

# **understanding health INSURANCE**

**Parent to Parent of NYS  
Family to Family Health Care  
Information and Education Center**

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## Health Insurance - Glossary of Terms

**Allowable Fee, or Usual and Customary Reimbursement (UCR):** The maximum amount a health insurer will pay for a service or procedure.

**Assignment:** The legal transfer of one person's interest in an insurance policy to another person.

**Balance Billing:** A billing practice in which you are billed for the difference between what your insurer pays and the fee that the provider normally charges. Balance billing is prohibited under most HMO contracts in New York, but may arise when you use services of out-of-network providers under a PPO or POS arrangement. See Preferred Provider Organization (PPO) and Point of Service (POS).

**Coinsurance:** An insurance policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula. Some insurance coverage requires you to pay a percentage of the cost of covered medical services, usually 20-30 percent. For example, you pay 20 percent of the expense and your insurance pays 80 percent of the expense. Your portion of the expense is called the coinsurance.

**Commercial Insurers:** Health insurance can also be written by life insurers, property/casualty insurers and other types of insurers. These insurers offer products similar to those provided by nonprofit indemnity insurers. (See non-profit indemnity insurers.) Policyholders are subject to deductibles and significant out-of-pocket costs unless they use a preferred provider network.

**Complaint:** A complaint occurs whenever a consumer or provider complains to the State of New York about a health insurer or Health Maintenance Organization (HMO).

**Co-payment:** A flat fee for specified medical services required by some insurers. For example, you pay a \$10 co-payment for a doctor visit or a \$50 co-payment for a hospital stay.

**Deductible:** The amount you must pay each year for your medical expenses before your insurance policy starts paying. Deductibles are common in fee-for-service coverage and PPOs.

**External Appeal/External Review:** You may request an independent external review when you are denied health care services on the basis that those services are experimental, investigational, or not medically necessary. The review is conducted by an external review organization that is not affiliated with your insurer, your doctor, or your family.

**Fee-for-Service (FFS):** Also known as indemnity insurance, FFS is a type of health coverage that typically allows you to go to any doctor or provider. Your insurance company

will reimburse your provider for each covered service provided. Deductibles and coinsurance usually apply in FFS coverage.

**First-level Internal Appeal Process:** Once you have received a decision on your utilization review appeal, you have completed the first-level internal appeal process. If the decision is not in your favor, you are entitled to request an external review. If you and your insurer waive the first level review, you are then permitted to proceed directly to an external review. (See utilization review appeal and external review.)

**Grievance:** A grievance is a complaint to an HMO by a member or provider about an action or decision. Decisions regarding the medical necessity of a service are not considered grievances. They are handled as utilization review appeals. (See utilization review appeal.)

**Health Maintenance Organization (HMO):** The HMO arranges for, or contracts with, a variety of health care providers to deliver a range of services to consumers who make up its membership. All HMOs employ managed care strategies that emphasize prevention, detection and treatment of illness. HMOs use primary care physicians as the coordinator of patient care needs. An HMO may offer consumers an HMO plan or POS plan. (See health maintenance organization plan and point of service plan.)

**Health Maintenance Organization (HMO) Plan:** A type of coverage that provides comprehensive health services to members in return for a monthly premium and co-payment. In an HMO plan, members may choose a primary care physician (PCP) who coordinates each assigned member's care. The PCP refers patients to specialists and provider services as needed. Although many HMOs require their members go to the doctors and other providers in the HMO provider network, some HMO plans offer the option to go out-of-network (for example in a POS plan). HMO plans often require members receive a referral from their PCP before seeing a specialist. (See primary care physician and point of service plan.)

**Non-profit Indemnity Insurers:** Non-profit indemnity insurers employ managed care strategies but offer a more traditional approach to coverage than HMOs. Non-profit indemnity insurers reimburse policyholders, physicians and hospitals. Non-profit policyholders are subject to deductibles and out-of-pocket costs that are considerably higher than those required by HMOs unless they use a preferred provider network.

**Out-of-pocket maximum:** The amount of co-insurance a member must pay before out-of-network claims will be paid at 100% of the allowed amount.

