CH. 9 INSURING YOUR HEALTH

1

IMPORTANCE OF HEALTH INSURANCE

- Next best thing to good health is good health insurance. Having adequate health insurance is critically important to your financial plan.
- Health care costs have grown dramatically in recent years, and a major illness or accident could wipe you and your family out financially if you are uninsured.
- About two-thirds of bankruptcies are due to problems paying health costs.
- Yet about 13% of the country does not have health insurance, though that number is decreasing.

2

CAUSES OF HIGH MEDICAL CARE COSTS

- Advances in medical technology
- Aging US population
- Poor demand-and-supply distribution of health care facilities
- Greater administrative costs, cost of litigation, etc.
- Increase regulation and compliance costs
- Insurance fraud

3

AVERAGE ANNUAL PREMIUMS

Age Of Member	Average Monthly Costs
Age 21	$425
Age 27	$446
Age 30	$483
Age 40	$544
Age 50	$760
Age 60	$1,154

Source: Healthcare.gov. Based on unsubsidized ACA plans.

4

HEALTH INSURANCE PLANS

- Private Health Insurance Plans
  - ✓ Available to singles or families
  - ✓ Provided as group health insurance plans through various employers or for purchase by individuals
- Two categories
  - ✓ Traditional indemnity (fee for service) plans
  - ✓ Managed care plans

5

TRADITIONAL INDEMNITY (FEE FOR SERVICE) PLANS

- A traditional insurance plan is known as indemnity or fee-for-service (FFS). It provides basic coverage for doctor visits, hospitalization, surgery and other medical expenses.
- Typically offer unlimited choice of doctors and hospitals.
- Pay deductible plus a percentage of eligible costs.
- Deductibles are usually about $250 for an individual, but they can be as high as $10,000. The higher the deductible, the lower the premium. Very healthy people without potentially dangerous hobbies can get away with a really low monthly premium by choosing a higher deductible. But should such a person get seriously sick or injured, it could mean paying a big chunk of cash.

6

TRADITIONAL INDEMNITY (FEE FOR SERVICE) PLANS

- Most FFS plans pay 80 percent of the total doctor bill once the deductible is met. That leaves 20 percent for you to pay, called the co-insurance.
- Most FFS policies include an annual maximum out-of-pocket amount for you. They also have a lifetime cap, meaning that when your bills reach that amount (usually $1 million or above) the insurance company won't pay any more.
- In many cases, FFS plans focus on treating health problems and not preventing them. As a result, they don't usually cover annual check-ups and other "well" doctor visits that can quickly amass costs, especially for families. FFS plans may also limit the number of days you can stay in the hospital and still receive coverage.

7

MANAGED CARE PLANS

- Managed care is a medical delivery system that attempts to manage the quality and cost of medical services that individuals receive.
  - ✓ Monthly payments made directly to organizations that provide health care such as HMOs, PPOs and other.
  - ✓ Designated doctors and hospitals provide services.
  - ✓ Hold down costs by controlling amount of care provided and emphasizing prevention. Most medical services including preventive and routine care are covered.
  - ✓ Charge copayments.

8

TYPES OF MANAGED CARE PLANS

- Health Maintenance Organizations (HMOs)
  - ✓ If your coverage is a Health Maintenance Organization plan, you'll generally only have coverage if you use a medical provider who is in-network with the plan, except for emergencies.
  - ✓ You'll likely need to choose a primary care physician (PCP) or your insurer will pick one for you. That person will serve as a "gatekeeper," meaning that you'll generally need to see your primary care physician for a referral before you can see a specialist.
  - ✓ As of 2022, 46% of Marketplace plans were HMOs.

9

TYPES OF MANAGED CARE PLANS

- Preferred Provider Organizations (PPOs)
  - ✓ Insurance company or other organization, contracts with a network of physicians and hospitals to provide services for negotiated amount.
  - ✓ PPOs will cover out-of-network care, but the deductible and other out-of-pocket expenses are typically higher (often significantly so) for out-of-network care.
  - ✓ A referral to a specialist is generally not required, which means policyholders can see a specialist without seeing a primary care doctor first.
  - ✓ As of 2022, only 14% of Marketplace plans were PPOs.

