LOUISIANA DEPARTMENT OF INSURANCE

Consumer's Guide to Individual Health Insurance

J. ROBERT WOOLEY, COMMISSIONER OF INSURANCE

Lousiana Department of Insurance 2004

This public document is published at a total cost of $2,783.25. Five thousand copies of this public document were published in this first printing at a cost of $2,223.25. The total cost of all printing of this document including reprints is $2,783.25. This document was published by State Printing, 950 Brickyard Lane, Baton Rouge, LA 70802 to provide consumers with information about their individual health care options and rights under special exception by the Division of Administration. This material was printed in accordance with standards for printing by state agencies established pursuant to R.S. 43:31. Printing of the material was purchased in accordance with the provisions of Title 43 of the Louisiana Revised Statutes.

Table of Contents

Message from Commissioner of Insurance

Robert Wooley

Health care costs are continuing to rise throughout the country. Consequently, the cost of health insurance has been a major issue for consumers in Louisiana and throughout the nation. Many of us have health insurance through our employers, but many others have to purchase individual health insurance to help with the cost of general health care needs and to protect themselves and their families against major illness, injury or accidents.

Choosing the best individual insurance policy for you and your family can be a difficult and stressful task. We hope this guide will be helpful to you by providing a general understanding of individual health insurance, explaining the different types of health insurance policies available and offering tips to consider when purchasing health insurance coverage. We also offer steps you should take if you have a problem with your health insurer, while outlining your appeal rights in the event of a dispute with your insurer. We have included in this guide a simple test that we hope will aid you in deciding what type of individual health plan is right for you.

Should you have any further questions regarding individual health insurance, or have problems with a company's services or a claim dispute, the Louisiana Department of Insurance is here to help. Please contact our Division of Health Consumer Affairs staff at 225-219-4770, or toll free, statewide, at 1-800-259-5300.

What You Need To Know About Health Insurance

Today, there are more types of health insurance, and more choices, than ever before. The information presented here will help you choose a plan that is right for you. You may be buying health insurance for the first time, or you may already have health insurance but want to consider changing plans. Married or single, children or no children, this information will help you find out how to choose a health insurance plan that best meets your health care needs and your wallet. Definitions of the health insurance terms used are included in the section called "Understanding Health Insurance Terms."

Why Do You Need Health Insurance?

Rising health care costs are a growing concern to everyone. Who will pay your bills if you have a serious accident or a major illness? You buy health insurance for the same reason you buy other kinds of insurance, to protect yourself financially. With health insurance, you protect yourself and your family against unaffordable medical care. You cannot predict what your medical care will cost. In a good year, your costs may be low. But if you become ill, your bills could be very high. If you have insurance, many of your medical costs are covered by the insurance company, not by you.

Where Do People Get Health Insurance Coverage?

If your employer does not offer group insurance, or if the insurance offered is very limited, you can buy an individual policy. You can choose fee-for-service or HMO protection, but you should compare your options and shop carefully because coverage and costs vary from company to company. Individual plans may not offer benefits as broad as those found in group health plans.

If you get a non-cancellable policy (also called a guaranteed renewable policy), then you will receive individual insurance under that policy as long as you keep paying the monthly premium. The insurance company may raise the cost of the monthly premium, but it cannot cancel your coverage. Many companies now offer a conditionally renewable policy. This means that the insurance company can cancel all policies like yours, but not just yours. This protects you from being singled out, but it doesn't protect you totally from losing coverage.

Before you buy any health insurance policy, make sure you know what it will pay for…and what it will not pay for. To find out about individual health insurance plans, you can call insurance companies and HMOs in your area, or speak to the producer (agent) who handles your auto or house insurance. Because all insurance companies and producers are required to be licensed or authorized to do business in the state, consider contacting the Louisiana Department of Insurance for verification, at 225-342-1200, before purchasing your policy.

The Department of Insurance does not recommend insurance companies but will provide information on when a company was authorized to do business in this state, its complaint history and its A.M. Best financial rating.

Because financial strength and ability to meet financial obligations to policyholders are very important when you are choosing an insurance company, you may also want to check the company's financial rating with other rating agencies such as Standard & Poor's and Moody's Investors Services. That information should be available at your public library or on the Internet. (Note – these agencies rate companies according to their present financial ability to pay claims, not by quality of products offered or by past or future ability to pay claims.)