**Participating Provider:** A health care provider (e.g., doctor, psychologist, hospital) who agrees to accept the terms, conditions and allowable payments of an insurer.

**Point of Service (POS) Plan:** A type of managed care coverage that allows members to choose to receive services either from participating HMO providers or from providers outside the HMO's network. Members pay less for in-network care. For out-of-network care, members usually pay a deductible and coinsurance.

**Preferred Provider Organization (PPO):** A type of managed care coverage based on a network of doctors and hospitals that provides care to an enrolled population at a prearranged discounted rate. PPO members usually pay more when they receive care outside the PPO network.

**Primary Care Physician (PCP):** An internist, pediatrician, family physician, general practitioner, or in some instances an obstetrician/gynecologist. If you are enrolled in an HMO, you usually must choose a PCP from a list of participating providers. The PCP coordinates your care and makes referrals to specialists as needed.

**Prompt Pay Complaint:** A complaint from a consumer or provider to the New York State Insurance Department about the late payment of claims.

**Referral:** Authorization from your primary care physician or health insurer to see a specialist or receive a special test or procedure. HMOs often require that you obtain a referral for most specialty care. It is important to know what your health insurer's rules and procedures are for referrals.

**Schedule of Allowances:** The set dollar amount the insurance policy covers for each procedure.

**Self-Insured Health Plan:** In this type of plan, an employer will pay for employees' health care costs out of a fund that the company has set aside for medical expenses. Employers may contract with an outside organization, often an insurance company, to administer the plan. Under a federal statute known as ERISA, the U.S. Department of Labor has authority over self-insured employer health plans. Therefore, New York's consumer protection and insurance laws do not apply.

**Specialist:** A doctor who has been specially trained in and practices a specific type of medicine other than primary care (e.g., cardiologists, dermatologists, gastroenterologists). If you are enrolled in an HMO, you usually will need a referral from your primary care physician to see a specialist.

**Utilization Review (UR) Appeal:** A UR Appeal occurs when a consumer asks an insurer to reconsider its refusal to pay for a medical service the insurer considers experimental, investigational, or not medically necessary. (See first-level internal appeal process.)

Reference: New York State Insurance Department [www.ins.state.ny.us](http://www.ins.state.ny.us)

# CHECKLIST FOR COMPARING POLICIES

Are These Services Covered?	Plan A	Plan B	Plan C
Cancer screening (colorectal cancer tests, mammograms, pap smears, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations (shots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Well-baby care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care for a pre-existing condition (one you have before joining the plan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental exams/treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye exams/glasses/contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing exams/hearing aids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient prescription medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical equipment for use at home (Durable Medical Equipment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospice care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alternative treatments (such as acupuncture)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adult day care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing home care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical tests (i.e. x-rays, mri, labs, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transplants (lung, heart, heart/lung, cornea, bone marrow, liver, pancreas, kidney)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision care, eyeglasses and exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital care -Surgery (inpatient and outpatient)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Office visits to your doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maternity care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Out of Area Coverage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital Care Room & Board, Misc. expenses incurred during stay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# CHECKLIST FOR DETERMINING WHAT HEALTH INSURANCE PLAN IS FINANCIALLY BEST FOR YOUR FAMILY

<b>Cost</b>	<b>Plan A</b>	<b>Plan B</b>	<b>Plan C</b>
How much will the premium cost me each month?	_____	_____	_____
If there is a deductible, how much will I have to pay before the plan starts to pay for medical care? For prescription medicines?	_____ _____	_____ _____	_____ _____
How much will I have to pay (co-payment) each time I use a service? Doctor visit Hospital visit Prescription	_____ _____ _____	_____ _____ _____	_____ _____ _____
How much more will I need to pay if I go outside the health plan's network of doctors, hospitals, and other providers to get services?	_____	_____	_____
Are there any annual limits for days or services covered and the amount spent on you?	_____	_____	_____
What is the maximum you will have to pay out-of-pocket each year?	_____	_____	_____
What is your coinsurance rate or co-payment, if there is one?(Note if there is a higher rate for special services, such as outpatient mental health care, specialists)	_____	_____	_____
What is the lifetime limit, if any, that you will be reimbursed?	_____	_____	_____
Total estimated yearly cost to you:	_____	_____	_____

# **INSURANCE FREQUENTLY ASKED**

## **QUESTIONS and ANSWERS**

### **What is a PPO?**

A PPO is a Preferred Provider Organization. If you use a provider (hospital, doctor or other medical provider) that is a member of the PPO you normally will pay a lower deductible and/or coinsurance amount. The insurance carrier can do this because the carrier and PPO have a written agreement to provide the carrier a discount for services provided to the carrier's customers. The insurance carrier passes on the savings to the customer in the form of lower deductibles and/or coinsurance.

