THE HYPERTEXT GUIDE TO

# HEALTH INSURANCE IN THE UNITED STATES

AFFORDABLE CARE ACT • INSURANCE DEFINITIONS
MEDICAL DEFINITIONS • IF YOU CAN'T BUY INSURANCE
OTHER WAYS TO GET HEALTHCARE • APPEALING INSURER'S DECISIONS
THINGS TO WATCH OUT FOR • REVISED NOV. 2017

This page was created in 2009 to help Americans get healthcare and/or insurance. Before the Affordable Care Act was available, many people could not afford insurance. And some who could afford it were rejected by the insurance companies.

The Affordable Care Act has improved things, but America's healthcare system is still less effective and more expensive than those of other industrialized nations. For example, our life expectancy is lower and our infant-death rate is higher. (See the footnotes at the end of this document.)

WHY YOU NEED HEALTH INSURANCE

In 2013, Time Magazine published *Bitter Pill: Why Medical Bills Are Killing Us*. An example from the article: an uninsured woman went to an emergency room because of chest pains. "After about three hours of tests and some brief encounters with a doctor, she was told she had indigestion and sent home." She was charged $21,000.

## INSURANCE DEFINITIONS

**Health plan** (or policy) A legal agreement between an insurer and an insured person or family. The insurer provides and/or pays for some of the insured's expenses for the length of the plan. Plans usually last one year and can be renewed.

**Enrollee** (policy holder, subscriber, member) A person who is insured by an insurance plan.

**Premium** The amount you pay your insurer every month.

**Covered services** Things the insurer will provide or pay for.

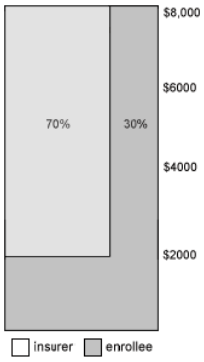
**Annual limits** How much your insurer will pay for some of the covered services during the year (for example, some prescriptions). You pay the full cost of anything more than that amount.

**Excluded services** Things the insurer will not provide or pay for.

**Copays** (copayments) Additional expenses you pay for some services, tests, or prescriptions.

**Deductible** The amount of your healthcare expenses you must pay each year before your insurer starts to pay part of them.

**Coinsurance** Once you have paid all of the deductible, you will only have to pay part of the additional major expenses for that year. The insurer will pay the rest. How much you will have to pay depends on the plan you chose.




This example shows how a 30/70 plan might divide an $8000 hospital bill. After you have paid a deductible (in this case, $2,000), you would only have to pay 30% of the remaining medical bills. Your share of the $8,000 would be $3,800. The insurer will pay the other $4200.

**Out-of-pocket** (OOP) The amounts you end up paying for the copays, deductible, and coinsurance. It does not include your premiums.

**Out-of-pocket maximum** This is the most you will have to pay during the year of the plan. Your insurer covers everything after that.

In 2017 the out-of-pocket limit for a Marketplace plan is $7,150 for an individual plan and $14,300 for a family plan.

## THE AFFORDABLE CARE ACT (ACA)

**Open Enrollment Period:** Healthcare.gov Marketplaces will be open from November 1st through December 15th, 2017.

**Sign up soon** More than 600,000 people signed up in the first week, twice as many as in 2016. And the enrollment period is only about half as long as it was last year, so there will probably be a big rush in the final weeks.

Some other marketplaces will be open longer. If you live in one of these places, check your marketplace for details.

California, Colorado, Connecticut, Massachusetts, Minnesota, New York, Rhode Island, Washington, and the District of Columbia

State Marketplaces goo.gl/Qwj84A

**Other times** You can buy ACA insurance at other times of the year, but only if you had insurance and lost it when your status changed. For example: if you lost or left a job with employer-sponsored insurance, became divorced, or are now too old to be covered by your parents' plan. If that happens, you will have 60 days to buy a new plan.