Tips when shopping for individual insurance:

- ☑ Shop carefully. Policies differ widely in coverage and cost. Contact different insurance companies, or ask your producer to show you policies from several insurers in order to compare the policies.
- ☑ Make sure the policy protects you from large medical costs.
- ☑ Read and understand the policy. Make sure it provides the kind of coverage that is right for you. You don't want unpleasant surprises when you're sick or in the hospital.
- ☑ Check to see that the policy states the date it will begin paying for medical services and what it covers or excludes from coverage.
- ☑ Make sure there is a "free look" clause. Companies are required by law to give you at least 10 days to look over your policy after you receive it. If you decide it is not for you, you can return it, and the company will refund your premium.
- ☑ Beware of single disease insurance policies. Some policies offer protection for only one disease, such as cancer. If you already have health insurance, your regular plan probably already provides all the coverage you need. Check to see what protection you have under your regular plan before buying speciality insurance.

What Are Your Choices?

There are many different types of health insurance. Each has pros and cons. There is no one "best" plan. The plan that's right for a single person may not be best for a family with small children. And a plan that works for one family may not be right for another.

For example, if your family includes just two adults, it may be less expensive for each of you to have individual coverage than for just one of you to have a family plan. If you have children, or if you might have children soon, you need a family plan. Because your situation may change, review your health insurance regularly to make sure you have the protection you need.

Choosing a health insurance plan is like making any other major purchase. You choose the plan that meets both your needs and your budget. For most people, this means deciding which plan is worth the cost. For example, plans that allow you the most choices in doctors and hospitals also tend to cost more than plans that limit choices. Plans that help to manage the care you receive usually cost you less, but you give up some freedom of choice.

Cost isn't the only thing to consider when buying health insurance. You also need to consider what benefits are covered. You should compare plans carefully for both cost and coverage.

Although there are many names for health insurance plans, this information classifies the plans as two main types:

- Fee-For-Service (or Traditional Health Insurance)
- Health Maintenance Organizations (or HMOs)

Which Type Is Right For You?

For each group, choose the statement **1** or **2** that best describes how you feel:

1. **Having complete freedom to choose doctors and hospitals is the most important thing to me in a health plan, even if it costs more.**
2. **Holding down my costs is the most important thing to me, even if it means limiting some of my choices.**

1. **I travel a lot or have children that live away from me, and we may need to see doctors in other parts of the state or country.**
2. **I don't travel a lot, and almost all care for my family will be needed in our local area.**

1. **I don't mind a health insurance plan that includes filling out forms or keeping receipts and sending them in for payment.**
2. **I prefer not to fill out forms or keep receipts. I want most of my care covered without a lot of paperwork.**

1. **In addition to my premiums, I am willing to pay for the cost of routine and preventative care, such as office visits, checkups, and shots. I also like knowing that I can get an appointment for these services when I want one.**
2. **I want a health plan that includes routine and preventative care. I don't mind if I have to wait for these services to be scheduled when an appointment becomes available with my doctor.**

1. **If I need a specialist, I probably will ask my doctor for a recommendation, but I want to decide whom to go to and when. I don't want to have to see my primary care doctor each time before I can see a specialist.**
2. **I don't mind if my primary care doctor must refer me to specialists. If my doctor doesn't think I need special services, that is fine with me.**

❒ If your answers are mostly **1**s: You want to make your own health care choices, even if it costs you more and requires more paperwork. Fee-for-service may be the best plan for you.

❒ If your answers are mostly **2**s: You are willing to give up some choices to hold down your medical costs. You also want help in managing your care. Consider a health maintenance organization (HMO).

❒ If your answers are a combination: You might want to look for a plan that combines some of the features of a fee-for-service plan and a health maintenance organization.

The differences among fee-for-service plans and HMOs are not as clear-cut as they once were. Fee-for-service plans have adopted some features used by HMOs to control the use of medical services. And HMOs are offering more freedom to choose doctors, the way fee-for-service plans do. By studying your health insurance options carefully, you will be able to pick the one that provides you with the coverage you need, no matter what it is called.

