HCV Meets Managed Care Health Insurance

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As this country plays catch-up with the other industrialized nations that make health insurance available to everyone, a lot of people are getting coverage for the first time. Unfortunately, the health plans being offered today are complicated; they are virtually all Managed Care Plans. Also, unlike countries that cover everyone under one plan, our health coverage is handled primarily through health insurance companies so there are major differences in coverage and what an insured person is expected to pay out-of-pocket.

Managed Care Plans attempt to direct a person's health care in a way that will be more cost efficient yet still provide quality medical care. How well they succeed with those goals is regularly questioned, but for us, as consumers, we have little choice.

These plans guide health care by limiting when and how we access medical providers as well as who. They also guide us through plan design as to how much they pay and how much they ask us as the insured person to pay out of our pocket.

While it appears that the growth of Managed Care Plans is helping to slow the growth in medical costs, the design of these plans requires us as insured members to take a more active role in our care and treatment choices.

On the market today, whether it is through government insurance exchanges or through private agents and companies, there are three primary types of Managed Care health plans, HMOs, EPOs, and PPOs.

HMO (Health Maintenance Organization) – This type of health plan has been around for several years. The main feature is the requirement that it will only cover medical costs when the member uses medical providers (doctors, laboratories, hospitals, etc.) that have signed a contract with the HMO to become a Network Provider. Except for charges related to a life threatening emergency, they do not pay anything for treatment performed Out-of-Network.

The distinctive feature of an HMO is that all care must go through a designated Primary Care Physician (PCP), appropriately nicknamed "The Gatekeeper." If you have a rash and need to see a dermatologist, you must first go to your PCP who will refer you to a panel dermatologist, assuming the Gatekeeper agrees that you should see one or it is a simple enough issue that he or she can provide the necessary salve or medication. The same would usually apply to a person with HCV who needs to see their specialist.

NOTE: Some HMOs will work with their members who are dealing with a chronic condition. For example, they may name a PCP for a member dealing with HCV, but will allow a "permanent" referral so the member can go directly to the specialist who will treat the HCV and function as the PCP on other medical issues.

EPO (Exclusive Provider Organization) – EPOs are similar to HMOs with one major exception, they do not require a Primary Care Physician or Gatekeeper. If a member wants to see a dermatologist, he or she finds one on the list of Network Providers and makes the appointment.

Other than that, they are similar to HMOs. You must use a Network provider to get any coverage.

There are a couple of areas where HMOs and EPOs are similar:

- **Emergency Care –** As mentioned, either type of plan would cover you if you went to an Out-of-Network Emergency Room for a life-threatening emergency. In most jurisdictions, courts have ruled that "life-threatening" means as it appears to a lay person, not a physician. A person who goes to an ER with chest pains should have coverage whether it's a heart attack or simply a bad stomach ache.
- **Choice of Providers –** Almost all HMOs and EPOs contract with large groups of providers who work under a corporate structure. In addition, rather than sign contracts with individual physicians in independent offices, physicians and other providers will form an Independent Practice Association (IPA) and the plan will contract with that umbrella group. Rather than being able to see any provider in a plan's Directory, you will be limited to the medical group or IPA in which you enrolled at the time of enrollment.

Preferred Provider Organization (PPO) – This type of plan provides greater flexibility in the choice of providers—unfortunately at the cost of a higher premium. Under a PPO plan, the plan will pay a benefit regardless of which provider is used; however, it will pay more of the medical bill if you use a Network Provider than an Out-of-Network one. A typical plan will pay 80% if you go to a Network Provider, but only 60% if using an Out-of-Network Provider.

A PPO plan "manages" your care through encouraging you to use their Network providers by paying more of the bill. While you can choose a Primary Care Physician from the Network if you wish, you have the right to see a specialist or other physicians in or out of the Network. Obviously, it is to your advantage financially to use Network Providers whenever possible.

NOTE: Keep in mind physicians don't keep track of which providers are in the PPO Network. When a doctor refers you to another physician or sends out to a

laboratory, you should always specify that he or she should only refer you to Network providers including hospitals and laboratories.

What Do I Pay?

As noted earlier, health plans vary greatly, yet there is no plan that will pay all of the medical bills. However, the amount an insured person must pay out-of-pocket falls into several areas that a plan may or may not have in its schedule.

