THE HEALTH INSURANCE HANDBOOK

Understanding & Shopping for Health Insurance

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The Health Insurance Handbook:
Understanding & Shopping for Health Insurance

2nd Edition

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Forward

This book is only intended as and expected to serve as a shopping guide. The hope is that after reading the book one can have an intelligent conversation with a sales representative from an insurance agency or insurance company, so that one purchases an insurance plan that best meets the needs of the purchaser and/or their employees.

The plan designs provided in this book are only intended as a guide to facilitate the discussion of the common options and approaches currently being used in the marketplace. It is still recommended that a purchaser work with a knowledgeable sales representative and ask all the pertinent questions when shopping for health insurance coverage. Also, please remember, many concepts in this book have been simplified with the hope of, and for the ease of, creating a basic understanding of health insurance plans and options in order to help facilitate an intelligent and meaningful discussion.

Preface

Why write this book?

The idea for writing this book came about while I was putting on many seminars on consumer driven healthcare over the last three years. The most interesting part of giving the seminars was that I had to spend more than half of the time during the seminars answering basic questions on health insurance. Even more so, when meeting with clients, most of my time was and still is spent on teaching the health insurance principles and health insurance plan basics. It is hard to help a client pick the correct health insurance program when everyone (the client, the insurance agent and the insurance company) has their own way of explaining the benefits of each program.

It is very easy for an insurance sales representative to over-simplify the explanation of the covered benefits, the application process and the underwriting process to a person shopping for health insurance until it is too late to add an important benefit that was needed but not included in the benefits covered by the purchased health insurance plan. This is why it is important to understand the basics of the available health insurance plan options and the pros and cons of the shopping process. Considering that for most individuals, especially those with family plans, the cost of health insurance is the 2nd or 3rd highest household expense, just behind the mortgage payment and the auto expenses. It is vitally important that an individual asks many questions and understands what benefits one is buying. It is also important that an individual knows what the potential out-of-pocket expenses could be if one ends up in the hospital for an emergency or is diagnosed with a serious illness; so the individual does not lose ones home and/or end up in bankruptcy.

Part One

The Basics of Health Insurance

Chapter 1

A Brief Background on Insurance

For starters, when we discuss insurance, and only insurance, we are only speaking of coverage for large unforeseen expenses. Basically, coverage just in case something happens. This is what insurance is designed and intended to provide, a safety net. No one wants to file a claim against their homeowners or auto insurance. However, when it comes to health insurance, the average persons' attitude is that they pay enough for it; so they want to get their money back by using it as much as possible. Therefore, when we discuss wanting better health insurance, what we really mean is that we want a better health benefit plan or a healthcare management program for an affordable price and with reasonable cost-shares. This is how health insurance differs from other insurance products; it's not just about catastrophic coverage.

Insurance works best when large groups of similar exposures or risks are pooled together and managed in order to limit overall losses. In the healthcare arena, pooling risk allows for the costs of treating and maintaining the health of all individuals, including both the healthy and the unhealthy individuals in a group. This is accomplished by having a large group of healthy individuals in a group that has unhealthy individuals in order to help offset the expenses of the unhealthy individuals. In turn, everyone is able to have affordable coverage and reasonable cost sharing. Otherwise, if only unhealthy individuals wanted coverage, it would be too expensive to purchase and the cost sharing would also be unaffordable, as is starting to become the case now in this country. For this reason, it is important that insured groups or pools not be too small, so that the insurance premiums and day-to-day cost-shares do not skyrocket beyond affordability. On the flip side, if the groups are too large, they become unmanageable; meaning that it becomes difficult for those that need help managing their medical conditions to get the help they need in managing their health issues when they need it most.

The benefits that are included in a health insurance program have changed over the last few decades. They have gone through cyclical changes that have generally followed the demographic changes of the country over the last three generations or so. Starting with the older Indemnity type plans ('70's thru mid '80's) to HMO plans (late '80's thru late '90's) and now Consumer Driven Healthcare Plans (CDHPs) (starting in '97), with the most well

known being HSA (Health Savings Account) Qualified plans (rolled out in ’04). Ironically, HSA plans, which are an expansion of the Archer MSA program started in ’97, are similar to the old Indemnity plans, with the exception being that they come with an available tax break incentive.

The old Indemnity type plans generally had an individual pay for the doctor’s office visit and prescription drugs as an out-of-pocket expense while having a very low hospital deductible or co-payment. Understandably, this was at a time that the doctor’s office visit cost was fairly inexpensive and the few prescription drugs that were available were also generally inexpensive. The demographics of the country at this time also played well into these plans as the largest group in the nation, the baby boomers, were all children. What is being referred to here is that not many people rushed to the hospital for every little thing and that there was a very young and very healthy generation that made up most of the population of the country, the baby boomers. This also was a time with a much lower utilization of the nation’s health care system.

The Indemnity plans were followed by the HMO (Health Maintenance Organization) style of plans, at a time when medical costs and breakthroughs were just starting to skyrocket. The focus became controlling expenses by managing them through a primary care doctor. For those that remember; there were many implementation issues in the early years, just as there now are with CDHP plans. The demographics of the country made the HMO plans work as the majority of the boomers (largest group born 1957 thru 1961) were in their mid-to-late 20’s and many decided not to have children until their 30’s. Therefore, we had a nationwide demographic group that was still relatively young and healthy, and not rushing to have kids. The HMOs were able to manage costs while the costs were just starting to increase at double digit rates. Unfortunately, HMOs created a “Free Healthcare” mentality in their early days by saying to people; pay the premium and get as much care as you need or want for little or no cost. The HMOs were not expecting usage to skyrocket at a rate of four (4) times the existing rate. Nor were the HMOs expecting the costs of prescription drugs and medical treatments to skyrocket in the double and sometimes triple digits as many significant medical breakthroughs were being made with regards

to prescription drugs and medical treatments all at the same time. The end result is what we now have, very high utilization of the nation's healthcare system which has lead to skyrocketing health insurance costs.

