



How to Get Health Insurance Coverage

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Over 14% of all U.S. families had no health insurance in 2001, according to the U.S. Department of Commerce. In South Dakota the number was 8.1%. That's still far too many vulnerable families.

Farm and ranch families have many reasons for going without health insurance:

- Since they are self-employed, they don't have access to group insurance, and the premiums seem exorbitant.
- It is 6 months to a year before a new health plan may become fully effective.
- Off-farm or off-ranch employers don't offer coverage or only offer coverage to full-time employees.

Most people today understand the consequences of not having health insurance coverage. With skyrocketing medical costs, it is essential. However, it can be very difficult to find the policy that best suits your family needs and your pocketbook. Even when health insurance is offered by an employer, you may still want supplemental insurance for more complete coverage for you and your family.

Health Insurance Selection Guidelines

First, determine if the company is licensed to offer health insurance coverage in South Dakota.

To do business in South Dakota, all sellers of insurance products are required to register with the State Division of Insurance. If the company you deal with is unauthorized and unlicensed, you have no financial safety net if it becomes insolvent and leaves you stranded.

A list of insurance companies (with their home office addresses and phone numbers) licensed to offer health

policies to South Dakotans is available. Write South Dakota Division of Insurance, 118 W. Capitol, Pierre SD 57501 or call 605-773-3563. For a list of companies offering major medical health coverage in South Dakota, go on-line at <http://www.state.sd.us/dcr/insurance/LHRatesForms/IndMedCarriers.htm> The State Division of Insurance can also provide you with the name of an in-state agent nearest you.

Questionable companies offer what they call "health care benefits." They also often offer coverage for people with serious pre-existing health conditions that other companies may not insure.

Some are "fly-by-night" companies that take payments for premiums and then close up shop and leave town, leaving consumers completely unprotected and unaware they've been left holding the bag until they file a claim for coverage and find they are completely responsible for a pile of medical bills.

In other cases, because the companies aren't licensed, they aren't regulated and if they deny claims, the consumer has no recourse. If a company is not licensed in South Dakota, contact the State Division of Insurance whose mission is to "prevent, investigate, and prosecute fraudulent insurance acts."

Second, investigate insurance plans; determine what each plan does and does not cover and get several quotes for similar coverage.

Because health insurance policies vary greatly in coverage and cost, it is important to comparison shop. Insurance quotes may be obtained directly through an insurance company, an insurance broker, or via the Internet. To get an

estimate of health insurance costs, contact several companies licensed in South Dakota. It is easy to search on-line for "South Dakota health insurance." Several companies (listed on the South Dakota Division of Insurance Web site) will provide you with a quote after entering the information requested.

If you are an employee, you usually have an option to pay a higher premium to include health coverage for your family. South Dakota has established certain mandated health benefits and health insurance laws (consult <http://www.insure.com>).

For instance, children born while the plan is in effect will be covered after application is made to include them; this works for adopted children as well. But you will need to check at what age or educational status your children are no longer covered under the family policy.

Group Health Insurance

Individuals covered under an employee benefits plan that includes group health insurance are truly fortunate. While individual insurance plans can deny coverage or increase rates to an individual due to poor medical conditions or high-risk situations, a group insurance plan cannot. Insurance companies must accept the entire group or none at all, nor can they increase rates to one individual. With group insurance plans, there is strength in numbers.

New members to a group health care plan may experience a waiting period before receiving protection. There may also be different protection plans offered by the employer to full-time and part-time employees; many part-time employees, for example, receive no health care benefits.

Decide whether you need permanent coverage or coverage for a certain period of time, such as 6 months (until your group insurance kicks in). If you only need temporary coverage, there are a number of private companies selling policies for periods of up to one year.

If you are terminating employment that offered health care coverage, investigate your eligibility for COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage—usually available for up to 18 months. COBRA health insurance is generally more expensive than when part of the premium was paid by the former employer, but it is less expensive than individual health insurance.

A cafeteria plan, also known as a Section 125 plan, pro-

vides a method for allowing the employee to choose from among a menu of benefit choices. The benefits may be fully or partially paid for by the employer. If you are required to pay for some or all of the benefits, you should consider paying for them on a pre-tax basis by utilizing a "Flexible Spending Account."

It works this way: You estimate the dollar amount of medical expenses of your family for the coming year and set that amount aside. Though it is wise to pay for medical expenses with pre-tax dollars, any funds not used from this account for annual medical expenses are lost to the employee at the end of the year.

