as either a non-cancelable and guaranteed renewable policy or as a guaranteed renewable policy. A non-cancelable policy cannot be changed unilaterally by the company. The premiums and provisions are guaranteed once the contract is issued. A guaranteed renewable policy cannot be canceled nor have its terms, other than premiums, changed by the company if timely payments of premiums have been paid. Make sure you have a policy that cannot be canceled. This protects you and guarantees your policy is renewable.

7. Rehabilitation Coverage

Rehabilitation coverage provides for vocational rehabilitation, allowing the policyholder to be retrained for employment through job-training and employment-related educational programs.

8. Cost-of-Living Rider

This provides for inflation adjustments to protect you from the impact of inflation.

Disability insurance is expensive. Generally, the annual premium will be around one to two percent of the income replaced. For example, a policy replacing \$50,000 per year of annual salary would cost about \$1,000 per year. However, it is something you should evaluate based upon your goals and objectives for you and your family.

Understand the Key Areas of Long-Term Care Insurance

Long-term care (LTC) insurance covers the costs of nursing-home facilities and long-term home health care. This type of insurance provides a daily dollar benefit—for example, \$100 per day for the cost of long-term care. It may help families with a history of long-term diseases or disability to plan for the future. Two disadvantages of this type of insurance are that it is expensive and that it has many exceptions and conditions for coverage.

There are four basic ways of paying for long-term care: self-insurance, Medicaid, Medicare, and long-term care insurance. Self-insuring means having enough money set aside through saving and investing to pay for future care. Medicaid will provide coverage for long-term care if your income and assets are low and you have exhausted your own assets. Medicare is the federal medical insurance program for those 65 or older or disabled. It will pay the costs of certain benefits but generally will not cover personal or custodial care. Finally, long-term care insurance covers the costs of nursing-home facilities and the costs of long-term home health care.

Key provisions that control your qualification for benefits include the type of care covered, the benefit period, waiting period, inflation adjustment provision, waiver of premium provision, and non-cancel ability provision.

There are five key areas of long-term care insurance:

- Comprehensive or facilities-only plans
- Daily benefit amount
- Benefit period
- Elimination period
- Inflation adjustments

1. Comprehensive or Facilities-Only Plans

Comprehensive plans help pay for care received at home as well as care received in long term care (LTC) facilities. Facilities-only plans require care at LTC facilities, which include nursing homes, assisted living facilities, and hospice and respite care facilities. These plans are generally cheaper.

2. Daily Benefit Amount

This amount is either the maximum amount or the actual amount the insurance will pay per day for covered services. Some plans offer benefits on a monthly or weekly basis. Understand the rules for any policy you may be considering.

3. Benefit Period

This is the amount of time that you wish to receive the daily benefit amount. The period can range from 2 to 10 years or for an unlimited amount of time. Your total lifetime benefit is your daily benefit multiplied by your benefit period. For example, if your benefit amount is \$110 per day * 1,825 days (five years), your lifetime benefit is \$200,750.

3. Elimination or Waiting Period

Your elimination period is a period of time during which you are ineligible for benefits (this is the time before the insurance company begins paying claims). Policies with short or no

elimination period are more expensive than those with longer elimination periods.

4. Inflation Protection

There are a number of options to help you protect yourself against the increased costs of care in the future. You can add options for automatic compound inflation, simple inflation, periodic inflation, or future purchases.

Understand How to Control Your Health-Care Costs

Controlling health-care costs is critical for you to achieve your personal and financial goals. Group health-care plans are usually more desirable than individual plans for three reasons. First, participants can generally get group coverage at lower rates. Second, employers often provide group coverage as an employee benefit. And third, people with existing health problems may find it easier to obtain group coverage because this type of coverage is offered based on the group as a whole rather than on the individual.

There are four important things you can do to control your health-care costs:

1. Live a healthy lifestyle.
2. Use a medical reimbursement account or health savings account.
3. Consider COBRA when changing jobs.
4. Opt out of a company insurance plan if you are already covered through a spouse's plan.