This brings us to today and Consumer Driven Healthcare Plans; mainly referring to HSA plans which are Qualified High Deductible Health Plans that offer a tax break for taking on the risk of having a significant deductible to pay before the health plan kicks in and starts covering medical expenses. These plans are a cost sharing model that appear similar in design to the old Indemnity plans and bring the hope of controlling cost increases in the healthcare system. The idea is that individuals will do a better job of managing their individual health with the help of their doctor if there is a financial incentive to do so in the form of a much more affordable health insurance plan and a tax break based on both the money spent on healthcare expenses as well as the money set aside specifically for healthcare expenses. In addition, the fact that individuals spend their own money first, there is the hope that the individual will shop around for the least expensive services, when appropriate; and that this will force healthcare providers to become more competitive in the way they price their services. This should help to keep prices down, reduce the rate at which prices rise and slow the rising demand for healthcare services by keeping utilization in check. Ironically, when looking at CDHPs as simply plans that are primarily cost sharing plans, the CDHP plans are not new; they are just existing health plans with a new name and an added tax break. Most would say that after three years, the CDHP model is still in its infancy. Unfortunately, it will be several years before we will see the effectiveness of the CDHP model.

There are some foreseeable changes coming in the next 10-to-15 years. The largest change being the changing demographics of the country. With the largest grouping of the baby boomers (born 1957 thru 1961) being between the ages of 46 and 51, one can estimate that we are just nearing the tip of the iceberg for the demands being made on our healthcare system. Therefore, instead of rushing into a short-term solution to this pending crisis; we can realistically, but aggressively, work on developing and implementing meaningful changes to the healthcare system over the next 5-to-10 years to keep cost increases and utilization under

control. In addition, we should see some relief from the Y or Echo generation, the kids of the baby boomers and the 1st half of the X-generation, which are now primarily between the ages of 7 and 24, and are as large a generation as the baby boomers. The exception is that they are more evenly distributed throughout their birth years, unlike the boomers who are primarily lumped into a 5-year age band, making the changing healthcare needs of the country much easier to manage from a planning perspective. Even though this young group is not the healthiest generation, they are still young, and that has its own benefits. However, and more importantly, they will only help offset or slow the rising cost of insurance, if they are actually paying into the healthcare system, whether or not they need healthcare currently; and if they are actually taking care of themselves, meaning actively managing their health through wellness programs.

Chapter 2

The Roles of the Interested Parties

The Role of the Insured

As an individual enrolled in a health insurance plan, you may not think that there are any things that are expected of you. However, there are inherent expectations that most would consider common sense expectations. In the following paragraphs the expectations related to the two distinct types of health insurance programs will be discussed. The first discussion will be on the expectations of what we have come to consider traditional health insurance plans; HMO, PPO & POS health plans. This will then be followed by a brief discussion on the expectations inherent in both CDHPs (Consumer Driven Healthcare Plans) and in a Universal Healthcare Plan.

The inherent or common sense expectations of a traditional health care plan are simply summarized as; pay your bills on time and only use the healthcare system when you need healthcare. This seems like a simple approach, and is, except that it keeps you from knowing what healthcare actually costs; does not give you a reason to care what healthcare costs; nor does it make you care about how much healthcare you actually use. In addition, other than suggesting that you should take care of yourself, so that you have a healthier and more enjoyable life, it is totally up to you to take care of yourself.

In a CDHP and, realistically, in a Universal Healthcare plan, the expectations for an insured individual are more defined. Besides paying the bills, there is an expectation that you will go for your wellness visits, that you will take care of yourself, and that you will only use the healthcare system when you need to use it. The idea is that you will work with your doctor to actively manage your health with the financial incentive that you will spend less on health insurance and on healthcare expenses. In addition, this idea is usually reinforced by having you pay a percentage of the actual expense, instead of just having a co-payment as a cost share. The overall result of better health management, with the help of your doctor, will be two-fold; you will be healthier and the utilization of the healthcare system will be lower, which will help keep healthcare costs in check.

The Role of the Employer

If you are an employer or a representative of an employer who is shopping for health insurance benefits for yourself and your company's employees, you need to decide, in advance, what the goal of the health insurance program is and what you may be willing to trade off to accomplish that goal. Most individuals would say that the number one goal is to keep the price of the health insurance plan down, since it is one of the employer's largest expenses. However, and in most cases, the goal is that the health insurance plan is an integral part of a strong benefits package and an overall business operations issue when considering the need to Recruit, Motivate, and Retain key employees of the business. At the end of the day, the insurance sales representative will show you options and service your account, but the sales representative is not your employee and is not there to help you run your business or deal with the fall-out if you chose the wrong health insurance program for your employees.

Overall, it is very important to understand your workforce and your business needs when shopping for a health insurance plan. Cost is a driving factor, but not the only factor when deciding what is best for your business and its employees. After all, a business does not operate without employees; and employees are not as productive when they are not happy or out sick on a regular basis. Remember that when making the final decision on a health insurance program that it will have far reaching repercussions; including recruitment, motivation and retention of your workforce. This is why it is important to work with a sales representative that is both knowledgeable and diligent in helping you achieve your goals by helping you choose the appropriate health plan and by properly servicing your account.

The Role of the Insurance Agent

The primary role of the insurance agent is to assist in finding and purchasing the health insurance plan or program that is the best fit for the needs of the person shopping for health insurance. In addition, the insurance agent is also responsible for being the point-of-contact for questions on the health plan you purchased and occasionally helping you resolve claim disputes. Most insurance agents work with multiple insurance companies and can show shoppers many different options, whether it is an individual insurance plan or a group insurance plan. Note that most insurance agents specialize or focus on specific market segments; so it important to work with an agent that has a good understanding of your market segment. Examples of this with approximate group sizes are; Individual, Small Group (2-100), Middle Market (100-3000), Large Group (3000+), Government.

