THE HYPERTEXT GUIDE TO

HEALTH INSURANCE IN THE UNITED STATES

REVISED 2016

Definitions Affordable Care Act If you can't get insurance Insurance appeals

This very basic description of health-insurance options can be a useful starting point for any American citizen or immigrant who is uninsured or whose insurance provides limited benefits and protections. The information was gathered from Healthcare.gov and other sources, but it may not be completely up to date.

DEFINITIONS

INSURANCE

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

Enrollee (policy holder, subscriber, member) Person covered by an insurance plan.

Premium The amount you pay your insurer every month.

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

Coinsurance Once you pay the deductible, you are only responsible for part of any additional medical expenses that are covered by the plan. How much that part is depends on the plan you have.

Copays (*copayments*) Some smaller expenses you must pay when you receive services, tests, or prescriptions.

Out-of-pocket The money you pay for the deductible, coinsurance, and copays (but not your premiums). Your **out-of-pocket maximum** (or limit) is the most you have to pay during the year of the plan. The OOP maximum for Affordable Care Act plans in the 2015 enrollment was only $6,850 for an individual and $13,700 for family.

Covered or excluded services A list of things or treatments that are part of (or are never part of) what the insurer will provide or pay for.

Annual limits How much your insurer will pay for some covered services each year (for example, certain prescriptions). You pay the full cost of anything after that.

MEDICAL

Provider Medical professional or organization that provides medical services.

Primary-care physician The doctor you see for your annual physical exam and the treatment of minor problems. **Primary-care providers** include nurse practitioners and others who provide basic health care or help patients obtain it. **Specialists** treat specific problems or areas (for example, the eyes) and have related skills (for example, surgery).

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 outside provider's fees (depending on the type of plan). Some plans do not apply this to out-of-network emergency rooms.

Referral Some plans do not allow you to see a specialist or have a test without the permission of your primary-care physician (or a specialist you were referred to).

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

Most MCOs are one of these types: Health Maintenance Organization (HMO), Point-of-Service (POS), Exclusive provider organization (EPO), and Preferred Provider Organization (PPO). Some insurers offer High Deductible Health Plans (HDHPs), which allow you to choose any providers you wish but have very high deductibles.

MANAGED-CARE ORGANIZATIONS COMPARED

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
If you go out of network, you pay	all	some	all	some

types of managed health care http://en.wikipedia.org/wiki/Managed_care
about high deductible plans http://en.wikipedia.org/wiki/High-deductible_health_plan

THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA), also known as Obamacare, made it possible for millions more Americans to finally get health insurance.

THE ESSENTIAL BENEFITS

ACA plans and recently created private plans must cover ten “essential benefits.”

- Hospitalization for an accident or illness.
- Free basic laboratory services. (Copays are required for other types.)
- Prescription drugs (which are usually equally effective generic versions).
- Outpatient care. (Things that do not require a stay in a hospital, such as doctor appointments and minor treatments.)
- Rehabilitative services to help relieve pain or aid recovery, and habilitative services to help you deal with long-term disabilities.
- Emergency room care. (Preauthorization is not required.)
- Free preventive care, including one visit a year with your primary-care doctor, immunizations, and any services recommended by the Preventive Services Task Force that apply to you.
- The other essential benefits are pediatric care for children under age 19; maternity and newborn care; services for mental or behavioral health.

Grandfathered plans Plans that were created before March 23, 2010, do not legally have to provide some of the benefits and protections that ACA plans must provide.

about grandfathered plans http://goo.gl/7yv4bh

THE PLANS

There are four types (levels) of plans, each with different prices for the premiums and different coinsurance percentages. For example, Bronze Plans have the lowest premiums but high deductibles. Your coinsurance will be 40% of any additional expenses until you have paid the annual out-of-pocket maximum (OOP). Your insurer pays the other 60% and any other expenses during that year. (The out-of-pocket maximum in 2015 was $6,850 for an individual or $13,700 for family.)

ACA PLANS COMPARED

PLAN LEVELS	BRONZE	SILVER	GOLD	PLATINUM
Premiums you pay	lowest	next lowest	higher	highest
Coinsurance you pay	40%	30%	20%	10%
Coinsurance your insurer pays	60%	70%	80%	90%

BUYING A PLAN

Who U.S. citizens, U.S. nationals, and legal immigrants can buy ACA plans.

what immigrant families need to know http://goo.gl/P7IYx1
immigration statuses that qualify http://goo.gl/qOQKhC

Where Your state's ACA Marketplace Exchange. If there is none, go to HealthCare.gov.