1. Live a Healthy Lifestyle

Living a healthy lifestyle is the most important part of controlling health-care costs. Take care of your body. Scriptures teach us that our bodies are temples (1 Corinthians 3:17). We must therefore learn to treat our bodies as the temples they are.

Learn to live in healthy mode. Get adequate exercise and adequate sleep. Going to bed early and rising early is wise counsel that dates back to Moses' time. Don't put anything into your body that would harm it.

Finally, maintain good relationships with family and friends. In times of trouble, family and friends can help and truly make a difference in our lives.

2. Use a Medical Reimbursement Account or Health Savings Account

A medical reimbursement account (sometimes called a flexible spending account or a medical savings account) is an optional employer-established savings plan that allows you to save pre-tax dollars for non-reimbursable medical expenses. Each year, you set aside a specific amount of money in this account on a before-tax basis; as you pay for medical bills out of pocket, you are reimbursed from this account.

An advantage of a medical reimbursement account is that it provides a way for you to pay for non-reimbursable medical expenses with pre-tax dollars. This savings plan is very flexible and covers many items that may not be covered by insurance plans, such as braces, contact lenses, glasses, and other miscellaneous medical expenses. Disadvantages of this type of account include a lot of paperwork and some expenses that are not eligible for coverage. There is a chance that you may lose the money you set aside in this account; if you do not use all the money you set aside by the end of the year, you lose it.

A health savings account (HSA) is a new option to help people pay medical expenses. For 2018, almost anyone with a qualified high-deductible health plan (which is a plan with a minimum deductible of \$1,350 for self and \$2,650 for a family) can also have an HSA. Contributions can be made by an individual or an employer (\$3,450 self, \$6,900 family, with catch-up limits for those over 55 of \$1,000). Individuals contribute each year into an account that grows tax-free to pay for future qualified medical and retiree health expenses.

Table 2. High Deductible Health Plan Contributions, Deductibles and Limits

High Deductible Health Plan Limits				
Maximum Contributions:	Self	Family	Catch-Up *	
2014	\$3,300	\$6,550	\$1,000	
2015	\$3,350	\$6,650	\$1,000	
2016	\$3,350	\$6,750	\$1,000	
2017	\$3,400	\$6,750	\$1,000	
2018	\$3,450	\$6,900	\$1,000	
Minimum Deductibles				
2014	\$1,250	\$2,500		
2015	\$1,300	\$2,600		
2016	\$1,300	\$2,600		
2017	\$1,300	\$2,600		
2018	\$1,350	\$2,650		
Maximum Out-of-Pocket Expenses:				
2014	\$6,350	\$12,700		
2015	\$6,450	\$12,900		
2016	\$6,550	\$13,100		
2017	\$6,550	\$13,100		
2018	\$6,650	\$13,300		

* If you turn 55 before the close of the tax year, you may also contribute an additional Catch Up amount.

One advantage of HSAs is that you are paying for “qualified medical expenses” on a tax-free basis. It can be used to pay for medical expenses before you reach your deductible limits. Earnings grow tax-free and carry over from year to year, and distributions may be used for medical expenses for your spouse or children.

One of its disadvantages is that deductible amounts are high. Moreover, if a distribution is not for qualified expenses, then the distribution is included in income and is subject to a 10-

percentpenalty (no penalty if taken after age 65).

3. Consider COBRA When Changing Jobs

If you use COBRA in between jobs, you are still able to have health insurance without getting individual coverage. However, a disadvantage of using COBRA is that you must pay the full cost of the insurance, and the cost may be substantially higher than it was before you left the company. Another disadvantage is that you must notify the company within 60 days of leaving that you are going to use COBRA.

