Fact Sheet

Types of Insurance Policies

Health insurance pays for expenses incurred for the diagnosis and treatment of covered medical conditions. There are many different types of health insurance plans available. The patient and his/her family choose the plan that best fits their specific needs, budget, and lifestyle. It's important to be aware of the state or federal agency that regulates the type of health insurance you are dealing with in case you have questions or experience problems. Each of the different policies has advantages and disadvantages. Read further to become familiar with the different types of health insurance to know what the patient is presenting for coverage.

Type of Insurance	Description
Indemnity Policies (Traditional Fee-for-Service Insurance)	Most indemnity policies allow the patient to choose any doctor and hospital they wish when seeking health care services. The biggest benefit of traditional fee-for-service insurance is choice. The patient decides which provider to see with few geographic limitations. An indemnity policy often has a deductible (the amount the patient must pay before policy benefits are provided). If a patient's health care charges are covered or eligible for payment, the applicable deductible applies. Once the deductible is met, remaining charges are reimbursed at a specified percentage rate according to the policy contract. The difference between eligible charges and the percent paid is a "copayment" which is the patient's responsibility. It is important to know who has jurisdiction over these plans in your state.
Preferred Provider Organizations (PPOs)	A **P**referred **P**rovider **O**rganization (PPO) provides a list of contracted "preferred" providers from which a patient may choose. The patient receives the highest monetary benefit when s/he limits health care services to the providers on the list. When a patient goes to a provider **not** on the preferred provider list, s/he is going "out-of-network"; the plan covers a smaller percentage of the expenses and may not cover any of the health care expenses based on the wording of the contract.
Health Maintenance Organizations (HMOs or Managed Care)	Membership in a **H**ealth **M**aintenance **O**rganization (HMO) requires members to obtain health care services from doctors and hospitals affiliated with the HMO. It is common practice in HMOs for the plan member to choose a primary care physician who treats and directs health care decisions and coordinates referrals to specialists within the HMO network. The doctors may be employees of the HMO or contracted providers. Since HMOs operate in restricted geographic regions, this may limit coverage if medical treatment is obtained outside the HMO network or coverage area. Some states require HMOs to cover medically necessary emergency services even when outside of the coverage area. The intent of managed care products is to create less costly health care services while maintaining quality health care by specifying provider choice. HMOs offer access to a comprehensive package of covered health care services in return for a prepaid monthly amount (premium). Most HMOs charge a nominal copayment dependent on the type of service provided.

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Self-Insured Health Plans (Single Employer Self-Insured Plans)	Self-Insured Health Plans have gained in popularity with large employers, labor unions, school districts, and other municipalities. These groups establish a pool of money and pay for their members' (employees') health care services from this pool. It is common for self-insured plans to turn over the administration of their health plans to a Third Party Administrator (TPA). The TPA handles all administrative tasks including claims processing and payments. Employers often contract with insurance companies to act as TPAs for all health care claims. Most self-insured health plans fall under the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct (ERISA). ERISA is a federal law enforced by the U.S. Department of Labor, Employee Benefits Security Administration (DOL-EBSA). If your patient is a member of a self-insured health plan through his/her employer or union, you can contact DOL-EBSA for any assistance needed. However, the DOL-EBSA does **not** regulate self-insured health plans that are sponsored through school districts, other municipalities, and/or churches. If the patient is a member of this type of plan, you can file complaints with the plan directly or you can seek a legal remedy through a court of law. The DOL-EBSA is available to answer questions about self-insured employer plans that fall under ERISA regulation. Contact the DOL-EBSA for clarification.
Exclusive Provider Organizations (EPOs)	Exclusive Provider Organizations (EPOs) provide lists of local contracted, *preferred* providers (doctors and hospitals) from which a patient can choose. The patient is only covered by his/her plan if s/he seeks treatment with a provider who participates in their network. There is no coverage for out-of-network providers. A patient with an EPO plan does not have a primary care physician directing his/her care; and s/he does not need a referral to a specialist within the network. Most EPOs charge a small copayment—with or without deductible— depending on the type of service provided.
High Deductible Health Plans (HDHPs)	A high-deductible health plan is a health insurance plan with a higher deductible than a traditional health plan. High deductible health plans have lower premiums making them attractive to employer groups and those purchasing their insurance through the ACA exchanges. Some high deductible health plans cover wellness services outside of the deductible. Participation in a qualifying HDHP is a requirement for a health savings account (HSA). A health savings account is a tax-free medical savings account. HSA dollars can be used to help pay deductibles and qualified medical expenses, including those not covered by the health insurance (e.g., dental and vision care).
COBRA	The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that extends a patient's current group health insurance when s/he experiences a qualifying event such as termination of employment or reduction of hours. The extension period is 18 months; some people with special qualifying events may be eligible for a longer extension. To be eligible for COBRA, the group policy must have been in force with 20 or more employees covered for more than 50% of its typical business days in the previous calendar year. Indemnity policies, PPOs, HMOs, and self-insured plans are all eligible for the COBRA extension; however, federal government employee plans and church plans are exempt from COBRA. Individual health insurance is also exempt from COBRA extensions.

Type of Insurance	Description
Supplemental Health Insurance Policies	Most *supplemental* health insurance policies pay in addition to a patient's comprehensive major medical coverage. These supplemental policies should not be used as a substitute or replacement for a traditional health insurance policy or a health plan. Supplemental health insurance can pay **limited** benefits such as a daily dollar amount if a patient is hospitalized (hospital income policy), or it can pay a lump sum dollar amount if a patient is diagnosed with a specified or named disease such as cancer. This type of supplemental policy can also be structured to pay expenses incurred during the treatment of the specified disease. Sometimes this insurance provides payment over and above a patient's medical expenses. It is important that you, as a provider, understand the limitations and exclusions of supplemental health insurance policies and how the policies coordinate benefits.