Marketplace exchanges by state http://goo.gl/cFscKz
HealthCare.gov main page https://www.healthcare.gov

When Open Enrollment begins in November and ends some time in January. Plans bought before December 15th start on January 1st. (After that, February 1st.) At any other time, you can only buy a new plan if you had been insured and your status changed. Examples of status changes include losing your job (and employer-provided insurance), getting divorced, having a baby, or moving to another state.

If your status changes, you have 60 days to apply for ACA insurance. Call your Exchange immediately.

How much Costs vary around the country. Prices are usually lower in states where more insurers compete, but local health-care costs also affect prices. And even though every state government has the power to deny unreasonable rate hikes, some refuse to.

Subsidies You may be able to get financial assistance paying your premiums if your household income is between 100% and 400% of the federal poverty level. The amount of that assistance will be sent directly to your insurer each month.

current poverty guidelines http://aspe.hhs.gov/poverty/index.cfm

Watch out for scams Criminals have set up fake state and federal exchanges. Both fake and real insurers send misleading emails suggesting they are part of the ACA or leading people to believe they will receive a subsidy.

USING HEALTHCARE.GOV

HealthCare.gov does not provide a clear on-site explanation of what it is or what to expect. The suggestions in this section may help you understand the federal and some state Exchanges. (The links and information may already be out of date, so read the Heathcare.gov site carefully.)

The Steps to Buying a Plan

1. **Decide** How much coverage will you need and how much can you afford to pay.
2. **Prepare** Find and organize all the information you will have to provide.
3. **Compare** Take a very careful look at the plans.
4. **Create an account** Name and address, a username, security questions.
5. **Apply** Answer questions about citizenship and household income.
6. **Enroll** Select the plan that best fits your situation. Pay the first premium.

7. **Follow up** Confirm that the enrollment has gone through.

Deciding and Preparing

Don't wait until the Open Enrollment Period begins. Even though the plans will not be available to study until then, you should complete the steps 1 and 2 long before that. A list of the required information is on the mail-in application.

Application forms https://marketplace.cms.gov/applications-and-forms/individuals-and-families-forms.html

Make sure everyone in the household has a social-security number, even babies. Getting a number could take a while, so apply now.

how to get a social-security number http://www.ssa.gov/ssnumber/

You can get a free email account from Yahoo!, Google, or other company.

Comparing

If you were insured and your status changed, you can preview the plans when it happens. But new buyers and those who have plans should not preview them before the November enrollment period start date because they may change.

Study the plans carefully. Find the ones that are most likely to fill your needs so you can quickly choose one when you reach the enrollment stage and know the final details.

Don't base your choice on premium costs alone. You won't know the *real* cost of a plan until you find out what *all* the copays, annual limits, and other expenses are. Look for plans that provide the treatments, drugs, and other things you need.

The four plan categories have many things in common, but some offer more benefits. You'll find those in the *Other Covered Services* section near the end of the Summary of Benefits.

You will have to supply some basic information to see the plans, but the premium price you will see at this stage will be an estimate, not the final price.

where you can see the plans https://www.healthcare.gov/see-plans/

Click the DETAILS button to see what else the plan offers. The new page will list the costs of the copays, deductibles, and out-of-pocket expenses. If the plan seems interesting, use the following links to download more information:

Summary of Benefits : what services are included and what they cost.
Provider directory : their network of physicians and medical centers.
Formulary : list of the drugs covered by the plan.
Plan brochure : general information about the plan.

Use these worksheets to help assess the plans.

Worksheet Questions hypertext.org/ENGLISH/insurance_questions.pdf
Worksheet Two Instructions www.hypertext.org/ENGLISH/wsinstructions.pdf
Worksheet Two hypertext.org/ENGLISH/worksheet.pdf
Worksheets for the Blind hypertext.org/ENGLISH/three_sheets.html

Creating an Account

This section only provides some hints to help you navigate. Some of the security questions ask for things anyone can find out, so supply impossible answers. (For example, substitute *1901* as the date you were married or *poison ivy* as your favorite radio station.) Good security answers help protect you against the very real danger of medical identity theft.[1]

Confirmations of the next three steps may take minutes or hours to go through. Don't sit there waiting for them, just check the page from time to time.

It can take a fairly long time to complete the next two steps, but you don't have to do it all at one time. You can log out and log back in at any time. If you have completed the application stage, select *Find my existing application.*

Applying

For help understanding the site (and for translations of it in many languages):

https://www.healthcare.gov/contact-us/ or 1-800-318-2596 or TTY: 1-855-889-4325

After completing the application, you will find out if you qualify for a plan, or a plan and a subsidy, or Medicaid and/or CHIP (which are explained in the next section).