4. Opt Out of a Company Insurance Plan If You Are Already Covered through a Spouse's Plan

Companies will sometimes offer you a cash incentive for refusing insurance coverage for yourself and your family. If you already have insurance through a spouse's (or parent's) company, and you are sure you will not lose coverage, opting out is an option.

If you opt out of insurance just to save money and you do not have other insurance, you may be giving up future financial security for additional cash now. This is a very dangerous situation; it is never recommended that you opt out unless you already have another form of insurance.

Know What to Look for When Shopping for Insurance

Selecting health insurance coverage may be the most important decision you make in regard to your financial plan. Medical problems are a leading cause of personal bankruptcy in the United States.

Health insurance is a technical and challenging issue; however, you can come to understand the different aspects of health insurance and use them to your advantage. Learn about the options for health insurance that are available to you and pick the options that will best help you achieve your personal goals. The following are some general tips to help you select the best option for health insurance.

1. **Always compare ratings.** As you look for health insurance, consider only high-quality insurance companies. Check with A.M. Best at <http://www.ambest.com> or Standard & Poor's at www.standardandpoors.com to review ratings on insurance companies. Look for strong companies with the least expensive, yet most comprehensive, plans.
2. **Protect yourself from catastrophic illnesses and accidents.** Know what you are buying. Read through the policies and avoid those with major exclusions or exemptions. Make sure you get needed coverage before you get optional coverage.
3. **Buy an individual policy if you are not covered at work.** If you are changing companies, consider using COBRA while you are between jobs. If your COBRA

insurance has run out, consider joining a PPO or an HMO to reduce your medical costs. Group plans are generally less expensive than individual plans.

4. **Consider higher deductibles to reduce premiums.** By taking on some of the risk, you can reduce your monthly payments.
5. **Look for policies with a guaranteed renewal.** Avoid policies that are not guaranteed to be renewable. The last thing you want to do is purchase a policy and then have it canceled after one period or year.

Lisa Collier Cool recommends that you ask the following questions to protect your health and your financial plan:

1. What is the real bottom line? Determine the total costs of your health insurance. Total costs include not just the annual costs but any deductibles for lab work, emergency care, and other coverage. Make sure the deductible is annual, and not for every time you visit the doctor. Also understand what it takes to reach the family deductible. In addition, weigh co-payments for lab tests, hospital care, emergency room visits, and so on. Finally, make sure you know your annual out-of-pocket maximum, or the maximum you will have to spend each year before the health plan pays 100 percent of all additional costs.

2. How well protected are you from catastrophic costs? Check your plan to determine the limits the insurance company will pay over you or a member of your family's lifetime. A low cap, such as \$100,000, would leave you exposed to additional costs over that amount from a major accident or disease.

3. Will you be able to use your regular doctors? Check the list of available doctors and hospitals for any plan you are considering. Since many doctors may accept a range of plans, discuss with your current doctor which plans they accept and if they would consider working with your "prospective" new health plan.

4. How complicated is it to see a specialist? With most of these plans, there generally is a medical "gatekeeper" you must work through to see a specialist. This gatekeeper decides whether or not the referral is necessary. Depending on your type of plan, it could be harder to see specific specialists. Make sure you understand what you are getting into before you commit.

5. Do you have a choice of hospitals? Most insurance plans are associated with specific hospitals and doctors. Check to make sure the plan covers your doctors and the hospitals they are affiliated with, as well as any nearby hospitals where you may be treated in an emergency. Also determine how your care would be handled if you were sick or hurt while traveling.

6. Are your prescriptions covered? If your plan includes prescription coverage, ask for its

“formulary” or the list of prescription drugs it covers. Some plans have tiered coverage, where coverage is grouped into different groups. Some drugs may not be covered at all if the insurance company considers that group of drugs experimental.

7. What other benefits are included? In addition to health care, some policies may also cover additional areas, such as dental and vision care, hearing aids, and other items. In addition, many also include services to keep you healthy, including discounts on gym memberships, weight-loss programs, and smoking-cessation programs.³

Understand Plans and Strategies for Health Insurance

As part of your Insurance Plan, you will need to include a section on health care strategies. Following are a few ideas for health strategies over different time periods of your life.