Another role of the insurance agent is to educate. An insurance agent should be able to teach you, and your employees, if applicable, the ins and outs of the coverage's of the health insurance plan you are purchasing or did purchase. This is an ongoing service that should be provided as long as you work with an insurance agent. In addition, agents typically have direct contacts at the insurance companies they represent, meaning that they can typically get an issue resolved more quickly than you can if you call into a call center. If you are working directly with the insurance company, they also provide this service either through a customer service center or local company sales representative. This is a very important service that you should not overlook, especially since you pay for it through your monthly premium payment.

The Role of the Insurance Company

The main role of insurance companies is risk management, primarily through the pooling of insured's and the management of their medical conditions. The pooling of insured's allows for the costs of the medical treatments of the insured individuals in a group to be evenly divided amongst the group. By having a large group of individuals paying for health insurance, including healthy individuals, it helps to make health insurance more affordable for all individuals. Otherwise, if only unhealthy people purchased health insurance, the price would be completely and totally unaffordable, since the insurance company would have to collect enough in health insurance premium payments to cover all the incurred medical expenses, plus cover their overhead or go out of business. This is actually one of the issues we have today, as many healthy individuals are not buying health insurance, and therefore; are not helping keep the premium costs down; and are forcing those that do need health insurance to pay more and more each year. Both young individuals and healthy individuals do not buy health insurance because they do not feel they need it and because they do not understand that uninsured medical claims are very expensive.

The other role that insurance companies provide is the management of medical conditions. This is as important a role, if not more important than the pooling of risk. Insurance companies are typically at the forefront of developing and implementing health management services under many different programs and give them all kinds of different names. The most common of these that many people are familiar with are Wellness Programs and Employee Assistance Programs. The reason these programs are so important to controlling overall costs is that it is far less expensive and much easier to work with an individual in managing their medical conditions than it is to deal with the serious side effects of untreated medical conditions. For example, the cost of helping an individual manage their high-blood pressure using medication and a personal medical health coach realistically costs just $2,000 to $3,000 per year versus the treatment of a heart attack or open-heart surgery typically costing between $100,000 and $300,000. The best part of being active in one of these health management programs is that everyone wins! The insured can expect to live a longer, healthier and more productive lifestyle, while fewer medical resources are used, and therefore the cost of

the health insurance should remain at a more reasonable and more affordable level for everyone.

Finally, the role of insurance companies that most people are familiar with is to provide insured's with a network of medical service providers' with pre-negotiated contract prices for medical services. When most people talk about the role of insurance companies, they are referring to this particular role; the benefits covered by the health insurance plan and the associated cost-shares or co-payments. As examples; which doctor can I go to; how much do I pay for a doctor's office visit; is my local hospital in the network; how much are prescription drugs going to cost me? Unfortunately, and in the big picture, this is the least important of all the services being provided by the insurance companies, as anyone can set up a network of service providers and negotiate discounts. Of course, the more business you send a medical provider the more willing they will be to negotiate a lower discount price; just realize that no one works for free and that all services have a minimum cost associated with them.

The Role of the Government

The role of government in healthcare is very complicated and usually mired in partisan politics. Unfortunately, you will get a different answer from every single person or politician that you speak to about the government's role. So, to keep things simple, I will just give a recap of the general system and some general program summaries.

When discussing health insurance, it becomes completely obvious that we are a nation of states. Health insurance programs, mandates and required coverage's are completely different in each and every state. There are national guidelines, but they are not as specific as the state guidelines. So, it makes it difficult to have a discussion on a national program when different states have different required benefits in their state specific health insurance plans.

An additional role that many states fill is that they provide programs for the uninsured, typically the poor and children. These programs fill a much needed gap in our healthcare system by focusing on individuals who either cannot afford to take care of themselves, or in the case of children, who need a significant amount of preventative care. The preventative care for children is very important as it helps stabilize future medical expenses by catching medical conditions early and keeping them in check. Providing basic coverage to the poor is also important, as helping them maintain their health is far less expensive than the constant utilization of hospitals for what could be basic medical care.

In addition, practically every state insurance department has a web site with information on all available programs; so you should use it if you want to know what is available in your state, as not all insurance sales representatives are fully knowledgeable about all the available state specific programs.

Chapter 3

Health Plan Review

PPO, POS, HMO

These are the three types of health insurance plan names most people are familiar with; Preferred Provider Organization (PPO), Point-of-Service (POS) and Health Maintenance Organization (HMO). Historically, they were very different types of plans and their covered benefits were much more complicated to understand. However, these days, the differences are not as great as they use to be, as many plans have eliminated the need for a Primary Care Physician as the gate-keeper for all referrals and treatments. All these plans tend to now have co-payments for the cost share on most services or standard deductibles. Therefore, they tend to mimic each other with only a few key differences in how one actually uses the plan. In addition, these plans do not typically cover any dental benefits, unless it is due to an accident; or vision benefits, other than maybe an annual check-up or accidental injury.

The primary difference between these programs today is the available provider network. PPO plans tend to have large national networks and include coverage for out-of-network services. POS plans tend to have regional provider networks and also include coverage for out-of-network services. HMO plans are typically localized networks that do not have coverage for out-of-network services. So, when trying to decide which type of plan to go with, knowing the coverage area you will need is important to your buying decision. Emergency Care is typically covered by all plans whether in-network or out-of-network.

The other factor in picking between programs is cost. Simply put, the larger the network of providers you want access to and the more benefits a plan covers; the more you will pay for the health insurance plan. The easiest way to understand why this is the case is because the costs of services vary throughout the country, as do the costs of services provided by specialists.

