Health Insurance

This section has been reviewed and approved by the Cancer.Net Editorial Board [1], March / 2012

Many studies show that successfully managing and treating illness is highly dependent upon access to high-quality health care. In the United States, such access generally requires health insurance to cover or offset the costs of care. Most people obtain their insurance through their employer or through government programs such as Medicare. A key to understanding insurance is knowing the meaning of the terms. Here are a few common terms related to health care and insurance:

- Co-insurance: The percentage of health care costs an insured patient pays after meeting a health care plan's yearly deductible. For example, an 80/20 co-insurance rate means that the insurance company pays 80% of approved health care costs, and the patient pays the remaining 20% of costs.
- Co-pay or co-payment: A set fee, in dollars, that an insurance provider requires a patient to pay each time care is received. For example, a visit to the oncologist may cost a patient $30 each time; insurance pays the rest of the visit's costs. The amount of the co-pay is set by the insurance provider and not the doctor's office.
- Deductible: The amount of approved health care costs an insured patient must pay out-of-pocket each year before the health care plan begins paying any costs.
- Insurance cap: The amount of money an insurance plan will pay in total benefits. Once a patient's medical bills reach that cap, the plan will no longer provide coverage. (Some rules are changing under the 2010 Health Reform law [2].)
- Out-of-network care: Health care providers or facilities that are not part of an insurance plan's approved list or network are considered ?out of network? (as opposed to being on an approved list or ?in network?) in a health maintenance organization (HMO) or preferred provider organization (PPO). Out-of-network care often costs patients more than in-network care, is often subject to a deductible, and may require pre-approval for certain services.
- Out-of-pocket costs: Expenses that must be paid from a patient's personal financial resources; any expenses not covered by insurance.
- HIPAA: Health Insurance Portability and Accountability Act. A law that helps protect the privacy of a patient's individual medical information, provides patients with access to their medical records, and helps people with health problems, such as cancer, get health insurance for themselves and their family members. Learn more at www.cms.gov [3].
- Precertification or preapproval: The process of requesting approval from an insurance plan for specific services before they happen, such as a treatment, procedure, or hospital stay; also called pre-approval. Many hospitals and clinics have precertification coordinators, patient navigators, or case managers that help patients with cancer through this process.
- Pre-existing condition: A medical condition that a person already has when enrolling in a new health plan. Many health plans have a period of time in which they will deny all claims related to pre-existing conditions. However, HIPAA sets limits on how long an insurance company can deny coverage for a pre-existing condition.(Some rules are changing under the 2010 Health Reform law [2].)
- Premium: The amount a person or company pays each month to keep insurance coverage.
- Reasonable and customary fees: The average cost for health services in a geographic area that insurance plans use to decide how much they will pay for those services. If a doctor's fees for a service are higher than average, the patient must pay the difference.
- For more definitions, read the Glossary of Cost-Related Terms [4].

Types of Health Insurance

The following information can help you understand the different types of health insurance coverage.

Private insurance

Before HMOs and PPOs were developed as systems to contain rapidly increasing health care costs, most people had one option for private health insurance: fee-for-service coverage. This type of plan generally does not place any restrictions on which doctors or hospitals you choose. You simply visit the doctor, hospital, or health care center of your choice, anytime or anywhere, submit a claim form, and the health insurance company pays the bill. Typically, you share some of the cost in the form of co-payments or co-insurance, and some types of services may not be covered.

Although fee-for-service plans allow for the greatest freedom in choosing doctors and hospitals, there may be restrictions to some services, including mental health services, physical therapy, home health care, investigative treatments, or alternative medicine.

HMO

An HMO can be thought of as a health care insurance club, with patients and doctors as members. It is set up to keep health care costs down by working with patients to comprehensively manage their health care. In an HMO, a person chooses a primary care doctor from an approved network.

As a member of an HMO, you pay a monthly premium and a small additional co-payment for each office visit. An HMO generally does not require you to submit any claim forms, unless you visit doctors who are not members of the plan.

An HMO may be an actual health care center, in which all of the doctors in the office are part of the organization. In other cases, individual doctors contract with the HMO to care for patients covered under the plan. This agreement is known as an individual practice association (IPA).

Because you pay a flat rate to your HMO, the plan will often encourage and cover preventive care intended to avoid the need for more expensive care later. However, as with most insurance plans, covered services vary. For example, some types of mental health services, alternative treatments, and physical therapy may not be covered, or covered only on a limited basis.