Students and young marrieds

- If married without kids, compare your group plans to a Health Savings Account to see which plan has the best coverage for the costs
- Once children come, switch to a traditional group plan to meet your family needs
- Build your emergency fund to meet your immediate needs for emergencies and disability
- Use a flexible spending plan if offered by your employer to reduce your medical expenses

Married with families

- Make sure you have sufficient health insurance to meet your family needs
- Review your insurance needs annually during the open period to be most cost effective with your health expenses
- Use a flexible spending plan if offered by your employer to reduce your medical expenses

Empty nesters

- Make sure you have sufficient health insurance to meet your family needs
- Review your insurance needs annually during the open period to be most cost effective with your health expenses
- As children leave home, make adjustments to your health insurance to be cost effective with your coverage
- Use a flexible spending plan if offered by your employer to reduce your medical expenses.
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Summary

Having adequate health insurance is crucial; health insurance ensures that you and your loved ones will receive the necessary medical treatment throughout the course of your lives. Health insurance offers you peace of mind and eliminates the financial risk of having to make large payments to health-care providers for injury or illness.

There are four major types of health insurance coverage: basic health insurance, major medical expense insurance, dental and eye insurance, and dread disease and accident insurance.

The three major providers of health insurance are private health-care plans, non-group coverage plans, and government-sponsored health-care plans. There are two types of private health-care plans: fee-for-service plans and plans provided by managed health-care providers. There are four main types of managed care providers: health maintenance organizations (HMOs), preferred provider organizations (PPOs), point-of-service plans (POSs), and exclusive provider organizations (EPOs).

Non-group coverage plans (also called individual health-care plans) are health insurance plans that cover individuals on a case-by-case basis. Finally, government-sponsored health-care plans are insurance plans that are sponsored by either the state or the federal government. Government-sponsored health-care plans fall under four headings: workers' compensation, Medicare, Medigap, and Medicaid.

There are four important things you can do to control your health-care costs:

1. Live a healthy lifestyle.
2. Use a medical reimbursement account or health savings account.
3. Take advantage of COBRA when changing jobs.
4. Opt out of a company insurance plan if you are already covered through a spouse's or parent's plan.

Finally, we shared some possible health strategies for different periods of your life.

Assignments

Financial Plan Assignments

Health insurance is an important part of every family's financial plan. While it is not necessary (or cost-effective, perhaps) to have every type of health insurance, it is important to have basic coverage should catastrophic accident or illness strike. Determine what you should have and include these in your [PFP Insurance Template](#) (LT01-09).

What is your vision and goals for health insurance? What kind of insurance should you have?

Your assignment is first to get a copy of your health insurance plan if you have one. Who is the plan's provider? What kind of coverage do you have? Which of the major types of health insurance coverage do you have?

As part of this, get a copy of your health insurance manual. Go through the manual and review the different types of coverage you have, the co-payments, where you can go for service, the available doctors and clinics, and so on. Plan now so you know where you can go to get coverage. Keep a copy of your insurance company's summary pages in your financial plan. In case of accident or illness, you can go to that summary page to find all the necessary phone numbers and addresses. By having this information readily available, you will also minimize the problems that might arise from misunderstanding your available benefits.

Finally, you should determine what insurance you should have. Develop plans and strategies to obtain the type of insurance you determine to be best for your situation.

Review Materials

Terminology Review

Basic Health Insurance. This is basic health coverage which covers hospital, surgical and physician expense insurance. It covers hospital insurance, which is hospitalization expenses including room, board, nursing, and drug fees; surgical insurance, which is the direct costs of surgery including the surgeon's and equipment fees; and physician expense insurance, which covers physicians' fees including office, lab, X-ray, and fees for other needed tests.