Deductible – This is the amount of money and insured person is expected to pay before the insurance company makes a payment. Sometimes, the deductible must be paid before the carrier pays anything, other than for preventive services. Sometimes the deductible only applies to certain medical charges such has hospital charges or prescription medications.

Deductibles accumulate on a calendar year basis. After each January 1, a new deductible must be met.

Co-Pays – This is the fee that is paid at the point of service. Some plans require you to pay $10 to $25 each time you visit the doctor—sometimes even more for specialists. Most plans charge a co-pay when you pick up a prescription. **NOTE:** Ask for and keep a receipt of every co-payment in case questions arise later.

Co-Insurance – This is the percentage of a covered medical bill that is paid by the insurance company, leaving you to pay the remainder. Much more common in PPO plans, this is the main reason to use only Network Providers in PPO plans.

Network Providers have agreed to limit what they charge for a procedure. If the PPO pays 80% of the bill, then you are only obligated to pay the remaining 20%, regardless of how much the doctor normally charges.

However, when you use an out-of-Network provider, your plan is only obligated to pay its percentage of the “usual, reasonable, and customary charge” for that procedure. Of course, this is often less than what the doctor is billing. In that case, you would be obligated to pay not only your percentage under Co-Insurance, but also the amount in excess of what the insurance company deemed “Reasonable.”

Out-of-Pocket Limit – Under the new healthcare law, every health plan must limit the amount of money an insured person can pay in any one calendar year for his or her portion of the covered charges. At present the out-of-pocket limit cannot exceed $6,350 for an individual or $12,700 for a family. While this may seem high, such a limit on an insured person’s payment is far better than having to pay 20% of a $200,000 hospital bill, which is not that large of a bill today.

Preventive Services – The new health care law also requires that all health insurance plans cover preventive services at 100% with no deductible or co-pay. This list currently includes over 50 services for adults, women, and children. You can find a complete list at:

https://www.healthcare.gov/what-are-my-preventive-care-benefits/

Regardless of which type of health insurance you have, it is very important that you actively participate in your health care and not rely on your doctor's recommendations without question.

Thanks to sites like the HCV Advocate and others on the web, there is a lot of information about hepatitis C and its treatment. Thanks to the Internet, you can stay current on new treatments, clinical trials, and new diagnostic methods. It would be nice if everyone could find a physician whose practice consisted only of HCV patients, but that is not possible. But you can become one of your physician's sources of new information about HCV treatments and trials.

You should feel free to print out information, cut out articles and take them to your physician. Hopefully, he or she is already current, but you may be providing new information. If your doctor is not the type that welcomes such input from the patient, you may be seeing the wrong doctor.

Find a doctor knowledgeable in HCV. This is true whether you are in an HMO and must have a "Gatekeeper" or finding a doctor in an EPO or PPO network to visit regularly.

However, the Network directories of providers will give you only minimal information about your choices, and it won't tell you which PCPs frequently treat patients with HCV or stay current about it. Clearly, you will need to do some research.

If you attempt to call the Managed Care Plan itself, they will not provide much information, as they are prohibited from "steering" patients to particular clinics or doctors, even if it would mean better health care.

Gastroenterology is the specialty that many people use. If available, you may also use a hepatologist—who may be more knowledgeable about HCV. If you wish, call several doctors' offices to learn more. Some questions you may want to ask include:

- Does the doctor treat other patients with HCV?
- Does he stay current on HCV treatments? Do not hesitate to ask very specific questions, referring to treatments and using terms you have learned in your research on HCV. If they don't know what you're talking about, scratch them off your list and move on.

- Who are the gastroenterologists, hepatologists, infectious disease specialists, or other HCV knowledgeable specialists that the doctor works with and refers patients to?

My colleague, Lucinda K. Porter, R.N. has an excellent Fact Sheet on Choosing a Physician; which you will find very helpful. You can find it at: http://www.hcvadvocate.org/hepatitis/factsheets_pdf/choosing.pdf

The days are long gone in any healthcare delivery system when patients could put themselves in the doctor's hands and rest assured that they were getting the best and latest treatment. However, in Managed Care systems, it becomes even more important that you stay actively involved in your medical care. To do that, you must find knowledgeable medical providers who not only know about HCV, but who will listen to you and answer questions candidly when determining the direction of your care.