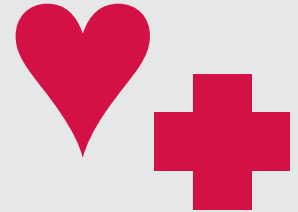


Life & Health Insurance Advisor



8084 Watson Rd. Suite 100
St. Louis, Mo 63119
Tel 314-849-6363
Fax 314-849-9292
www.archbrokerage.com



Health Insurance

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Invest in Your Health: Choosing the Best Health Insurance Plan

The Kaiser Family Foundation reports that individual health insurance premiums for self-only coverage averaged \$3,606 in 2010, while premiums for family coverage averaged \$7,102. The plan you choose also determines how much you will spend on health care out of pocket. Read on to find out how to make the best investment of your health insurance dollars!

1 Assess your family's situation. Do you plan to have children in the coming year? Does your plan provide maternity benefits? Will you have to add a spouse to your plan, or maybe a child who is graduating from college? How much does your plan charge for family coverage? All plans must now cover children up to age 26, whether you declare them as dependents or not, although "grandfathered" plans



can exclude young adults if they have access to health benefits through an employer.

2 Determine how the plan fits your family's risk tolerance and health. Are you savers or spenders? Relatively healthy individuals who budget their healthcare costs and have savings might prefer a plan that gives them greater choice of healthcare provider or that allows them to build

This Just In...

Affordable Care Act consumer protections would apply to student health insurance under a Department of Health and Human Services-proposed rule. The rule would define student health plans offered by a college or university through a health insurance company as "individual health insurance coverage." This would require them to comply with consumer protections created by the Affordable Care Act, including:

- ✳ No lifetime dollar limits on coverage of "essential benefits."
- ✳ No coverage rescissions because of unintentional mistakes on an application.
- ✳ No pre-existing condition exclusions for students under age 19.

The rule would not apply to plans self-funded by a college or university. It would also allow a transition period for the dollar limit requirement, requiring student health insurance

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savings. These individuals should look at a fee-for-service plan, a POS plan or a high-deductible health plan with a health savings account. Those who don't want to worry about budgeting for their healthcare costs might prefer an HMO plan or POS plan with a low deductible.

3 Save for uninsured health expenses. If your employer offers a flexible savings account (FSA), take advantage! You can use funds in your FSA to pay for qualified healthcare expenses, including health insurance premiums, vision care, dental care, etc. Any contributions you make do not count toward your taxable income.

Health savings accounts (HSAs) offer another option. To open an HSA, you must

have a high-deductible health plan and no other health insurance coverage. Contributions to your HSA do not count toward your taxable income. As with an FSA, you can use funds for any IRS-qualified healthcare expense.

4 Weigh the importance of provider choice. Before switching plans, check the preferred or network provider list. If your provider is not included, decide how important provider choice is—using network providers will save you money.

5 Check the optional coverages included in the plan. Plans sometimes include optional coverages, such as maternity benefits or alcoholism/addiction treatment benefits, for which you pay extra. Cancelling

This Just In

plans to have an annual limit of at least \$100,000 on essential benefits for policy years beginning on or after January 1, 2012. Plans with policy years beginning after September 23, 2012 must fully comply with annual limit restrictions.

Approximately 1,500-2,000 higher education institutions offer some type of health coverage. Some plans are comprehensive but others offer only limited benefits. Plans are treated differently depending on how and where they're offered, which has created a patchwork of regulation.

optional coverages you don't need can save you money.

6 Consider a higher deductible. You can lower your monthly premiums by increasing your annual deductible. You'll pay more out of pocket before your plan's benefits kick in, but the premium savings could be worthwhile. Unless you have savings, beware selecting a deductible so high that it could jeopardize your finances if you had a serious illness or accident.

7 Check the plan's prescription coverage. Most plans have a formulary, or a list of drugs the plan covers. Some plans use "tiers," covering different categories of drugs at different levels. For example, some plans cover a higher percentage of the cost of generic drugs or drugs with a proven record of efficacy for certain conditions. If you regularly take a specific drug, see how your

H health plans fall into four broad categories: traditional fee-for-service plans, preferred provider organizations (PPOs), health maintenance organizations (HMOs) and point-of-service plans (POSs).

A fee-for-service plan allows you to use any healthcare provider and pays a set percentage typically 80 percent, of "reasonable and customary" fees for covered services after you meet the policy's annual deductible. You pay the remaining 20 percent, along with any amount over the "reasonable and customary" charges for your area. These plans are the most expensive and are getting harder to find.

A PPO contracts with a network of doctors; plans typically reimburse a higher percentage of fees for in-network doctors; however, you can go out of network.

