Every person with limb loss has questions about health insurance, from the patient who hasn’t yet left the hospital to the person who has been an amputee for many years. The following roundtable discussion focuses on common questions, with advice and perceptions presented by ACA, regional representatives of ACA’s National Peer Network, and contributing healthcare professionals.

**What’s the difference between indemnity and managed care plans?**

**ACA:** A true indemnity plan has no networks of any kind. You can choose any doctor or any hospital without restriction. Because these plans don’t limit access to healthcare, they typically feature dramatically higher premiums and out-of-pocket costs.

Managed care plans (HMO, PPO, and POS) account for the vast majority of healthcare in the U.S. PPOs feature the fewest restrictions (you can go out-of-network) but have the highest costs (though still less than an indemnity plan); HMOs have the most restrictions (you can’t go out-of-network) but your costs are significantly lower than a PPO or indemnity plan. Managed care plans control costs by limiting your choices to doctors, prosthetists, and hospitals with which the insurance company has a contract. Lower costs usually come from the insurance company negotiating reduced charges with these providers.

**Regional Representative Sherri Samuels:** Indemnity plans, also known as fee-for-service plans, will reimburse you for your medical expenses for all or (usually) part of a visit to a provider of your choice. These are the traditional 80/20 or 70/30 plans that we often hear about. In many cases, the services available to you and the reimbursement amounts may be limited. This coverage offers the most freedom of choice, but it comes with a higher price tag. This is why I believe managed care plans are more popular.

HMOs provide treatment on a prepaid basis. You’ll also have a co-pay. HMOs tend to be the least expensive plans around, but there’s a catch. You’re generally limited to the HMO’s network of providers, and you must get a referral from your primary care doctor to be allowed to see a specialist. Your O&P providers are all considered specialists.

PPOs are the most flexible plans. You pay a monthly premium, but rather than prepaying, you only pay when you get medical care. There are co-pays and deductibles in this type of plan. The PPO contracts with a network of doctors and hospitals that work at a set, discounted rate. If you’re willing to pay more, you can go out-of-network. And you don’t need a primary care physician to see a specialist.

POS plans combine parts of both of HMOs and PPOs. You will see a primary care physician, like an HMO, who will refer to an in-network specialist. You will generally have no deductible and a minimal copayment. You can, however, go out-of-network with a deductible and increased co-pay, just like a PPO.

**Regional Representative Charlie Steele:** 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 in 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 healthcare providers to give a range of services to plan members at reduced cost. In general, you’ll have less paperwork and out-of-pocket costs with a managed care plan and a broader choice of healthcare providers with an indemnity plan.

**Robert Brown, MS, CPO, FAAOP:** An indemnity plan reimburses you for your medical expenses regardless of who provides the service, although the amount of your reimbursement may be limited sometimes. The coverage offered by most traditional insurers is in the form of an
indemnity plan. Different plans use different methods to determine how much you'll receive for your medical expenses:

- Reimbursement (actual charges): The insurer will reimburse you for the actual cost of specified procedures or services, regardless of how much that cost might be.
- Reimbursement (percentage of actual charges): The insurer pays a percentage of the actual charges for covered procedures and services, regardless of how much those procedures and services cost. A common reimbursement percentage is 80 percent. This has the same effect as a 20 percent co-payment.
- Indemnity: The insurer pays a specified amount per day for a specified number of days. Although your reimbursement amount doesn't depend on the actual cost of your care, your reimbursement will never exceed your expenses.

There are three basic types of managed care plans: health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point of service (POS). There are important differences and similarities between these types of plans. All managed care plans involve an arrangement between the insurer and a selected network of healthcare providers. All offer significant financial incentives to policyholders to use the providers in the network.

HMOs provide medical treatment on a prepaid basis (you pay a monthly fee, regardless of how much medical care you need in a given month). In return, most HMOs provide a wide variety of medical services. With few exceptions, members must receive treatment from providers within the HMO network.

A PPO is made up of healthcare providers that serve only a specific group. Rather than prepaying for medical care, members pay for services rendered. The price for each type of service is negotiated in advance by the healthcare providers and the PPO sponsor. The PPO sponsor (usually an employer or insurance company) generally reimburses the member for the cost of treatment, less any co-payment. In some cases, the physician may bill the insurance company directly for payment. The insurer then pays the covered amount directly to the healthcare provider, and the member pays the co-payment amount.

In a POS plan, you pay no deductible and usually only a minimal co-payment when you use an in-network healthcare provider. You must also choose a primary care physician who is responsible for all referrals within the POS network. If you go outside the network for healthcare, you’ll likely be subject to a hefty deductible (around $300 for yourself or $600 for family), and your co-payment will be about 30-40 percent of the physician’s charges.

