

What do I need to know about Private Health Insurance?

In today's complicated health care environment, finding your way through health insurance plans can seem overwhelming. Many families have access to health insurance as a part of the benefit package their employer offers, while others purchase health insurance on their own. Many of the 'mandates' for coverage issued by the state legislature are not equally applied to group and individual policies. As you seek to ensure your family's coverage needs are met, it is important to learn about the types of insurance plans, their limits, and the policy owner's rights.

Types of Health Insurance

Each year fewer Hoosiers are covered under fee-for-service health insurance plans in which insured individuals go to a doctor of their choosing and then submit their own health insurance claims. Today more Americans are covered by one of the following arrangements:

Preferred Provider Organization (PPO). A PPO is a network of doctors and hospitals that have agreed to a discounted amount in exchange for direct reimbursement from an insurance company or administrator. This network of providers is offered through a health plan either a group or individual basis. Typically there are deductibles and co-insurance amounts as part of the benefit plan design. Services can be provided by non-contracted providers; however, a higher copayment and deductible amount is usually associated with out-of-network services.

Health Maintenance Organization (HMO). An HMO is a form of managed care in which services are provided through a restricted network of providers. Enrollment in an HMO requires the selection of a primary care physician (family doctor) who may refer to specialists for health services. HMOs may also offer a Point of Service (POS) option, which allows more flexibility when choosing a physician. The POS option may not require referrals for specialty care. The POS option is generally more expensive and may require higher copays and deductibles.

Individual/ Family plans. Another option for families is to buy their own health insurance. There are many plan designs to choose with varying deductibles, co-pays and co-insurance amounts. The Patient Protection and Affordable Care Act made it easier to compare and purchase health insurance plans. Individuals wishing to purchase plans may visit www.healthcare.gov to view the plan options.

Health Savings Accounts (HSA). Health Savings Accounts are used in conjunction with a qualified High Deductible Health Plan (HDHP). These types of plans are becoming more popular with employers and individuals as the monthly cost is typically less than that of a PPO plan due to the higher deductible. Families can put money into the HSA on a pre-tax basis, and unlike a Flexible Spending Account (FSA), any unused money rolls over from year to year. Employers may offer the choice of a PPO plan and a HDHP plan and the cost differences can be significant. Many people select the HDHP plan and put the difference in cost into their HSA account – a wise move!

Self-Funded versus Fully Insured: Understanding the difference

There are two ways an employer can structure a group health plan: self-funded or fully-insured. Self-funded plans use the employer's money to pay medical claims. Employers contract with an administrator, perhaps an insurance company, to process and pay claims with the employer's money. In contrast, fully-insured plans use the insurance company's money to pay claims. Employees typically contribute towards the premium regardless of which type of plan they have. It is important to know which plan you have because only insured and individual/family plans are regulated by the state's Department of Insurance. Self-Funded plans fall under federal law and do not have to follow state-mandated benefits. Your employer can tell you which type of plan you have.

To address conflicts with **self-insured** plans, contact the U.S. Dept. of Labor Pension & Welfare Benefits Administration:

□ in Northern Indiana, call **1-312-353-0900**

□ in Southern Indiana, call **1-859-578-4680**

To address conflicts with **fully insured** plans, contact the Indiana Dept. of Insurance, Consumer Services Division: **1-800-622-4461**

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Flexible Spending Accounts:

A flexible spending account (or flex account) is offered as an option, often in addition to insurance, through some employers. A flex account allows an employee to set aside a portion of their earnings to pay for qualified expenses (defined by the IRS), such as medical expenses and dependent care expenses. Money deducted from an employee's pay into a flex account is pre-tax money. These plans can provide an important tax benefit for some families. When evaluating this type of plan, carefully consider what expenses are allowable and how much money will be used in a year. *Money not spent during the designated year is lost.*

For More Information about Insurance Plans and Benefits:

Insurance plans come with materials that explain benefits, procedures for obtaining authorization of services, and addressing appeals and concerns. Employers, human resources departments, and plan administrators are key sources for this type of information and may share it electronically. Additionally, the Patient Protection and Affordable Care Act added consumer protections, including out of pocket limits and additional services that apply to certain plans.

Keep in mind, in order to be eligible for a coverage exemption from the Internal Revenue Service (IRS), you and each member of your family must do one of the following: have qualifying health coverage called minimum essential coverage, qualify for a health coverage exemption, or make a shared responsibility payment with your federal income tax return for the months that you did not have coverage or an exemption.

The penalty for not having an ACA compliant plan in 2017 is \$695 per adult and \$347.50 per child (up to \$2,085 for a family), or 2.5% of your household income above the tax return filing threshold for your filing status – whichever is greater. To avoid the penalty, you must obtain health coverage that is Minimum Essential Coverage. Check the [IRS Minimum Essential Coverage Chart](#) to make sure your coverage qualifies.

Who to contact with complaints:

When you have a complaint, be sure to review your policy booklet to ensure the service in question is covered and proper pre-certification, network use and claim submission guidelines were followed. Families should keep a copy of all bills, claims and other documentation to assist in the resolution of any issues. If a claim is denied, the reason should be stated on the explanation of benefits. If there is a disagreement with the denial, check your policy or employee booklet for the company's appeal procedures. The company should be able to answer procedural questions about appeals over the phone. Any appeal should be in writing and may require further information.

Families who have tried unsuccessfully to resolve a claim issue and who have a plan that is self-funded can take unresolved complaints to the U.S. Department of Labor (DOL) Pension and Welfare Benefits Administration at the numbers in the left-hand column.

If your family health plan is fully insured or an individual/family plan, contact the Indiana Department of Insurance, Consumer Services Division. Complaint forms and additional consumer information are available on the Department's web site: <http://www.in.gov/idoi>.

Programs and systems change often. It is important to ensure that you are using the most current information. This fact sheet was updated August 2018. Please check http://fvindiana.org/fact_sheets for the most recent edition.

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