**Accurate information** about the ACA is hard to find, and not just because so many confusing statements and actions have been coming out of Washington. It is also a result of cuts the Department of Health and Human Services made funding the nonprofit groups that help people understand the plans and navigate the signup process.

Fortunately, the **Kaiser Family Foundation site** can help you. A few of their pages:

frequently asked questions goo.gl/NLbA5o
general information https://www.kff.org
unofficial ACA subsidy calculator goo.gl/P5V3os

**Also see:**

the Affordable Care Act site www.healthcare.gov
Help understanding the site (and translations of it)
https://www.healthcare.gov/contact-us/
1–800–318–2596 or TTY: 1–855–889–4325
Basic Health Plan Questions: a worksheet
www.hypertext.org/ENGLISH/questions.pdf

**Grandfathered plans** are those sold before March 23, 2010, and group plans that existed before then. They don't have to offer some of the benefits ACA Marketplace plans must include.

## MEDICAL DEFINITIONS

**Provider** A medical professional who, or organization that, provides medical services.

**Primary-care physician** The doctor you see for annual exams and the treatment of minor problems.

**Primary-care providers** Nurse practitioners and others who provide basic healthcare or help patients obtain it.

**Specialists** Doctors who treat specific problems or areas (for example, cancers) and have related skills (such as radiation).

**Referrals** Some plans require you to get permission from your primary-care physician (or a specialist you were referred to) in order to get a test or an appointment with a specialist.

**Network** The doctors, hospitals, and other providers that have contracts with an insurer. If you go **out of network** to other providers, you must pay part or all of the other provider's fees (depending on the type of plan). Some plans do not apply this to out-of-network emergency rooms.

**Managed care** Managed-care organizations (MCOs) can deal with all of your medical needs. Some have most of their doctors and facilities in one place, others have contracts with a network of providers in your area.

Most MCOs are one of these types:

- Health Maintenance Organization (HMO)
- Point-of-Service (POS)
- Exclusive Provider Organization (EPO)
- Preferred Provider Organization (PPO).

TYPES OF MANAGED-CARE ORGANIZATIONS

| TYPE OF ORGANIZATION | HMO | PPO | EPO | POS |
|---|---|---|---|---|
| You must have a primary–care physician | yes | no | no | yes |
| You must get referrals | yes | no | no | yes |
| Amount you must pay if you go out of network | all | some | all | some |

managed health care

http://en.wikipedia.org/wiki/Managed_care

Basic Health Plan Questions: a worksheet

www.hypertext.org/ENGLISH/questions.pdf

Other types of plans or alternative ways to pay for healthcare:

You can also buy an expensive high deductible health plan (HDHP) that will let you choose any providers you wish.

about high deductible plans

http://en.wikipedia.org/wiki/High-deductible_health_plan

Or you may be able to set up one of the types of savings accounts for your estimated healthcare needs.

Flexible Spending Accounts (FSA)

https://en.wikipedia.org/wiki/Flexible_spending_account

Health Savings Accounts (HSA)

https://en.wikipedia.org/wiki/Health_savings_account

Health Reimbursement Accounts (HRA)

https://en.wikipedia.org/wiki/Health_Reimbursement_Account

**Health insurance co-ops** (cooperatives) are nonprofits owned by their members. They can be national, state, or local. Four co-ops will be available at a few Marketplaces in fall 2017.