Generally, managed care plans are more cost-effective for the average individual in the long run. In contrast, indemnity plans usually hit you with more out-of-pocket charges (in the form of deductibles and co-payments) and often place caps on the amount of lifetime benefits. But indemnity plans give you more freedom in choosing healthcare providers. Choosing between indemnity and managed care plans ultimately depends on your situation and preferences. If your goal is to minimize costs, you’re probably better off with a managed care plan. On the other hand, if your goal is maximum flexibility and cost isn’t a major factor, you should consider an indemnity plan.

I lost a limb while I was unemployed and didn't have coverage. Does this mean I can't get covered in a new job because I have a pre-existing condition?

ACA: No. This is one of the most misunderstood aspects of being an amputee. Some think they can't switch, but this isn't true. But this myth is understandable because it actually was the case until 1996. Before then, if you had limb loss and wanted to switch jobs, you could be denied coverage under your new job on the grounds that it was a pre-existing condition. This understandably resulted in people refusing to change jobs, creating a phenomenon referred to as “job lock” until the issue was finally addressed on a
national level. The question is, how long have you been without coverage? You can’t be excluded for a pre-existing condition unless your break in coverage was over 63 days. The fact that you’re unemployed has nothing to do with coverage. If you’re unemployed but on COBRA, your coverage can’t be denied or limited by a pre-existing condition. If you didn’t have insurance at the time of your amputation, depending on how long you weren’t covered, an insurance company may limit your benefits for up to the first 12 months after you apply for a new health insurance policy.

Regional Representative Renee Loth Cali: Check with your state disability insurance office. Each state has different laws regarding unemployment; five states provide disability insurance that works in conjunction with employers’ insurance coverage.

Regional Representative Sherri Samuels: Not necessarily. If you’ve maintained your insurance coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act) then you should be covered in accordance with your policy. And, when you get a new policy, as long as you have maintained coverage, there should not be a pre-existing condition limitation (although a few states may allow this – check with your own state’s insurance commission for details). If your insurance policy has lapsed and you are getting new coverage, then it depends on the provisions of your new policy and any state limitations on pre-existing conditions.

Regional Representative Charlie Steele: Here’s another “it depends” answer. It depends on the state you live in and whether they have passed prosthetic parity legislation or other legislation defining pre-existing conditions. Some states prohibit insurance companies from discriminating against people with pre-existing conditions; some allow insurance companies to not cover your pre-existing condition for the first six months of your new policy. Other insurance companies
simply won’t cover you or will do so with high premiums and co-pays. It depends on the insurance carrier of your new employer; most have a 6-month waiting period until a claim can be considered or paid for a new employee with a pre-existing condition. It’s always a good idea to check out the benefit plan in this regard with your potential new employer before accepting the job. This applies even if you’re employed and you’re simply switching employers.

Regional Representative
Laura Willingham: This is a common concern. You should discuss this specific issue with a case manager, because each situation is different.

Robert Brown, MS, CPO, FAAOP: Health insurance can be a little tricky for people with pre-existing conditions. An insurer may be understandably reluctant to accept someone into their plan who is likely to need expensive treatment and medication. But when people with pre-existing conditions change jobs, or become sick while on one plan and are forced to look for another carrier, serious problems may arise.

There are several solutions, but ultimately someone must pay the costs. The question is, who should that be? Should a person with a pre-existing condition pay a higher premium than someone who is healthy, or excluded from purchasing insurance altogether? Should the insurance company be responsible for providing coverage to every person, regardless of health, and ignore the actuarial guidelines for price? Or should the government subsidize the costs for everyone and ensure access and affordability for all citizens? These are tough questions, with answers that are now being vigorously debated across the country. A number of state legislatures have enacted laws that require private insurance companies to accept everyone who applies, regardless of condition. Some of these plans call for the insurance company to bear the burden of financial loss, while others make it such that people who can afford to pay are charged a higher premium.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 was the result of many discussions and state legislation enacted in the early 1990s. It guarantees that no one can be denied group health insurance through an employer because of a pre-existing condition, nor can anyone be required to pay a higher premium than anyone else in the same employment category. HIPAA goes a long way to address the problem of pre-existing conditions and health insurance granted through an employer, but it doesn’t pertain to people who are self-employed or who have private insurance. HIPAA does extend its eligibility to individuals who change employers, as long as they do not let their coverage lapse for more than 63 days between jobs.

Know your rights. If you have a pre-existing medical condition and need health insurance, it’s smart to check with your employer first. Familiarize yourself with your rights before you discuss your options with private insurers.

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