Managed Care: A Way to Control Costs

Managed care influences how much health care you use. Almost all plans have some sort of managed care program to help control costs. For example, if you need to go to the hospital, one form of managed care requires that you receive approval from your insurance company before you are admitted to make sure that the hospitalization is needed. If you go to the hospital without this approval, you may not be covered for the hospital bill.

What are the types of Insurance?

Fee-for-Service

Fee-for-service is the traditional kind of health care policy. Insurance companies pay fees for the services provided to the insured individuals covered by the policy. This type of health insurance offers the most choices of doctors and hospitals. You can choose any doctor you wish and change doctors at any time. You can go to any hospital in any part of the country.

With fee-for-service, the insurer only pays for part of your doctor and hospital bills. This is what you pay:

- A monthly fee, called a premium.
- A certain amount of money each year, known as the deductible, before the insurance payments begin. In a typical plan, the deductible might be $250 for each person in your family, with a family deductible of $500 when at least two people in the family have reached the individual deductible. The deductible requirement applies each year of the policy. Also, not all health expenses you incur will count toward your deductible. Only those expenses that are covered by the policy will be applied to the deductible. You should refer to the insurance policy to find out which health benefits are covered.
- After you have paid your deductible amount for the year, you share the bill with the insurance company. For example, you might pay 20 percent while the insurer pays 80 percent. Your portion is called coinsurance.

To receive payment for fee-for-service claims, you may have to fill out forms and send them to your insurer. Sometimes your doctor's office will do this for you. You also need to keep receipts for drugs and other medical costs. You are responsible for keeping track of your medical expenses.

There are limits as to how much an insurance company will pay for your claim if both you and your spouse file for it under two different individual plans. A coordination of benefit clause usually limits benefits under two plans to no more than 100 percent of the claim.

Most fee-for-service plans have a "cap," the most you will have to pay for medical bills in any one year. You reach the cap when your out-of-pocket expenses (for your deductible and your coinsurance) total a certain amount. It may be as low as $1,000 or as high as $5,000. At this point, the insurance company pays the full amount for medical services in excess of the cap for the benefits your policy says it will cover. The cap does not include what you pay for your monthly premium.

Some services are limited or not covered at all. You need to review your policy for preventative health care coverage such as well-child care.

There are two kinds of fee-for-service coverage: basic and major medical. *Basic coverage*, in most health care plans, pays toward the costs of a hospital room and care while you are in the hospital. It covers some hospital services and supplies, such as x-rays and prescribed medicine. In most policies, basic coverage also pays toward the cost of surgery, whether it is performed in or out of the hospital, and for some doctor visits. *Major medical* insurance begins to pay for medical services when your basic coverage does not pay. It covers the cost of long, high-cost illnesses or injuries.

What is a "Customary" Fee?

There is no standardized method of calculating fee allowances. Each insurer independently establishes its own internal procedure for covered charges. If a non-network provider is used the policyholders may experience much higher out-of-pocket expenses than anticipated because they will be responsible for any charges in excess of the covered or allowed charges, plus their designated co-payments.

Questions to Ask About Fee-for-Service Insurance...

- How much is the monthly premium? What will your total cost be each year? There are individual rates and family rates.
- What does the policy cover? Does it include prescription drugs, out-of-hospital care or home care? Are there limits on the amount or the number of days the company will pay for these services? The best plans cover a broad range of services.
- Are you currently being treated for a medical condition that may not be covered under your new plan? Are there limitations involved in the coverage?
- What is the deductible? Often, you can lower your monthly health insurance premium by buying a policy with a higher yearly deductible amount.

- What is the coinsurance rate? What percent of the allowable services listed on your bills will you have to pay?
- What is the maximum you will pay out of pocket per year? How much will it cost you directly before the insurance company will pay everything else?
- Is there a lifetime maximum cap on the amount the insurer will pay? After the cap has been reached, the insurance company will not pay any more expenses. This is important to know if you or someone in your family has an illness that requires expensive treatments.

Health Maintenance Organizations (HMO)

Health Maintenance Organizations (HMOs) are prepaid health plans. As an HMO member, you pay a monthly premium. In exchange, the HMO provides comprehensive care for you and your family, including doctors' visits, hospital stays, emergency care, surgery, lab tests, x-rays and therapy.