10

TYPES OF MANAGED CARE PLANS

- Exclusive Provider Organization (EPO)
  - ✓ An EPO plan only covers in-network care (except in emergency situations), but policyholders will generally not need to pick a primary care physician, nor will they need to get a referral to see a specialist. So, the policyholder can choose to see any specialist in the plan's network without needing to see a primary care doctor first.
  - ✓ Provides reduced costs services but only from affiliated provider.
  - ✓ Services from non-affiliated providers must be paid 100% by patient.
  - ✓ As of 2022, 36% of Marketplace plans were EPOs.

11

TYPES OF MANAGED CARE PLANS

- Point-of-service Plan (POS)
  - ✓ A hybrid plan from an HMO that allows out-of-network services paid like an indemnity plan (plan pays a percentage of fee).
  - ✓ Requires policyholders to choose a primary care physician and get referrals in order to see a specialist.
  - ✓ These plans do cover out-of-network care after a referral from the PCP, but out-of-pocket costs can be significantly higher for out-of-network care than for in-network care.
  - ✓ As of 2022, only 4% of Marketplace plans were POS plans.

12

MANAGED CARE PLANS

Managed care considerations (HMO, EPO, PPO and POS)				
	HMO	EPO	PPO	POS
Does it cover out-of-network services?	No (In emergencies only)	No (In emergencies only)	Yes	Yes
Do you need a referral from a primary care doctor to see a specialist?	Usually	No	No	Usually

13

GOVERNMENT HEALTH INSURANCE PLANS

- Medicare is a federal health insurance program in the United States for people aged 65 or older and younger people with disabilities, including those with end stage renal disease and amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease).
  - ✓ It was begun in 1965 under the Social Security Administration and is now administered by the Centers for Medicare and Medicaid Services (CMS).
  - ✓ Medicare is divided into four Parts: A, B, C and D.
  - ✓ In 2022, Medicare provided health insurance for 65.0 million individuals - more than 57 million people aged 65 and older and about 8 million younger people.

14

MEDICARE

- Medicare Part A (Hospital Insurance)
  - ✓ Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care).
  - ✓ It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.
  - ✓ Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

15

MEDICARE

- Medicare Part B (Medical Insurance)
  - ✓ Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.
  - ✓ Part B helps pay for these covered services and supplies when they are medically necessary.
  - ✓ Most people pay a monthly premium for Part B.

16

MEDICARE

- Medicare Part D (Prescription Drug Coverage)
  - ✓ Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a plan approved by Medicare that offers Medicare drug coverage.
  - ✓ Most people pay a monthly premium for Part D.

17

MEDICARE

- Medicare Part C (Managed Medicare)
  - ✓ Part C allows patients to choose health plans with at least the same service coverage as Parts A and B (and most often more), often the benefits of Part D.
  - ✓ Part C's key differences with Parts A and B are that Part C plans include an annual out-of-pocket expense limit in an amount between $1500 and $8000 and do not have lifetime coverage limits.
  - ✓ Public Part C Medicare Advantage health plan members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by Original Medicare (Parts A & B).

18

GOVERNMENT HEALTH INSURANCE PLANS

- Medicaid is a state-run public assistance program that provides health coverage for adults and children with limited income and resources.
  - ✓ Eligibility varies by state.
  - ✓ Medicaid is the largest source of funding for medical and health-related services for people with low income in the United States, providing free health insurance to 85 million low-income and disabled people as of 2022.
  - ✓ Primarily paid by states with federal assistance.

19

GOVERNMENT HEALTH INSURANCE PLANS

- Tricare is a health care program of the United States Department of Defense Military Health System. Tricare provides civilian health benefits for U.S Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component.
- The Veterans Health Administration (VHA) is the component of the United States Department of Veterans Affairs (VA) that provides healthcare and healthcare-adjacent services to veterans through the administration and operation of 146 VA Medical Centers (VAMC) with integrated outpatient clinics, 772 Community Based Outpatient Clinics (CBOC), and 134 VA Community Living Centers (VA Nursing Home) Programs.

20

WORKERS' COMPENSATION INSURANCE

- Workers' compensation insurance, commonly known as workers' comp, provides financial support for employees who get hurt or sick on the job.
  - ✓ It helps pay for their medical bills, lost wages, rehabilitation, and more. This insurance also protects employers from potential lawsuits related to workplace injuries.
  - ✓ Businesses with employees are required to carry this coverage in most states.

