

COMPARING HEALTH INSURANCE PLANS		Student/Class Goal How can students go about finding the best insurance plan for their family from the large number of plans available?
Outcome <i>(lesson objective)</i> Compare and contrast insurance plans and make a wise decision about choosing the best health care plan for their needs.		Time Frame 2 hours
Standard <i>Read with Understanding</i>		NRS EFL 4-6
COPS Determine the reading purpose.	Activity Addresses Components of Performance When confronted with reading various types of text; such as websites or brochures with insurance language, students will determine which medical plan is best for them.	
Select reading strategies appropriate to the purpose.	Similarities and difference strategies will be honed when students use the compare and contrast diagram.	
Monitor comprehension and adjust reading strategies.	Using a graphic organizer will keep the questions that they are trying to answer in front of students.	
Analyze information and reflect on its underlying meaning.	Students will be evaluating which insurance services are most important to them and selecting plans based on personal need.	
Integrate it with prior knowledge to address reading purpose.	As students consider the affordability, accessibility, availability, choice, coverage, and flexibility of each plan, they will place a value on whether or not it should be considered the best plan for their needs.	
Materials Health Insurance Company flyers/brochures/packets <i>Health Insurance Compare-Contrast Diagram</i> <i>Which Type is Right for You?</i> Survey <i>Which Health Insurance Plan Is Best for You?</i> Chart		
Learner Prior Knowledge Ask students about having health insurance. Let them explain their experiences in the health care system. What happens when people need medical assistance and do not have insurance? Brainstorm the importance of health insurance. TEACHER NOTE although this lesson covers health insurance, the same lesson strategies could be used with auto, life, homeowners, etc. and might want to be pursued by students.		
Instructional Activities Step 1 - Students will research different types of health insurance and discuss the terminology. Everyone can identify unfamiliar words from the text or the teacher can choose words prior to reading. Working in pairs, they can choose two – four words from the list on the board. Words can be written on note cards and students can predict possible meanings by using context clues or they can look-up words in the dictionary. Write these definitions on another note card. Trade cards with other students and match definitions to words. Practice using these new words in sentences. TEACHER NOTE Teacher and students can make inquiries online or at insurance agencies to find various health insurance resources. One resource, Types of Health Insurance , contains information about Indemnity, Managed Care, HMO, PPO, POS. Step 2 - Working in pairs or as a large group, students can first consider similarities and then draw out the differences for Indemnity and Managed Care plans. Complete the <i>Health Insurance Compare-Contrast Diagram</i> for these two types of plans. Step 3- Take the <i>Which Type is Right for You?</i> survey. Choose the statement that best describes how you feel from each group of two. If your answers are mostly 1s - You want to make your own health care choices, even if it costs you more and takes more paperwork. Fee-for-service may be the best plan for you. If your answers are mostly 2s - 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. If your answers are some 1s and some 2s - You might want to look for a plan such as a preferred provider organization that combines some of the features of fee-for-service and a health maintenance organization.		

Step 4 - Before choosing a plan, decide which services are most important to you. This checklist is a start; add any additional services students suggest.

- Hospital Care
- Surgery (inpatient and outpatient)
- Office Visits
- Maternity Care
- Well-baby Care
- Immunizations
- Mammograms
- Other Services
- Medical Tests & X-rays
- Mental Health Care
- Dental Care
- Vision Care
- Prescription Drugs
- Home Health Care
- Nursing Home Care

Step 5 - Use three Ohio insurance companies to compare. These might be the choices or additional information might have been collected on other companies.

[Medical Mutual](#)

[Anthem Blue Cross Blue Shield](#)

[Kaiser Permanente](#)

[United Health Care](#)

TEACHER NOTE Many quotes can be given and are available online, such as: [Ohio Individual and Family Health Insurance](#), [Individual Health Insurance](#), or [Individual Health Quotes](#). Become very aware of how these sites are structured before sending your students to them. Students may not want to give their personal information.