The HMO arranges for this care either directly in its own group practice and/or through doctors and other health care professionals under contract with the HMO. Usually, your choices of doctors and hospitals are limited to those that have agreements with the HMO to provide care. However, exceptions are made in emergencies or when the care is medically necessary.

There may be a small copayment for each medical service, such as $5 for a doctor's visit, $25 for care by a specialist or $200 for hospital emergency room treatment. Your total medical costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

Because HMO physicians receive a fixed fee for your covered medical care, it is in their interest to make sure you get basic health care for problems before they become serious. HMOs typically provide preventative care, such as office visits, immunizations, well-baby checkups, mammograms and physicals. The range of covered services varies in HMOs, so it is important to compare available plans. Some services, such as outpatient mental health care, often are provided only on a limited basis.

Many people like HMOs because they do not require claim forms for office visits or hospital stays. Instead, members present a card at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with a fee-for-service plan.

In some HMOs, doctors are salaried. Salaried doctors have offices in an HMO facility at one or more locations in your community as part of a prepaid group practice. In others, independent groups of doctors contract with the HMO to take care of patients. These are called individual practice associations (IPAs), and they are made up of private physicians in private offices who agree to care for HMO members. You select a doctor from a list of participating physicians that make up the IPA network. If you are thinking of switching into an IPA-type HMO, ask your doctor if he or she participates in the plan.

In almost all HMOs, you either are assigned or you choose one doctor to serve as your primary care doctor. This doctor monitors your health and provides most of your medical care, referring you to specialists and other health care professionals as needed. You usually cannot see a specialist without a referral from your primary care doctor, who is expected to manage the care you receive. This is one way that HMOs can limit your choices; however, exceptions may be allowed for some specialists.

Before choosing an HMO, it is a good idea to talk to people who are enrolled in one. Ask them how they like the services and care given.

Questions to Ask About an HMO...

- Are there many doctors to choose from? Do you select them from a list of contract physicians or from the available staff of a group practice?
- Which doctors are accepting new patients?
- Does the HMO offer the services you want? What preventative services are provided? Are there limits on medical tests, surgery, mental health care, home care or other support offered? What if you need a special service not provided by the HMO?
- What is the service area of the HMO? Where are the facilities that serve HMO members located in your community? How convenient to your home and workplace are the doctors, hospitals and emergency care centers that make up the HMO network?
- What happens if you or members of your family are out of town and need medical treatment?
- What will the HMO plan cost? What is the yearly total for monthly fees? In addition, are there copayments for office visits, emergency care, prescribed drugs or other services?

Facts To Consider

- Always remember to **read your application**, particularly if the insurance representative completed the application for you, to assure that all information is correct. The company can decline the policy if pertinent information was not disclosed on the application.

- All health plans have a provision titled "Exclusions and Limitations." Such provisions should be reviewed very carefully before you accept the policy. If a benefit or service is limited or excluded, you will not be covered, even though that treatment may be considered medically necessary.

- Before an insurance company will accept you as a potential policyholder, the company may want to place an exclusionary rider on your policy for a specified condition. If the policy is issued with an exclusionary rider, you will be responsible for the cost of any medical care received for the treatment of the excluded condition. That will include--but not be limited to--doctor visits, prescription drugs and emergency care services.

- Individual policies generally pay benefits for your spouse and on your dependent children up to the age specified in the policy. However, your insurance company cannot terminate coverage for dependent children who lack other means of support due to mental or physical handicaps.

- Because some individual policies contain both In-Network and Out-of-Network benefits at different percentages (for example, In-Network 90% vs. Out-of-Network 60%), the insurer is not required to pay the Out-of-Network provider at a higher percentage. Use caution when making the decision to utilize an Out-of-Network provider for medical care and treatment. You may find yourself paying more than you anticipated.

Do I Have Appeal Rights Under My Individual Health Plan?

Yes. When your health plan denies a service because they feel it is not medically necessary, you have a right to appeal the decision with your health plan. The appeals process involves a two-level internal appeal and an external or independent appeal. If a delay in the process will seriously jeopardize your life, health or ability to regain maximum function, an expedited appeal is available. The appeals process is conducted as follows:

- **FIRST LEVEL INTERNAL APPEAL -** This appeal is requested by the covered person within 60 days of receiving the adverse determination. The Medical Necessity Review Organization (MNRO) has 30 working days following the request for appeal to notify in writing both the covered person and the provider of their decision. MNROs are licensed entities that determine the medical necessity of health care services.

