

Ohio Health Insurance

Buyer's Guide

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Shopping for health insurance can be a daunting task and the research to find the right plan can be quite tedious. This guide will help you better understand the important aspects of the **Ohio** Health Insurance market and help you feel more confident in making the best decision and avoid the various “gotchas” and outright scams for which people tend to get propositioned.

Who needs Individual & Family Health Insurance?

The simple answer is any one who can't get health insurance through their employer. However, there are some specific scenarios with corporate health plans to consider:

Your company-provided health insurance is too expensive ... For you – companies are only required to pay for 50% of an employee's coverage (some companies may pay more or even all of your cost) and depending on the average age and overall health of your fellow employees even your half can cost hundreds of dollars a month. Also, corporate health insurance plans tend to have lower deductibles and stronger coverage than you might want to pay for. If you find yourself in this scenario, it might make sense to explore individual health insurance on your own. Keep in mind that individual health insurance can exclude coverage for pre-existing health conditions and may not cover maternity in **Ohio**.

For your dependents (wife, husband, child(ren)) – While an employer will pay anywhere from half to all of the cost of the employee's corporate health insurance plan they may not cover the cost of including your spouse and/or children on the plan. Adding a member of your family on your corporate plan can be quite expensive. In this scenario it definitely makes sense to explore individual or family health insurance outside of the corporate plan for your dependent(s).

My company doesn't offer health insurance to employees ... Health insurance benefits are typically offered by larger and more established and profitable companies to ensure employees are well taken care of and to reduce employee turnover. If you're employed by a company that doesn't yet have the resources to offer group health insurance you may want to cover yourself with individual or family health insurance. You might even hit your boss up for a monthly allowance for health insurance if you consider yourself of value to the company.

You own your own business or are self-employed ... You are responsible for covering yourself first and then your employees. Obtaining a health insurance policy for you and your family is part of good financial planning and important in ensuring business continuity. In this scenario you should absolutely consider covering yourself with individual or family health insurance first and when the time is right cover your employees with group health insurance.

COBRA ... when people leave a company, in certain situations, they are often offered, by law, the ability to continue their corporate coverage but at their own expense. This means they will need to pay full price for their plan. This is usually an exorbitant amount that may not make sense to pay if you're in good health. If you are in good health and are offered COBRA you should absolutely consider obtaining individual/ family health insurance on your own.

Short-term ... Sometimes you know you're going to be covered by another plan in a few months. A common example is when you start a job and aren't allowed to join the health plan until after 90 days. This is a perfect situation for short-term health insurance.

What are My Options for Individual and Family Health Insurance?

Co-pay Plans - This is a very common type of health insurance plan for individuals and families. It has a catastrophic portion to the plan for major medical expenses but also, in many cases, offers co-pays for Dr's visits, medication coverage, and annual preventative benefits. There are usually some limitations of these plans including separate deductibles for drugs, limitations on preventative care, and some plans will limit the number of available co-pays (i.e. 2 Dr's co-pays per year) and may exclude preventative benefits all together.

Catastrophic/ Major Medical Plans - these plans are typically lower in cost than co-pay plans because they are generally more profitable for the insurance companies. These plans do not cover any medical expenses (no co-pays, preventative benefits, or medications) until you meet the selected deductible. Before you consider this type of plan you should also think about the psychological aspects of having this type of plan. You will have to pay for many of your medical expenses so could be looking at \$100 for a doctor's visit and full price for your medications. Some feel it's almost like not having health insurance unless something major happens and "knock on wood" it's relatively rare that people have large medical expenses. Some prefer this but others, especially those with children, might be better off considering a copay plan for the co-pays for Dr. visits and drugs and preventive benefits. This type of plan is ideal for someone who is generally healthy and/or doesn't mind paying out-of-pocket for medical expenses as long as they're protected from the "catastrophic" medical expenses.

HSA qualified plans – this plan works just like a catastrophic/ major medical plan but with the option of opening a specific type of financial account (Health Savings Account) in which you can put away pre-tax dollars to cover any out-of-pocket medical expenses. My experience has been that many people who take these plans either never open the financial account or do but never contribute. So, before you consider this type of plan to determine if you are OK with paying for upfront medical expenses out-of-pocket or if you feel you would take the time to open the financial account and contribute to it on a regular basis. In many cases, you'll realize that you won't and you should opt for a co-pay or traditional catastrophic plan.

SCAMS/ GOTCHAS - What plans and offers should I stay away from or be concerned about?

In any industry and with any service-offering there are always unscrupulous individuals or companies that are solely interested in the almighty dollar and think nothing of their client's financial or physical well-being. Here are some things to look out for.

High Pressure Tactics – A bit of a “no-brainer” but if someone is trying to get you to make a decision immediately without allowing you to see a proposal with details of the plan, or ask for an expensive application fee – STAY AWAY! Common tactics include telemarketers telling people that they have a group plan that the prospect can take part in but they have to order right then as there are only “x” number of spots left or that the plan has no co-pay and no deductible and allows them to go to any doctor they want. These are typically discount plans that very few medical facilities will accept and are missing the most important parts of an insurance plan (see Top 10 Things to Consider In Searching for a Plan) ... General Rule is if someone wants to charge an application fee and wants you to make a decision right then – Ask for more details and if they resist excuse yourself politely from the call and try another independent agent!