Medicare

Medicare is the government-supported health-care program for people who are 65 and older or who are disabled. It pays for much of their health care, but not all of it. Prescription drugs, deductibles, and coinsurance, for example, are not covered.

"Medicare Supplement Insurance" (often referred to as Medigap) is a health insurance policy sold by private health insurance companies to fill the "gaps" in Medicare coverage. To buy a Medigap policy, you generally must have Medicare Part A and Part B.

The supplemental health insurance plans A through J are federally prescribed plans sold by different insurance companies quoting a variety of prices for each plan. Compare plans offered by different companies in the annually published "South Dakota Consumer's Guide to Insurance to Supplement Medicare," available from your nearest Senior Health Information and Insurance Education (SHIINE) representative. Contact SHIINE through your SDSU county Extension educator or go on-line at <http://www.state.sd.us/social/ASA/SHIINE/SupplementalGuide/index.htm>

Individual Health Insurance

Individual health insurance is for people who either don't have insurance through their employer or who need to supplement the insurance they do have. Individual and family coverage is generally available for anyone not covered by Medicare.

Individual medical policies are much harder to qualify for, are more expensive than group insurance, and have more restrictions on coverage than their group counterparts. Those needing individual health insurance are the self-

employed, employees of small companies that don't offer health insurance benefits, people between jobs, young adults moving off their parents' policy, widowed or divorced who have lost their spouse's group coverage, and those who retire early and no longer have health insurance coverage until they may qualify for Medicare.

Unlike group insurance, almost all insurance companies require extensive questioning about medical history and sometimes a physical exam before you can qualify for individual health insurance. Even then, insurance companies often put restrictions or limitations on pre-existing conditions, or deny coverage altogether. As a way to save money, you may want to see if any groups, clubs, organizations, or churches in your region pool their resources to offer group insurance to individuals and families before you commit to an individual policy.

Types of Medical Coverage

Understand the following terms when investigating health insurance:

Deductible—initial portion of any loss you pay before receiving insurance benefits, i.e. \$500 or more. The deductible is paid before the company pays any additional expenses incurred.

Ask if the deductible is a per year, per person or family, or per episode charge (i.e. per doctor's office visit, per medical prescription, per hospital visit, or per accident).

Coinsurance—the proportions of any loss suffered that the insured and insurance company pays, i.e. 20/80; often referred to as the copayment. The smaller number is the percentage that the insured person pays.

Coinsurance cap—the annual out-of-pocket payments made by the insured; the remaining amount due is the responsibility of the insurance company. Determine if the cap is for any one event, for the year, or lifetime of the whole family or per individual.

Maximum lifetime benefit—the dollar amount that the insurance company will pay for medical expenses over the lifetime of the insured. Ask if it is per individual covered or for all family members specified on the policy.

Consider, when evaluating health insurance coverage policies, the type of coverage you and your family require.

There are two levels of coverage: basic and major (or catastrophic) coverage. Usually, it isn't the general doctor bills that could eat up your life savings, but a serious accident or illness that could financially ruin a family.

Most insurance agents recommend that you make sure your health insurance policy incorporates both basic and major coverage. If you have to limit the coverage, major medical would be a "must."

Basic Coverage

This includes hospital, surgical, and medical expenses:

Hospital coverage—costs for a stay in the hospital, including room and board, routine laboratory expenses, general nursing services, basic supplies, and drugs. There is usually a maximum dollar amount specified per day and a maximum number of days.

Surgical coverage—costs for surgical procedures performed, including the surgeon, anesthesiologist, hospital providers, and others at the usual, customary, and reasonable charge for services in your geographical area. There will likely be requirements specified for the deductible and coinsurance.

Medical expense coverage—costs for physician and medical services other than those directly connected with surgery, including X-rays, non-surgical outpatient procedures, doctor's visits, prescription drugs, and other bills. A dollar maximum amount per year as well as coinsurance and a deductible clause are included.

The deductible clause may be written on an item basis rather than in terms of an annual dollar amount. That is, every time you are treated for whatever ailment, the deductible is in force for each ailment.

Major Medical Coverage

Major medical coverage covers a broader range of medical expenses in the hospital, surgical, and medical expense plans. Policy lifetime limits can be as high as two million dollars with deductibles as high as two thousand dollars.

