

All About Insurance

Health insurance is not the same as health care!

Health care is something you and your personal doctor do together, to keep you healthy. Health insurance is more like a bet between you and the insurance company. You pay your premiums and hope that insurance will pay for your medical care. The insurance company collects your premiums and hopes to keep from paying your medical bills.

The business of the insurance company is to make money. They can do this by writing insurance policies that are limited by exclusions and waiting periods, and that charge monthly premiums, high deductibles, co-pays, and co-insurances. They use a very specialized vocabulary that makes it hard to understand what's going on. This handout is to help you understand your insurance better.

A special note about "out-of-network" caregivers:

If I "don't take" your insurance, it does not mean I won't see you - it means your insurance will not pay as much as they would if you went to the doctors they chose for you. I will still be your personal physician! We can figure out how much your insurance will cover, and how much of the fee you will have to pay. See below for more information on this.

Vocabulary you should know:

Benefit - The amount your insurance agrees to pay for a particular service.

Claim - A form filled out and mailed to the insurance company by you or your doctor, asking your insurance to pay for particular medical services. You "file a claim" (fill out and send in the form) after every visit, if you expect the company to pay for it.

Co-insurance - The part of your bill, in addition to the co-pay, that you must pay. Co-insurance is usually a percentage of the total medical bill - for example, 20 percent (for every \$100 charged, you pay \$20 on top of your co-pay).

Co-pay (co-payment) - An amount chosen by your insurance company, that you have to pay at each visit. Your insurance is supposed to pay the rest of the medical bill.

Deductible - The amount of money you must spend on medical care, before your insurance starts to pay anything. You will have to pay 100% of your doctor bills until you "meet your deductible" by spending this much. When you pay a medical bill, you have to send in a form to make it count towards your deductible. The amount you paid toward your deductible goes away at the end of each calendar year (December 31) and you have to start over again.

Denial - Insurance refuses to pay a medical bill. They send you a letter explaining why. You can appeal this decision. Sometimes the problem can't be fixed, and you have to pay the whole medical bill yourself.

EOB (Explanation of Benefits) - A report from your insurance company telling how much they have paid for your care and how much you owe the doctor. The EOB is not a bill for you to pay the insurance company, but it is like a bill for what you have to pay the doctor. The doctor receives a copy of the EOB, too.

Exclusion - Something your insurance will not pay for under any circumstances. An insurance policy will usually have a list of exclusions (for example, dental care and cosmetic surgery). However, other exclusions might be hidden in the "Definitions" section of the policy. Watch out how your policy defines "medical emergency," "medically necessary," "accidental injury," "experimental treatment," "pre-certification," "pre-existing condition," and "reasonable and customary." If your situation doesn't fit into the policy's definitions, the insurance company won't pay the bills.

Individual insurance - Insurance that you shop for and pay for by yourself, not sharing the cost with anyone.

Group insurance - Insurance that you apply for as a member of a group, sharing the cost. Lots of people have group insurance through their workplace, and their employer shares the cost with the group.

In-network doctor - Also known as "preferred" or "participating". Refers to a doctor who has signed a contract with your insurance company. If you go to an in-network physician, you might not have to pay as big a deductible, co-pay or co-insurance.

Medicaid (Title 19) - A national health insurance policy for citizens with low incomes. Medicaid reimburses doctors very little, so most doctors who see people with Medicaid must work for federally-funded low-income clinics, where their salary is subsidized. Medicaid rules are State laws, and voters could change them.

Medicare (Title 18) - A national health insurance policy for all citizens over 65, and those with disabilities or on kidney dialysis. Medicare does not pay as much as other insurances do, for medical care. The government has cut payments (to doctors) for medical care steadily since 1991; a 12% cut is planned for 2009, and a 13% cut for 2010. Because of this, many doctors do not sign contracts with Medicare, so they are all "out of network," and their patients have to pay a bigger share, or pay for all, of their care. Medicare rules are national laws passed by Congress, and voters could change them.

Open enrollment period - An amount of time, usually a month, during which you can ask for changes in your insurance (for example, adding a new baby to your policy). This month usually occurs in the autumn. Your insurance is supposed to send you an announcement of the exact dates.

