HMOs & HIV

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The news about HMOs is always a downer. The claims you file routinely get rejected or “lost.” The amount you have to pay out of pocket for drugs or treatments keeps going up. Or you finally find a doctor you love only to have her drop out of your insurance plan’s network or, squeezed by paltry HMO compensation, drop out of sight altogether.

HIVers typically have it extra bad because HMOs try their best not to pay for all the care and meds you need. It can take weeks, even months, for a health insurance company to start bankrolling your new HAART combo. And, as the case of HIVer Belynda Dunn shows, HMOs often go to great lengths to deny lifesaving experimental treatments (Dunn needed -- and got -- a liver transplant).

But many docs and insurance experts say that with enough persistence and savvy, you *can* get the services you need -- and deserve. It may take a bigger battle than you ever imagined, but dig in and don’t let the petty and tricky red tape faze you. Jacques Chambers, who headed the benefits program at AIDS Project Los Angeles, says, “It may take some doing, but with enough hard work, you can get most of the care you need.”

Know Your Rights

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), an incredibly complicated law that made it easier for anyone with a pre-existing condition like HIV to get coverage. Suppose you suddenly leave your job and want to buy health insurance. If you had insurance for at least 18 months at your old job, then no insurer can deny you coverage or charge you a higher premium because of your serostatus. The same is true if you were on Medicaid or Medicare and then become self-employed. Unfortunately, if you didn’t have health coverage for 18 months, all bets are off. For more about buying health insurance, click on www.ehealthinsurance.com. The site lets you compare the costs of the plans available to the self-employed in your area.

What if you come off Medicare or Medicaid and get a job? Some employers offer policies that make you wait from 3 to 18 months before you get coverage if you have a pre-existing condition. This can be a major bummer, but there’s a way around it: Use your time on Medicare or Medicaid as credit. So, if your employer forces you to wait six months before you’re eligible for the company’s health-care plan, and you were on Medicaid for two months, you will get out of jail in -- duh! -- four months. For a fuller explanation of your rights under HIPAA, click on www.hcfa.gov/medicaid/hipaa

or call 800.633.4227.

Dial-a-Doc

A primary-care doctor who knows the ins and outs of HMOs is an expert and advocate you can consult when your health insurance company starts hassling you. These days, many docs have assistants that do nothing but deal with managed-care messes. If you make nice, they'll make calls.

As if there was any doubt, a recent study showed that the more HIV experience your doctor has, the longer you live! That's one reason HIV doctors and patients are mobilizing for a fully credentialed AIDS specialty (see "The Doctor is Out"). AIDS specialists will be better able to prevent, diagnose and treat the rich array of ills bedeviling HIVers -- not simply prescribing sophisticated meds but distinguishing depression from low testosterone from anemia from... The American Academy of HIV Medicine (AAHIVM), which is spearheading the "specialist" cause, maintains a list of accredited AIDS specialists on its website. Click on www.aahivm.org/new/index.html, or call 866.241.9601.

But given the fierce financial Catch-22 many dedicated HIV docs face in the age of managed care, Dr. Dreamboat may no longer be accepting new patients. Another good source of physician leads is your local AIDS service organization (ASO), which is likely tapped into the local grapevine of who's good *and* available. Christine Lubinski, executive director of the HIV Medicine Association, a Washington, DC-based trade group for AIDS docs, also urges HIVers to consider a county hospital or local government-run clinic. "When some private AIDS docs have closed, the best viable alternative is often the county health department or public hospital," she says. "These places will make room for you, and you shouldn't assume they're offering substandard care. Some of the best HIV specialists in the country practice in the public sector." The main drawbacks? Longer waits for appointments, crowded waiting rooms and more-outdated reading material.