- **SECOND LEVEL INTERNAL APPEAL -** If the first-level appeal decision upholds the denial, the covered person can request a second-level appeal within 30 days of receiving the first-level appeal decision. The review panel must hold a review meeting within 45 working days of receiving the request for the second-level review. The MNRO has five days following the completion of the review meeting to issue a written decision to the covered person.

- **EXTERNAL REVIEW -** If the second level appeal decision upholds the denial, the covered person, with the concurrence of the treating provider, may request an external review within 60 days of receiving the second-level appeal decision. The MNRO must provide any relevant information to the designated Independent Review Organization (IRO) within seven days after receipt of request for external review. The IRO shall provide notice of its recommendation to the MNRO, the covered person and the provider within 30 days after receiving the second-level decision information.

- **EXPEDITED INTERNAL APPEAL -** An expedited appeal can be requested when a denial involves a situation in which the time frame would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. In such a case, the MNRO must make a decision and notify the covered person and/or provider as expeditiously as possible, but no more than 72 hours after the appeal is commenced.

EXPEDITED EXTERNAL REVIEW – After receiving an adverse determination involving an emergency medical condition, the covered person's health care provider may request an expedited external review. Within 72 hours of receiving appropriate medical information, the Independent Review Organization (IRO) shall make a decision to uphold or reverse the denial and notify the covered person, the Medical Necessity Review Organization (MNRO) and the treating provider of the decision.

When Does Medical Necessity Review Organization (MNRO) Apply?

You are afforded these appeal rights if you are insured through a fully insured health plan that subjects benefit eligibility to medical necessity requirements. A fully insured health plan is one that is "insured" through a licensed insurance company. Self-funded, employer-sponsored health plans are exempt from the MNRO appeal rules under the federal labor law (ERISA).

The law does not apply to health plans provided by the federal government (including Federal Employee Programs, Medicare and Medicare+Choice), nor does it apply to plans providing only "excepted benefits"(Limited benefit health plans providing coverage only for such conditions as cancer, dental, disability, accidental injuries).

What if I don't receive a certificate of creditable coverage, or lose one that I received?

A certificate of credible coverage indicates the length of time you have been continuously covered under a qualifying previous health plan and allows waiver of any waiting period related to a preexisting condition. In most cases, your first step should be to contact the plan administrator or your prior health plan. Ask for a copy of the certificate of creditable coverage; it should be free of charge. If you do not automatically receive a certificate of creditable coverage or receive one before you need it, you should:

- Contact the plan administrator if you have been in a group plan;
- Contact the health insurance issuer if you have had individual coverage.

Because some people have had creditable coverage through multiple sources, you should always check with all sources to be sure you get the credit you deserve. If you lose your certificate, you can go back and request another one, free of charge. In most cases, even if you do not receive a certificate, you can use other evidence to prove creditable coverage. These include:

- Pay stubs that reflect a premium deduction;
- Explanation of benefit forms;
- A benefit termination notice from Medicare or Medicaid; and
- Verification by a doctor or your former health care benefits provider that you had prior health coverage.

What are the circumstances in which I will have portability?

(Portability is the exemption of the standard preexisting condition under a subsequent health insurance policy following the termination of a policy or plan from a previous health insurance policy or plan.)

- You lose group health plan coverage, you meet the definition of a HIPAA eligible individual and you wish to purchase individual health insurance coverage.
- You have individual health insurance coverage or any other type of creditable coverage, and you enroll in a new group health plan.

What does portability NOT do?

- Portability does not guarantee that if you move from one plan or policy to another the benefits you receive will be the same as those that were available to you under your old plan or policy. Coverage under the new plan could be less (or more) generous, and premiums and cost-sharing arrangements (deductibles and copayments) may differ.

- It does not "guarantee" that an insurance company has to issue you an individual policy. Insurers have the right to reject coverage based upon their underwriting guidelines. However, if a policy is issued, any creditable coverage that you have will be portable to the new individual health plan.

If I had health coverage under my spouse's old job but I lost that coverage and do not have access to group coverage through my new job, can HIPAA help me as an individual?

