Choosing the Right Health Insurance Plan - What is the different between PPO, HMO, POS and HSA plans?

Choosing the right health insurance plan can be confusing. When open enrollment rolls around at your office, you can easily get lost in alphabet soup of acronyms and a dizzying array of coverage options.

Fortunately, most options can be boiled down to two basic types of managed health care plans – health maintenance organizations (HMOs), and preferred provider organizations (PPOs).

PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

A preferred provider organization (PPO) also enters into contractual agreements with health care providers and creates a "provider network" But unlike HMOs, PPO health insurance will cover some – but not all- of the cost of care administered by out-of-network providers.

If you select a PPO, you will have low co-payments as long as you see in-network physicians. Another advantage of PPO insurance is that unlike an HMO, you do not need a primary care physician's permission to see a specialist (as long as the specialist is in network).

However, PPOs also have a few disadvantages. Going out-of-network for your medical care is likely to cost you – either you'll have to pay a deductible for the difference between what the out-of-network physician and an in-network physician charges. However, unlike many HMO plans, a PPO health insurance plan generally will pick up at least some of the cost of out-of-network care.

In addition, you may have to pay higher co-payments if your doctor charges more than is "reasonable and customary" (according to the insurer) for a service.

In summary, PPO health insurance offers a wider range of access than HMO insurance, but your out-of-pockets costs tend to be higher.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

A health maintenance organization (HMO) contracts with health care professionals and facilities to create a "provider network". If you choose HMO insurance, you'll typically pay just a small co-payment if you visit a physician or hospital within the plan network. HMO insurance often features lower premiums and co-pays than other plans.

However, HMO insurance is also among the least flexible types of health insurance plans. When you sign up for one of these plans, you must choose a primary care provider (PCP). If your current physician is not in the plan, you will have to find another doctor, or pay to see your current physician.

Typically, HMOs will not pay for non-emergency care if it's performed by an out-of-network physician or facility. You'll also need a referral from your PCP to see a specialist.

In general, HMOs offer you the lowest out-of-pockets costs for your care. The tradeoff is that your access to care outside the network is extremely limited.

HOW HMOs AND PPOs DIFFER

The following outline compares some of the features of HMOs and PPOs. These are general rules and you should speak with your human-resources office at work or directly with your plan. If you are in the process of deciding between enrolling in a HMO or PPO, you often can compare the plans by going on-line to the plans' websites to learn about the available benefits and costs.

Which health care providers must I choose?

- HMO: You must choose doctors hospitals, and other providers in the HMO network.
- PPO: You can choose doctors, hospitals, and other providers from the PPO network or from out-of-network. If you choose an out-of-network providers, you most likely will pay more.

Do I need to have a primary care physician (PCP)?

- HMO: Yes, your HMO will not provide coverage if you do not have a PCP.
- PPO: No, you can receive care from any doctor you choose. But remember, you will pay more if the doctors you choose are not "preferred"providers.

How do I see a specialist?

- HMO: You will need a referral from your PCP to see a specialist (such as a cardiologist or surgeon) except in emergency situations. Your PCP also must refer you to a specialist who is in the HMO network.
- PPO: You do not need a referral to see a specialist. However, some specialists will only see patients who are referred to them by a primary care doctor. And, some PPOs require that you get a prior approval for certain expensive services, such as MRIs.

Do I have to file any insurance claims?

- HMO: All of the providers in the HMO network are required to file a claim to get paid. You do not have to file a claim, and your provider may not charge you directly or send you a bill.

- PPO: If you get your healthcare from a network provider, you usually do not need to file a claim. However, if you go out-of-network for services, you may have to pay the provider in full and then file a claim with the PPO to get reimbursed. The money you receive from the PPO will most likely be only part of the bill. You are responsible for any part of the doctor's fee that the PPO does not pay.

How do I pay for services in the network?

- HMO: The only charges you should incur for in-network services are copayments for doctor's visits and other services such as procedures and prescriptions.
- PPO: In most PPO networks, you will only be responsible for the copayment. Some PPOs do not have annual deductible for any services, in-network or out-of-network.

How do I pay for services out of the network?

- HMO: Except for certain types of care that may not be available from a network provider, you are not covered for any out-of-network services.
- PPO: If you choose to go outside the PPO network for your care, you will need To pay the provider and then get reimbursed by the PPO. Most likely, you will have to pay an annual deductible and coinsurance. For example , if the out-of-network doctor charged you $200 for a visit you are responsible for the full amount if you have not met your deductible. If you have met the deductible, the PPO may pay 60% or $20 and you will pay 40% or $80.