**Healthcare-sharing ministries** are co-ops for people who share specific religious or ethical beliefs.

**Group Plans** Some professional and social associations offer group insurance plans. The cost of membership plus premiums might be less than buying an individual plan.

an overview of the many forms of insurance

goo.gl/pqBpR7

Consumer Reports' Guide to Health Insurance

goo.gl/A5DTxw

**If you don't buy a Marketplace-approved plan,** buy carefully. There are many bogus companies that sell fake plans.

**Help buying insurance** Licensed insurance **brokers** can explain the fine print and help you find the best deal. They represent you and get a commission from any company you sign up with. **Agents** only represent the company they work for.

about insurance brokers

http://en.wikipedia.org/wiki/Insurance_broker

## IF YOU CAN'T BUY INSURANCE

**Department of Veterans Affairs** Eligibility for VA health benefits and services is limited to those who served in active military service and were discharged or released under conditions other than dishonorable. To apply for VA benefits:

https://www.va.gov/healthbenefits/apply/veterans.asp

MEDICARE AND CHIP

If you don't qualify for a Marketplace plan, you may still be eligible for Medicaid (free or low-cost insurance for adults) and/or CHIP (the Children's Health Insurance Program).

Medicaid and CHIP coverage

goo.gl/DMJvNm

about CHIP

goo.gl/gVRgQs

state Medicaid and CHIP policies

www.medicaid.gov/medicaid/by-state/by-state.html

## OTHER WAYS TO GET HEALTHCARE

**Planned Parenthood** offers services for women and men. In addition to pregnancy information and prenatal care, there are screenings for cancers and sexually transmitted diseases, and other services.

https://www.plannedparenthood.org

**Community health centers** provide basic primary care for free or a fee based on your income.

community health centers http://bphc.hrsa.gov/about/

find a community health center goo.gl/LD8VN

**Retail walk-in clinics** can deal with minor problems and flu vaccinations. Some stores, supermarkets, and drugstores have them. Fees are relatively low, and prices for services are usually listed outside the clinics and on their websites.

find walk-in clinics goo.gl/90ClHp

Some non-profit organizations offer free flu shots in the fall.

**Hospital emergency rooms** (ERs) must help you if you need immediate assistance (such as a broken leg), but they don't treat things like cancer. And they can be very expensive.

**For-profit emergency rooms** are private and found in places like shopping malls and storefronts. They often charge high prices and can be aggressive about payment.

Do not go to any ER unless you have a very serious problem.

**Find financial and other kinds of assistance** There are charities, organizations, clinics, and others that help the uninsured and the under-insured obtain treatments, drugs, travel to distant hospitals, and other things. Here are a few:

assistance with prescriptions, financing, and other things

goo.gl/tfMiRT

finding assistance (cancer)

http://www.cancerfac.org/

**Bargain with providers** Insurers negotiate prices with doctors, labs, and hospitals. Any of those might also be willing to give you reductions and/or let you pay in installments. Use the Healthcare Blue Book to find out what is a reasonable price.

Healthcare Blue Book

goo.gl/IFiiG

negotiating with providers

goo.gl/ovTMM

ways to save money

http://well.blogs.nytimes.com/tag/patient-money/

**Avoid for-profit hospitals** They are allowed to charge you much more than they charge insurers. Some nonprofit hospitals also overcharge the uninsured, even though they receive tax breaks to help people who cannot afford.expensive care.

**Ask other people** Support groups are especially helpful, and most members are happy to share information.

in-person and online support groups

https://en.wikipedia.org/wiki/Support_group

**Go to another city** Extreme differences in prices exist even within a single U.S. city. In 2015 the Blue Cross and Blue Shield Association reported that the cost of knee surgery ranged from $16,772 to $61,585 in hospitals in the city of Dallas.

This disparity led to the growth of domestic medical-tourism networks that match less-wealthy patients with less-expensive hospitals and doctors. Some employers and insurers have them arrange treatment for their employees or enrollees. You may be able to do the same.

advantages of seeking treatment in other U.S. cities

https://khn.org/news/domestic-medical-tourism/

AARP article on domestic medical tourism

goo.gl/dw5cq7

**Go to another country** Healthcare in some countries is better than what some U.S. MCOs offer. And it can cost much less, even with international travel.

You will have to pay the full cost at the time of treatment. And there are risks, but reliable expert providers exist. Books, organizations, websites, magazines, and travel agencies offer advice and/or arrangements. But many will only send you to hospitals that pay them finder's fees.