Comprehensive Health Plan

A comprehensive health insurance plan provides both the coverage of the basic plan and the broad, high-limit coverage of major medical insurance. It usually includes an

annual deductible (which varies from \$500 to \$10,000 annually) and a 20:80% coinsurance requirement for all expenses (you pay 20% of the cost and the company pays 80%) up to the coinsurance cap (typically set at \$5,000 to \$10,000, above which the company pays in full). Maximum lifetime benefit is at least one million dollars (the amount set by South Dakota law). After the maximum lifetime benefit is reached, you pay in full. Ask when the deductible period begins and ends.

Health Care Management Plans

Because health costs have increased so rapidly, different health care management plans have been devised to limit health care costs.

Most insurance companies offer the same types of managed health care plans to individuals that are offered to groups. Without a management plan, the personal indemnity coverage is much more expensive. A limiting of choices is the major drawback to group health policies.

Healthcare Maintenance Organization (HMO)

If you choose an HMO, you will have to select your doctor from a list of professionals the organization has chosen. If you're looking for the least expensive coverage and don't insist on seeing a particular physician, an HMO might be your best bet. It may be too restrictive if you spend much time traveling out of your home state or HMO area.

Preferred Provider Organization (PPO)

If you select a PPO, you're free to continue using your family doctor or any other physician you choose. However, if the doctor or hospital you choose is not on the list of preferred providers, the plans generally cover only half of the total costs.

If freedom of choice is important to you, you'll probably want to choose a PPO even though premiums will be higher.

Protect Yourself

The September 2002 issue of Consumer Reports magazine outlines several "traps" you may face in maneuvering through the health insurance market.

Trap 1: No coverage for existing illness

Most individual policies are medically underwritten (meaning that insurance companies look closely at the applicants' medical records and turn down people who pose too much risk). The companies tend to exclude coverage for serious conditions, for they must be able to cover the cost of everyone's claims. Exclusions are handled through a waiver or rider. Look for surcharges for insuring a person with a potentially expensive treatment and for other ways that companies avoid expensive claims.

Trap 2: Gaps in state regulation

South Dakota offers broader health insurance rights for consumers than they can get under national laws. But you must still be on guard for fraudulent schemes. The South Dakota Division of Insurance provides the following guidelines when seeking individual insurance:

- Coverage that boasts low rates and minimal or no underwriting should be a signal for you to look deeper.
- Make sure your insurance agent is selling a state-licensed insurance product.
- Deal with reputable agents. Watch out when the person trying to sell you coverage says he or she doesn't need a license because the coverage isn't insurance or is exempt from regulation.
- Check the benefit booklet for the name of the insurer represented by the insurance agent to see whether it names a licensed insurer that is fully insuring the coverage.
- Beware if the plan being advertised is covered only by "stop-loss insurance" or if the plan is an "ERISA" or "union" plan. Contact the state insurance department. These plans are illegal in South Dakota.

Trap 3: Under-financed risk pools

South Dakota does not have a risk-pool per se to cover those who are "uninsurable." Instead, all carriers licensed in the state must offer guaranteed issue health insurance up to a designated percentage of the policies sold. Only then can they refuse to offer coverage to an applicant that they feel is beyond their ability to cover.

When all state carriers have filled their quota for guaranteed issuance, the Department of Insurance increases the percentage cap for required guaranteed issues.

Trap 4: Cracks big enough to fall through

There is little help for self-employed people seeking individual or family health insurance, especially if they are saddled with major health problems. They likely will have to pay high premiums and have to accept limited coverage to even get approved for health insurance.

There is, however, help for workers and their families when they change or lose jobs. Under Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), health insurance coverage is provided for those who meet the guidelines. HIPAA sets minimum standards for providing coverage of last resort, but coverage in South Dakota goes beyond the federal minimums.

Applicants must have left a group plan in which they had 12 months (instead of 18 months) of prior creditable health insurance. With the exception of short-term major medical health insurance as the last coverage, any (rather than just the last) creditable coverage lost involuntarily can be used as a trigger for “guaranteed issue.”

To qualify for guaranteed issue insurance in South Dakota, COBRA coverage must be exhausted first. Also, there cannot be a break in health insurance coverage in excess of 63 days.

Guaranteed issue is not applicable if the insured decides to drop coverage because it is too expensive. And change or loss of job must be legitimate to qualify for guaranteed issue coverage.

