

Health Insurance FAQs

Why should I have health insurance?

The cost of health care has risen drastically over the past few decades. If you do not have medical insurance to help pay bills, a serious injury or illness can be financially devastating to you and your family. If you don't have coverage you can be exposed to high health care bills; or, if you have too little or the wrong kind of coverage, you won't have enough protection.

What Types of Health Insurance Are Available?

Major Medical Plans

This type of policy is usually effective in covering serious illness or injury where costs are high. Hospital care, drugs and doctors' visits are usually covered. These benefits can be delivered in several different ways:

- *Indemnity plans* - These major medical plans typically have a deductible – the amount you pay before the insurance company begins paying benefits. After your covered expenses exceed the deductible amount, benefits usually are paid as a percentage of actual expenses, often 80 percent. These plans usually provide the most flexibility in choosing where to receive care.
- *Preferred Provider Organization (PPO) plans* – In these major medical plans the insurance company enters into contracts with selected hospitals and doctors to furnish services at a discounted rate. As a member of a PPO, you may be able to seek care from a doctor or hospital that is not a preferred provider, but you will probably have to pay a higher deductible or co-payment.
- *Managed Care Organization (MCO) plans* – These major medical plans usually require you to choose a primary care physician (PCP) from a list of network providers. Your PCP is responsible for managing all of your health care. If you need care from any network provider other than your PCP, you may have to get a referral from your PCP to see that provider. You must receive care from a network provider in order to have your claim paid through the MCO. Treatment received outside the network is usually not covered, or covered at a significantly reduced level.
- *Point of Service (POS) plans* – These major medical plans are a hybrid of the PPO and MCO models. They are more flexible than MCOs, but do require you to select a primary care physician (PCP). Like a PPO, you can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the additional cost.

Limited Benefit Plans

These types of policies provide limited coverage for a particular health care setting, ailment or disease. Here are some of the options that may be available to you:

- *Basic Hospital Expense Coverage* – Covers a period of usually not less than 31 days of continuous in-hospital care and certain hospital outpatient services.
- *Basic Medical-Surgical Expense Coverage* – Covers costs associated with a medically necessary surgery, including a certain number of days (usually not less than 21 days) of in-hospital care.

- *Hospital Confinement Indemnity Coverage* – Covers a fixed amount (usually not less than \$40) for each day that you are in a hospital. The benefits paid are not based on your actual expenses.
- *Accident Only Coverage* – Covers death, dismemberment, disability or hospital and medical care caused by an accident. You can also purchase specified accident coverage that covers only certain accidents.
- *Specified Disease Coverage* – Covers diagnosis and treatment of a specifically named disease or diseases, such as cancer. However, please consider:
 - *Cancer insurance is not a substitute for comprehensive major medical coverage* – Cancer treatment only accounts for a small percentage of the American public's health care bill. Insurance coverage for all conditions – not just cancer – is essential.
 - *Consider a major medical policy if your family is not protected* – If you and your family are not protected against catastrophic medical costs, consider a major medical policy. These policies provide for payment of a large percentage of eligible expenses after a deductible is paid. Furthermore, once you have paid a predefined out of pocket maximum, the insurance company will pay 100% of eligible expenses up to the policy limits.
 - *You may not need extra coverage* – Ask yourself these three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?
 - *Duplicate coverage is expensive and unnecessary* – Buy major medical coverage first, and then make sure a cancer policy will meet any needs not covered by your primary plan. Don't assume that double coverage will result in double benefits.
 - *Check the policy's limitations* – Some limited benefit or specified disease policies pay only for hospital care. Many treatments, including radiation, chemotherapy and some surgeries are often given on an outpatient basis. Cancer patients often face large, non-medical expenses that are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.
 - *No policy will cover cancer diagnosed prior to your policy application. You may be subject to pre-existing condition timeframes.* – Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.
 - *Most cancer insurance does not cover cancer-related illnesses* – Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia. Related problems or complications might not be covered. Read the policy limitations and exclusions carefully.
 - *Many policies contain time limits* – Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.
- *Other Limited Coverage* – You can purchase insurance covering only dental or vision or other specified care.

Additional Coverage Options

These types of policies provide added protection should you become disabled, require long-term care, or enroll in Medicare:

- **Disability Income** - This coverage provides for weekly or monthly benefit payments while you are disabled after a covered injury or sickness. The disability payment is usually a set dollar amount not to exceed a certain percentage of your income. Your disability payments may be reduced by other income you receive, such as Social Security disability or retirement benefits. These policies usually expire when you become eligible for Medicare.
- **Long-Term Care Insurance** - This policy usually pays for skilled, intermediate and custodial care in a nursing home, and also for care in other settings, such as the home, adult day-care center or assisted living facility. The policy usually pays a fixed amount per day while a person is receiving care.
- **Medicare Supplemental Coverage** - The federal Medicare program pays most medical expenses for people 65 or older, or for individuals under 65 receiving Social Security disability benefits. However, Medicare does not pay all expenses. As a result, you may want to buy a Medicare Supplement policy that helps pay for certain expenses, including deductibles not covered by Medicare. For more information on Medicare and coverage options, contact our **Senior Health Insurance Benefits Advisors Program (SHIBA)** or call 800-247-4422.