If you think the results are not correct, you can appeal them.

how to appeal a Marketplace decision http://goo.gl/emCruS

Enrolling

The tax credit (subsidy) will be divided in 12 equal parts and sent directly to the insurer by the Exchange each month. If you expect your household income will be much higher next year (which might reduce your subsidy), have the Exchange use a smaller amount. For example, a subsidy of $1200 would pay $100 a month. If you use it all and earn too much, you might have to pay some of the money back. But if you apply only $80 each month to the premium, and earn more money than you expected, you might not have to pay anything. Or, if you *don't* earn too much, you can use the other $240 to pay your taxes—or have it added to your tax refund.

reporting life and income changes http://goo.gl/bn6Ctl

Following up

A few days after you have paid the first premium, you should log onto your account and click on your application. *My Coverage page* will have details about your enrollment. If you have not yet been enrolled, ask the insurer if they received your premium. If they did, ask when you will be enrolled. If you haven't been enrolled yet, call back every day until you are.

You will receive membership cards and other information in the mail. If you find any errors or have any questions, contact the insurer.

PRIVATE INSURANCE

You have have insurance, but you do not have to buy it from the Marketplace. However, you should be very careful if you buy directly from an insurance company. Avoid grandfathered plans, which may cost less but rarely offer as much health or economic protection as the Marketplace plans.[2]

Watch out for bogus companies. They will take your money but cannot be found when there are bills to pay. Some use names that resemble legitimate firms and may even sell their products through licensed agents.[3]

Group Plans

Some professional and social organizations offer group insurance plans. The cost of membership and insurance might be less than an individual plan.

Insurance Brokers

A **licensed broker** can help you find the best deal in private or ACA plans. But you don't pay a broker because they get a commission from the company you decide to sign up with. An **insurance agent** only represents one company. (Some agents call themselves brokers, so be sure to find out which type they really are.)

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

IF YOU CAN'T GET INSURANCE

MEDICAID AND CHIP

If you can't get a Marketplace plan, you will probably be eligible for Medicaid (the free or low-cost insurance for adults) and CHIP (the Children's Health Insurance Program). The Exchange will tell you if you are.

about your Medicaid or CHIP coverage http://goo.gl/DMJvNm

You may not be able to get Medicaid if you live in a state that did not expand it. The ACA made Medicaid available to anyone who could not buy a plan, but the Supreme Court decided states could refuse to expand it. Almost a third did—even though the federal government would have paid all or most of the expense.[4]

if your state does not expand Medicare http://goo.gl/rzfGk2
about CHIP http://goo.gl/gVRgQs

Apply even if your state did not expand Medicaid. There may still be space, or your representatives may have finally decided to expand the program.

state Medicaid and CHIP policies http://goo.gl/k3c039

OTHER WAYS TO GET HEALTHCARE

If you can't get Medicaid or buy an ACA plan health insurance until the next Open Enrollment period, you might try these alternatives. The first three can't help with disease like cancer, but they can help with problems that require immediate attention, such as automobile accidents.

Community health centers The ACA greatly expanded funding to these centers because they provide primary-care services for free or a fee based on your income.

about community health centers http://bphc.hrsa.gov/about/
find a community health center http://goo.gl/LD8VN

Emergency rooms Hospital ERs must help if you need immediate assistance (such as a broken leg), but they don't treat things like cancer. And they are not free.

Private emergency rooms in shopping malls and other places often charge high prices, even for simple treatments, and they can be very aggressive about payment.

Don't go to either type of ER unless you have a serious problem.

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.

some walk-in clinics http://goo.gl/90ClHp

For Serious Illnesses

Seek assistance There are businesses, organizations, charities, and clinics that help the uninsured and the underinsured obtain treatments, drugs, travel to distant hospitals, and other things. Here are a few:

financial assistance and other resources http://goo.gl/m9VCT
finding assistance http://www.cancerfac.org/
financial help for people with cancer http://goo.gl/JVtru
assistance obtaining prescription drugs http://goo.gl/fY7FM

Negotiate with providers Insurers bargain with doctors, labs, and hospitals, any of which might be willing to give you similar breaks and/or let you pay in installments. Avoid for-profit hospitals because they are allowed to charge the uninsured much more than they charge insurers. Some non-profit hospitals also overcharge, even though they receive billions of dollars worth of state and federal tax breaks to provide "charity care and community benefit."[5]

Healthcare Blue Book (to find fair prices) http://goo.gl/IFiiG
negotiating with providers http://goo.gl/ovTMM
how to save money http://well.blogs.nytimes.com/tag/patient-money/