- If you meet the requirements to be a HIPAA eligible individual, you must get a choice of individual coverage with no preexisting condition exclusion, either through a health insurance issuer or through the Louisiana Health Plan (HIPAA and/or High Risk Pool).

- In order for you to qualify for the HIPAA pool, loss of group coverage must be through no fault of your own, and you must have been previously insured for at least 18 months continuously.

Questions and Answers About Premiums

Why do companies raise premiums?

- Insurance companies often raise premiums when the cost of paying medical claims increases.
- Medical cost inflation is a major factor that contributes to premium increases.
- Medical utilization or an increase in the number medical procedures performed each year also causes premium increases.
- Cost shifting occurs when one group of patients pays less than the true cost of their medical care. When this happens, providers may overcharge others to make up the difference.

What do your premiums pay for?

Premiums help pay policyholders' claims and other expenses, such as agent commissions, premium taxes and administrative expenses.

How do insurance companies determine premiums?

An insurance company considers many factors when setting premiums, such as:

- Cost of medical care
- Covered benefits
- Age of the policyholder (both current age and the age when the policy was issued)
- Gender
- Lifestyle habits (such as smoking)
- Geographic area
- Additional coverage added to the policy

Medical Privacy

The Federal HIPAA privacy rule provides that an individual has a right to adequate notice of how an insurance company or medical provider may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. More information regarding the Federal HIPAA Privacy Rules can be accessed at the United States Department of Health & Human Services Web page at www.os.dhhs.gov.

What are Supplemental Health Plans?

Supplemental health plans provide limited coverage and benefits for specified losses. You should use these policies as supplements rather than substitutes for basic or comprehensive health insurance. Because these policies are designed to only provide coverage for a specified disease or condition, you should read these policies very carefully, so that you will have a better understanding of the covered benefits.

Accident Only

These policies cover death, disability, hospital and medical care resulting from an accident. Benefits vary greatly. A variation of these types of policies, called accidental death and dismemberment, can pay additional benefits for death due to such things as motor vehicle or at-home accidents.

Cancer

Cancer policies provide limited benefits when the insured person is diagnosed with cancer (as defined in the policy contract). Most policies contain a schedule of benefits describing the amount of payments for "covered" cancer treatments. Not all forms of cancer are covered under these policies.

Many specified disease policies only provide coverage for the actual treatment of the specified disease and will not cover charges that do not directly treat the specified condition. For example, a person being treated for cancer requires chemotherapy, which may cause extreme nausea. An anti-nausea medication is prescribed to make the treatment more bearable. The insurer probably will not cover the drug since it is treating the nausea, not the cancer.

Critical Illness

Critical Illness policies pay a lump sum if you are diagnosed with a specified critical illness. The sum is paid directly to the insured, regardless of any other sources of income. Most policies define "critical illness" as stroke, heart attack, cancer that is life threatening, paralysis, deafness, organ transplant requirement, blindness, kidney failure, etc.

Dental

Dental insurance usually provides benefits for care and treatment of the teeth and gums. Benefits vary from policy to policy as some may cover 100 percent of preventative care (such as semi-annual check-ups or fluoride treatments) while others may only cover a portion of preventative care. Typically, dental insurance plans provide limited benefits for preventative, basic, major and orthodontic services. There is normally an annual benefit maximum for covered services. If any benefits for orthodontic procedures are included, they may be very limited and have a lifetime benefit maximum.

Disability Income

Disability Income policies pay a weekly or monthly income for a specific period if you suffer a disability and cannot continue to work. The disability may involve sickness, injury or a combination of the two.

The disability payment is usually a set dollar amount not to exceed a certain percentage of your income. Most disability income policies reduce benefits based on other income to which you may be entitled, such as sick leave, Social Security benefits, workers' compensation benefits or sabbatical pay. Be aware that some disability income policies contain an elimination period, measured from the start of each disability. During that time, no benefits are paid. Elimination periods vary, generally from 30 days to six months, depending on the policy. A policy with a longer elimination period may provide lower premium payments.

An insurance company paying for a disability claim may require the policyholder to provide a written doctor's report. The frequency of this requirement depends upon the particular policy. For example, a given insurance company may require such medical updates every month. In addition, the insurance company may monitor certain public activities by policyholders who file claims, which may fight fraud and keep insurance costs down.