Restrictions

Compared with fee-for-service plans, total medical costs in an HMO are usually lower and more predictable. However, these reduced costs are typically accompanied by additional restrictions, including:

- Fewer choices of doctors and hospitals, as only doctors and hospitals that are members of the HMO are covered under the plan, although many companies make exceptions as medically necessary and for emergencies. Many HMOs allow you to visit doctors outside the plan for a higher fee (called ?out of network? care).
- Access to a specialist often requires a referral from your primary care doctor.
- Precertification is usually required before nonemergency hospital visits and some types of specialist care, and a person needs to call the HMO within 24 hours of any emergency care.
- Pre-existing conditions may not be covered. (Some rules are changing under the 2010 Health Reform law [2].)
- Some types of services, such as mental health services, physical therapy, home health care, or investigational treatments, may not be covered.

PPO

A PPO is a type of health insurance in which a person is offered a network of approved doctors, and most of the medical costs are covered when visiting doctors that are part of the network. However, a PPO typically does not require you to see a designated primary care doctor who manages your care and controls your access to a specialist. A PPO may also be more flexible than an HMO in allowing visits to out-of-network doctors, although these visits usually require you to pay a larger portion of the bill. It may also require you to pay a deductible or co-insurance for some services.

Restrictions

The restrictions associated with a PPO may include:

- Doctors and hospitals that are limited to the PPO network, although this selection tends to be larger than the network of an HMO
- Precertification may be needed for some types of care, especially if the facility or doctor is outside of the network.
- Pre-existing conditions may not be covered. (Some rules are changing under the 2010 Health Reform law [2].)
- Some types of services, such as mental health services, physical therapy, home health care, investigational treatments, or alternative medicine may not be covered.

Government-sponsored insurance

Medicare

Medicare is health insurance provided by the federal government for those 65 and older, as well as for some disabled Americans. People over 65 who are eligible for Social Security or Railroad Retirement benefits automatically qualify for Medicare, along with their spouse. Medicare has different ?parts? that serve different, sometimes complementary, purposes.

- Medicare Part A covers inpatient care (such as hospital care), skilled nursing care, hospice care, and a limited scope of home care services. These services are free.
- Medicare Part B provides financial coverage for doctor services, outpatient care, physical and occupational therapy, and selected supplies that are deemed medically necessary.
- Medicare Part C, also called Medicare Advantage, are insurance plans managed by private Medicare-approved companies. It combines Medicare Parts A and B and may include prescription drug coverage.
- Medicare Part D is a benefit that people can enroll in that covers prescription drugs. The Medicare Modernization Act of 2003 (MMA) provided this prescription drug benefit.

However, Medicare does not cover all health care expenses. These expenses are called ?gaps? and some people decide to purchase a Medigap policy to pay co-payments, co-insurance, deductibles, and other out-of-pocket expenses. During the past several years, there have been many revisions to the Medicare laws about what outpatient treatments are covered. Depending on a patient's Medicare plan, they may be responsible for a 20% co-payment if no other insurance is available.

Medicaid

Medicaid is a health insurance program paid for jointly by the federal and state governments and administered by each state. It covers people who are eligible because they are elderly, blind, or disabled, as well as certain people in families with dependent children. Each state operates the

program individually and determines who is eligible and what services are covered in that specific state.

For more information about Medicare and Medicaid visit www.cms.gov [3]. Medicare information can also be found at www.medicare.gov [5]. And, some rules on Medicare and Medicaid are changing under the 2010 Health Reform law. See www.healthcare.gov [6] for full information.

Other coverage

Other types of insurance cover a person's needs not covered by health insurance.

Supplemental insurance. A supplemental insurance policy helps cover expenses not covered by your primary insurance or the costs you pay as part of your existing plan. This policy generally covers deductibles, co-insurance, co-payments, and other out-of-pocket expenses. It may also offer additional benefits, such as compensation for lost earnings due to missed work.

Disability insurance. Disability insurance replaces income lost if you are unable to work due to a long-term illness or injury. Such coverage is often provided through your employer or government-sponsored programs, although individual policies are also available.

Hospital indemnity insurance. Hospital indemnity insurance provides limited coverage for hospital stays, usually a fixed amount each day, up to a maximum length of stay. People may decide to purchase supplemental insurance (see above) if their basic insurance plan limits coverage of hospital care.

Long-term care insurance. Because most basic private insurance plans and Medicare generally provide very limited coverage for long-term care such as nursing home care, some people elect to obtain additional coverage to offset the costs of such care.

Taxes

Fortunately, some medical expenses not covered by insurance, including mileage for trips to and from appointments, prescription drugs, and meals during lengthy medical visits, can be deducted from federal income taxes. A tax advisor can help clarify these rules.