Medical tourism If you don't have insurance or your plan does not offer or allow the treatment you need or want, consider going to another country. Healthcare in some countries is better than what many U.S. MCOs offer, and it can cost much less than what you would be charged here. But finding reliable providers is not easy. Although many books, websites, magazines, and travel agencies offer advice, many are really middlemen who will send you to hospitals that pay them finder's fees.

medical tourism (overview) http://en.wikipedia.org/wiki/Medical_tourism
medical tourism (assessment) http://goo.gl/cd4Gi
medical tourism http://goo.gl/gIW76
healthcare systems in 191 countries http://goo.gl/Jn1Oz

Use a patient advocate These individuals and organizations can help you with many types of problems, including making medical decisions and understanding bills. If you are hit with a ridiculously high hospital bill, the cost of an advocate's services will probably be much less than the amount you will save.

about patient advocacy http://en.wikipedia.org/wiki/Patient_advocate
how medical billing advocates can help http://goo.gl/0NADjR
a list of specific services http://goo.gl/a7Pcw
ADVOConnection directory of advocates http://goo.gl/a7Pcw

INSURANCE APPEALS

Before the ACA became law, insurers could cancel your policy if you developed an expensive illness. All they had to do was claim you had committed fraud when you applied for the policy. Evidence of fraud could be as simple as the failure to list a minor childhood illness.[6] They can still deny you a treatment or drug, but denials can now be appealed more effectively.

DENIALS

In some cases you may decide that you would prefer to be treated by a different specialist or have a type of therapy your insurer does not provide (or wish to provide). 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 convinced that a particular treatment is necessary, try to get your primary-care physician or a specialist to write your insurer and explain why that treatment or drug should be allowed.

If you go to an out-of-network provider and then try to get your insurer to pay the bill, you will have make a *very* good case for needing that treatment.

ACA and recent private plans

Internal appeal You must first ask your insurer to make a full and fair review of their decision to deny the drug or treatment. (If you need it urgently, the insurer must respond as soon as possible.)

The period allowed for filing an appeal may be very short, so do it right away.

how to request an internal appeal http://goo.gl/qjD3aU

External review If your insurer does not agree to your request, ask for an external review. An outside group with no connection to your insurer will look over your appeal and decide what should be done.

how to request an external review http://goo.gl/oo4jUw

Grandfathered Plans

The appeals process is not as easy for people with grandfathered plans because those are not required to comply with the same appeals rules as ACA plans. And some companies have histories of denying treatment simply because they know that most people don't have the time, energy, money, or knowledge needed to fight them.

Insurers are required to make every denial in writing. If they try to do it any other way, insist on a written response. As soon as you have it, write the company and explain the problem as clearly and briefly as you can. Always state exactly what you want them to do. Be sure to include the number that identifies the denial.

Keep the originals of everything they send you, and make notes. Send important letters by certified mail and request signed receipts. Keep copies of every letter you send. If you must do anything on the phone, write down what you and the people you speak to say, the name of everyone you speak to, the time, date, and other details.

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 your insurer sent a letter advising you of an appeal meeting you can attend, and it arrived just before or after it took place, tell your state's Department of Insurance.

If the company has not contacted you within ten business days of the time you mailed the letter, call. Keep after them. 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 Try to resubmit it. Some insurers allow second- and third-level appeals (which might be done by an independent review organization).

If the insurer ignores you or says the decision is final, contact your state's Department of Insurance and ask what appeals may still be available to you. (The Department may be called a Division or Commission, so you may have to search for your state government's site and the word *insurance*—for example, *texas.gov insurance*.)

departments of insurance, by state http://www.naic.org/state_web_map.htm
guide to the appeals process http://goo.gl/LWVhu
consumer assistance programs, by state http://goo.gl/XzS9vH
navigating health care www.ahrq.gov/consumer/qualcare.html
a sample claims appeal letter http://www.healthsymphony.com/appeal.htm

If your state insurance department is no help, and your health is in danger, contact every politician who represents you.

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

parity implementation coalition http://parityispersonal.org

Suing over a denial In most cases you can't sue. And if you can, the lawsuit could cost more than paying for the treatment yourself. Moreover, the Supreme Court has ruled that treatment-rationing is legal and insurers that improperly deny treatment do not have to pay you (or your heirs) any more than the cost of what they denied.[7]

THINGS TO WATCH OUT FOR

Medical credit cards Do not use these for essential medical treatments. They are intended for procedures like plastic surgery that are not covered by most insurance.

Providers like the cards because they don't have to deal with insurers and can charge for the entire procedure as soon as you give them the card. These are *not* payment plans, although some providers may tell you they are.