### **What are eligible expenses?**

Eligible expenses are medical expenses incurred by an Insured Member for covered services listed in the health insurance plan that are ordered or prescribed by a Physician for the treatment of a covered Accident or Sickness and are Medically Necessary. In most health insurance plans, the amount of expenses in excess of the Usual and Customary Charges, as determined by the insurance carrier, in the geographic area where the expenses are incurred are not considered Eligible Expenses.

### **What is a deductible?**

A deductible is the amount of eligible expenses incurred during a Calendar year that an Insured Member must pay before any benefits are payable. In some health insurance plans, eligible expenses incurred after September 30th, which have not been paid because the deductible has not been met, may be used to help satisfy the deductible for the next calendar year.

### **What is coinsurance?**

Coinsurance is the percentage applied to eligible expenses after subtracting the deductible. In many health insurance plans the coinsurance an Insured Member is responsible for is capped after a certain dollar amount of eligible expenses have been incurred.

### **What is a doctor's office visit co-pay?**

A doctor's office visit co-pay is the fixed amount payable by an Insured Member on a per visit/service basis.

### **What is the difference between an in-network provider and an out-of-network provider?**

An in-network medical provider is a provider that is a member of a PPO that is approved by your insurance carrier. An out-of-network provider is not a member of a PPO that is approved by your insurance carrier. The amount you will be responsible for paying will be less if you use an in-network provider than an out-of-network provider.

### **"Can I be reimbursed for services already provided? Or do I need PRE-AUTHORIZATION in order to be reimbursed?"**

Many health insurance and managed care companies will not even consider reimbursing you for services provided and paid for PRIOR to your call. They will require that you receive their authorization first.

If you are eligible to file claims for reimbursement, then ask:

### **"What is the rate of reimbursement?"**

That is, what percentage of the money that you spend will be reimbursed to you?

For example, if you spend \$100 out-of-pocket for one hour of individual psychotherapy and then submit a claim for reimbursement, should you expect to get the full \$100 reimbursed? Probably not. How much will be reimbursed?

### **What is a lifetime maximum benefit?**

A lifetime benefit maximum is a cap on the amount of benefits available to a policyholder. The cap is designed to keep the cost of benefits affordable and to stabilize potential future costs. Many health plans cap lifetime benefits at \$1 million and are most often applied to mental illness, drug and alcohol treatment, or organ transplants.

If a plan has a relatively low lifetime maximum cap, think carefully about how much risk you're willing to assume. Even if you're healthy, the expenses incurred from one severe car accident -- including hospitalization and outpatient physical therapy -- could easily exceed a \$100,000 cap.

### **What do most people worry about?**

#### ***Pre-existing Conditions: New Federal Law***

Many people worry about coverage for ***pre-existing conditions***, especially when they change jobs. Recent changes in federal law help assure continued health insurance coverage for employees and their dependents. Starting July 1, 1997, insurers may impose only one 12-month waiting period for any pre-existing condition treated or diagnosed in the previous six months. Your prior health insurance coverage will be credited toward the pre-existing condition exclusion period as long as you have maintained continuous coverage without a break of more than 62 days. Pregnancy is not considered a pre-existing condition, and newborns and adopted children who are covered within 30 days are not subject to the 12-month waiting period.

If you have had group health coverage for two years, and you switch jobs and go to another plan, that new health plan cannot impose another pre-existing condition exclusion period. If, for example, you have had prior coverage of only eight months, you may be subject to a four month pre-existing exclusion period when you switch jobs. If you've never been covered by an employer's group plan, and you get a job that offers such coverage, you may be subject to a 12-month pre-existing condition waiting period.