POINT OF SERVICE (POS) PLANS

This is a type of managed care health insurance system. It combines characteristics of both the HMO and the PPO. Members of a POS plan do not make a choice about which system to use until the point at which the service is being used.

Point of services Plans (POS) are sometimes called an "open ended PPO". This is because a point of service plan offers an approved network of medical care facilities and physicians for their policy holders to choose from just like HMOs and PPOs.

A major difference is that point of service plans allow for their policy holders to receive their medical care outside of the network, though use of facilities and physicians within the network is encouraged.

Based upon the idea that medical costs may be offered at a lower cost in exchange for limited choices in medical care facilities and physicians, point of service plans have several variances from similar plan types. For example, newly enrolled policy holders of a point of service plan

are required to choose a primary care doctor to keep tabs on their health. This doctor becomes the new policy holder's point of service and is chosen from the list of pre-approved doctors in the provider's approved medical care network.

Advantages of POS plans

- POS coverage allows you to maximize your freedom of choice. Like a PPO, you can mix the types of care you receive. This freedom of choice encourages you to use network providers but does not require it as with HMO coverage.

- As with HMO coverage, you pay only a nominal amount for network care. Usually, your co-payment is around $10 per treatment or office visit.

Disadvantages of POS plans

- As in a PPO, there is generally strong financial incentive to use POS network physicians. Thus, if your doctor is outside of the POS network, it will cost you more.

- In most cases you must reach a specified deductible before coverage begins on an out-of-network care. On average, individual deductibles are around $300 per year, and the average annual family deductible is about $600. This deductible amount is in addition to the co-payment for out-of-network care.

- As an HMO, you must choose a primary care physician (PCP). Your PCP provides your general medical care and must be consulted before you seek care from another doctor or specialist within the network. This screening process helps to reduce costs both for the POS and for POS members, but it can also lead to complications if your PCP doesn't provide the referral you need.

HEALTH SAVINGS ACCOUNT (HSA) PLANS

A Health Savings Account (HSA) helps you save money on health care. By making you a part of the medical services decision process, HSAs are designed to help you manage medical expenses and reduce the continuing raising of health care expenses. Equally as important, the money you save remains part of your retirement account, even if you leave your present employer. In short, if you don't use all the money in your HSA for expenses, it can accumulate as tax-free savings for your retirement. One final benefit, HSAs can pay for many more procedures than were ever allowed before by other insurance types of programs.

The HSA program has two parts: A high-deductible health plan (which usually costs less than other health plans) and a tax advantaged, portable savings account for payment of current medical bills which bills like a medical IRA.

How does the HSA work?

- Dollars put into a Health Savings Account can be withdrawn instantly for qualified medical expenses as needed; any dollars remaining can be saved for spending in future years, or invested to accumulate savings for health needs after retirement.

How does a HSA coordinate with your health insurance?

- HSAs don't replace a normal or typical health insurance policy. They are designed as a supplement to a high deductible health insurance policy.

- Because the HSA is tied to a high-deductible health insurance policy, you will "pay as you go" for medical care using your tax-free HSA dollars until you spend up to the deductible. Once you meet the deductible, the health insurance pays for most of your medical expenses for the rest of the year. You may choose your own doctor or level of care. By themselves, HSAs are savings vehicles – not insurance policies – so they don't restrict your access to coverage or your choice of providers.

It is important to note that while the HSA health insurance plans do not provide first dollar coverage for benefits like office visits and prescription drugs. However, this does not mean that you will have to pay the "off the street" rate for these services. Once you are a member of a carrier's insurance plan, the most you will have to pay for an in-network service is the contracted rate the insurance company has with that provider. Typically, the contracted rate is significantly less expensive than the cost of those services without health insurance.

One advantage of the HSA insurance plan is the cost. Since these plans are high deductible health plans with limited coverage prior to reaching the deductible, they tend to be considerably less expensive than a traditional health insurance plan. In some instances, the savings can be enough to fund your health savings accounts.

Although HSA health insurance plans are a great option for employer groups, they are particularly well suited for individuals who pay for their own health insurance, such as the self-employed, employees of companies that do not offer health insurance benefits, and graduate students.

When viewing HSA insurance plans, you will want to pay particular attention to how comprehensive each plan's benefits are after the deductible has been reached. Be certain to choose a health savings account insurance plan that provides the same level of coverage as a traditional health insurance plan once the deductible has been reached.