

EDUCATING YOUR CLIENTS ABOUT INDIVIDUAL HEALTH INSURANCE



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Education: A Valuable Part of the Agent–Client Relationship

Consumers today are eager for trustworthy information about meeting their health care needs. Who better to provide it than *you*, their professional insurance advisor? Instead of simply being a solution-seeker, you have the opportunity to step into the important role of educating your clients. Help them...

Understand the changing marketplace. Individual health plans are now widely marketed and health care issues are receiving increased attention in the media.

Educate! Introduce them to individual health insurance, how it works, and what types of plans are available to them

Identify their needs. Every client is different, and their coverage alternatives range from comprehensive plans to HSA programs. They might need help determining which plan is right for them.

Educate! Engage them in a discussion about what benefits they need and how much they can afford in a health plan

Make informed decisions. “Consumer-driven health care” is catching on, with more people looking for new ways to manage their health expenditures. Plus, selling consumer-driven plans requires greater client education than traditional plans because they may involve more basic benefit structures, including health savings accounts, higher deductibles and other cost-sharing features.

Educate! Recommend ways to save on health expenses and ensure they understand their policy’s benefit and cost structure

“Your professional guidance makes a difference in the quality and appropriateness of your clients’ individual health insurance choices.”

While considering their health insurance options, your clients have more information to process than ever before. Through client education, you can help them learn the facts and make well-informed choices. And chances are they’ll keep coming back to you for more expert advice as other insurance needs arise!

The Agent’s Role in Promoting Health Literacy

As an insurance agent, you play a critical role in helping your clients understand their health plans and how to use them. Some ideas:

- Help facilitate the application process by explaining what benefits they’re applying for and how individual health underwriting works.
- Make sure your clients are comfortable with the basic terminology of their policies - words like copay, coinsurance, and deductible are often misunderstood or confused with one another.
- Encourage your clients to get the information they need from their health care providers. Not only will this help them better understand their treatment options, but it will also help ensure they maximize their insurance benefits.

Health Literacy is the ability to read, understand, and effectively use basic medical instructions and information.

- ✓ According to the Institute of Medicine, nearly half of all American adults have difficulty understanding and using health information.
- ✓ Everyone in the United States is susceptible regardless of age, race, education or income.
- ✓ Low health literacy costs the health system as much as \$58 billion a year.
- ✓ Annual health care costs for those with low literacy skills are four times higher than for those with higher literacy skills.

Source: www.askme3.org

Helpful Resources

- **National Association of Health Underwriters**
www.nahu.org/consumer/index.cfm
- **www.ehealthinsurance.com**
- **America’s Health Insurance Plans**
www.ahip.org
- **Partnership for Clear Health Communication**
www.askme3.org

Individual Health Insurance: The Basics

When an individual or family does not have access to major medical insurance through their employer or government program, they may choose to purchase an individual health insurance policy.

How it works...

Health insurance is important to have because it ensures access to health care and minimizes the financial loss that can result from treating a serious illness or accident.

Insurance companies enable policyholders to share the costs of possible economic loss by pooling the risk of health care costs across a large number of people. Insureds pay premiums based on the average cost of medical care for a group of people and receive medical benefits—and financial protection—when health care costs arise.

Each state sets its own requirements for individual health policies and regulates how they can be marketed and sold.

Types of Individual Major Medical Health Plans...

Basic Benefit plans provide essential benefits (i.e., inpatient hospitalization and outpatient surgery coverage) at an economical price. These plans may be appropriate for people who primarily want protection against the event of a serious accident or illness.

Comprehensive plans provide the widest array of benefits and flexible plan options. They typically cover a variety of medical services, so they tend to have the highest prices. These plans are appropriate for people who want a more extensive range of benefits.

HSA-qualified high deductible health plans offer coverage coupled with the option to open a Health Savings Account (HSA). These plans are a good option for people looking for more control over how their health care dollars are spent.

Short-term plans provide temporary coverage for those in-between jobs or waiting for group coverage to begin. They are best for those who need coverage for a definite period of time (i.e. 3 months) before beginning coverage under a permanent policy.

Choosing the right plan...

