Navigating Health Insurance

1. Why do you need health insurance?
2. What are your options?
3. Do you have a choice? If so, how to select a plan.
4. Using your covered benefits.
5. Understanding claims-related paperwork.
6. Appealing claim denials.

Why do you need health insurance? The main reason is that health care is expensive. It can be so expensive that you run out of savings. Even if you are healthy and have great habits, you can get injured or develop a costly health problem. Health insurance pools money from individuals and sponsors so people who need a way to pay for their health care can do so.

What are your options? American health insurance is very complicated. Your options are based on your age and income, as well as the state you live in and who people in your family work for. Most states have made Medicaid available to people who are working, but don't make much money, as well as people who aren't working because they are students or caregivers. People who make a little too much to qualify for Medicaid or who live in a state with low Medicaid income limits can qualify for discounts on health insurance through their state's health care marketplace. Go to healthcare.gov and fill in some basic information to get more details.

If you or your spouse works for a large employer, the health insurance they offer is probably going to be your best option. Large groups of insured people have a lot more power to negotiate with insurance companies than small groups or individuals. Large employers also use benefits like health insurance to compete for qualified employees. The employer will typically cover quite a lot of the total premium, so the employee may pay some part of the cost, but not as much as an individual would pay without the employer's contribution.

Do you have a choice of health plan? This is where things get complicated. An employer might offer employees just one plan. However, if you are choosing among plans, you will need to do some math. Don't just look at the monthly premium! Insurance companies structure their plans so the total likely cost is the sum of the monthly premium and the other costs that you will bear if you use your coverage. If the enrollment paperwork includes information on the highest cost you might have to bear, try adding that to the premium. These costs include such things as copays, coinsurance, and deductibles. Your out-of-pocket maximum is the total amount beyond your premium contributions that your insurance company can require you to pay each year. Adding your total premium costs to your total-out-of-pocket maximum costs will give you a better idea of the actual value of your health plan options.

Cost is not the only issue to consider when choosing a health plan. There may be limits on the type or amount of services that are covered. If you or a family member will need a specific type of care, check the list of covered benefits to see how they compare between plans. Even if the care you need is

covered, it's important to know whether there is someone who offers that kind of care within the plans' lists of doctors, nurses, hospitals, and other facilities (we call those "provider networks"). If you need coverage for a specific kind of medication, you can check a list called a formulary to see whether it's eligible for coverage and how much you will have to pay out-of-pocket for it. The bad news is that both provider lists and formularies can change unexpectedly.

Talk to friends and family who have experience with the various options you're considering. They can help with the decision-making process by letting you know, for example, how long they had to wait for an appointment with a specialist. They can also tell you whether they have had problems with benefits being denied (more about that later).

Using your covered benefits. If your health plan has a deductible, you will need to spend that amount of money yourself every year before your coverage kicks in. Some plans have a separate deductible for medications. Most plans now cover preventive care completely, so the deductible is likely to apply primarily to the care you receive when you are sick or injured. Get familiar with the provider network (see above) and choose a primary care provider. If you are enrolled in Medicaid, this choice will be made for you, unless you identify someone when you enroll.

Health plans now offer options for care that don't require you to leave the house. Most plans have nurse help lines that can be very helpful if you're trying to decide whether or not you can treat a health problem on your own. Since the COVID-19 pandemic, telehealth options have become more widely available. You may be able to visit with a doctor or nurse practitioner on your phone or another device. If you're not feeling well or caring for a sick family member, this can be a great alternative to an in-person visit.

Don't put off preventive care! Keep in mind that there is a wide range of preventive care that is covered without any out-of-pocket costs (copays or deductibles). No one wants to think about getting sick, but delaying care can lead to serious problems when a condition is diagnosed. Some preventive care isn't pleasant, for example, colonoscopies! However, coverage for care that doesn't require you to spend money beyond your premium costs tells you that preventive care experts have found that people should be encouraged to use it.

Understanding paperwork on claims. "Paperwork" here includes the emails, texts, and phone calls you get from your health plan, as well as actual paper documents. Rule #1: open that email or envelope and read the message. You may think that it can only be bad news, but that's not always true. If you don't understand what the message is trying to tell you, there is no shame in asking. Do you have a friend or family member who is used to dealing with this kind of information? If you are getting insurance through your own or a family member's employment, there will be someone in the company who is responsible for helping with employee benefits like health insurance.

