Private Insurance

There are numerous private insurance options for both individuals and families in Minnesota. Private insurance can come through an employer or be purchased individually. Some employers automatically take a certain amount from employees' pay for health care coverage or simply include health coverage as a benefit. At other workplaces, employees pay a monthly premium for individual or family coverage.

Choosing a private insurance plan

People who do not currently have health insurance or are deciding whether to switch insurance plans may wish to consider a few key points before purchasing a plan:

- If a person wants care from a specific doctor, it is important that the doctor be on the new plan's preferred or network provider list. Most insurance companies offer better coverage for medical services from the doctors on their in-network lists. Some plans do not cover out-of-network providers except for in emergencies.
- It is wise to compare insurance plans. If asked, insurance companies can provide copies of their certificates of coverage (also called *contracts* or *summary plan descriptions*). The certificates describe the plan's benefits, exclusions, and conditions.

Think about the kind of services you are most likely to need and compare plans to determine if that service is covered and to what extent. Types of services that may be covered include:

- Ambulance services
- Chemical dependency treatment
- Chiropractic care
- Dental care
- Durable medical equipment
- Emergency care
- Hospice care
- Hospitalization
- Mental health therapies
- Physical, occupational and speech therapies
- Physician care
- Prescriptions/medication expense
- Preventative care
- Nursing home or transitional care facilities
- Urgent care

(952) 838-9000 • Toll-free in Greater Minnesota: (800) 537-2237 • PACER@PACER.org • PACER.org

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Each plan covers a variety of services to a greater or lesser degree. Under the Affordable Care Act (ACA), there are essential benefits that must be covered on fully-insured plans. These include services with in the following categories:

1. Ambulatory patient services (care you get without being admitted to a hospital)
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices (to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
8. Laboratory services
9. Preventative services and chronic disease management
10. Pediatric services, including oral and vision care

Getting help to choose a plan

As part of the Affordable Care Act, the federal government has produced a website for health care consumers, **www.healthcare.gov**. It includes information on all public and private insurance options within each state, giving consumers an opportunity to compare coverage benefits and premiums before purchasing a plan.

In Minnesota, the marketplace through which health insurance may be purchased is called **MNSure** (**www.MNSure.org**).There are navigators available to assist with choosing a MNSure product. Brokers or agents are individuals that are paid by the individual insurance companies to sell their products. PACER Center is a non-profit advocacy agency that can also assist in navigating MNSure.

Determining if a plan is fully insured or self-insured

It is important to know if a plan is fully insured or self-insured. Different laws regulate the two types of coverage. Group plans, which are typically available through an employer, can be either fully insured or self-insured. Federal law says that insurers must say if a plan is self-insured.

With *fully insured* plans, the employer pays all or part of employees' premiums to an insurer, and the insurer pays claims out of the pool of premiums it collects from everyone it insures. State law regulates fully insured plans.

Under *self-insured* plans, the employer is responsible for collecting or funding a pool of premiums and paying all health care claims out of company assets. Self-insured plans are regulated by federal law (Employee Retirement Income Security Act, or ERISA).

Using both private insurance and public insurance

Private insurance for Minnesota families of children with disabilities or special health care needs may not be enough to cover the cost of all health care services. In that case, the family may consider obtaining public insurance as well. It may be Medical Assistance (MA) or Medical Assistance/TEFRA (Tax Equity and Fiscal Responsibility Act). TEFRA is medical assistance for children with disabilities who meet certain eligibility requirements. If a child qualifies for MA/TEFRA, MA/TEFRA may also pay outstanding medical bills for services received up to three months before the date of the family's application for MA/TEFRA.

A family currently using both private insurance and public insurance may wish to contact its county's human services department or county financial worker to determine if it is cost-effective for the county to pay the family's monthly private insurance premium.

Helpful definitions

Certificate of coverage (also known as a contract or summary plan description) is the written terms of an insurance plan. It explains the details of how the coverage works, including exclusions, conditions, and how to file claims.

Co-insurance is a percentage of the remaining medical expenses the insured person or family must pay after they pay the deductible. For example, a co-insurance of 25 percent means that the insured pays 25 percent of the remaining medical cost after paying the deductible. The insurance company then pays 75 percent of the remaining cost.

A ***Copay*** is a set amount of money paid each time an insured person receives a medical service. For example, a $20 copay for doctor appointments means that the insured person pays that amount each time they see the doctor for services.

Conditions are the requirements of an insurance plan. For example, paying a copay or a deductible, seeing a provider on the provider list, and receiving prior authorization are conditions of the plan.

A ***deductible*** is a set amount of money an insured person or family must pay for health services before the insurance company pays. It is in addition to regular scheduled premiums paid by the insured. With a $2,000 deductible over one year, for example, the insured person or family pays the first $2,000 of cumulative medical expenses. Then the insurance company begins paying toward medical expenses. When the year ends, the process begins again and the family must pay a $2,000 deductible over the next year, and so on. The deductible year often follows the calendar year, so that January 1 marks the beginning of a new deductible cycle.

Exceptions are circumstances that may allow a person to qualify for medical services to be covered despite conditions or exclusions.

Exclusions are circumstances that might disqualify a person from receiving coverage for a particular service.

Medicaid, also known as Medical Assistance in Minnesota, is the state run government insurance to assist low income families or individuals with disabilities. It consists of both state and federal funds.

Medicare is the federal insurance plan for individuals over age 65, or for individuals under 65 that have a disability.

MNSure is the marketplace where insurance products can be purchased in Minnesota.

Open enrollment is a time period where an individual can enroll in a health plan each year.

Out of pocket maximum is the maximum amount of money a person is expected to pay for health services each year. This includes copays, deductibles, and co-insurance, but not premiums.

Preferred provider list (also known as a network provider list) is a list of health care providers, such as doctors or hospitals, for which an insurance plan provides better coverage. Emergencies are almost always exceptions to the preferred provider list.

A ***premium*** is the amount of money paid to purchase insurance.

Prior authorization is when an insurance company must approve a person to receive a specific medical procedure or care before the person actually receives it. If the insurance company does not authorize the care, it might not pay for it.