You have several factors to consider while selecting the right health plan for you and your family. Here are some practical questions you might want to answer with help from your agent:

- ✓ What insurance benefits do you anticipate using?
- ✓ How much do you want (or can you afford) to spend on health insurance premiums each month?
- ✓ How many times a year do you visit a family physician or specialist?
- ✓ Do you want to utilize options such as preventive care and supplemental accident?
- ✓ What is the most you can afford to pay out-of-pocket in the case of a serious accident or injury?
- ✓ Do you need coverage for the long-term or short-term?

Applying for Coverage...

Insurance agents help their clients determine their coverage needs, match them with the appropriate health plan, and guide them through the application process.

Eligibility. Applicants must meet age, health, residency, and occupation/avocation requirements to be eligible for coverage.

Underwriting. This is the insurance company's process of determining whether or not they will accept an insurance application for coverage.

Individual health applications are underwritten based upon various criteria applicable to all individuals applying for coverage. All decisions are made on an individual basis and take into account the applicant's entire medical profile.

To effectively underwrite each application, an insurance company must obtain complete medical information on the applicant(s) through the use of health questions on the application, and, as necessary, a combination of telephone verification and/or medical records.

Individual Health Insurance: Definitions

Agent. An individual licensed by the state who sells insurance products and services to the public.

Applicant. The person applying for an insurance policy.

Benefit. Amount an insurance company pays to a claimant, assignee, or beneficiary when the insured suffers a loss covered by the policy.

Claim. A request by the individual that benefits be paid.

Coinsurance. The payment percentage (i.e. "20% in an 80%/20% arrangement) an insured is required to pay for a medical claim, apart from any copayments or deductibles.

Condition. Disease, illness, ailment, injury, bodily malfunction, or pregnancy of an individual.

Copayment. A specific charge (i.e. "\$35 office visit copay") a policyholder pays to a provider for a specific medical service or supply at the time it is received.

Cost Sharing. The sharing of costs between the health care plan and its insured through deductibles, co-insurance and co-payments.

Coverage. The different types of options selected and the benefits paid under a plan or insurance contract.

Deductible. A specific dollar amount that the insured must pay out-of-pocket each year before the insurance company will make any benefit payments for claims.

Effective Date. The date when the policy becomes effective and in force.

Eligible Expense. The portion of the medical care provider's services that are covered for payment under the terms of the health plan or insurance contract.

Exclusion. Specific conditions listed in the policy for which the policy will not provide benefit payment.

First-dollar Benefit. Medical expense coverage/benefit under which the insurer begins to reimburse the insured for eligible medical expenses without first requiring the insured to make an out-of-pocket contribution.

Lapse. Termination of a policy due to non-payment of premiums.

Mandated Benefits. Health care coverage required by state and federal law to be included in health insurance contracts.

Negotiated Fees. Service fees agreed upon by Preferred Provider Organizations (PPOs) and providers. Rates are usually based on services defined by the Current Procedural Terminology (CPT) codes, generally at a discount from what the provider would usually charge. Providers cannot charge more than this fee.

Network Providers. Limited grouping or panels of providers in a PPO arrangement. Insureds may be required to use only network providers or may have additional liability for using non-network providers for medical services.

Options. Insurance benefits not automatically included in the policy which are available to the individual as an option at an additional premium.

Out-of-pocket maximum (OOPM). The maximum amount that an insured is required to pay under a plan or insurance contract.

Participating Provider. A provider who has agreed to contract with a PPO to provide eligible services to covered persons.

Renewal. Continuance of coverage under a policy beyond its original term by the insurer's acceptance of the premium for a new policy.

Pre-existing Condition. Any condition or diagnosis for which medical treatment was received within a specified period prior to the effective date of the new policy.

Pre-existing Condition Clause. A clause in an insurance contract or plan that specifies if benefits will or will not be paid for a pre-existing condition.

Premium. Periodic payment to keep an insurance policy in force.

Preventive Care. Wellness and health promotion services that may be part of the benefits package of a health care plan.

Reasonable and Customary. The maximum amount a plan or insurance contract will consider eligible for reimbursement, based upon prevailing fees in a geographic area.

Rider (Exclusion). An amendment to an insurance contract that limits or excludes an existing coverage for certain conditions. For example, a rider to a policy may exclude coverage for treatment to an applicant's knee.

Underwriting. The process of determining whether or not the insurance company will accept an insurance application.