Agents Pushing for Face-to-face Appointments – I realize this might sound counter-intuitive. Why wouldn't you want to have someone come to your house to go over plans? A good agent will often be willing to sit down with you if you ask. As you might probably guess many agents feel that by meeting with you face-to-face it increases their chance of “closing” before they leave. Many shoppers prefer to gather information and digest it before making a decision.

Agents that Claim They Offer a Plan that Accepts Everyone without Underwriting – At the time of this writing (2008), there are a very limited number of situations where individuals are offered a policy without going through a medical underwriting process to determine your coverage ability. If you're being offered a health plan that an agent claims takes everyone and has no underwriting then you are likely being offered a discount plan and you should consider benefits and network carefully before making your final decision. Do not make an immediate decision – especially if they are asking you to sign up via phone and ask for payment and a pricey application fee. If you are a part of a group (i.e. corporate, association, franchise, unions) you might be offered a plan that does not exclude you due to pre-existing conditions. Even with these plans you should consider benefits and limitation carefully before you make a decision. You should be especially careful if the agent is pressuring you to make an immediate decision via phone without providing you with plan details and requiring a high “application” or “enrollment” fee. If it sounds too good to be true or you're being pressured to make an immediate decision or are asked to pay a high application fee or are told it is guaranteed issue without having to go through underwriting or are being propositioned for a face-to-face pitch – you should have your guard up and fully understand what you're getting into before making an immediate decision.

Top 10 Things to Consider in a Health Insurance Plan:

1) *Maximum Out-of-pocket (AKA Coinsurance Maximum, AKA Stop Loss)* - DO NOT BUY A PLAN WITHOUT CONSIDERING THIS FEATURE FIRST. – this is the dollar amount that indicates the most you could spend on medical expenses in-network and out-of-network within the calendar year should something catastrophic happen. Despite all of the nice bells & whistles a plan might have, this feature (maximum out-of-pocket), in our opinion, is THE most important feature. This dollar amount consists of the deductible and coinsurance limit.

2) *Lifetime Maximum (No Annual Maximums)* – Many companies have adequate lifetime maximums which is the maximum they will pay for medical expenses during your life as long as you're on the policy. Anything over \$3 million lifetime maximum is usually sufficient.

BE CAREFUL - Some plans might also have per incident or per year maximums that supersede the lifetime maximums.

3) *Price* – We all have budgets. Once you have determined what type of plan makes most sense for your situation and preferences you should comparison shop. A good independent agent can help you quickly shop apples-to-apples between the major insurance providers. You can also use online quoting and comparison systems such as those found at [Ohio Life and Health Homepage](#). You may find huge differences in pricing for comparable plans offered by different companies. No one insurance provider, at this time, is the low cost leader for every situation.

4) *Network* – The 2 main types of networks for individual and family plans in **Ohio** are HMO and PPO. HMO (Health Maintenance Organizations) - HMO's can offer better benefits for comparable pricing to a PPO. What you might give up in return is freedom to go to any doctor you would like at anytime and often have to get referred to specialists, etc. Also, if you find yourself needing non-emergency medical attention outside of your HMO area you could be responsible for paying the entire bill yourself without reimbursement from the HMO. PPO (Preferred Provider Organization) - These networks are typically much larger than the HMO networks and allow you to go to any doctor you would like but the insurance company will pay more if you go to one of the medical facilities that will take that particular insurance company.

5) *Reputation* – research the company. Check the **Ohio** Department of Insurance (TDI) website, check Google using the name of the insurance company and the word “complaint” or “scam” or “ripoff”. Every insurance company has complaints against them but you can determine the serious violators pretty easily with a little research. Part of the reason people complain about insurance (other than price and coverage) is that they do not understand how their coverage works when they first buy and think the insurance company is not paying what they should. A good independent agent will always ensure you fully understand the benefits and limitations of your chosen plan.

6) *Underwriting* – waiver, riders, exclusions, rate increases, declines – Each insurance company has different underwriting policies and this could be a top 3 most important factor in some cases. If you have a heart condition you might find one company would decline you, another might cover you but not the heart condition, yet another might just charge a little rate increase but will cover you and the condition. It would be pretty obvious which company would be the best to choose. Your independent agent should be able to determine these things before you even apply.

Being declined/ Ineligible - You might find that you are not eligible for coverage from any of the individual health insurance companies due to your pre-existing condition(s) and treatments. First off, don't think that this means the underwriters think you're on your death bed. Their decision is not based on mortality but on whether or not they have a likelihood of being profitable. If you take multiple medications or have a possibility of needing surgery or other expensive treatments you could be declined by one or all of the individual health insurance companies. Due to HIPAA regulations, the State of **Ohio** has made health insurance available to individuals who are otherwise declined by insurance companies or don't have other means for getting covered. Check with the **Ohio** Department of Insurance coverage options and associated pricing.