Complete the *Which Health Insurance Plan Is Best for You?* chart. This activity could be done individually with higher level students while lower level students could be paired together. Based on the information gathered, students will then choose a High, Medium, or Low value for each criteria. Finally, have students rank the three companies as to their first, second, and third choice. Students can then write a couple paragraphs in their journal describing why they chose this company to best satisfy their needs.

Assessment/Evidence *(based on outcome)* Teacher observation
Health Insurance Compare-Contrast Diagram
Which Health Insurance Plan Is Best for You? Chart
Journal entry

Teacher Reflection/Lesson Evaluation
Not yet completed.

Next Steps

Technology Integration

Health Insurance Guide-Types of Health Insurance <http://www.healthinsuranceadvice.org/index.html>

Medical Mutual <http://www.medmutual.com/>

Anthem Blue Cross Blue Shield <http://www.anthem.com/health-insurance/home/overview>

Kaiser Permanente <http://www.kaiserpermanente.org>

United Health Care <http://www.uhc.com>

Ohio Individual Family Health Insurance <http://www.ehealthinsurance.com>

Individual Health Insurance <http://www.anthem.com/individual>

Individual Health Quotes http://www.individualhealthquotes.com/quote.jsp?lst=bw&link_id=1000&state=OH

Check-up on Health Insurance Choices <http://www.ahrq.gov/consumer/insuranc.htm#head27>

Income, Poverty, and Health Insurance Coverage in the United States: 2004 <http://www.census.gov/prod/2005pubs/p60-229.pdf>

Agency for Healthcare Research and Quality <http://www.ahrq.gov/>

Purposeful/Transparent

Insurance and medical terminology can be daunting for students. Activities are structured so that information processing, vocabulary development and discussion are a natural part of the learning.

Contextual

Students often have many questions about health insurance and which plan is actually the best choice for them. By doing these

activities, they will be able to compare several plans and state their reasoning for choosing the appropriate plan for their family.

Building Expertise

Charts are used as graphic tools to scaffold learning and build understanding of comparison and difference.

Which Type is Right for You? Survey

Choose the statement that best describes how you feel from each group:

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 country.
2. I do not 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 preventive 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 preventive care. I don't mind if I have to wait for these services to be scheduled for an available appointment with my doctor.

1. If I need to see a specialist, I probably will ask my doctor for a recommendation, but I want to decide when 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.

Checklist of Services

Put a check in front of those services that are important to you.

- Hospital Care
- Surgery (inpatient and outpatient)
- Office Visits
- Maternity Care
- Well-baby Care
- Immunizations
- Mammograms
- Medical Tests & X-rays
- Mental Health Care
- Dental Care
- Vision Care
- Prescription Drugs
- Home Health Care
- Nursing Home Care
- Other Services _____
- Other Services _____
- Other Services _____

Health Insurance Compare & Contrast Diagram



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	providers/accessibility	
	cost/affordability	
	freedom of choice	
	coverage/available options	
	benefit limitations	

Which Health Insurance Plan Is Best for You?

Compare current health insurance plans from three companies of your choice. Explain your reasons in each box.

Criteria	Company A	Company B	Company C	Rank Criteria
Accessibility to providers				High Medium Low
Affordability or cost				High Medium Low
Flexibility or choice				High Medium Low
Coverage & available options				High Medium Low
Availability of benefits				High Medium Low
Rank Company	1 2 3	1 2 3	1 2 3	

Determine which company has the best options for you and your family. Evaluate the criteria by circling either a High, Medium or Low value. Based on overall value, rank each company with 1 being your first choice.

HEALTH INSURANCE GUIDE

<http://www.healthinsuranceadvice.org/index.html>

The Types of Health Insurance <http://www.healthinsuranceadvice.org/types.html>

Health insurance plans are usually described as either indemnity (fee-for-service) or managed care. These types of plans differ in important ways that are described below. With any health plan, however, there is a basic premium, which is how much you or your employer pay, usually monthly, to buy health insurance coverage. In addition, there are often other payments you must make, which will vary by plan. In considering any plan, you should try to figure out its total cost to you and your family, especially if someone in the family has a chronic or serious health condition.