Limited Benefit Plans

A growing trend in today's health insurance marketplace is a movement to have available lower cost medical plans that have limited benefits as well as coverage limits. The most basic of these plans are Discount Only plans which are typically sold as Guaranteed Issue medical insurance plans and only provide a discount on medical services if you use a medical service provider in the company's network. Other, more commonly available health insurance plans are referred to as Mini-Meds. Basically, when you buy one of these plans; what you are buying is a package of specifically chosen benefits. The plans typically only cover a limited number of doctors office visits on a per-person basis; have an annual dollar limit for prescription drugs; and have an annual dollar limit on hospital expenses. Once the pre-chosen limits are reached, the individual is responsible for all the expenses incurred above the limited benefit. Unfortunately, the end result is that these plans can create a false sense of security, and individuals do not end up realizing the financial risk involved until it is too late. Therefore, one should be extremely careful when purchasing one of these plans.

Consumer Driven Healthcare Plan (CDHP)

Consumer Driven Healthcare Plan (CDHP) is the catch phrase of the modern push in the health insurance marketplace for controlling skyrocketing costs. The catch-phrase and original program actually dates back to circa 1997, when the Archer Medical Savings Account (MSA) program was rolled out nationwide, but only as a test program. The MSA program is the program that has morphed into today's Health Savings Account (HSA) program. The most recognized component of the CDHP insurance program is the Health Savings Account (HSA) Qualified Plan, which is a specific High Deductible Health Plan and will be discussed in the following section.

The idea behind consumer-driven-healthcare is that if you give people a financial incentive to take care of themselves; they will take better care of themselves and therefore utilize fewer medical services. By lowering the utilization of medical services, the healthcare system costs should not increase as rapidly as they have been, and therefore; the future cost of care should rise much slower than it has been the last few years. Plus, since insured individuals have to spend their money before the health plan kicks in, the insured individuals are more likely to shop around for their healthcare services, if appropriate, which will also help keep rising costs in check. In essence, individuals are being asked to be more pro-active in working with their doctors to manage their medical conditions, and getting a financial incentive as a bonus to better health, along with what should be a healthier and more active life.

One important item to note is that when looking at CDHPs as plans that ask for cost sharing by insured individuals, all plans are CDHPs! Is not paying a co-payment a cost share? Is not paying a percentage of an incurred medical expense a cost share?

Another important item to note is that even in a Universal Healthcare model (See Chapter 4), the number one way to control costs within the healthcare system is to limit utilization, by limiting people's access to health care. This currently happens in many nations that have Universal Healthcare programs. CDHPs actually work with insured individuals and provide them incentives to take better care of themselves. So, in the CDHP model,

utilization is not limited by delaying or denying healthcare, but is reduced by helping individuals pro-actively manage their health with the help of their doctors.

Health Savings Account (HSA) Qualified Plans

HSA Qualified High Deductible Health plans can simply be summarized as a specific group of health plans that have an up-front deductible which allow you, if you choose, to pay for the pre-deductible expenses and other qualified medical expenses with tax free dollars. The dollars become tax free by being contributed to a personal account, usually a checking account, that is a specially designated account called an HSA (Health Savings Account). However, before you can open an HSA, you must first be enrolled in an HSA qualified health plan. In an HSA qualified health plan, the plan deductible applies to doctors office visits, prescription drug costs and hospital expenses. Note that some HSA plans include Wellness Care as a benefit, meaning that the insured will not have to pay for recommended wellness visits, such as physicals.

Many people confuse HSAs with other types of accounts, like Flexible Spending Accounts (FSAs), which many refer to at work as use-it or lose-it accounts. This is not the case with HSAs, as HSA accounts are personal accounts, and if the money is not spent during the current year, it continues to roll forward indefinitely, until it is used tax free for medical expenses. Also, because the HSAs are personal accounts, they belong to the individual and not the employer; so the money in the account belongs to the individual as soon as it is deposited in the account and the individual controls how the money is spent.

The single greatest point of confusion with regards to HSAs is that the far majority of all the marketing of the HSA program and implementation of the HSA program is spent solely discussing the Health Savings Account component, and almost no time is spent discussing the health plan that has an up-front deductible. When shopping, you need to look at the health plan component of an HSA Qualified health insurance program, and decide if having a deductible is realistic. The plus side is that the health insurance plans themselves are significantly less expensive, so much so, that you will typically save the majority of the deductible by spending a lot less on the premiums for the health insurance; and most likely have a lower overall potential liability, if you choose the correct plan.

Chapter 4

Universal Healthcare

The discussion of a Universal Healthcare program is once again at the forefront of all the discussions on the affordability of health insurance in this country. Many latch on to the concept of "Universal Healthcare" as the "One and Only" solution to all of the problems ailing our current healthcare system. Unfortunately, many are unaware of the day-to-day ramifications of Universal Healthcare. Cost controls are mainly attained by limiting access to care, meaning longer waiting times for all medical treatment and the potential closing and consolidation of hospitals and clinics, as currently happens in many nations that have Universal Healthcare. In fact, there still exists a private pay system in the countries that have Universal Healthcare for those individuals that can afford to pay for services out-of-pocket instead of having to wait for care, or they just come to our country and pay for the best readily available care in the world.

The overall issue of Universal Healthcare that it is a "system" in these other countries. If you go to a public university to become a doctor, for free, you don't have large debts to pay when you are done becoming a doctor. Plus, you then work for a government run hospital and let all the liability and management issues be taken care of by the government. The thought here is that we need to understand that Universal Healthcare is more than just negotiating for better prices and guaranteeing everyone coverage. We need to look at and address all the components of the system when and if we implement our own Universal Healthcare program in this country.

One current issue that needs to be resolved in our country is the Medicaid reimbursement rate being paid to medical service providers. In many cases, providers are getting reimbursed significantly less than the actual cost of the medical services being provided. The issue is that the cost difference then needs to be paid by the private sector, mainly individuals that have private insurance either personally or through their employers. The important point to note is that this discussion is about a percentage of cost, so a healthcare provider is actually providing their services at a loss. This is an issue we need to make sure we address in order to help maintain the quality of care in our healthcare system as well as helping to keep doctors, clinics and hospitals from going out of business.