Out-of-network physician - Also known as "non-preferred" or "non-participating": a doctor who did not sign a contract with your insurance company. When you go to an out-of-network physician, you usually have to pay a bigger portion of your doctor bill than if you stayed "in network."

Policy - The year-long legal contract between you and your insurance company, which gives the rules for how much your insurance will pay, and how much you will pay, and when. Usually, you can make changes to your policy only during the last month of each policy year (often in the autumn).

Pre-authorization - A process that determines what your insurance agrees to pay for, used for unusual or expensive procedures. You, or your doctor, has to call or write to the insurance company, explaining what you need (for example, a CT). The doctor has to fill out forms showing the care is medically necessary, is not experimental, etc. The doctor must use your medical records to provide this information. Then the insurance company will either agree to pay for the care, or not.

Pre-certification - Another form of pre-authorization. You might have to get pre-authorized AND pre-certified, for the company to pay a bill - it depends on your policy rules.

Pre-existing condition - A medical condition that you had before signing your insurance policy. A company can refuse to give you an individual policy if you have a pre-existing condition. A group policy can impose a special waiting period (a "pre-existing condition exclusion period"), during which they won't pay for anything concerning the pre-existing condition (like medicines). How does the insurance company decide what pre-existing conditions you have? By reading through your medical records. Anything a healthcare provider has written about you may be used by the insurance company.

Premium - The bills charged to you, by your insurance company, just to have your policy. If you miss a payment, your insurance company is entitled to cancel your policy. Also, the cost of your premium can suddenly increase, especially if your health gets worse.

Waiting period - An amount of time chosen by your insurance company, that must pass before your policy start to work. If you have medical expenses during this time, your insurance will not pay for them.

How to Deal With Your Insurance

1. When you see your doctor, **take your insurance card**. Your doctor will need it, to bill your insurance.
2. **Open every piece of mail** you get from your insurance company. Look for every EOB, which tells you how much you need to pay your doctor. Pay exactly the amount it says, so the payments will count toward your deductibles. (Note: the EOB says, "This is not a bill," because it is not a bill for you to pay the insurance company. It IS a bill for you to pay your doctor.) Save all your insurance papers together in a special file.
3. **If you have a claim denied**, call the insurance company to ask why, and write down the date, time of day, name of whoever you talk to, and what they answer. Most of these phone calls are recorded, so you can ask for a review later, if you need to. If you will have to file an appeal, go to the "Survivorship A to Z" website (www.survivorshipatoz.org) and select the topic "Health Insurance Claims Appeals." They have step-by-step instructions, and sample letters you can fill out and send.

4. **Do not go to the emergency room**, unless you have a true emergency that threatens your life, or your health. Insurance usually won't pay for emergency room visits. You can call Dr. Leigh 24 hours a day, 7 days a week.

5. **If you have a true emergency**, and are forced to go to the emergency room, make sure you, Dr. Leigh, or someone you trust, calls your insurance company within 24 hours to notify them. This is your best chance to get the emergency care paid for by insurance.

6. **If you are planning any expensive or unusual medical procedure** (like getting physical therapy or getting a CT scan), call your insurance company and ask if it needs to be pre-authorized or pre-certified, and how to do this.

7. **Look at your policy.** Find where it tells what your co-pays and co-insurances are for in-network and out-of-network doctors. Underline or circle the most important information:

- Deductibles - don't forget they re-set on January 1st each year!
- Open enrollment period - the dates change every year!
- Exclusions - and the "Definitions" section.
- List of treatments that must be pre-authorized and/or pre-certified.
- Rules for appealing a denied claim (deadlines, documents, and the exact procedure).

8. **Ask your insurance and your caregivers if they have contracts** with each other. Don't forget that *all* healthcare providers are out of network for you, *unless* they have a contract with your insurance company! This may include: hospital doctors, x-ray providers, emergency room doctors, nursing-home or rehab doctors, psychiatrists, physical therapists, etc.