Insurance and clinical trials

Many states have laws or agreements requiring health plans to play for regular care that is part of a clinical trial [7], a research study involving people. The National Cancer Institute (NCI) has a map [8] and links to states that provide this coverage. In addition, the NCI offers a guide to clinical trials and insurance coverage [9].

Medicare covers routine costs related to trials that test investigational cancer therapies. In some programs, researchers will reimburse for expenses associated with participating in the research such as transportation, childcare, meals, and accommodations. For more information, read www.cancer.gov/clinicaltrials/digestpage/medicare [10] and/or www.cms.hhs.gov/clinicalTrialPolicies/ [11]

Finally, The NCI and Department of Defense (DOD) have entered into an agreement for TRICARE beneficiaries to allow active duty members, their eligible family members, retirees and their eligible family members, and survivors of all uniformed service members to participate in certain NCI-sponsored clinical trials. Learn more about this program at www.cancer.gov/cancertopics/factsheet/NCI/TRICARE [12].

Insurance Examples

Understanding the benefits and limitations of your health insurance policy can be challenging, but it is important to learn exactly what your coverage provides. The following examples may help illustrate how co-pays, co-insurance, and deductibles work. You are strongly encouraged to talk with a representative of your insurance provider, who can explain the details of your specific coverage.

Insurance Example #1: Co-pays

Let's say Anna needs to see two specialists this week: Dr. Smith and Dr. Jones. Dr. Smith charges $100 a visit, and Dr. Jones charges $500 a visit. If Anna's insurance states she pays $20 co-pays for visits, how much does she pay out-of-pocket at the appointments?

Answer: Anna will pay $20 at each doctor's office. Since a co-pay is a set amount of money, the patient's payment doesn't depend on the amount of the bill.

Insurance Example #2: Co-Insurance

Let's say Martin needs to see two specialists this week: Dr. Andrews and Dr. Adams. Dr. Andrews charges $100 a visit, and Dr. Adams charges $500 a visit. If Martin's insurance states he must pay 20% co-insurance for visits, how much does he pay out-of-pocket at the appointments?

Answer: Multiply each bill by the co-insurance percentage.

Martin's payment to Dr. Andrews would be $20, since $100 x 20% = $20

Martin's payment to Dr. Adams would be $100, since $500 x 20% = $100

Insurance Example #3: Co-Insurance and Deductibles

Let's say Kathy has a deductible of $2,000 a year, and her co-insurance for a hospital visit is 20%. She had a surgery that cost $10,000. How much does she have to pay out-of-pocket?

Answer:
Step One: Subtract the deductible from the total bill, so $10,000 - $2,000 = $8,000.

Step Two: Then, multiply that difference by the co-insurance percentage, so $8,000 x 20% = $1,600. This gives the patient's co-insurance amount.

Step Three: Add together the deductible ($2,000) and the co-insurance amount ($1,600) to find the total amount that the patient would pay. In this example, Kathy would pay $3,600.

More Information

Managing the Cost of Cancer Care [13]

Understanding the 2010 Health Reform Law [2]

Getting Organized [14]

Additional Resources

Allsup [15] has successfully secured disability benefits for more than 170,000 deserving customers.

U.S. Government's website on health reform law: www.HealthCare.gov [16]

American Cancer Society: Medical Insurance and Financial Assistance for the Cancer Patient [17]

Cancer*Care*: Cancer Facts: Financial Assistance for Cancer Care [18]

America's Health Insurance Plan (AHIP) publishes consumer guides [19] for various kinds of insurance, including health insurance, managed care, and long-term insurance.

Last Updated: March 28, 2012

Links:
[1] http://www.cancer.net/about-us
[2] http://www.cancer.net/node/24921
[3] http://www.cms.gov
[4] http://www.cancer.net/node/24917
[5] http://www.medicare.gov
[6] http://www.healthcare.gov
[7] http://www.cancer.gov/clinicaltrials
[8] http://www.cancer.gov/clinicaltrials/ctlaws-home
[9] http://www.cancer.gov/clinicaltrials/learning/insurance-coverage/page1
[10] http://www.cancer.gov/clinicaltrials/digestpage/medicare
[11] http://www.cms.hhs.gov/clinicalTrialPolicies/
[12] http://www.cancer.gov/cancertopics/factsheet/NCI/TRICARE
[13] http://www.cancer.net/node/24865
[14] http://www.cancer.net/node/24916
[15] http://www.allsup.com
[16] http://www.HealthCare.gov
[17] http://www.cancer.org/docroot/MLT/content/MLT_1x_Medical_Insurance_and_Financial_Assistance_for_the_Cancer_Patient.asp?
[18] http://www.cancercare.org/get_help/assistance/cc_financial.php
[19] http://www.ahip.org/content/default.aspx?bc=41%7C329