These are NOT health insurance plans:

- **Discount Plans** - You may receive advertisements from plans offering discounts on health care for a monthly fee. These are not health insurance plans and participants do not have the same protections as under licensed health insurance plans. The Department of Insurance strongly recommends that you thoroughly investigate any plan promising deep discounts for a “low” monthly fee and weigh the benefits against the cost carefully.
- **Non-Licensed Risk-Sharing Plans** - You may receive offers to join a group or association that will take your monthly payments, put them in a savings account (or trust) with other participants’ money, and then help pay some of your health care costs as needed. Such arrangements are not insurance, and the participants do not have the same protections as purchasers of licensed insurance plans. The Department of Insurance strongly recommends that you thoroughly investigate such plans before joining.

Can my employer change our health insurance carrier and level of benefits during the year?

Yes. It is entirely up to the employer whether or not they will offer health insurance to employees at all, and they can change carriers and level of benefits at any time.

What happens when my group health coverage ends?

You can apply for individual health coverage under the Health Insurance Portability and Accountability Act (HIPAA) federal law. This type of policy is issued on a guaranteed issue basis if you meet the qualifying criteria. However, there is no limit on the maximum premium the insurance company can charge. Care for preexisting conditions may not be excluded from coverage if you apply for individual coverage within 63 days of the date your group coverage ends.

What happens to my group health coverage if I leave my employer?

You may be eligible for protection under the Consolidated Omnibus Budget Reconciliation Act (COBRA) law and are entitled to a minimum of 18 months of continuation coverage. You can find out more about COBRA continuation of group health benefits from the U.S. Department of Labor **Office of Employee Benefits Security Administration** website or call 866-444-3272.

Can health insurance companies deny my application for individual major medical insurance due to a health condition?

Yes, a company has the right to deny your application for a “preferred” or “street” major medical plan due to a health condition. However, the company then must offer major medical coverage through Idaho’s High Risk Pool Plans (HRP). You can choose a plan from five HRP plan options. HRP plans will be available at least until December 31, 2013. Federal healthcare reform may determine if Idaho continues the High Risk Pool on and after January 1, 2014. Once you are accepted for any individual major medical coverage, the company cannot cancel your policy except for nonpayment of premium.

What is a preexisting condition?

This is normally a physical or mental condition for which medical advice, diagnosis, care or treatment is recommended or received during a specific timeframe before the effective date of the policy, typically the prior six months. An individual major medical plan may also include a condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment in the six months before the effective date, or a pregnancy existing on the effective date. Major medical policies with an effective date of January 1, 2014, or later will no longer include preexisting condition exclusions.

What assistance is available?

Many programs are available through federal or state government to assist with the high cost of health care and health insurance.

- Contact the Idaho Department of Insurance for information about high-risk pool coverage for individuals who are denied coverage.
- Contact the **Idaho Department of Health and Welfare** to learn about eligibility for Medicaid (for low-income and disabled persons), the State Children’s Health Insurance Program (SCHIP), prescription drug assistance programs, or other state assistance. Contact the **U.S. Department of Health and Human Services** for information about Medicare or other federal programs. In addition, the federal government provides tax credits for certain workers who have lost their jobs because of federal trade agreements or whose pension program has failed.

What is a “self-insured” plan?

An employer may choose to “self-insure” the employees’ health plan by paying out benefits from its own funds. Typically, an insurance company administers the program, but the liability for paying for the care of the employees rests on the employer. Workers should understand that if their employer “self-insures,” state patient protections (such as access to internal and external appeals processes, assurance of certain benefits, and the right to have grievances heard by the Department of Insurance) do not apply. All federal protections (i.e., HIPAA and COBRA) do remain. You can find out more about self-insured plans from the U.S. Department of Labor **Office of Employee Benefits Security Administration** website or call 866-444-3272.

Where can I go for help?

If you have any questions about your policy, your rights and protections, or a potential agent or insurer, contact the Idaho Department of Insurance at 334-4250 in the Boise area, or 800-721-3272 toll-free statewide. You can also contact the Department for assistance if you have a grievance

against a licensed health insurer or agent. You can file a written complaint against an insurer or agent [here](#).

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