How to tell if an out-of-network doctor is a good deal:

- They have something special you can't get in-network - location, expertise, accessibility, how much time they spend with you, extra services, etc.
- Look at your policy: What is the deductible for in-network? For out-of-network? You would have to pay one of these before your insurance will pay bills. Important: If you pay a medical bill out-of-network, it does not count toward your in-network deductible, and vice-versa.
- Look at your policy: What is the co-pay for in-network doctor visits? Often, you do not have to pay this for an out-of-network doctor.
- Look at your policy: If your doctor bill was \$100, how much of the fee would you have to pay? Subtract from that amount, the co-pay you would have paid in-network (if you don't have out-of-network copays). How does this compare to the amount you would pay an in-network doctor?
- Ask the out-of-network doctor if they will help you, if you have trouble filing your insurance claims, getting pre-authorizations, or appealing denials.

Here is an example of a patient who prefers her out-of-network caregiver, a physical therapist:

"Not only does my therapist [have] expertise, he also listens to his patients. He spends a full hour listening to my concerns and working one-on-one with me... I would visit this therapist even if my insurance didn't cover any of the cost.

"...My insurance currently pays 75% of the costs for visits to out-of-network providers. So for a \$128 visit, my insurance company will reimburse me \$96. That means I end up with a bill for \$32...

If I went to an in-network provider I would owe a \$25 co-pay. Subtract that \$25 from the \$32 I pay out of pocket and the visit only costs me \$7 more than visiting an in-network therapist. The peace of mind and trust in a good health care provider is certainly worth \$7 more a visit." (<http://onefrugalgirl.blogspot.com>)

10. **Watch carefully for announcements** in your mail, of changes in how your insurance handles out-of-network and other issues. Big lawsuits are underway, by doctor and patient groups, against Aetna, Blue Cross/Blue Shield, Cigna, Health Link, Unicare, United Health, Wellpoint/Anthem, and others. (As of 2009, some of these lawsuits have been settled, and insurance companies forced to change their policies and pay fines.) Also, a consumer group has asked the Department of Justice for an anti-trust investigation of the health

insurance industry, on the grounds that 94% of health insurances are regional monopolies (HCAN, Health Care for America Now). These developments might change how your insurance does business.

11. **Consider improving your policy**, if you are able, during the Open Enrollment period - a good time to review the changes to your policy.

About High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs):

With this kind of insurance, you pay a lower premium and you have a very high deductible. Most people will pay most or all of their medical costs themselves every year, due to not meeting the high deductible. However, by paying the low premiums for the HDHP, they get a health savings account. All money put into this account is tax-free, and it does not disappear on January 1st (as do payments toward deductibles). They have an HSA card which they can use for medical costs. Some employers help to pay the premiums and/or add money to the savings account. HSA money can usually be used for alternative practitioners, and there are usually no in/out-of-network issues.



My Dream:

I know that everybody wants health insurance, and everyone is concerned about "the problem of the uninsured." Kind of blaming the victims, right?

*But I look forward to a day - soon, please! - when nobody cares anymore about health **insurance**, because they can easily get health **care**.*

- *People will not spend so much personal energy worrying about getting sick, getting injured, getting pregnant, or having kids - they can turn their minds to other aspects of a creative, fulfilling life.*
- *They will not struggle to pay for their doctor bills, hospital bills, or medicines. 'Medical bankruptcy' will be a peculiarity of American history, just like 'child labor.'*
- *Doctors won't have to try to figure out whether they can see another low-income patient without going broke. They won't be afraid of going out of business by offering excellent care to the sickest patients, who need it most.*
- *Ordinary office workers, just trying to make a living, won't have jobs that consist of denying health care over the phone all day. The occupation of "Claims Denial Specialist" will no longer exist.*
- *Insurance corporation CEOs, like Aetna's Ron Williams (yearly salary \$1,091,764), Cigna's H. Edward Hanway (salary \$1,142,885), United Health's Stephen Hemsley (\$1.3 million), and WellPoint's Angela Braly (\$1,135,538) - they'll all have to get normal jobs.*
- *(Figures from www.fiercehealthcare.com, "Daily News for Healthcare Executives", May 14, 2009).*

The rules that govern what corporations can and cannot do are laws, made by elected officials, and ratified by voters. This means we can change the way things are. We may not do it all this year, but we can do it.

In the meantime, I'll try to help you deal with your insurance, while striving to be the most available, most economical, most excellent personal doctor you've ever had.