An HMO requires you to use physicians within the HMO's network; HMOs typically do not pay anything for out-of-network treatment, except in case of emergency. HMOs give you less flexibility in provider choice, but usually require lower out-of-pocket payments than other plans.

POS plans combine features of HMOs and PPOs. Most POS plans require you to choose your primary care physician from within the POS network, but allow you to use out-of-network specialists with a referral from your primary care physician. Your co-payments will be higher for out-of-network services. ■

plan covers it. Plans may add or drop certain drugs that were covered the previous year. Some plans also offer lower costs for mail-order drugs.

8 Check the plan's out-of-pocket maximums. Some plans place no limit on the amount you have to pay out of pocket over the year. Avoid plans that don't have an out-of-pocket maximum. Most plans include the deductible, coinsurance and copayments in calculating your out-of-pocket expenses, but this definition can vary from plan to plan. For example, in some plans the out-of-pocket limit doesn't include your cost-sharing for all services, such as prescription drugs.

9 Take advantage of wellness benefits. Employer-sponsored group plans generally offer more wellness benefits than individual plans, but many individual plans have wellness benefits as well. These can include programs for smoking cessation, diabetes management and weight loss, along with preventive health screenings. Taking advantage of wellness benefits can improve your health and lower your healthcare costs.

10 Know what your plan covers before scheduling treatments. To control premium increases, some insurers are cutting back on benefits. Before using any elective service, check your plan to avoid unexpected bills. For example, if your plan covered 24 visits to a chiropractor last year, don't assume that your renewal plan provides the same benefits.

For a review of your family's healthcare coverage and needs, please call our office. ■

Using Life Insurance for Charitable Giving

Life insurance does more than protect families from the financial costs of a breadwinner's untimely death. It can also help individuals make a substantial bequest to a favorite charitable organization and possibly enjoy a tax break as well.

There are several ways life insurance can help you make a donation to a cause you believe in:

1 Name the charity as the beneficiary of a life insurance policy you already own or buy for this purpose. Instead of giving several hundred or thousand dollars to your charity every year, investing

that money in life insurance premiums can guarantee a sizable donation, even if you should die prematurely. Your charity will receive a guaranteed contribution—the policy's death benefit—upon your demise. And since some life insurance policies offer a waiver of premium if you become disabled before age 65, you can guarantee this donation no matter what your health situation later in life.



Name the charity as the primary beneficiary if you want the death benefit to go to it first. If you want a family member to receive the death benefit and the charity to receive it only if your primary beneficiary dies before you do, name the charity as the contingent beneficiary.

Tax consequences: If you retain ownership of the policy, you receive no income tax deduction for the policy's current value or any premium payments you make. However, you retain control over the policy and can change the beneficiary should your situation change.

2 Apply for life insurance that the charity will own. Many larger nonprofits have "planned giving" programs to help donors do this. Instead of paying premiums to an insurer, you make a donation to the nonprofit to cover premiums. This approach benefits the charity and the donor. According to the National Committee on Planned Giving, "If the charity provides the initial funding and is the owner of the policy, it may have the right to collect cash dividends, borrow against the policy, and make partial or complete surrenders of the policy."

Tax consequences: If you make an annual contribution to the charity for the amount of policy premiums, you can receive a charitable deduction for these amounts.

3 Donate a life insurance policy to the charity. The simplest way to use life insurance in charitable giving is to donate a policy to the charity. Let's say you bought a permanent life policy years ago. Your children are now grown and the policy has cash

value. You can donate the policy to a charity, which can then access the cash value as either a policy withdrawal or loan, or it can wait to obtain the full death benefit.

Tax consequences: You might be able to deduct premiums you paid or the policy's replacement value, whichever is less, from your income taxes as a charitable donation. However, some states do not consider a non-profit to have an insurable interest on a donor's life. Consult a tax professional for more information.

4 Make a charity the beneficiary of your tax-qualified account, such as a pension, 401(k) or IRA. If your heirs inherit these accounts, they must pay income taxes on withdrawals. If your total estate is large enough, it might have to pay estate taxes, reducing usable balances even more. A qualified nonprofit can avoid estate and income taxes. To make up the difference in what your family members would have otherwise inherited, you can purchase a life insurance policy, naming them as beneficiaries. They will receive the policy's death benefit outside the estate, and not subject to income taxation.

Tax consequences: No immediate tax benefits to you, but this method can prevent taxes from eating up assets your heirs receive.