Federal law also makes it easier for you to get individual insurance under certain situations, including if you have left a job where you had group health insurance, or had another plan for more than 18 months without a break of more than 62 days.

If you have not been covered under a group plan and have found it difficult to get insurance on your own, check with your state insurance department to see if your state has a risk pool. Similar to risk pools for automobile insurance, these can provide health insurance for people who can not get it elsewhere.

### **What Is Not Covered?**

While HMO benefits are generally more comprehensive than those of traditional fee-for-service plans, no health plan will cover every medical expense.

Few plans cover eyeglasses and hearing aids because these are considered expenses to be budgeted for. Very few plans cover elective cosmetic surgery, except to correct damage caused by a covered accidental injury. Some fee-for-service plans do not cover

wellness checkups. Procedures that are considered experimental may also not be covered. Some plans cover complications arising from pregnancy but do not cover normal pregnancy or childbirth.

Health insurance policies frequently exclude coverage for pre-existing conditions, but, as explained, federal law now limits exclusions based on such conditions.

Insurers will not pay duplicate benefits. A husband and wife may each be covered under a health insurance plan at work but, under what is called a coordination of benefits provision, the total you can receive under both plans for a covered medical expense cannot exceed 100 percent of the allowable cost. Also, if neither of the plans covers 100 percent of your expenses you will only be covered for the percentage of coverage (for example, 80 percent) that your primary plan covers. This provision benefits everyone in the long run because it helps to keep costs down.

### **What Happens to My Insurance if I Lose My Job?**

If you have had health coverage as an employee benefit and you leave your job, voluntarily or otherwise, one of your first concerns will be maintaining protection against the costs of health care. You can do this in one of several ways:

- First, you should know that under a federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA), group health plans sponsored by employers with 20 or more employees are required to offer continued coverage for you and your dependents for 18 months after you leave your job. (Under the same law, following an employee's death or divorce, the worker's family has the right to continue coverage for up to three years.) If you wish to continue your group coverage under this option, you must notify your employer within 60 days. You must also pay the entire premium, up to 102 percent of the cost of the coverage.
- If COBRA does not apply in your case-- perhaps because you work for an employer with fewer than 20 employees-- you may be able to convert your group policy to individual coverage. The advantage of that option is that you may not have to pass a medical exam, although an exclusion based on a pre-existing condition may apply, depending on your medical history and your insurance history.
- If COBRA doesn't apply, converting your group coverage is not for you, AND you are healthy, not yet eligible for Medicare, and you expect to take another job, consider an *interim or short-term policy*. These policies are designed to provide medical insurance for people with a short-term need, such as those temporarily between jobs or those making the transition between college and a job. These policies, typically written for two to six months and renewable once, cover hospitalization, intensive care, and surgical and doctors' care provided in the hospital, as well as expenses for related services performed outside the hospital, such as X-rays or laboratory tests.
- Another possibility is obtaining coverage through an association. Many trade and professional associations offer their members health coverage-- often HMOs-- as well as basic hospital-surgical policies, and disability and long-term care insurance. If you are self-employed, you may find association membership an attractive route.

### **What is the first thing I should know about buying health coverage?**

Your aim should be to insure yourself and your family against the most serious and financially disastrous losses that can result from an illness or accident. If you are offered health benefits at work, carefully review the plans' literature to make sure the one you select fits your needs. If you purchase individual coverage, buy a policy that will cover major expenses and pay them to the highest maximum level. Save money on premiums, if necessary, by taking large deductibles and paying smaller costs out-of-pocket.

**One of my medical bills was turned down by the insurance company (or health plan). Is there anything I can do?**

Ask the insurance company why the claim was rejected. If the answer is that the service isn't covered under your policy, and you're sure that it is, check to see that the provider entered the correct diagnosis or procedure code on the insurance claim form. Also check that your deductible was correctly calculated. Make sure that you didn't skip an essential step under your plan, such as preadmission certification. If everything is in order, ask the insurer to review the claim.

## **WEBSITES TO ASSIST WITH QUESTIONS ABOUT HEALTH INSURANCE**

<http://www.ins.state.ny.us/faqcs1.htm> - This site outlines consumers' rights, provides information about different plans and gives tips on comparing and contrasting different health insurance options and companies.