Indemnity and managed care plans differ in their basic approach. Put broadly, the major differences concern choice of providers, out-of-pocket costs for covered services, and how bills are paid. Usually, indemnity plans offer more choice of doctors (including specialists, such as cardiologists and surgeons), hospitals, and other health care providers than managed care plans. Indemnity plans pay their share of the costs of a service only after they receive a bill.

Managed care plans have agreements with certain doctors, hospitals, and health care providers to give a range of services to plan members at reduced cost. In general, you will have less paperwork and lower out-of-pocket costs if you select a managed care type plan and a broader choice of health care providers if you select an indemnity-type plan.

Over time, the distinctions between these kinds of plans have begun to blur as health plans compete for your business. Some indemnity plans offer managed care-type options, and some managed care plans offer members the opportunity to use providers who are "outside" the plan. This makes it even more important for you to understand how your health plan works.

Besides indemnity plans, there are basically three types of managed care plans: PPOs, HMOs, and POS plans.

Indemnity Plan

Also known as traditional or fee-for-service, allow you to choose any doctor or hospital you want. In return, you pay an annual deductible, then a percentage of your medical bill. Although these plans offer the greatest freedom to select any doctor, they are usually the most expensive option available. You or they send the bill to the insurance company, which pays part of it. Usually, you have a deductible. such as \$200. to pay each year before the insurer starts paying.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the "Usual and Customary" charge for covered services. The insurer generally pays 80 percent of the Usual and Customary costs and you pay the other 20 percent, which is known as coinsurance. If the provider charges more than the Usual and Customary rates, you will have to pay both the coinsurance and the difference.

The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals. It may not pay for some preventive care, like checkups.

Managed Care

Preferred Provider Organization (PPO). A PPO combine elements of indemnity and managed care plans. Each time you need care, you choose among doctors who belong to the PPO network or any non-network doctor. You pay less when you use the network's "preferred providers." However, you can see any doctor any time you wish, usually without getting an okay from the plan first. If you choose not to use the plan's preferred providers, you will probably have to pay more for care.

If you go to a doctor within the PPO network, you will pay a co-payment (a set amount you pay for certain services. say \$10 for a doctor or \$5 for a prescription). Your coinsurance will be based on lower charges for PPO members.

If you choose to go outside the network, you will have to meet the deductible and pay coinsurance based on higher charges. In addition, you may have to pay the difference between what the provider charges and what the plan will pay.

Health Maintenance Organization (HMO). HMOs require that you pay a small, set co-payment when you use the plan's HMO doctors. You generally don't have to pay a deductible in an HMO. You usually select a primary care physician who manages all of your health care and serves as a gatekeeper for specialty care. If you go to doctors who are not in the HMO, you pay the full cost of the care (unless it's an emergency situation). Most HMOs are relatively inexpensive, offer preventive care services, and have special programs for disease management

There are many kinds of HMOs. If doctors are employees of the health plan and you visit them at central medical offices or clinics, it is a staff or group model HMO. Other HMOs contract with physician groups or individual doctors who have private offices. These are called individual practice associations (IPAs) or networks.

HMOs will give you a list of doctors from which to choose a primary care doctor. This doctor coordinates your care, which means that generally you must contact him or her to be referred to a specialist.

With some HMOs, you will pay nothing when you visit doctors. With other HMOs there may be a co-payment, like \$5 or \$10, for various services.

Point-of-Service (POS) Plan. Many HMOs offer an indemnity-type option known as a POS plan. POS plans or Open Access HMOs add an out-of-network benefit to HMOs. Like HMOs, you select a primary care physician who manages all of your care and is responsible for referring you to plan specialists.

In a POS plan however, you have the option of going outside the HMO network (although you'll pay more for care received outside of the network).

The Sources of Health Insurance <http://www.healthinsuranceadvice.org/sources.html>

Health insurance is generally available through groups and to individuals. When you receive group insurance at work, the premium usually is paid through your employer. For individual insurance, it is best to contact a professional health insurance agent to review your options.