While there may be issues with the state of our current healthcare delivery system, we still have the best overall level of care in the world. In addition, we have an "on demand" mentality and system of care when it comes to both access to care and availability of care. We love this aspect of our healthcare system, and will not be happy if we have our access to care even more constrained than it has started to become today, due to a shortage of specialists and nurses. In addition, our survivability statistics are far better than many of our counterpart nations that have universal healthcare with respect to both critical illness and complications from basic surgeries, meaning people are less likely to die from medical conditions in our country than almost all the countries that have Universal Healthcare.

Issues to consider…

Who decides on what benefits will be covered?
Who decides if a benefit is too expensive to provide?
Who authorizes and schedules doctor's appointments?
    What if it's an emergency?
    Who decides if it's an emergency?
Who authorizes medical procedures and medical necessity?
Will we create a new government bureaucracy to oversee the system?
Who will make hiring and employee out-sourcing decisions for the new system?
Who will make investment decisions in order for hospitals to buy new equipment?
Who will be liable for medical mistakes? Will the liability be limited?

Part Two

The Basics of Shopping for Health Insurance

Overview

This half of the book has been broken up into two sections; one for individuals shopping for health insurance for themselves and their family, and one for those shopping for a group health insurance plan for a small business. Each of the two sections will only address their specific topic; therefore you need only read the section that pertains to your particular situation. At the beginning of each section, a series of implementation strategies is included to help serve as a guide when discussing how to design and implement a specific plan for your situation. Sample plan designs are included on the pages that follow the implementation strategies in order to help clarify the recommended strategies.

In general, the most common approaches to health insurance plan design and implementation are; sticking with a health plan that has co-payments on all services, switching to an HSA plan with an up-front deductible or going with a combined model and implementing an HRA (Health Reimbursement Arrangement) , which is an option only available to employers. Some pros and cons of these scenarios will be discussed in each section. The important thing to consider when you make your final decision is to make sure the plan is affordable and that the plan meets your specific needs. Since you are the buyer, you are ultimately responsible for making sure you choose the correct health insurance plan. The sales representative is only there to help you.

Remember; the implementation strategies being provided here are meant to serve as a guide to you, so that you can have an intelligent discussion with a knowledgeable sales representative when you are shopping.

Section I

Individual Health Plans

In the case of an individual health insurance plan, a person looking to get insurance for themselves or their family needs to understand that the health insurance plans available to individuals are not the same health insurance plans that are available to a company or a group. For starters, individual plans are usually medically underwritten, meaning that you can be denied coverage if you are not healthy. In addition, you can be retroactively denied coverage and have your coverage cancelled for non-disclosure of existing medical conditions, up to 2 years after the purchase. Therefore, it is important to disclose all medical issues in advance when shopping for health insurance. Existing medical issues that are disclosed during the application process can be covered by the insurance company, at their discretion, and claims submitted for treatments of those conditions will then be covered. In addition, filing a claim for a pre-existing condition that was disclosed will not potentially cause the insurance policy to be terminated by the insurance company.

Another consideration when applying for health insurance is to consider what benefits you really need and the cost sharing you are willing to commit to. If you are primarily worried about keeping the cost of the health insurance plan down, then you must be willing to pay for basic medical expenses first, by taking on a deductible. Simply put, the less you want to spend when getting treatments, the more you will pay for the health plan, and vice-versa. The sample health plans that are included at the end of this chapter; Sample Health Plan A through Sample Health Plan H, are shown in the order from the most expensive type of health plan (Sample Health Plan A) to the least expensive type of health plan (Sample Health Plan H), which will allow you to see that the cost of a health plan is mainly a factor of how much you are willing to pay out of pocket at the time you incur medical expenses.

In advance, you must also decide if you are willing to purchase coverage if an insurance company offers you coverage, but excludes coverage for specific medical conditions. Basically, these non-covered medical expenses fall into two categories. Category one would be generally excluded medical conditions; coverage for maternity is a very common condition that is excluded in individual health insurance policies. Category two would be pre-existing conditions, where an insurance company would offer coverage but exclude a specific medical condition,

such as covering a medication for high blood pressure that you are currently taking.

HSA qualified medical plans have become one of the most popular health plan options in the individual health plan marketplace today. The HSA qualified plans are low cost, since they have upfront deductibles, and allow you to set money aside tax free in an HSA (checking) account for your medical expenses. You do not have to set up the HSA account; but since you get a tax break just for depositing the money in the account, whether or not you spend it on medical expenses, there is absolutely no reason not to set up the account. In addition, many of the financial institutions that provide HSA accounts pay interest on the money on deposit in the HSA account and even allow for some of the money in the account to be invested in the stock market. The best part is that you will not pay taxes on the earnings in these accounts, since they grow tax deferred and the money can be spent tax free, as long as it is spent on medical expenses.

The philosophy today on HSAs is that they are only good for the young, the healthy and the wealthy. Not surprising is that this mantra comes from the investment industry which is targeting investment dollars for portfolios to manage. Ironically, the opposite is also true and will make HSA qualified health plans even more popular now that you can set aside more money than your deductible on a pro-rated basis. The amount of money that you can set aside in an HSA account changes every year, so you need to ask your sales representative what the current amount is at the time you enroll. An example of what makes HSA qualified health plan make sense for an unhealthy individual is that if you already spend a significant amount of money on co-payments and other cost shares every year; you can save a significant amount on your health plan costs by switching to an HSA qualified health plan that has a deductible (see Sample Health Plan H); get a tax break by paying your medical expenses from the HSA account; and have a maximum amount of expenses that you can budget for, since many HSA qualified plans pay 100% of expenses above the deductible or have a maximum out-of-pocket expense limit.

In summary, you need to do your homework when you are shopping for health insurance. In advance, you need to know what, if any, trade-offs you are willing to make at the time of the final purchasing decision. For example; is a high up-front

deductible acceptable and/or will an exclusion for a pre-existing condition be acceptable? Most importantly, do not rush into a purchasing decision, and be honest with the sales representative, as in the end you, the insured, are responsible for the medical expenses, not the sales representative. Also, make sure to read through the insurance policy when it arrives and that the insurance policy is actually providing the coverage that you thought you purchased. All insurance companies allow for cancellation of new insurance policies within a few days of receipt of the policy and a full refund of payments made; so use this time to confirm the agreed upon health insurance coverage, including reading through the list of exclusions listed in the policy, if any.

