A Health Insurance Insider Offers Words of Advice

New York Times

WENDELL POTTER is a 20-year health insurance veteran who served in top public relations jobs at such firms as Cigna and Humana. Now a senior analyst at the Center for Public Integrity, Mr. Potter has written “Deadly Spin,” a tell-all about practices of the health insurance industry. The book chronicles insurers’ attempts to influence legislators, policy makers and the public, as well as his own change of heart about his work.We asked Mr. Potter what consumers can do about rising health care costs and about practices they should be wary of. His responses, below, have been edited and condensed for space.Q. Knowing what you know about how the industry works, what is the most important piece of advice you can offer readers when it comes to choosing and paying for health insurance? A. I would encourage people to completely ignore the marketing materials you receive from the insurers. The information is geared to persuade people to buy the product. It doesn’t explain the benefits clearly.If you’re trying to buy insurance in the individual market, you should know that those insurers are looking to sell coverage only to young and healthy people. If you aren’t particularly young or healthy, you’ll be charged more or have limited benefits or both. And even if you get insurance through your employer, you need to read carefully.In either case, always ask the insurer or your benefits department for a copy of the actual policy you’re considering. Read it, and find out what the benefits are and what your financial obligations — co-pays, co-insurance, deductibles, premiums — will be.Don’t expect everything that you need will be covered in the policy. Things like maternity benefits, transplant coverage and of course experimental procedures may be excluded. That’s the kind of information you will never see in the marketing materials, but it’s vital to making your choice.Q. What kinds of policies should consumers avoid? A. I’d be wary of these so-called mini-med or limited-benefit plans. These are sold largely to individuals or through small employers, but we’re also seeing more big companies, such as fast-food chains, offering these plans.This is fake insurance, in my view. Most policies have low premiums but also unreasonably low annual or lifetime caps on coverage. Some don’t pay for hospitalizations.The health law eliminates these plans in 2014, when no lifetime or annual caps on coverage will be allowed, but in the meantime these

policies trouble me a great deal. And the insurance industry will lobby heavily for more flexibility to offer limited benefits even after 2014. So, be on guard.Q. Where can people find straightforward information on available policies? A. Before the new law, it was virtually impossible to get comparable information on various health plans. But now you can get lots of useful information at www.healthcare.gov. For instance, you can plug in your information and get some preliminary comparisons for rates from different insurers in your area. This information will get richer as time goes on.In addition, most state insurance departments are ramping up their efforts to offer consumers more and better information. Always check your state's Web site when you're choosing health insurance.Q. Are health insurers really providing clear and accurate policy information to the resources you mention above? A. Well, the industry isn't happy about it, but they have to comply. Bigger companies with big compliance departments can do this pretty easily. The bonus for them is that it shakes out some of the junk players in the industry and weeds out the bad actors.You have to remember, the health law is a huge boon to the industry. They are not fighting it — in fact, they are moving toward it. Whatever regulations and changes they may have to put up with, the fact remains that millions of uninsured Americans will now have to buy insurance. That represents massive new profits for the industry. So yes, big insurers are complying with the law.Nonetheless, I encourage people to contact the Department of Health and Human Services and express their point of view on what information they need from the insurance industry. You can be sure H.H.S. is hearing plenty from the insurance industry. It also needs to hear from consumers.Q. What about the trend toward so-called consumer-driven health care? This has led to a major increase in the use of high-deductible health care plans by employers and individuals. But can people realistically afford these policies? A. The industry push toward consumer-driven health care is one of the reasons I left my job. I didn't like having to be a spokesperson for these plans, because it was clear that many people with modest incomes could not afford them.Take a couple I write about in my book. She's a schoolteacher, and he is self-employed. They have five children. With a deductible of $11,000, the couple was paying almost all of their health care bills out of pocket. It didn't take long for them to realize that with that kind of burden, they could no longer afford the $858 monthly premium. Something had to give."Consumer-driven" was certainly not invented by consumers, as the name implies. It was invented by executives of insurance companies and big corporations, who saw this as a way to shift more of the cost from their firms to consumers.There is the notion that once people have more skin in the game, they'll become more sophisticated and savvier users of health care. The reality is that more and more people are forgoing needed care in these plans. People who don't get the care they need are more likely to have an emergency, driving up health care costs.Worse, the industry was so successful in persuading lawmakers that consumer-driven was an irreversible trend, the new health care law doesn't do enough to address

high-deductible policies. That’s one of my great disappointments with the new law.My advice to consumers considering these plans is to try your best to know exactly what you can afford. If the out-of-pocket costs are going to be impossible for you, it may well make sense to pay more in premiums for more extensive coverage. For the most part, high deductibles make sense only for the young and healthy or wealthy.Q. You hear so many stories about denied coverage. If I have a claim that’s been denied, is it even worth trying to appeal? A. As insurers are forced to behave better in other ways, my fear is they will start denying even more claims and procedures. That’s why it’s very important for consumers to be aware of their rights to appeal. With the new law, all consumers will have access to two layers of review. That’s a significant victory.Most important, if you feel you have been denied something you should have and that your doctor has prescribed and approved, don’t accept the denial as the last word. Insurers count on people just giving up.I say, don’t give up. If you need help, ask your doctor’s office or find a patient advocate. Be the squeaky wheel. Insurers do not want bad P.R. Companies will frequently reverse a denial if you file a formal appeal.But what I saw when I was inside was that too often people didn’t file the appeal to begin with.