For more information on life insurance and its many uses, please contact us. For advice on the tax consequences of any form of charitable giving, including with life insurance, please consult your tax advisor. ■

Getting the Most Out of a Visit to the Specialist

In 2007, visits to medical specialists represented 22.2 percent of all physician office visits, while visits to surgical specialists accounted for 19.8 percent. Seeing a specialist costs more than seeing a primary care physician. A specialist also does not know your entire medical history like your primary care physician does. Here's how to make a visit to the specialist worth your time and money.

Planning your visit.

What is the purpose of your visit? If your primary care physician refers you to a specialist, ask why. Does he/she want the specialist to confirm or make a diagnosis, put together a treatment plan or provide a service (such as surgery) that your primary care physician doesn't provide? Knowing the goal of your visit can help keep you and your providers on track.

What level of care do you need? Some specialists have very narrowly focused practices. For example, oncologists treat cancer patients, but some oncologists treat children only, while others focus on gynecological

cancers. Do you need the expertise of a specialist with a highly focused practice, or will one with a more general practice do? Usually the more specialized the practice, the longer you will wait for appointments and the more you will pay for care.

Which specialist will you see? Your primary care physician will likely give you the name of a colleague or two. But ultimately, it's your decision because you are responsible for the quality of healthcare you receive. A physician can "specialize" in any field of medicine regardless of whether he/she has received advanced training. To check whether a physician has completed an approved residency program and passed an exam in his/her specialty area, check the listings at the American Board of Medical Specialties, www.abms.org. The Medicare Physician Compare site provides performance information on physicians and other healthcare professionals. You can find physicians by geographic location and specialty at www.medicare.gov/find-a-doctor/provider-search.aspx.

What does your insurance require? Before making an appointment, review your coverage. Some plans require a primary care provider's referral and/or preauthorization before it will pay for a visit to a specialist. Check to see what type of documentation your plan requires and follow requirements to the letter to avoid claim disputes.

Have you selected an in-network provider? Check your plan's preferred provider list. Choosing an out-of-network provider



can add hundreds or even thousands of dollars to your out-of-pocket costs.

When will you see the specialist? If time is critical, ask your primary care provider's office to request an appointment for you.

What information will your primary care provider give the specialist? Before the appointment, ensure your primary care provider communicates the reason for the referral and provides your medical history and relevant test or imaging results.

What medications do you take? Be-

fore your visit, list all medications you take, including dosages and frequency. Don't forget over-the-counter medications, vitamins, supplements and herbs, as many of these interact or interfere with other drugs.

At your visit.

What will you discuss? To start, ask your specialist if he/she knows the reason for the referral and whether your primary care physician has provided all relevant records. After a review of your records and an examination, you will want to discuss your treatment plan. What are the potential side effects or complications and how likely are they? How will your condition and any recommended treatments affect your general health and quality of life? Feel free to discuss, even debate, your treatment plan. If you have concerns, you can always ask for a second opinion.

Depending on your situation, you might also want to discuss preventive or self-care. Are there things you can do to improve your condition or prevent it from worsening?

Will you see the specialist again? If your treatment plan includes surgery, will the specialist provide follow-up care, or will your primary care physician? Will you visit the specialist on an ongoing basis, or will your primary care physician manage your treatment?

For more information on the benefits provided under your health plan and how to use them, please contact us. ■

Do You Have an Advance Directive?

A study recently released by the National Center for Health Care Statistics (NCHS) estimated that only 5-15 percent of adults in the U.S. have completed advance directives.

An advance directive (AD) allows a patient to communicate healthcare preferences if he or she can no longer make these decisions. ADs include living wills, treatment directives and do-not-resuscitate orders. This type of advance care planning can help ensure that wishes about end-of-life care are honored.

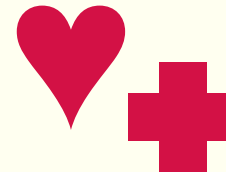
Twenty years ago, Congress passed the Patient Self-Determination Act (PSDA) requiring most health care facilities to inform adult patients about their rights to execute an AD. Research indicates that the preference for having an AD can be influenced by individual attitudes, cultural beliefs, health conditions, and trust in healthcare professionals.

The NCHS study found a higher prevalence of advance

directives among adults in long-term care populations compared with the overall U.S. adult population. Overall, 28% of home health care patients, 65% of nursing home residents, and 88% of discharged hospice care patients had at least one advance directive on record. The most common types of ADs among health care, nursing home and discharged hospice care patients were living wills and do not resuscitate orders.

The laws governing advance directives and living wills vary by state. To ensure your healthcare providers comply with your wishes, please use documents that comply with the laws of your state. The National Hospice and Palliative Care Organization provides state-specific advance directive forms for free single-copy use by individuals for personal and family benefit at www.caringinfo.org/i4a/pages/index.cfm?pageid=3285. ■

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