Sample Health Plan A

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$5 - $15	Co-Payment
Specialists Office Visit Cost Share	$5 - $20	Co-Payment
Urgent Care Cost Share	$0 - $25	Co-Payment
Emergency Room Cost Share	$0 - $25	Co-Payment
Out-Patient Surgery Cost Share	$0 - $50	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$0 - $50	Co-Payment
Prescription Drug Cost Share		
Generic	$0 - $5	Co-Payment
Non-Generic	$5 - $10	Co-Payment

Sample Health Plan B

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$10 - $20	Co-Payment
Specialists Office Visit Cost Share	$10 - $25	Co-Payment
Urgent Care Cost Share	$25 - $75	Co-Payment
Emergency Room Cost Share	$25 - $75	Co-Payment
Out-Patient Surgery Cost Share	$50 - $100	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$50 - $100	Co-Payment
Prescription Drug Cost Share		
Generic	$5 - $10	Co-Payment
Non-Generic	$10 - $20	Co-Payment

Sample Health Plan C

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$15 - $25	Co-Payment
Specialists Office Visit Cost Share	$15 - $30	Co-Payment
Urgent Care Cost Share	$25 - $100	Co-Payment
Emergency Room Cost Share	$50 - $100	Co-Payment
Out-Patient Surgery Cost Share	$100 - $250	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$100 - $250	Co-Payment
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$15 - $30	Co-Payment

Sample Health Plan D

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$20 - $30	Co-Payment
Specialists Office Visit Cost Share	$20 - $40	Co-Payment
Urgent Care Cost Share	$50 - $100	Co-Payment
Emergency Room Cost Share	$75 - $150	Co-Payment
Out-Patient Surgery Cost Share	$250 - $500	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$250 - $500	Co-Payment[1]
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$20 - $40	Co-Payment

1 – A $500 co-payment could be per admission or per day, up to a maximum annual amount per insured individual, typically $2,000 per insured individual per year.

Sample Health Plan E

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$30 - $45	Co-Payment
Specialists Office Visit Cost Share	$30 - $50	Co-Payment
Urgent Care Cost Share	$50 - $150	Co-Payment
Emergency Room Cost Share	$100 - $250	Co-Payment
Out-Patient Surgery Cost Share	$500	Co-Payment or Deductible
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$500 - $1,500	Deductible[2,3,5]
Prescription Drug Cost Share		
Generic	$5 - $20	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan F

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$30 - $45	Co-Payment
Specialists Office Visit Cost Share	$30 - $50	Co-Payment
Urgent Care Cost Share	$50 - $150	Co-Payment
Emergency Room Cost Share	$100 - $250	Co-Payment

Hospital Cost Share $1,500 - $5,000 Deductible[2,3,5]
Including In-Patient & Out-Patient Treatments

Prescription Drug Cost Share

Generic	$5 - $20	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan G

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share Including Specialists Office Visit		Deductible[2,3,5] and/or Percentage of Cost[4]
Urgent Care Cost Share	$50 - $150	Co-Payment
Hospital Cost Share Including In-Patient & Out-Patient Treatments Including Emergency Room Treatments	$1,500 - $5,000	Deductible[2,3,5]
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan H

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share Including Specialists Office Visit	Deductible[2,3,5]
Urgent Care Cost Share	Deductible[2,3,5]
Hospital Cost Share Including In-Patient & Out-Patient Treatments Including Emergency Room Treatments	Deductible[2,3,5]
Prescription Drug Cost Share	
Generic	Deductible[2,3,5]
Non-Generic	Deductible[2,3,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Section II

Group Health Plans

As an employer or employer representative shopping for health insurance, you have the very daunting task of having to find a way to do the right thing for your employees, their families, the business and yourself. You not only have to educate yourself on all the available health insurance plans; the different types of benefits covered by the different health insurance plans; and find an insurance sales representative that you trust; but you also have to make sure that the health insurance plan you pick fits your budget and will not effect company morale or employee recruitment and retention.

In this section, the goal is to explain the most common health insurance plan types available, detailed in the following pages as Sample Health Plan A through Sample Health Plan H. In addition, two transition strategies will also be outlined to help you move from the very expensive traditional health insurance plans with very low co-payments to the inexpensive up-front deductible health insurance plans, with the HSA (Health Savings Account) qualified health plan being the most recognized of these plans. As part of the transition strategy discussion, you will also be introduced to HRAs (Health Reimbursement Arrangements), which are very flexible employer driven health plans that combine traditional health plans with upfront deductible health plans. Finally, and still very important, there will be a discussion on absenteeism and presenteeism, as well as on Wellness Programs and the overall issue of being an experience rated group, as it relates to escalating health insurance expenses for your business.

The most common health insurance plan that we are all familiar with is a health insurance plan with co-payments for all of the healthcare services that we use on a regular basis. Sample Health Plan A through Sample Health Plan D are examples of this type of health plan. In general, the lower the co-payments are, the more a health insurance plan costs. This type of health plan became mainstream in the country starting in the 1980's, as this type of plan is the model on which HMOs were based. This HMO model was that you would have to have a primary care doctor that would help manage your health issues and help manage utilization of healthcare services, which would in turn keep costs in check. To this day, these plans are still very common and very popular throughout the country.