21

WORKERS' COMPENSATION INSURANCE

- Workers' compensation insurance covers employees who become sick or injured at work. Benefits typically include:
  - ✓ Medical Expenses: This coverage can help pay for related doctor visits, hospital stays, surgeries, medications, and other treatments.
  - ✓ Lost Wages: If an employee can't work due to their injury or illness, it can cover a portion of their regular wages.
  - ✓ Rehabilitation Costs: It can cover physical therapy, occupational therapy, or other forms of rehab that the employee needs to recover.
  - ✓ Disability Benefits: Workers' compensation coverage may pay short- or long-term benefits if a work-related injury disables an employee
  - ✓ Death Benefits: If an employee dies because of a work-related injury or illness, workers' comp coverage can help the employee's dependents with funeral expenses and other forms of financial support.

22

AFFORDABLE CARE ACT OF 2010

- The Affordable Care Act (ACA), formally known as the Patient Protection and Affordable Care Act (PPACA) and colloquially as Obamacare, is a landmark U.S. federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.
- Two key goals:
  - ✓ Reduce the number of uninsured citizens.
  - ✓ Reduce the increases in health care costs by providing a "state based" health insurance exchange in each state.

23

AFFORDABLE CARE ACT

- Require health insurance plans to provide following:
  - ✓ Cover pre-existing conditions.
  - ✓ Children may be covered by parent's plan until age 26.
  - ✓ No lifetime dollar limits on total coverage.
  - ✓ Must cover preventive care and medical screenings.
  - ✓ Insurance companies must spend at 80% of premiums on claims.

24

AFFORDABLE CARE ACT

- ACA mandated that health insurance exchanges be provided for each state. The exchanges are regulated, largely online marketplaces, administered by either federal or state governments, where individuals, families and small businesses can purchase private insurance plans.
- States that set up their own exchanges have some discretion on standards and prices. For example, states approve plans for sale, and thereby influence (through negotiations) prices. They can impose additional coverage requirements—such as abortion. Alternatively, states can make the federal government responsible for operating their exchanges.

25

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26

AFFORDABLE CARE ACT

- Four level of benefits may be provided
  - ✓ Bronze plan covers 60% of benefit costs
  - ✓ Silver plan covers 70% of benefit costs
  - ✓ Gold plan covers 80% of benefit costs
  - ✓ Platinum plan covers 90% of benefit costs
- Premium assistance - Eligible individuals receive a tax credit to cover part of premiums.
- Additional taxes to pay for plan - Income from self-employment and wages of single individuals in excess of $200,000 annually are subjected to an additional tax of 0.9%. The threshold amount is $250,000 for a married couple filing jointly (threshold applies to their total compensation), or $125,000 for a married person filing separately.

27

LONG-TERM CARE INSURANCE

- Long-term care (LTC) insurance helps pay for long-term care like nursing homes, hospice care, adult day care and getting assistance with activities of daily living, such as bathing, dressing and eating.
  - ✓ The average cost of long-term care insurance is $1,200 a year for a 60-year-old man for $165,000 coverage, according to the American Association for Long-term Care Insurance (AALCI).
  - ✓ The average long-term care insurance cost for a 60-year-old woman is $1,960 for the same coverage.

28

LONG-TERM CARE INSURANCE

- Long-term care insurance can play an important role in your long-range financial plan, but long-term coverage isn't cheap. It's a good idea to buy long-term care insurance before your 50s.
- Long-Term Care Insurance Pros
  - ✓ Helps supplement health coverage. Medicare covers medical issues but may not help pay for long-term care needs.
  - ✓ Offers long-range financial security. Living on a fixed income in retirement years is hard enough without paying thousands each month for long-term care.
  - ✓ Helps your loved ones. If you wind up needing long-term care, your loved ones may have to figure out a way to pay for care.
- Long-Term Care Insurance Cons
  - ✓ Not everyone is eligible and LTC insurance can be expensive.
  - ✓ Not many insurance companies offer LTC coverage.

29

LONG-TERM CARE COSTS WITHOUT INSURANCE

Type Of Care	Average Cost Without Insurance
Semi-private room in a nursing home	$6,844 per month
Private room in a nursing home	$7,698 per month
Assisted living facility, one bedroom	$3,628 per month
Health aide	$20.50 an hour
Homemaker services	$20 an hour
Adult day care center	$68 per day

Source: Administration for Community Living.

30