Managed Care Joins Death and Taxes

The direction of health care seems inevitable-so be sure you know where you're going

January 1, 1997 By Frank Pizzoli

Death and taxes have been joined by a third inevitable force known as managed care. Private insurance companies and state and federal programs such as Medicaid and Medicare are increasingly embracing managed-care principles in the form of health maintenance organizations (HMOs).

A stable assumption in an unstable world is that most health care plans will eventually adopt managed care. The swelling ranks of employers changing to managed-cares systems lower their annual premium increases, on average, from 10 percent to 1.6 percent. But many health advocates are concerned that the chronically ill pay the real price in corner-cutting care.

To avoid the obstacles to state-of-the-art care-including forced shifts to new physicians and disqualification due to pre-existing conditions-HIV positive people covered by HMOs must understand how managed care works; it's as vital as remaining involved in treatment decisions.

During the past 15 years, managed-care plans-as modified by consumer rebellions against their abuses-have evolved to include the following essential elements (be sure to carefully read your plan's literature and find out what HMO regulations your state has):

Insurance Portability

Currently, when consumers move between jobs or back into the work force, their coverage (if any) changes depending on each employer. With the federal Health Insurance Portability and Accountability Act of 1996, effective July 1, 1997, everyone will gain the right to keep whatever plan their previous employer offered until new coverage is available. But while the law stipulates that people must be offered insurance, it neither sets a minimum standard for coverage nor requires that coverage be affordable.

Pre-Existing-Condition Coverage

The new law will also remove "pre-existing conditions" as an obstacle to coverage for many-but not all-individuals transferring from group-to-group, group-to-individual or individual-to-group plans. Any business with two or more employees (in some states, the employer is counter) is

subject to the law. (Uninsured individuals and Medicaid recipients are not affected.)

Regardless of how many times you change jobs, the law prohibits any employers or insurance companies from imposing more than one 12-month waiting period for coverage due to pre-existing conditions. Even that waiting period is prohibited under the following circumstances:

- If you are currently employed, your insurance has been in effect for at least 12 months, and you are moving to a new job, there can be no waiting period. Any time less that you were covered on your old job is subtracted from the 12-month waiting period.

- If you are unemployed with no coverage and find a job, to avoid a waiting period you must not have had treatment for or a diagnosis of serious illness (which includes testing HIV positive) for the six months preceding the day your new coverage starts.

- If you quit or were laid off and carried your own plan under COBRA (the older federal law entitling some employees to retain the medical insurance offered by their previous employer), then in order to eliminate the waiting period for an individual or new job's plan, you must have kept your COBRA coverage intact until a new plan takes effect. If you have had coverage for 12 months, the waiting period does not apply.

Don't let coverage lapse for more than 63 days, or a pre-existing-condition clause may be imposed.

Provider Networks

Managed-care plans assemble networks of primary-care physicians, specialists and hospitals. A primary-care physician acts as your "gate-keeper," treating you on a regular basis and deciding when you need specialist care. Primary-care physicians or specialists schedule each hospital admission, unless you must be admitted in an emergency. Managed-care plans make some provision for emergency care, but check on the definition of "emergency" before one arises.

Doctors and hospitals participating in managed care are required to follow cost and clinical standards, which may cause problems for people with HIV. Gatekeepers and specialists within the network may not have direct experiences with AIDS care. New treatments, such as protease inhibitors with all their "when-to-begin" questions, may not be adequately reflected in clinical standards, leading to denials for drugs you and your doctor have decided upon. Many managed-care companies have promised to cover the expensive new combination treatments, but Karen Timour of ACT UP/New York's Insurance and Healthcare Access Committee notes, "Some companies may pay for only one protease inhibitor, or limit access to combination therapy. The situation is extremely fluid right now, and different HMOs will make different decisions."

If you seek alternative or nutritional treatments, a narrow definition of “medically necessary” may exclude many options. Coverage is often allowed only for “replacement” nutrients rather than for higher doses needed for prophylaxis or treatment. If standard treatments have failed you, document this as evidence you need alternative care. A small but growing number of insurance companies are now offering plans-for higher premiums-that cover several forms of alternative health care.

Increasingly common battlegrounds for PWAs with managed care are coverage decisions for drugs that are “off-label” (prescribed for a different purpose than what the FDA approved) or “experimental” (under study before FDA approval). If you have completed an off-label clinical trial of a drug, present the drug’s positive effects on your health. If coverage of a treatment is denied as “experimental,” check your policy’s definition of the term. If it is vague or nonexistant, challenge the insurer on the grounds that your policy is unclear. If the definition is clearly stated, ask your doctor to advocate in favor of the treatment, and try to negotiate for coverage with the insurer. If you are still refused coverage, your only recourse is to file a complaint with your state’s insurance department or sue.

Determine before or at the time of enrollment what procedures are to be followed in case of a disagreement over who should pay for care or what kind of care is necessary. Many states require managed-care plans to maintain some form of due process for consumers to redress grievances. Also, many states have “bad faith” laws to protect consumers from vaguely worded contracts.

Under managed care, primary-care physicians face incentives to hold down costs. One common cost-control method is capitated payment, a fixed monthly amount paid by the HMO to your doctor. If you care costs less than the paid rate, an HMO profits; if your care costs more, it loses. Thus, doctors may resist seeing patients multiple times because they are paid the same amount for one or 10 visits. Also, physicians are financially rewarded for limiting access to expensive specialists. Primary-care physicians reduce referrals to specialists by learning to treat more medical conditions themselves. For instance, U.S. Healthcare pay doctors as much as 1.5 percent more per patient per month if they owrk 50 to 60 hours a week.

If you feel that your primary-care physician has wrongly denied you access to specialist care, ask him or her: Am I being denied access to a specialist because you’re seeking financial reward? Have you completed special training in the specialty you’ve denied me?

If authorization for your care is denied up front, or care is deemed medically unnecessary afterward, ask about the reviewer’s credentials. In many states, doctors’ care can only be challenged or denied by someone of like training or specialty.

Simple human error is another reason patients’ care is denied. All health care billing is based on codes indicating levels of care and specific treatment. Ask your plan’s billing office for the codes that identify your treatment; file them for future reference in case reimbursement is denied.

Out-of-Pocket Costs

In keeping track of your out-of-pocket expenses, there are four basic areas to watch: Outpatient doctor visits, specialist charges, hospital stays and lab work. There is usually little or no cost to patients who see primary-care physicians within the plan’s network. Your plan may offer unlimited visits to your primary-care physician or may limit the number on an annual basis. After reaching your annual limit, you may be required to pay for all, or a copayment of, an office-visit charge.

Some plans insist you see only specialists in their network. Others will allow you to go outside the network but will impose copayments of 20 percent or more of the total cost. If your current primary-care doctor or specialists are not part of your new plan, ask them to apply for network membership. Your treatment may also be continued by requesting that your new plan make a compassinate exception.

For hospital costs, there are limits on both the daily charge and the number of consecutive days of admission. Plans often set annual dollar limits on lab and/or diagnostic work. Before undergoing a procedure, inquire about its cost to keep track of when you might reach your ceiling.

Just like with HIV, information is your best defense when trying to make the most of medical services under a managed-care plan. Be informed. It’s your plan.

For more information on HMOs, call the National Committee for Quality Assurance at 800.839.6487 (or http://ncqa.org) or Families USA Foundation at 617.338.6035. For alternative medical coverage options, call the Alliance in Alternatives in Healthcare at 800.966.8467.

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