At the other end of the spectrum, we have health insurance plans that have an up-front deductible for all services; doctors office visits, hospital services and prescription drugs. Some of these plans pay 100% of healthcare expenses above the deductible, while others ask you to pay a percentage of the incurred healthcare expenses until you reach a calendar year out-of-pocket maximum. The most common of these plans today are considered HSA qualified health insurance plans and allow you to open a Health Savings Account. The nice thing about these Health Savings Accounts is that you get a tax break just for putting money into the account. If you have medical expenses, you can then pay for the expenses with tax free dollars out of the account. If you don't have medical expenses, you can just leave the money in the account, usually collecting interest, until you do need it at some point in the future. The expectation is that this will help people save money for future healthcare expenses. Unfortunately, you can only have an HSA if you are enrolled in an HSA qualified health plan and are not covered by any other health plan.

HSA qualified health plans have become all the rage lately, good and bad (due to poor implementation), and considering that health insurance premium rates are still rising by double-digit percentages every year, HSA qualified health plans should become the mainstream plan within a few years. An implementation issue with HSA plans today is that the industry philosophy is that they are only good for the young, the healthy and the wealthy. Not surprising is that this mantra comes from the investment industry, which is targeting investment dollars for portfolios to manage. Ironically, the opposite is also true. If you already spend several hundred dollars, if not several thousand dollars, on healthcare expenses every year, you may actually save money by switching to an HSA qualified health plan. The reason is that you will start off by saving money on the deductible, then you also get to save money on your taxes because of the tax break, and finally, these plans have limits on your annual out-of-pocket expenses on a calendar year basis, which also allows you to budget for your healthcare expenses.

There are two distinct ways of transitioning from health insurance plans with low co-payments as the method of cost sharing to up-front deductible plans that ask you to pay the discounted

insurance company rate for healthcare expenses until you satisfy the deductible. Method one allows for a smoother transition by using a HRA (Health Reimbursement Arrangement) as the method of transition. Method two is the head-first method, where you just switch completely from one to the other with no transition period in between. Ironically, if done properly, both methods are effective and manageable. It is important that you know your employees; how they will react to a sudden change; and that you provide a lot of education about the health insurance plan and how it will affect them, in advance.

The HRA transition method is an employer driven method. In other words, it places you, the employer, in charge of the health plan and how it is managed. Don't let this frighten you, as you will find that there are many companies that will be more than happy to administrate the program for you for a very nominal fee. The fee will be well worth it in most cases, just because of HIPAA regulation and liability issues. The simplest way of explaining how this would work is that you would move through three distinct phases, explained in the following paragraphs, and something your insurance sales representative can help clarify for you. The advantage of using HRAs for employers is that you, the employer, decide on how the arrangement will work, as long as you stay within the legal guidelines.

Phase 1: Starting from a traditional health plan with co-payments on all healthcare services, you would first switch to a health plan that has a hospital only deductible that you will cost share with the employee, see Sample Health Plan E & F. For instance, if the hospital deducible is $2,500 for an employee only plan or $5,000 for a family plan, you can offer to reimburse the employee up-to 80% of the deductible, $2,000 and $4,000, respectively, but only if the expense is actually incurred. The reason that this approach works well is that you see immediate savings in your health plan premium expenses, and typically only end up reimbursing ~20% of the overall potential liability. As the employer, this risk-reward equation is manageable; and for the employee, they do not need to worry if they do have an expense, as it will be reimbursed to them by you.

Phase 2: The next phase in the transition is to switch to a health plan that has a deductible that applies to both the doctor's office visits and the hospital expenses, both of which you will cost share with the employee, see Sample Health Plan G. For instance, if the deducible is $2,500 for an employee only plan or $5,000 for a family plan, you can offer to reimburse the employee up-to 60% of the deductible, $1,500 and $3,000, respectively, but only if the expense is actually incurred. You would reimburse slightly less in this scenario since you are reimbursing more day-to-day expenses than under the hospital only deductible, so you will actually be reimbursing more than you would be in Phase 1. The reason that this approach still works well is that you are seeing additional and immediate savings in your health plan premium expenses. As the employer, you are still in a better position to handle this risk-reward equation than the employee is; and for the employee, they still have a comfort level in knowing that you will be helping them with their expenses.

Phase 3: In this phase, the deductible will now apply to all healthcare services; doctor's office visit, hospital expense and prescription drug coverage, see Sample Health Plan H. This actually gives you two ways to approach the reimbursement scenario. First, you could continue to reimburse on a percentage basis, as you have in Phase 1 and Phase 2. Secondly, you can choose to select a health plan that is an HSA qualified up-front deductible health plan, and instead of reimbursing expenses as incurred, you can contribute a set amount into an employees personal HSA (checking account). At this point, it is important to really know your employees. For the HSA implementation strategy, see the next paragraph.

The complete and total transition to an HSA qualified health plan is somewhat challenging, with the most important aspect being considerable and thorough employee education. I can not stress this point enough, as it will be the deciding factor as to whether or not you are able to successfully transition to an HSA qualified health plan. Since there is considerable health insurance plan premium savings, there are many ways to approach this transition, and I will only discuss a couple of these methods here, but you should discuss the many other options with your health insurance sales representative.

One method is to let the employees save money on their cost share of the health plan premium payment, which gives them more take home pay, while you, the employer, take your savings and contribute it to the employees HSA, so that the employees have money to spend on expenses that count towards their deductible. Employees should also be encouraged to contribute their savings to their own HSA. As the health plan premium savings decreases over time, you would contribute less and less to the employees HSA, which by this time they will hopefully have funded and will continue to fund.

Another method, is for you, the employer, to keep all the savings and fully fund the employees HSA, based on their deductible, even if it means contributing more than you saved. The idea here is to make the transition as easy as possible for employees. By fully funding the deductible in the first year, you are actually giving the employees a better health plan and should not have any complaints. However, as you reduce your contributions to employee HSAs over the following years, it will be very critical that the employees continue to fund their own HSAs. The employer savings will come over time by stabilizing health plan costs, as a combination of health plan premium paid and HSA contributions made to employees.