Group Policies

You may be able to get group health coverage, either indemnity or managed care, through your job or the job of a family member.

Group health insurance coverage through an employer or other group also has both advantages and disadvantages. Advantages include part or all of the premium being paid by the employer or other policy holder. Group policies are usually less expensive than individual policies. Usually everyone is eligible for coverage regardless of health. Group health insurance coverage is typically comprehensive, and premiums can be deducted from paychecks if the policy holder is the employer. Coverage generally cannot be cut off because of the number of claims someone has. With most group health insurance policies, you can select your own health care providers.

Disadvantages of group health insurance policies include losing coverage when you no longer belong to the group. However, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires a continuation privilege meaning that you can keep group insurance coverage by paying the premium yourself if you leave the group for a specified time period. Widows with dependent children, and divorced or separated spouses and dependent children, and divorced or separated spouses and dependent children may do so for three years. Retired people, their spouses and dependent children may do so for 18 months as can unemployed and reduced-hour employees and their dependent children.

Many employers allow you to join or change health plans once a year during open enrollment. But once you choose a plan, you must keep it for a year. Discuss choices and limits with your employee benefits office.

Individual Policies

If you are self-employed or if your company does not offer group policies, you may need to buy individual health insurance. Individual policies cost more than group policies.

The advantages of having an individual health insurance policy include being able to tailor the policy to one's particular situation. For example, added protection not available under a group plan may be included in an individual plan or additional protection over and above that available plan or additional protection over and above that available through group plan may be part of one's individual health policy.

Selecting one's health care provider including doctors is another advantage individual health care policies have over some group policies.

But individual health policies do have disadvantages. Requirements to be met before being fully covered may be more restrictive. Individual policies are usually more expensive than group policies. Claims must be filed which is not the case with all group policies. Preventive health

care may not be covered. A higher deductible may be part of the individual health care policy, and lower limits for some coverage including major medical, mental health, and chemical dependency treatment may be part of the individual health policy.

Some organizations, such as unions, professional associations, or social or civic groups, offer health plans for members. You may want to talk to an insurance broker, who can tell you more about the indemnity and managed care plans that are available for individuals. Some States also provide insurance for very small groups or the self-employed.

Medicare

Americans age 65 or older and people with certain disabilities can be covered under Medicare, a Federal health insurance program.

In many parts of the country, people covered under Medicare now have a choice between managed care and indemnity plans. They also can switch their plans for any reason. However, they must officially tell the plan or the local Social Security Office, and the change may not take effect for up to 30 days.

For those people enrolled in the traditional Medicare plan, there are private insurance options that help cover some of the gaps in Medicare coverage. These supplemental policies are sometimes called Medigap or Medicare Supplements (MedSupp). These policies must cover certain expenses, such as the daily coinsurance amount for hospitalization. Some policies may offer additional benefits, such as coverage for preventive medical care, prescription drugs, or at-home recovery.

Call your local Social Security office or the State office on aging to find out what is available in your area.

Medicaid

Medicaid covers some low-income people (especially children and pregnant women), and disabled people. Medicaid is a joint Federal-State health insurance program that is run by the States.

In some cases, States require people covered under Medicaid to join managed care plans. Insurance plans and State regulations differ, so check with your State Medicaid office to learn more.

The Types of Insurance Benefits <http://www.healthinsuranceadvice.org/benefits.html>

Most plans provide basic medical coverage, but the details are what counts. The best plan for someone else may not be the best plan for you. For each plan you are considering, find out how it handles these benefits.

In general, seven different types of health insurance benefits may be offered on separate contracts or in different combinations on a single contract.