Evaluating the coverage of an individual health policy and understanding how to anticipate rate increases is a challenge to the most skilled consumer. However, in South Dakota we are fortunate because all individual market carriers doing business in this state are required to register and to provide insurance to residents leaving a group or individual coverage. All products sold in South Dakota must meet specified premium limits and minimum coverage standards to be registered with the Division of Insurance.

The sad fact is that there is no guarantee that everyone needing health insurance can get a policy regardless of health status. No federal laws are in place to regulate minimum coverage standards or set premium cost limits. The self-employed are left without an adequate safety net and have no access to guaranteed issue rights.

For this reason, a Governor’s task force has been formed to propose ways to extend reasonably affordable comprehen-

sive health insurance coverage to the self-employed.

Currently, about the only strategy left to the self-employed person who has difficulty in obtaining private insurance is to have the spouse employed where he/she may take advantage of group health insurance benefits for the family. Otherwise, they will have to pay high premiums, establish high deductibles, pay a higher percentage of the coinsurance, and be satisfied with a higher coinsurance cap and maybe a lower lifetime benefit. The only other alternative is to go without health insurance.

Trap 5: Limitations in certain types of policies

One-disease insurance. Once you have broad coverage for every major health risk, any other coverage for a specific disease is redundant and a waste of money. It would be useless to have a cancer policy if a heart problem was the reason health care was needed.

Accident insurance. Such policies pay specific medical expenses resulting from an accident but pay nothing if needed health care results from illness. Again, this is redundant coverage because a standard health policy should cover health expenses resulting from either accidents or illnesses.

Health policies pitched by celebrities on TV. The premiums appear to be unusually low, but these policies usually have extremely long waiting periods before they cover any pre-existing conditions—far longer than the waiting periods required by underwriters who don’t have to pay for expensive advertisements and celebrity endorsements.

Policies sold through unsolicited mail offering spectacularly low rates. Many of these policies also have unusually long waiting periods for pre-existing conditions.

Student health insurance. Chances are, your student is already covered under your family health policy until he or she is 18 or for as long as the student stays in school. Check your policy and call your agent.

Most indemnity policies. They pay you a flat rate, sometimes a mere \$50, for every day you spend in the hospital. That’s not very helpful, considering that the average daily rate at many hospitals now tops \$500. Use only as a supplement to help with deductibles and incidentals not covered by the primary plan.

Consumers should take care to ask the insurance agent whether the health coverage they are purchasing is fully

insured by licensed insurers. To operate in South Dakota, anyone selling health coverage must first have it approved by the state insurance department.

A “union plan,” health coverage that seems unusually “cheap,” health coverage that is issued with few questions about your health condition, or a plan that refers only to a “stop-loss” insurer should alert you to question the agent or to contact the state insurance department.

If you feel you have received poor treatment by any health insurance company, contact the South Dakota State Department of Insurance at 1-800-768-3467, by writing S.D. Division of Insurance, 118 West Capitol, Pierre, SD 57501 or file your complaint on-line at <http://www.state.sd.us/dcr/insurance/fraud/consumrefer.htm>

Lowering the Cost of Health Insurance

Do you consider cutting your insurance premiums when it gets tough to pay all the bills? During times of reduced income, it is really important to continue insurance coverage.

Check with your insurance company; there may be a grace period in making payments from 10 to 30 days. If you allow your insurance to lapse, you may not be able to renew. Contact your insurer and ask what payment options are available.

Check to see if smaller premiums are possible utilizing some or all of the following strategies:

- Raise the deductible dollar amount. Set aside savings to pay the deductible.
- Change to a monthly, quarterly, or semi-annual payment plan with the same coverage.
- Consider an 80:20 (instead of 100-0) coinsurance level.

Some companies even offer 70:30 coverage.

- Look at the possibility of lowering the coinsurance cap or maximum amount that the company will pay.
- Determine when copayments are required. What happens, for example, if you call to talk to a doctor instead of setting up an appointment? Are you charged for every prescription written?
- Check for additional discounts for which you might qualify.
- Change to a more basic coverage.

When people fail to carry insurance, they have fewer options for covering their losses. Some sell their possessions to pay the bills; others request financial assistance from their family, friends, and/or community. Health insurance is a way to protect what the family has accumulated and enable the insured to cover the charges for health care services.

Resources:

The Consumer Insurance Guide. Accessed on 8/5/02 at <http://www.insure.com/health/hipaa.html>

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