Medical Tourism (CDC)

goo.gl/TE9dbD

National and international accredited hospitals

http://www.worldhospitalsearch.org

State Department information about foreign travel

goo.gl/qzJJK2

Health Costs: US and Other Countries (PBS)
goo.gl/XWgtoZ

healthcare systems in 191 countries

goo.gl/Jn1Oz

**Travel assistance** If you travel for treatment in the U.S. or abroad, ask if the hospital has lower-rate arrangements with local hotels. If not, ask for discounts when you contact hotels.

groups that assist with medical travel in the U.S.

http://www.joeshouse.org/Resources.aspx

## APPEALING INSURER'S DECISIONS

Before the ACA became law, insurers could cancel your policy if you became ill. They only had to claim you committed fraud when applying for the policy. Evidence could be as simple as the failure to list a childhood illness. They can still deny drugs or treatments, but now it is easier to challenge them.

Some insurers may deny treatment simply because they know that most people don't have the time, energy, money, or knowledge needed to fight them.

### DENIALS

There may be times you want or need a specialist who is not in the network, a type of therapy your insurer does not provide, or a more effective drug. It will probably be denied for one or more of these reasons:

- it is "not medically necessary"
- it is an "experimental" treatment
- it is not part of the plan you signed up for.

If you are denied a necessary drug or treatment, ask your doctor write your insurer to explain why you need it.

**Suing over a denial** is difficult and not always possible. And if you can sue, the lawsuit might cost more than paying for the treatment yourself. Treatment-rationing is legal and if insurers improperly deny treatment, they do not have to pay you (or your heirs) any more than the cost of what was denied.

### APPEALS

#### Grandfathered plans

It is harder to appeal decisions by these plans because they do not have to comply with the same rules as ACA plans. See *Steps for appealing denials* below.

#### ACA and recent private plans

**Internal appeal** First, ask your insurer to make a full and fair review of the decision to deny. The period allowed for filing may be very short, so do it right away. If you need treatment urgently, the insurer must respond as soon as possible.

how to request an internal appeal goo.gl/qjD3aU

**External review** If your insurer does not agree to your request, ask for an external review. That means an independent review organization (IRO) that has no connection to your insurer will decide what should be done.

how to request an external review goo.gl/oo4jUw

#### Steps for appealing a denial

Insurers must make every denial in writing. If they do it any other way, insist on a written response. If you still do not understand why it was denied, write asking for an explanation.

Your letter should state your problem clearly. Explain why you disagree with their decision, and exactly what you want. Always include the number that identifies the denial.

appealing a denial (Washington state information)

goo.gl/dcLpr3

how to write a claims appeal letter (Wikihow)

www.wikihow.com/Write-a-Medical-Claim-Appeal-Letter

**Keep everything they send you** and copies of everything you send them. Important letters should be sent by certified mail and require signed receipts. When you phone, write down the names, time, date, and what was said. (If the insurer or MCO has a call-tracking system, you may be able to cite that later if you have to prove when you called.)

**If the insurer does not contact you** within ten business days of the date you mailed the letter, call them. Don't stop.They may be hoping you will give up, that the appeal period will run out, or that you will soon be dead.

**If your appeal is turned down**, see if you can resubmit it. Some insurers allow second- and third-level appeals. If they say the decision is final, contact your state's Department of Insurance to ask what appeals may still be available to you.

departments of insurance, by state

http://www.naic.org/state_web_map.htm

**If your state insurance department can't help** and your health is in danger, contact every politician who represents you.

**Mental-health or substance-use-problem benefits** If you were denied any that are included in your health plan, contact the Parity Implementation Coalition.

Parity Implementation Coalition

http://parityispersonal.org

THINGS TO WATCH OUT FOR

**Medical credit cards** Do not use them for essential medical treatments. They are intended for procedures that are not covered by most insurance, such as plastic surgery. The initial rates may seem low, but using these cards could be more expensive than negotiating with providers.