1. **Hospitalization** provides for daily room and board charges; routine nursing care; hospital expenses, such as x-rays, anesthesia, medicine, and operating room; and other services relating to medical care and treatment of patient while in the hospital. The agreement may set dollar allowances for the different items or provide full service. Hospital expense insurance is the most widely used type of health insurance.
2. **Surgical** provides payment in accordance with a schedule of fees, fixing maximum reimbursement for each type of operation. Fees for office calls made before and after the operation may be included. The cost of the policy bears a direct relationship to the maximum the company contracts to pay.
3. **General medical** covers medical expenses other than surgery. It pays for doctor visits at the hospital, office, or home with certain limitations on the number of calls and the fee per call. The benefits and coverage vary with the policy. This is normally written with other types of health insurance, not as a separate contract.
4. **Major medical** helps meet the large costs of serious (catastrophic) accidents or prolonged illness. It is a form of protection against large medical bills not covered by hospital- surgical plans. It does not specify the exact amount for various services, but shares with you the expense of major medical insurance. There are 1) high maximum limits; 2) a deductible provision, similar to that found in most automobile collision insurance; and 3) a co-insurance clause. This requires the insured person to pay part of the total bill, over and above the deductible.
5. **Comprehensive expense insurance** is a health plan that combines features of the four insurances listed above (hospitalization, surgical, general medical, and major medical). It generally has a co-insurance provision and a deductible clause. Maximum benefits on these plans are generally high.
6. **Dental expense insurance** is coverage that helps pay for normal dental care as well as damage caused by accidents. This type of insurance is generally available through group insurance plans and sometimes offered by employers as a fringe benefit. Almost all policies cover oral exams, x-rays, fillings, cleaning, extraction, bridge work, dentures, oral surgery, root canal, etc. There is usually a deductible, and usually a co-insurance feature requiring the insured to pay from 20 to 50 percent of the cost above the deductible.
7. **Loss of income or disability** provides benefits when you cannot work because of sickness or accident. The terms of the policy determine: 1) the length of the waiting period before payment is made, 2) the amount of regular cash benefits, and 3) the number of payments to be made. An individual policy insures up to a certain percentage of a person's gross earnings and provides benefits, often for a lifetime. Loss of income is the oldest kind of health insurance.

Also ask about:

- Care and counseling for mental health.
- Services for drug and alcohol abuse.
- Obstetrical-gynecological care and family planning services.
- Ongoing care for chronic (long-term) diseases, conditions, or disabilities.
- Physical therapy and other rehabilitative care.
- Home health, nursing home, and hospice care.
- Chiropractic or alternative health care, such as acupuncture.
- Experimental treatments.

Choosing a Good Health Plan <http://www.healthinsuranceadvice.org/choosing.html>

Whether you end up choosing an indemnity plan, PPO, POS, or HMO plan, there are a number of important things to consider in choosing the right one. These include: services offered, choice of providers, location, costs, and quality of care.

Services Offered

Look at the services offered by each plan. What services are limited or not covered? Is there a good match between what is provided and what you think you will need? For example, if you have a chronic disease, is there a special program for that illness? Will the plan provide the medicines and equipment you may need?

Find out what types of care or services the plan won't pay for. These usually are called exclusions.

Few indemnity and managed care plans cover treatments that are experimental. Ask how the plan decides what is or is not experimental. Find out what you can do if you disagree with a plan's decision on medical care or coverage.

Cost

The following plan features affect how much you pay for your health care:

- **Premiums.**
The overall cost of providing the plan is called the premium. In most cases, you pay a portion of the premium through payroll deductions, while your employer contributes a portion on your behalf.
- **Deductibles.**
In some plans, you have to meet a deductible. This means that you pay a certain amount of health care expenses each year before the plan begins to pay for your care. Some plans, such as HMOs or POS plans, may not require that you meet a deductible if you use in-network services.
- **Co-payment/coinsurance.**
You'll usually pay something out-of-pocket each time you see a doctor. In an HMO or POS network, it is probably a set dollar amount (around \$10) called a co-payment. In an indemnity plan, PPO or non-network POS plan, you typically pay coinsurance . a fixed percentage of the covered charges . and any charges not covered by the plan.
- **Out-of-pocket maximum and lifetime maximum.**
Many plans have an out-of-pocket maximum. If you pay enough in medical costs to meet this maximum, the plan will pay 100% of your medical costs for the rest of the year. If you expect high medical expenses, you may want to find a plan with a low out-of-pocket maximum. Some plans also have lifetime maximums which cap how much a plan will pay in your lifetime. Once you reach your lifetime maximum, your plan will no longer pay for your care. Most HMOs do not have lifetime maximums. If you expect to have significant medical expenses, make sure to check the plan's lifetime maximum.
- **Exclusions and limitations.**
There are some services that plans won't cover. usually because they are not considered medically necessary. In addition, some

services, such as mental health and substance abuse treatment, may be limited. Review each plan's exclusions and limitations. Keep in mind that you have to pay the full cost of care that isn't covered.