The initial rates on these cards are usually low, but they end up being very expensive. You would be better off negotiating directly with the providers.

the small print of medical credit cards http://goo.gl/yIHCH

when your doctor sells credit cards http://on.wsj.com/UKQQnM

Overcharges and reduced services There are many ways insurers and providers can overcharge or underserve you. For example, most insurers and MCOs limit how much doctors in their networks can spend on their patients each year (*capitation*) or require them to change prescriptions, tests, or treatments.[8]

Clerks may make errors (or changes required by the insurer or MCO) in prescriptions or tests. Call Customer Service. If they refuse to correct the error, ask your doctor to contact the administration and tell them why the request is important.

The intentional billing error is the most common form of fraud practiced by providers. These include billing for services that were not performed (*phantom billing*), charging for a more-expensive service than the one provided (*upcoding*), and billing separately for tests or procedures performed at the same time by the same person (*unbundling*).

They also make unintentional billing errors, which is another reason to always check your medical bills. But because insurers and providers use many different codes, you might have to hire a medical-billing advocate to interpret the bills.[9]

If your provider's billing department decides not send a bill to you and instead gives it to a collection agency, you are in for trouble. If the amount is very small, the agency may choose not to contact you—but they will still report you to the credit agencies. Write your representatives in Congress and ask them to take time out from trying to repeal the ACA so they can fix this major problem.

While you are waiting for that to happen, check your credit rating frequently.

managing health-insurance bills http://goo.gl/No4c6

FOOTNOTES

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1. Medical-identity theft can create expensive legal, credit, and health problems. If someone uses your identity to get medical treatment, records of your blood type, allergies, and other things may be changed, which could harm or even kill you.
(In 2013, 1.8 million Americans were victims of medical-identity theft.)

Federal Trade Commission identity theft hotline: 1 877 ID-THEFT
Federal Marketplace Call Center: 1 877 438-4338 TTY: 1 866 653-4261
dealing with medical identity theft http://goo.gl/WE4Dmq

2. Not having enough protection A study of bankruptcies that were filed in 2007 found that three-quarters of the people who were bankrupted by medical debts *had medical insurance*. American Journal of Medicine, August 2009 http://goo.gl/Tfz75

3. Bogus companies In 2000−2002 at least 144 companies that failed to pay more than $250 million in claims. GAO-04-512T http://goo.gl/Nm2Xo

4. States that refuse to expand Medicaid To see if there have been recent changes, see the Kaiser Family Foundation's Current Status of State Medicaid Expansion Decisions. http://goo.gl/G0QC45

5. Hospital charges "Huge hospital markups burden patients," Atlanta Journal-Constitution, 20 April 2011, and "Bitter Pill: Why Medical Bills Are Killing Us" Time Magazine cover story, 20 Feb. 2013. http://goo.gl/D5XBc

6. Canceling policies An insurance-company bureaucrat who terminated the policies of 301 sick people in a single year was praised for saving the company about six million dollars in "unnecessary" healthcare expenses. "Health insurer tied bonuses to dropping sick policyholders," Los Angeles Times, 9 Nov. 2007. http://lat.ms/UKRwcH

7. Supreme Court decisions Rationing treatment: Pegram v. Herdrich, No. 98-1949, 2000. Limiting payments for improper denials: Aetna Health Inc. v. Davila and Cigna healthcare of Texas Inc. v. Calad.RETURN

8. Pressure on doctors A survey of 1,200 physicians by the Medical Society of the State of New York found that 87% felt pressured to prescribe treatments based on cost, 93% were made to change prescriptions, and 62% felt they might be dropped if they did not follow company policies. "Survey Reveals that Doctors Feel Pressured by Health Insurers" http://www.mssny.org/mssnyip.cfm?c=i&nm=Insurance_Carrier_Rules

9. Billing errors An example: Dr. Beth Nash had to deal with a hospital billing department over a $7,000 bill for cardiology services for her daughter—who had not been to a cardiologist. The hospital threatened to pass the bill to a collection agency, but later realized that it *had* been paid in full. They did not apologize.
Dr. Nash wrote in her blog, Care Triad:

- The primary focus was on collecting as much money as possible
- The naming of the billing department was based on their own internal language and made no sense to the patient ("cardiology and other services")
- The physician of record was some behind-the-scenes person who we never met
- There was no attempt on the bill to explain where any of the numbers came from

Care Triad http://www.caretriad.com/2013/04/patient-centered-billing/

Disclaimer: This overview is not intended as legal advice, but only to provide an idea of the health insurance choices you may have. It does not necessarily endorse the links provided. The information is not complete, and some of it may have changed.

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