<http://www.nyshmoguide.org/> - you will find easy-to-read tables comparing HMO performance and premiums, historical complaint data and tips on how to choose an HMO

[www.insurancehelp.com](http://www.insurancehelp.com) – designed to be a “one-stop insurance information center” for the seriously ill and their caregivers.

[www.insurancehelpny.com](http://www.insurancehelpny.com) - *Insurance Information Center* - designed to be a “one-stop insurance information center” for seriously ill and their caregivers – contains glossaries, checklists, patients rights, what to do if denied services, etc. Phone No. 1-866-694-6743

[www.ins.state.ny.us](http://www.ins.state.ny.us) - NY State Insurance Department – ***to file complaints***  
(212) 480-2289 and/or (800) 342-3736 Fax No. (212) 480-2310

[www.oapwd.org/nuscripts.htm](http://www.oapwd.org/nuscripts.htm) - NYS Commission on Quality of Care

# 10 TIPS AND QUESTIONS TO ASK BEFORE SELECTING AN INSURANCE CARRIER

1. Read and compare the policies thoroughly –list your needs and compare with the policies.
2. Find out how to obtain Durable Medical Equipment (also referred to as “DME”). Is there a cap on Durable Medical Equipment?
3. BEFORE you enroll make sure that the insurance company has or offers services and coverage that your child will need, for example:
  - a. Is the location of a specialty clinic realistic for your needs?
  - b. Are there limits on specialty visits; nursing, therapy?
  - c. Does the policy cover the specialist you need? If not, can you go out of network and be covered?
  - d. Does it cover prescriptions? Durable Medical Equipment? Nursing?
  - e. Is it user friendly for authorizations and the length of time to get approvals?
4. Find out if there is a yearly cap. Lifetime cap?
5. Are there deductibles?
6. Verify insurance coverage prior to any procedure and/or specialist appointment.
7. Verify that the specialist your primary care provider is sending you to accepts your insurance.
8. Keep copies of all claims, receipts of co pays, denials, etc.
9. Find out as much information as possible about your child’s diagnosis and necessary treatments. Each child has different health care needs and those needs will greatly affect your choice of insurance providers. **List all of your child’s needs and compare them to what health plans offer.**
10. Learn the standard treatment guidelines for your child’s particular diagnosis. You can check this with specialty organizations (i.e. National Cancer Institute or National Institute of Health (NIH)).

# **TIPS that could play a vital role in determining your insurance**

## **Should you end coverage for a family member who has other insurance?**

If your spouse or partner has coverage through his or her employer, you may want to look at whether you should keep them covered under your employer's insurance plan. If the cost is minimal to you, it may be best to keep them covered so that your employer's insurance can pick up some of the costs that your spouse or partner's insurance does not cover. When you are looking at costs, be sure to compare the deductibles and co-payments of the plans.

## **Make a list of your health care needs.**

Do you have ongoing health care expenses? If so, would those expenses be paid under another plan? Do you expect to have surgery this year? If so, compare the plans for what hospitals they cover and how much of the expenses they will cover.

## **Get a summary list of what is covered under each plan.**

Your employer should be able to provide you with this list. If you do not have one, most health plans now publish a summary list on the plans' web sites. Compare the list of what's covered to the list of your needs. Does one plan match your needs better?

## **Can you keep your current health care providers?**

Many plans will give you a list of the providers who accept that health plan. Some of these lists are kept up-to-date and some aren't. To be sure, call your health care provider's office and ask whether they accept the health plan that you are considering.

## **Get information about the quality of care under a health plan.**

How does the quality of health care rate under this health plan? Are members of the plan satisfied with their care? Is there a long wait to get appointments? Read the HealthCareCoach.com article, "[Assessing the Quality of Health Plans.](#)" A few states also now offer report cards on managed health care plans. Keep in mind: A report card that is three years old may not reflect the quality of care that a health plan can offer you today. Also, local information can be important. A health plan that is doing a good job in another state may not do as good a job in your area.

### **REFERENCES:**

[www.healthcarecoach.com](http://www.healthcarecoach.com)

<http://www.ahcpr.gov/consumer/qntool.htm>