Know Your HMOs From Your PPOs

There are basically three types of health insurance plans: health-maintenance organizations (HMOs), preferred-provider organizations (PPOs) and fee-for-service. HMOs offer you a network of doctors you will pretty much have to see if you want the insurance company to pay. PPOs also offer a network of doctors, but you have the option of going out-of-network, which, of course, means paying more money. PPO premiums are also higher than those for HMOs, and the fine print in your PPO plan may contain more restrictions on which services are covered.

But most experts say that in such states as New York and Florida, where HMOs are relatively new, it's best to go with a PPO if you can afford it. The less entrenched the HMO, the less connected it is to the local network of AIDS docs. More important, PPOs offer the widest range of physician options. "The hassle factor with HMOs can be enormous," says Susan Dooha, director of health policy at New York City's Gay Men's Health Crisis. "You have to get approval every time you want to see a specialist." Dooha allows that many of her clients get frustrated with PPOs as well, especially when it comes to filling out paperwork or finding out which services are covered. But, with more choices, she says, HIVers often find a doctor or specialist they love who is not in-

network. When you make that kind of match, Dooha says, it can lead to a profound improvement in the quality of your care.

Fee-for-service plans are the priciest, but they offer the most freedom in choosing a doctor. Basically, you can see whomever you want and you don't need prior approval for services. However, when these plans are affordable for the ordinary mortal, it is often because they cover a quite limited range of treatments. They also tend to have a higher deductible, which means that you might have to pony up the first $500 or $1,000 of your health insurance costs before the fee-for-service plan kicks in. Given the greed of the managed-care system nowadays, you're going to pay a hefty premium for the right to choose your own doctor and coordinate your own health care.

Reject That Rejection

Membership has its privileges, and belonging to a managed-care plan often entitles you to a generous ration of rejection: claims unprocessed and unpaid, services denied. The situation has become so extreme that two years ago the Connecticut attorney general filed suit against the state's four largest HMOs, charging them with denying patients care just to boost profits. Investigations by *The New York Times* and other media have found that insurers systematically reject claims for services that they do in fact cover. The reason you may have to resubmit the same form numerous times and make repeated calls before you hear that the check is in the mail, many experts say, is that your HMO is looking to control cash flow.

Knowing the economic motives of your HMO will be cold comfort, however, when that reimbursement check keeps not arriving. But don't panic. Karen Kligler, a New York City-based consultant who helps patients battle rejected claims, prescribes persistence: Call the company, get the name of the rep "assisting" you and take detailed notes. While they'll sometimes acknowledge the mistake and correct it over the phone, they're more likely to point to some tiny technical error you, your doctor or their computer made -- and that will require you to start the process all over again. (Having the name and notes gives you a leg up if the claim is rejected a second time.) It may sound paranoid, but rejection is a policy pursued by the HMO on the calculation that you'll give up first. Don't. If you show them you're willing to fight, they may soon get the message, Kligler says. But if you still can't get satisfaction, Kligler suggests filing an appeal with the managed-care company.

Most states also have insurance departments that will adjudicate disputes with health insurance companies. In California, if your insurer turns down your appeal, you can file a complaint with the state's Department of Managed Care. The agency will try to render a decision within 30 days (click on www.hmohelp.ca.gov/gethelp, or call 1-888-HMO-2219). In New York, the state Department of Insurance allows you to file complaints online. Check out www.ins.state.ny.us/complhow.htm, or call 1-800-342-3736.

Kligler adds that you may want to take the time to write a letter to a local politician, asking them to do the same on your behalf to your insurer. Bad publicity is to managed-care companies what water was to the Wicked Witch of the West. Finally, you may want to consider hiring a consultant like Kligler to help. She takes no money up front but charges a percentage of whatever she

manages to wrestle out of the witch. For a list of consultants who can help you beat your HMO, click on the website of Alliance of Claims Assistance Professionals, www.claims.org. “The companies are betting that patients who get rejected are not going to fight,” says Kligler. “But if you accept it, it’s your loss. On the other hand, if you keep pounding away, in most cases they will reconsider and eventually pay.”

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