Providers like these cards because there is no need to deal with insurers, and they can charge for the entire procedure as soon as you give them the card. These cards are *not* payment plans, although some providers may tell you they are.

The Small Print of Medical Credit Cards (Money)

goo.gl/yIHCH

**Medical-identity theft** Never give your insurance or medical information to unauthorized people, or allow anyone to use your identity to get medical treatment. It could result in changes to your medical records that might harm or even kill you.

And it can be expensive. Medical-identity theft costs most of its victims thousands of dollars in medical, legal, and other bills. One report estimated that it took an average of than 200 hours to deal with all the problems.

The Rise of Medical Identity Theft (Consumer Reports)

goo.gl/db36c8

dealing with medical identity theft

http://goo.gl/WE4Dmq

Federal Trade Commission identity theft hotline:
1 877 ID–THEFT

**Medical bills can hurt your credit rating.** A claim could be filed against you if bills are misplaced, misaddressed, or not sent. A Federal Reserve study found unpaid medical bills are responsible for about half of all problems with consumer credit reports.

Federal Trade Commission consumer information

https://www.consumer.ftc.gov

Medical debt ruining credit scores (Washington Post)

goo.gl/GMFhpu

**Overcharges and reduced services** There are many ways insurers and providers can overcharge or underserve you. For example, they might limit how much doctors in their networks can spend on their patients each year (capitation) or require them to change prescriptions, tests, or treatments.

**Clerical errors** If you find an mistake, call Customer Service. If they refuse to correct it, ask your doctor to contact the provider or insurer and explain the error.

**Intentional billing errors** These are the most common forms: billing for services that were not performed (phantom billing), charging for a more-expensive service (upcoding), and billing separately for tests or procedures performed at the same time by the same person (unbundling).

**Unintentional billing errors** Because insurers and providers use many different and confusing codes, you might have to hire a medical-billing advocate to interpret the bills. Advocates can identify errors and negotiate reductions with insurers and providers. If there are many errors, an advocate might be able to save you much more than the cost of his or her services.

how medical billing advocates can help (New York Times)

goo.gl/0NADjR

Medical Billing Advocates of America

https://billadvocates.com

**REFERENCES**

**Where America ranks in healthcare**

| | |
|---|---|
| by life expectancy | goo.gl/X3lxQ4 |
| by infant mortality rate | goo.gl/1ojjL0 |
| in the developed world | goo.gl/zxUHLm |

**Why you need health insurance** *Bitter Pill: Why Medical Bills Are Killing Us,* Time Magazine cover story, 20 Feb. 2013

goo.gl/D5XBc

**Medical debts** More than half of all U.S. personal bankruptcies in 2007 were caused by medical debts.

*American Journal of Medicine,* August 2009

goo.gl/Tfz75

**Bogus companies** In 2000–2002 at least 144 companies failed to pay more than $250 million in claims.

GAO–04–512T goo.gl/Nm2Xo

**Hospital charges** *Huge hospital markups burden patients,* Atlanta Journal-Constitution, 20 April 2011.

**Knees** *A knee replacement surgery could cost $17k or $61k. And that's in the same city.* Washington Post, 21 Jan 2015 goo.gl/yZv58H

**Canceling policies** An insurance-company bureaucrat who terminated the policies of 301 sick people in one year was praised for saving the company about six million dollars in "unnecessary" healthcare expenses. (The average claim cost was $20,000.) *Health insurer tied bonuses to dropping sick policyholders,* Los Angeles Times, 9 Nov. 2007. goo.gl/Esz8Jy

**Limited services** In 2008, the Medical Society of the State of New York surveyed 1,200 physicians. It found that 93% were made to change prescriptions, 87% felt they were pressured to prescribe treatments based on cost, and 62% felt they might be dropped if they did not follow company policies. goo.gl/fsqML7

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