Dental and Eye Insurance. This is insurance which covers only dental work and expenses relating to the eyes and teeth. Generally, it is only partial costs of eye exams, glasses, contact lenses, dental work, and dentures. Know your coverage, as the amount covered varies by plan provider. These plans are generally expensive, unless they are provided as part of an employer plan.

Dread Disease and Accident Insurance. This is a special insurance to cover a specific type of disease or accident. Generally it provides only for 'specific' illnesses or accidents on the "covered" list, and it provides a set maximum dollar amount of reimbursement. This insurance is generally expensive, unless included in your company's total health plan. Generally, concentrate on making your health coverage as comprehensive as possible.

Exclusive Provider Organization (EPO). These are similar to an HMO, but operates through an insurance company. It is funded through an insurance company, with health care provided by contracted providers. Only care received from contracted providers is

covered (unless in an emergency situation).

Fee for-service (or traditional indemnity plans). These are health care plans where the doctor bills the patient directly, and the patient is reimbursed, to a specific percentage, by the insurance company. They provide the greatest flexibility for choosing doctors and hospitals, they define the percent of each claim the policy will cover, and they define the amount the insured must pay before a claim is eligible for reimbursement. Generally these plans are more expensive and require more paperwork.

Government-Sponsored Health Care Plans. Government-sponsored health care plans are insurance plans which are sponsored either by the state or the federal government. These plans fall under three headings: Workers' Compensation, Medicare, and Medicaid.

Health Care Coverage. Health Care Coverage is divided into four areas: basic health insurance, major medical expense insurance, dental and eye insurance, and dread disease and accident insurance.

Health Care Providers. These are the major providers of health care. They fall into three types: Private health care plans, which are either fee-for-service (or traditional indemnity plans) or managed health care (HMO, PPO); Non-group (individual) health care plans, or Government-sponsored health care plans.

Health Maintenance Organizations (HMOs). HMOs are prepaid insurance plans which entitle members to the services of specific doctors, hospitals and clinics. They are the most popular form of managed health care, due to their costs, which are roughly 60% of fee-for-service plans. They provide a system of doctors and hospitals for a flat fee, and emphasize preventive medicine and efficiency, and subscribers pay a relatively small co-pay for services rendered. They provide little choice of doctors and hospitals. As such, service may be less than at other facilities and referrals sometimes difficult to get.

Insurance. Insurance is tool or product that transfers the risk of certain types of losses or events from an individual to another institution. By transferring risk, it can help the individuals achieve specific goals if they die, get sick or become unable to work.

Liability Coverage. Liability is the financial responsibility one person has to another in a specific situation. Liability results from the failure of one person to exercise the necessary care to protect others from harm. Personal liability coverage protects the policyholder from the financial costs of legal liability or negligence. There are two major forms of liability insurance: the liability portions of homeowners and auto insurance and an umbrella liability coverage.

Major Medical Insurance. This is major coverage of medical costs over and above the basic health insurance coverage. It covers medical costs beyond the basic plan. These normally require a co-payment and/or a deductible. There is a stop-loss provision, which

limits the total out-of-pocket expenses incurred by the insured to a specific dollar amount and a life-time cap for the insurance company, which limits the total amount the insurance company will pay over the life of a policy.

Managed health care providers. These are insurance companies which provide pre-paid health care plans to employers and individuals. There are four main types of managed care: i. Health maintenance organizations (HMOs), Preferred provider organizations (PPOs), POS Plans (POS), and Exclusive Provider organization (EPOs). They pay for and provide health care services to policy holders and they provide the most efficient payment of bills. However, they limit choices to the doctors and hospitals that participate and they require policy holders to pay a monthly premium and share the cost of care.

Medicaid. Medicaid is a medical assistance program, operated jointly by the states and federal government, to provide health care coverage to low income, blind, or aged persons. Medicaid payments may be used to offset the premiums, deductibles, and co-payments incurred with Medicare. There is no guarantee that this plan will be around in its present form.