Finally, and especially important if you are an employer who's health plan premiums are experience rated, meaning that claims filed each year will affect how much your health plan premium will increase at renewal, it is very important that you institute a Wellness Program at your company. The single most effective way to lower the healthcare expenses within a group, and therefore keep health insurance plan premiums in check, is to have healthier employees; and the most effective way of accomplishing this is by implementing a Wellness Program. Wellness Programs go well beyond just helping lower healthcare expenses. Wellness Programs also help reduce absenteeism, better known as sick days, as well as presenteeism, otherwise thought of as sick employees who come to work and get everyone else sick or, more importantly, employees that can cause others to get hurt if they make careless mistakes in their duties because they are sick or medicated. So, make sure you make the effort and take the time to discuss Wellness Programs with your health insurance sales representative.

Sample Health Plan A

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$5 - $15	Co-Payment
Specialists Office Visit Cost Share	$5 - $20	Co-Payment
Urgent Care Cost Share	$0 - $25	Co-Payment
Emergency Room Cost Share	$0 - $25	Co-Payment
Out-Patient Surgery Cost Share	$0 - $50	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$0 - $50	Co-Payment
Prescription Drug Cost Share		
Generic	$0 - $5	Co-Payment
Non-Generic	$5 - $10	Co-Payment

Sample Health Plan B

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$10 - $20	Co-Payment
Specialists Office Visit Cost Share	$10 - $25	Co-Payment
Urgent Care Cost Share	$25 - $75	Co-Payment
Emergency Room Cost Share	$25 - $75	Co-Payment
Out-Patient Surgery Cost Share	$50 - $100	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$50 - $100	Co-Payment
Prescription Drug Cost Share		
Generic	$5 - $10	Co-Payment
Non-Generic	$10 - $20	Co-Payment

Sample Health Plan C

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$15 - $25	Co-Payment
Specialists Office Visit Cost Share	$15 - $30	Co-Payment
Urgent Care Cost Share	$25 - $100	Co-Payment
Emergency Room Cost Share	$50 - $100	Co-Payment
Out-Patient Surgery Cost Share	$100 - $250	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$100 - $250	Co-Payment
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$15 - $30	Co-Payment

Sample Health Plan D

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$20 - $30	Co-Payment
Specialists Office Visit Cost Share	$20 - $40	Co-Payment
Urgent Care Cost Share	$50 - $100	Co-Payment
Emergency Room Cost Share	$75 - $150	Co-Payment
Out-Patient Surgery Cost Share	$250 - $500	Co-Payment
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$250 - $500	Co-Payment[1]
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$20 - $40	Co-Payment

1 – A $500 co-payment could be per admission or per day, up to a maximum annual amount per insured individual, typically $2,000 per insured individual per year.

Sample Health Plan E

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$30 - $45	Co-Payment
Specialists Office Visit Cost Share	$30 - $50	Co-Payment
Urgent Care Cost Share	$50 - $150	Co-Payment
Emergency Room Cost Share	$100 - $250	Co-Payment
Out-Patient Surgery Cost Share	$500	Co-Payment or Deductible
In-Patient Hospital Stay Cost Share Including Surgery Cost Share	$500 - $1,500	Deductible[2,3,5]
Prescription Drug Cost Share		
Generic	$5 - $20	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan F

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share	$30 - $45	Co-Payment
Specialists Office Visit Cost Share	$30 - $50	Co-Payment
Urgent Care Cost Share	$50 - $150	Co-Payment
Emergency Room Cost Share	$100 - $250	Co-Payment
Hospital Cost Share Including In-Patient & Out-Patient Treatments	$1,500 - $5,000	Deductible[2,3,5]
Prescription Drug Cost Share		
Generic	$5 - $20	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan G

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share Including Specialists Office Visit		Deductible[2,3,5] and/or Percentage of Cost[4]
Urgent Care Cost Share	$50 - $150	Co-Payment
Hospital Cost Share Including In-Patient & Out-Patient Treatments Including Emergency Room Treatments	$1,500 - $5,000	Deductible[2,3,5]
Prescription Drug Cost Share		
Generic	$5 - $15	Co-Payment
Non-Generic	$20 - $50	Co-Payment or Percentage of Cost[4,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

4 – A deductible may also apply before the cost-share begins.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

Sample Health Plan H

Cost Share Example for Major Services Only

Doctors Office Visit Cost Share Including Specialists Office Visit	Deductible[2,3,5]
Urgent Care Cost Share	Deductible[2,3,5]
Hospital Cost Share Including In-Patient & Out-Patient Treatments Including Emergency Room Treatments	Deductible[2,3,5]
Prescription Drug Cost Share	
Generic	Deductible[2,3,5]
Non-Generic	Deductible[2,3,5]

2 – Deductibles are typically calendar year and are twice the base for plans that cover more than one insured. For example, if the deductible for one insured is $1,500, then the deductible that covers more than one insured is $3,000.

3 – There may also be a cost-share above the deductible up-to a maximum calendar year dollar amount. For example, one may have to pay 20% of the expenses accrued above the $1,500 deductible up-to a maximum out-of-pocket of $5,000.

5 – The cost sharing will most likely count towards a calendar year maximum out-of-pocket expense.

About the Author

Mr. Antonio Paulo Pinto has been operating an insurance agency since 2002, and has spent a significant amount of his time focusing on health insurance programs specifically addressing the needs and issues of individuals and small businesses. He has given numerous seminars on health insurance program design and implementation strategies to individuals, small business owners and even other insurance agents. In addition, Mr. Pinto is very active in his community and volunteers his personal time to a variety of non-profits and community groups.

Mr. Pinto is currently a licensed Insurance Producer and a licensed Certified Insurance Consultant in the state of Connecticut. He has a Masters in Business Administration from the Lally School of Management & Technology at Rensselaer Polytechnic Institute with a concentration in Entrepreneurship, as well as a Bachelor of Science in Chemical Engineering from Rensselaer.

Recently, Mr. Pinto was selected by New Haven Business Times to their 13th Annual 2006 Forty under 40. A list honoring forty individuals under the age of 40 in the Greater New Haven, CT area for their professional success and community involvement.