Waiver/Riders/Exclusions – In considering your medical history, many insurance companies consider the option of placing a waiver, rider, or exclusion on coverage of a pre-existing condition. These terms essentially mean that they will not cover medical expenses related to the waived, ridered, or excluded pre-existing condition. These exclusions of coverage can be for a certain period of time or indefinite. Also, the exclusions of coverage are often for outpatient treatment only and may cover in-patient treatment. Make sure you clarify these points if you end up with an exclusion. Also consider that each company's underwriting department has different guidelines. So a condition that may be excluded by one company might be acceptable without an exclusion to another company.

Rate Increases – Underwriting departments' responsibility is to understand an applicant's pre-existing condition(s) and determine if they can be approved with or without an exclusion. In order to increase the chances of being profitable an insurance company may increase the "preferred" rate on your policy during the initial underwriting (only) to cover likely medical expenses for any preexisting condition. Once you have been approved for coverage an insurance company can not single you out for a rate increase.

7) *Drug coverage* – many plans have a drug deductible before you can pay copays for medications. They may also have a maximum allowable – If you prefer a plan with drug co-pays there are a few important things to consider.

a. Drug Deductible – some companies' drug benefits may have some type of drug deductible. Some have an overall drug deductible for each person applying meaning you will have to spend that much on medications before you can pay co-pays for generic or name brand drugs. Others only apply the drug deductible to name brand drugs so you can pay a co-pay from the start for generic medications. This is helpful since many medications have generic alternatives.

b. Annual Maximum – Many policies are going to have a limit on the retail value of outpatient medications they will cover per year.

8) *Preventive (Wellness) Benefits* – Many co-pay plans (not all) will have some level of preventative benefits. Many times these plans have a dollar limit to be used toward preventative benefits. An important thing to understand with this benefit is that the money can only be used towards certain benefits:

a. Women – benefits can typically only be used to cover cost of pap smears and after a certain age (or younger if family history) mammography's for women. Any blood work or other routine labs or tests are typically out-of-pocket.

b. Men – the benefit is usually limited to PSA (prostate screening) tests and colorectal screenings and at older ages could help pay for such things as a colonoscopy. There are often, however, often benefit limitations. Thoroughly review your benefits to understand what is covered by the plan and what isn't.

9) *Dr's co-pays* – Many co-pays are relatively low so this feature shouldn't be a primary deciding factor in your decision. However, when considering co-pay plans understand that some may offer only a couple to a few copays per year where many other copay plans offer unlimited Dr's visits per year.

10) *Financial Rating* – ability to pay claims is very important and a company's financial rating is the primary indicator of the insurance company's ability to pay. A-rated companies or better are preferable to many.

How to Search for the Best Plan

Online Quoting Systems – Nowadays you can get pricing for various plans right online from a number of websites including [Ohio Life and Health homepage](#). Websites such as this one will show you plans and the associated preferred pricing from many of the major insurance providers. Some things to understand as you're reviewing pricing:

1. Pricing for plans are identical – Insurance plans, by law, are the same price for same plans no matter what website or independent agent you use. The pricing seen on websites will be the same from site-to-site and there is no ability to negotiate a better price or for the insurance company or independent agent to charge you more unless there are medical conditions that affect the rate in underwriting.

2. Underwriting determines final pricing – The pricing shown on the independent agent websites and the pricing on the insurance company websites show preferred pricing and may not be final pricing. Once you select the right plan you will need to complete an application and your medical history will be considered to determine final rate, whether or not there would be a waiver (not cover) of a pre-existing condition, or if you would even be approved for coverage. If there are no or just minor medical conditions you should likely get the preferred rating shown on the website.

Working with a good independent insurance agent can ensure you make the best decision – An honest and experienced independent agent can help you make a decision on the best plan or help validate your thoughts on plans. The surprising thing too many people is that, by law, there are NO FEES of any type to work with an independent agent. The independent agent only gets paid if you run the application through them. If you run the application directly through the insurance company the insurance company is just more profitable.

A good independent agent will also help with any issues, changes, re-evaluations, or other matters, through the life of the plan. As an independent agent, I tell my clients to think of me as their personal HR person for health and life insurance benefits. If you ever have any questions or want to make a change or re-evaluate your health insurance or life insurance just call or email me any time.

In conclusion I hope this guide was helpful to you in being able to make a more educated decision on which health insurance plan is going to be best for you and/or your dependents. If you would like personal, honest, and experienced assistance in finding the right health insurance plan please do not hesitate to contact **Ohio** Life and Health.

About **Ohio** Life and Health – [Ohio Life and Health homepage](#) – **Ohio** Life and Health is a full service health and term life insurance agency offering free support to individuals, families, self-employed, small business owners, and Medicare recipients, to understand options for **Ohio** Health Insurance and **Ohio** Term Life Insurance coverage.