If none of these options are available, you can direct your questions to the toll-free number that appears on your insurance card. The problem is that you may need to invest some time waiting on hold. If your question isn't too complicated, you should be able to get an answer eventually.

One kind of document that often confuses people is the Explanation of Benefits (EOB). This message should come with a very large notice that says something to the effect of THIS IS NOT A BILL. Even so, the costs listed often include the full price of the service you received. You might want to hang on to the EOB message (paper or otherwise).

One very important way to make sure you are paying for the services you actually received is to review the listing of services on your claims statement (EOB). If the EOB does not provide sufficient details, you may wish to ask the insurer for more information. The review doesn't have to be too technical. For example, look at the column called Dates of Service. Were you actually receiving the listed service on those dates? If there are charges you don't understand, the process described in the first paragraph of this section should be helpful. You can challenge charges that you think are wrong—a hospital date after you went home, for example, or an X-ray that you didn't have done.

Finally, keep copies of your documentation and a list of phone calls, case numbers, and people you talked to. Doing so will support your case if there is a problem with your claim. If you aren't able to take this step yourself, identify a family member who can help out.

Appealing service and claim denials. This is undoubtedly the toughest challenge with health insurance. You may have read the media coverage about formulas used by some insurance companies to deny coverage for some types of care even if they are clearly needed. State and federal agencies are looking into this kind of abusive practice right now, but it's hard to stop completely.

Your insurer may provide a list of services that require what is called prior authorization (PA). For these services, your doctor has to give the insurer detailed information about why the service is needed. The insurer reviews the information to decide whether or not to cover it. There can be legitimate reasons for PA, particularly for very expensive or unusual services. For example, over time, some kinds of treatment have proven to do more harm than good despite having a lot of support originally. However, PA is very time-consuming for doctors' offices and PA policies can delay needed tests or treatment.

If your doctor's initial request for PA is denied, you need to keep track of whom you talked to about what, and when, just as with other information about health insurance claims. Again, this can be a problem if you are very sick or busy, so it's really helpful to have a friend or family member to help out.

The appeals process for PA and claims denials starts within the insurance company's own process. Company policy and procedure will be set out in your coverage documents or on the insurer's website. Be sure you identify the process that is specific to your plan. Big insurers like Anthem and United Healthcare offer hundreds of different kinds of coverage. You (or your helper) should have easy access to forms that are used to submit appeals.

When the problem is with PA, your doctor's office has to take the lead because they have the detailed clinical information needed to resolve the problem. If you have an urgent need for the service, there should be a protocol to get your request processed faster. However, most (or even all) of the conversations with the insurer about PA have to come from the doctor who ordered the service.

What if you have already received a service and the insurer refuses to pay for it? In this case, a lot of the process depends on what kind of health insurance you have. Whatever type of coverage you have, you

will need to go through the insurer’s appeals process before you turn to other options. Don’t try to do this on your own unless you are pretty sure you can handle it! Your doctor’s office, hospital, or other health service provider should be able to help. Again, see if you can identify a friend or family member who is good at working through this kind of problem. There are also professionals who do this work for a fee.

Why does the type of health insurance matter? If your coverage is through the ACA marketplace or your employer has bought coverage from an insurer, your state Department of Insurance will provide specific consumer protections if you have run out of options with your insurer. However, these state protections are not available for nearly half of Americans who have coverage through their own or a family member’s employer. The reason is that many employers, including nearly all of those with a lot of employees, don’t pay insurance companies to cover their employees’ health care costs. Instead, they cover these costs themselves through a process called self-insurance. It can be very confusing to distinguish the type of employer coverage because self-insured businesses often employ insurance company staff to administer their insurance plans. Your health insurance ID might feature the logo of an insurance company that is just the administrator, not the actual insurer of your benefits.

The reason so many employers self-insure is that by doing so, they avoid being subject to state insurance regulation. The only oversight for these plans is provided by the US Department of Labor. This arrangement is helpful for large multi-state employers because they don’t have to comply with the different rules for each state where they have workers. However, it reduces the level of protection for the people insured in these plans. Even if the plan has wrongly denied coverage and the patient is harmed, the patient can only get the value of the service that was denied.

In summary, know how your health care coverage works. If you have a problem with it, start with your insurer’s administrative process, take advantage of your state Department of Insurance options if your plan falls under their rules, work with your doctor’s office or other service provider, try to find a helper if you need one, and document, document, document.