Hospital Indemnity

Hospital Indemnity policies provide benefits for each day of hospital confinement. The benefits are usually specified dollar amounts and are not based on actual expense.

Home Health Care

Home Health Care policies cover services prescribed by a physician and provided by a Medicare-certified or a state-licensed home health care service. The care must help with activities of daily living or the supervision or protection of a patient with cognitive impairment (such as Alzheimer's disease or senility). Some policies offering nursing home coverage automatically offer home care as well.

Nursing Home Care

Nursing Home Care policies offer an alternative for some people and cover either one level or several levels of care such as custodial, intermediate and skilled. Cognitive impairment or the inability to perform one or more of the activities of daily living will activate the benefit trigger of this care.

Long-Term Care

Long-Term Care policies usually pay for skilled, intermediate and custodial care in a nursing home.

Benefits for personal care (custodial care) may also be provided if that care is received in approved facilities. These policies usually pay a fixed amount per day while a person is in a nursing home. Most policies contain waiting periods during which no benefits are paid.

Normally, long-term care policies pay only for expenses in facilities that are licensed by the state and/or participate in Medicaid and Medicare and meet the policy's definition of skilled, intermediate or custodial care. For this reason, it is important to find out about the types of nursing homes that are available in your area before you buy the policy.

Medicare Supplement

Medicare Supplement policies are designed to pay 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 consider purchasing a Medicare Supplement policy that helps pay for certain expenses, which can include deductibles not covered by Medicare.

Understanding Health Insurance Terms

Coinsurance - The amount you are required to pay for medical care in a fee-for-service plan after you have met your deductible. The coinsurance rate is usually expressed as a percentage. For example, if the insurance company pays 80 percent of the claim, you pay 20 percent.

Coordination of Benefits - A system to eliminate duplication of benefits when you are covered under more than one health plan. Benefits under the two plans usually are limited to no more than 100 percent of the claim.

Copayment - Another way of sharing medical costs. You pay a flat fee every time you receive a medical service (for example, $5 for every visit to the doctor). The insurance company pays the rest of the expense.

Covered Expenses - Most insurance plans, whether they are fee-for-service or HMOs, do not pay for all services. Some may not pay for prescription drugs; others may not pay for mental health care. Covered services are those medical procedures the insurer agrees to pay for. They are listed in the policy. (Also see "Customary Fees," pg. 10.)

Creditable Coverage Certificate - The certificate of insurance history is intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a new health plan can apply a preexisting condition exclusion. The certificate of creditable coverage is a written document that reflects certain details about an individual's prior health coverage, including the dates that the individual was covered.

Deductible - The amount of money you must pay each year to cover your medical care expenses before your insurance policy starts paying for a medical claim.

Exclusions - Specific conditions or circumstances for which the policy will not provide benefits.

HMO (Health Maintenance Organization) - Prepaid health plans. You pay a monthly premium and the HMO covers your doctors' visits, hospital stays, emergency care, surgery, checkups, lab tests, x-rays and therapy. You must use the doctors and hospitals designated by the HMO.

Managed Care - A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. It is a way to manage costs and use while maintaining the quality of the health care system. All HMOs and many fee-for-service plans have managed care features. Individuals have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a prenegotiated basis.

Maximum Out-of-Pocket - The most money you will be required to pay per year for deductibles and coinsurance. It is a stated dollar amount set by the insurance company, in addition to regular premiums. (Also see "Customary Fees," pg. 10.)

Noncancellable Policy - A policy that guarantees you can receive insurance, as long as you pay the premium. It is also called a guaranteed renewable policy.

Preexisting Condition - A health problem that existed before the date your insurance policy became effective.

Premium - The amount you pay in exchange for insurance coverage.

Primary Care Doctor - Usually your first contact for health care. This is often a family physician or internist, but some women use their gynecologist. A primary care doctor monitors your health, diagnoses and treats minor health problems and refers you to specialists if another level of care is needed.

Provider - Any person (doctor, nurse, dentist) or institution (hospital or clinic) that provides medical care.

Third-Party Payer - Any payer for health care services other than you. These would include an insurance company, HMOs and the Federal Government.

Your Health Care Contact Numbers

Louisiana Department of Insurance
J. Robert Wooley, Commissioner
P.O. Box 94214
Baton Rouge, LA 70804-9214