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The November Dilemma: Choosing Your Health Plan Gets More Complex

IT'S OPEN ENROLLMENT season, when employees must choose from the alphabet soup of health plans offered for the coming year. And this time it's tougher than ever to figure out which option — HMO, PPO, POS, HSA — is best for you.

There are more types of plans available these days, and the distinctions between them are becoming less clear as companies deal with the rising cost of health care by shifting more of the burden onto employees. Even some of the traditionally cheapest plans now charge deductibles and co-insurance.

In the end, the choice of a health plan involves a gamble. You must assess your own health situation and ability to pay, and weigh them against the chances that you'll need major medical care or routine preventive services. Here is some advice on how to make the best choice for your personal situation.

■ **Health Maintenance Organizations:** One of the most surprising developments in health insurance during the past few years is the comeback of the HMO. The plans were vilified by lawmakers and consumer groups for restricting patients' access to care, but experts say the current crop of HMOs appears to be far more user-friendly. The biggest change: Many HMOs now let patients see certain commonly used specialists such as gynecologists without a referral from their primary-care doctor.

HMOs can be good for healthy families who use a lot of routine care — such as physicals and vaccinations — and who aren't likely to need nonnetwork specialists. If you have a child who gets frequent ear infections, or you visit your primary doctor regularly for asthma or other chronic illness, you pay a small co-payment each time instead of high out-of-pocket bills or co-insurance, as you may in other plans.

Even so, you're still limited to using doctors in the HMO's network. Also, while HMO premiums are usually less expensive than other plans, some plans have started tagging on low deductibles to force patients to cover a portion of the bill.

■ **Point-of-Service Plans:** Like HMOs, POS plans tend to cost less when it comes to routine and preventive care, because they charge a simple co-pay for office visits. POS can be a good choice for anyone who uses a high volume of routine care, such as families with children, pregnant women, or anyone who likes to see a primary doctor regularly — say, for colds and flu.

The big benefit of a POS plan is the ability to also go out of network for specialized care. You can see nonnetwork doctors on occasion and still get a portion of the costs covered.

Monthly premiums for these plans are normally slightly higher or comparable with HMOs. But take a look at your finances — if the out-of-pocket costs for a nonnetwork visit will be out of reach, the flexibility of a POS plan is moot.

POS plans can work well for "people who just want the safety net to say 'if I ever want to go out of network, I can,'" says Abbie Leibowitz, co-founder of Health Advocate Inc., which advises patients on health-insurance issues.

■ **Preferred-Provider Organization:** Many people like a PPO because it allows them to see any specialist or doctor within the network without a referral. But that flexibility comes at a price. While monthly premiums may be only slightly more than other plans, PPOs typically require you to pay a lot more for care.

Families with children or pregnant women may be wise to steer clear of a PPO, otherwise basic services like checkups and vaccinations may end up costing a lot more than necessary.

Prime candidates for PPO plans are those who have health ailments that require a lot of care by specialists — for instance, if you need to see a gastroenterologist regularly to treat acid reflux — and you don't want the hassle of go to a primary care doctor all the time for referrals. Also, someone who worries about catastrophic illness, as older adults often do, might feel that PPO gives them faster access to doctors.

Checklist

Questions to ask yourself when choosing an employer health plan:

- Do you have enough money saved to cover large medical bills if you wind up needing care and you have a high deductible?
- Do you need many routine and preventive health-care services, such as immunizations and well-baby checkups?
- Do you like having a primary-care doctor to coordinate care, or do you prefer to just see specialists on occasion?
- Will you want to visit specialists outside the health plan's network?

Some employers now offered a tiered system of PPOs that let employees choose a smaller network of doctors for a lower premium. But a smaller network limits choice, when choice is often the very reason patients choose a PPO.

■ **High-Deductible Plans:** Many employers are offering PPO plans with deductibles over \$1,000, encouraging employees to pay a heftier portion of their medical bills out of pocket. About 10% of employers now couple these plans with health savings accounts, pretax money that employees can tap for out-of-pocket medical costs. If the money isn't used, it stays in the account, grows tax-deferred and can be withdrawn for any reason after age 65.

These plans generally have cheap premiums, so they appeal to people with fewer health-care needs. Young, healthy people who don't tend to use routine, preventive services, and who don't expect to require a lot of medical care, may opt for one of these plans because it allows them to save on upfront costs.

But this idea is potentially risky. Those who are chronically ill, or even healthy people who unexpectedly require major medical care, will pay that large deductible amount every year. And they may have to pay a percentage of medical care co-insurance — after that. These plans often include skimpier coverage than other plans, too.

Remember, you're locked into the plan only for a year. If something pops up, you can always change health plans next year.