Choice

What doctors, hospitals, and other medical providers are part of the plan? Are there enough of the kinds of doctors you want to see? Do you need to choose a primary care doctor? If you want to see a specialist, can you refer yourself, or must your primary care doctor refer you? Do you need approval from the plan before going into the hospital or getting specialty care?

Quality of Care

Quality is hard to measure, but more and more information is becoming available which will enable consumers to quantify quality in a health plan. There are certain things you can look for and questions you can ask. Whatever kind of plan you are considering, you can look into the quality of individual doctors and hospitals.

There are a number of sources of information available that can be used to determine which plan offers the best quality of care. Although relying on any one of the following indicators alone is not enough to determine a plan's overall quality, taking all of these pieces of information into account when selecting a health plan provides a more accurate picture of the plan's ability to provide quality care.

- ***Check whether the plan is accredited.***
This means that the plan has passed certain quality tests. Look for accreditation by National Committee for Quality Assurance (NCQA) for HMOs and POS plans (www.ncqa.org); American Accreditation HealthCare Commission/URAC for PPOs (www.urac.org); and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for hospitals (www.jcaho.org).
- ***Ask your employer for a "report card" that grades the plans.***
If one is not available, you can look for report cards on the NCQA web site or through certain publications, like U.S. News and World Report.
- ***Ask for your doctor's opinion of the plan.***

To research the quality of an HMO or POS plan:

- Ask your employer or health plan for a HEDIS (Health Plan Employer Data and Information Set) report. It can tell you:
 - how satisfied current members are
 - the percentage of members and doctors who have recently left the plan
 - the plan's record on preventive care. for example, in the past year, how many eligible members were immunized, received prenatal care and were screened for cancer
 - the plan's ability to treat chronic conditions (e.g., does the plan have special disease programs for ailments like heart conditions, diabetes and arthritis)

Location

Where will you go for care? Are these places near where you work or live? How does the plan handle care when you are away from home? What if a family member, like a son or daughter in college, lives in a different part of the country?

Ask Yourself:

- ***Do you have a favorite doctor whom you wish to continue seeing?***
 - If so, find out if your doctor belongs to, or is interested in joining, any network plans available to you. The same doctor will cost less when seen through a PPO, HMO or POS network. If your doctor is not in a network plan, you could use both your doctor (at a higher cost) and network doctors (at a lower cost) through a PPO or POS plan. If you don't wish to use network providers at all, an indemnity plan or a managed care plan with good out-of-network coverage may be best for you.
 - If not, a managed care plan, such as an HMO, PPO or POS plan, can provide quality doctors at a lower cost than an indemnity plan.
- ***Is it important for you to see your own specialists?***

In HMOs and POS networks, your primary care physician has to approve specialty care in advance. More often than not, this approval is easy to get and you'll usually have some choice among network specialists. Note: some primary care doctors only refer patients to specialists in their own practice, and some doctors may not be accepting new patients. This can be misleading if you think you have access to everyone in the plan directory. You may want to call the plans you're considering and ask about their access to specialty care.

- ***Are certain medical issues important to you?***

Different plans cover different services. Some plans place limits on the amount they will pay for certain services. It's important to find out whether and how the medical conditions important to you are covered. To do so, look at each plan's benefit description material or call the health plan. You can also ask your employer for a HEDIS (Health Plan Employer Data and Information Set) report on the plan, which can tell you whether the plan has special disease programs. for example, for arthritis, mental health, HIV-AIDS, or diabetes treatment.