Medicare. Medicare insurance provides medical benefits to the disabled and to those 65 and older who are covered by Social Security. Its cost is covered through Social Security taxes. Individuals can get insurance through Medicare that would be prohibitively expensive through other channels, however, it doesn't cover all the costs and expenses and individuals must pay certain amounts. In addition, there are limitations to the coverage, such as out-of-hospital prescription drugs and limitations to the number of days in skilled nursing facilities. Medicare is Divided into three parts: A,B, C.

- Medicare Part A is compulsory and covers all hospital related expenses, such as bed and board, operating room costs, and lab tests. Patient pays a deductible and coinsurance payment.
- Medicare Part B is voluntary, with a monthly charge. It covers doctors' fees and other outpatient treatment. Patient pays a premium, deductible, and 20% of approved charges.
- Medicare Part C (Medicare Advantage) provides three program alternatives: coordinated care plans, private fee-for-service Medicare, and health savings accounts (HSAs) .

Non-group Coverage Plans. These are health insurance plans which cover individuals on a case-by-case basis and are traditionally the most expensive type of coverage. They provide a custom insurance policy to the purchaser. They are expensive, usually 15% - 60% more expensive than a group policy and may require subscribers to pass a medical exam.

Point of Service Plans (POS). These plans have attributes of HMOs, PPOs, and indemnity plans. The point at which benefits are received determines the amounts of

benefits paid. POS may include HMO, PPO, and indemnity type programs, and the POS may also have a gatekeeper.

Preferred Provider Organizations (PPOs). PPOs are insurance plans which are essentially a cross between the traditional fee-for-service and an HMO. PPOs are organizations where in-plan provider's fees are covered, and out-of-plan providers results in higher fees. Insurers negotiate with a group of doctors and hospitals to provide care at reduced rates, while giving insurers the ability to go to non-plan doctors. PPOs provides health care at a discount to fee-for-service plans. They provide a group of doctors which work at reduced costs to the participants, while assessing an additional fee if the participant uses a non-member doctor or center. PPOs are more expensive than HMOs and use of non-PPO providers results in higher out-of-pocket costs.

Private Health Care Plans. These are health care plans sold by private insurance companies to individuals and employers as part of a benefits package.

Workers' Compensation. Workers compensation is state insurance program that insures against work-related accidents and illness. Workers' Compensation provides insurance to workers injured on the job, regardless of whether they have other health insurance or not. It only covers work-related accidents and illnesses, and coverage is determined by state law and varies state by state.

Review Questions

1. What is currently a major concern in the health-care industry? Why is the cost rising?
2. What are the four major types of health insurance coverage?
3. What is a co-payment? Is there a deductible?
4. What are the three major types of health-care plans?
5. What are four important things you can do to control your health-care costs?

Case Studies

Case Study 1

Data

Steven has a major medical policy for \$1 million. The policy has a \$500 deductible, an 80 percent co-insurance provision, and a \$5,000 stop-loss limit. He recently incurred \$10,500 worth of covered medical expenses.

Calculations

What amount will the insurer pay in this situation? What amount of these covered medical expenses will Steven pay?

Case Study 1 Answers

The insured pays the deductible first (\$500), then the insurance company and the insured split the remainder (80 percent / 20 percent), up to the stop-loss limit of the insured (\$5,000).

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The breakdown of payments for covered medical expenses are as follows:

	Total Expenses	\$10,500	Insurer Pays	Steven Pays
Deductible	\$500		\$0	\$500
Remaining	\$10,000			
80/20 Split			\$8,000	\$2,000
Total Payments	\$10,500		\$8,000	\$2,500

¹ “Constancy Amid Change,” *Ensign*, Nov. 1979, 80

² <http://www.ssa.gov/dibplan/dqualify4.htm>

³ “7 Key Questions to Ask,” *Reader’s Digest*, Apr. 2006, pp. 102–103