Insurance Woes Common For Patients With Diabetes

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WASHINGTON — Sixty-year-old Janice Ramsey used to have something in common with other Deltona, Fla., residents—she was a small business owner who had health insurance. But 7 years ago, all that changed.

Ms. Ramsey's problems started when she switched health insurance plans. "I purchased a new individual plan because the old one was a little high," she said at a press briefing sponsored by the American Diabetes Association and Georgetown University. "I had the plan for a year and a half, and then I went to use it." She needed the coverage to help pay for some blood work, which revealed that she had type 2 diabetes.

Once the claims for the tests were submitted, the insurer took another look at Ms. Ramsey's policy. "The plan said I must have had diabetes before I took their coverage, and they dropped me," she said. "I was out all the premiums I had [paid]."

She then found coverage through an association health plan—a plan that covers members of trade associations and other small groups. But after paying premiums on that plan for 18 months, she had trouble again.

"I found out that the policy I had bought was fraudulent," she said. "I had to use it because [the doctors] thought I was having a heart attack, and I went in for a catheterization. They didn't pay a dime."

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She was stuck with $23,000 in bills, which she eventually paid back. The plan then went bankrupt, and "they were not licensed in Florida, so the insurance commissioner told me I didn't have a chance to get any money back," she added.

Since then, Ms. Ramsey has tried to get other coverage, to no avail. "I've contacted a lot of companies, and the answer is the same, 'Sorry, we cannot help you; you have diabetes,' " she said. "They kind of just hang up on you, like you don't even count." She is hoping that she can hang on for another 5 years, when she'll be eligible for Medicare.

Ms. Ramsey's case is not uncommon, according to Karen Pollitz, project director at the Georgetown University Health Policy Institute and lead author of a report analyzing 850 case studies of diabetes patients who have had problems obtaining or keeping adequate health care coverage. "Even before we began this report, there were studies providing evidence that people who have serious or chronic illnesses are disadvantaged in the insurance system in the U.S. today," she said.

On average, about 2 million Americans lose their health insurance every month, Ms. Pollitz noted. "Some move right on to the next plan, some are uninsured for a month or two, and some are uninsured for a very long time before they manage to regain their coverage."

However, the burden is not spread equally, since people in poor health are twice as likely to be without insurance for a lengthy spell as those in good health.

People with diabetes need coverage that meets the three A's: accessibility, affordability, and adequacy, she continued. "Most people's problems [were caused by] a transition in coverage; people had lost their prior coverage or were about to lose their coverage and had encountered obstacles or penalties that made it harder to move on to their next coverage."

Ms. Pollitz and her colleagues attempted to resolve the patients' insurance problems, with little success. For example, 377 people who had lost their job-based coverage were eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), but after they saw what the premiums would be—much more expensive than the premiums they paid on their earlier policies—only 15 people were able to enroll.

Further, 87 people were eligible for individual coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), but only 11 were able to buy the coverage. And 344 people lived in states that had high-risk pools to help the uninsured, but only 7 ended up enrolling.

As for Medicaid, although a "large number" of patients had very low incomes—less than $1,000 per month—only 6 ended up being able to enroll in Medicaid, she said.

State high-risk pools were a good example of coverage barriers, according to Ms. Pollitz. Some of the pools were not very accessible; many had waiting lists or were closed to new enrollments. In Florida, where Ms. Ramsey lives, the high-risk pool "has been closed to new enrollees for more than a decade," she noted.

Affordability is another problem with high-risk pools, since the coverage always costs 50%-100% more than what a private individual insurance policy would cost. For example, in Illinois, premiums can range as high as $1,084 per month, she said. The plans also are age rated, so the costs can grow three to four times in size as beneficiaries approach age 65.

Adequacy is also an issue with high-risk pool policies, Ms. Pollitz said. "High-risk pools often exclude preexisting conditions, so the thing that makes you eligible in the first place is excluded for 6-12 months." Some pools also have limits on coverage for prescription drugs and mental health care.

On the private insurance side, the high-deductible policies that are increasing in popularity "really hit people with diabetes," she said, noting that supplies for diabetes patients, such as medications, test strips, and insulin can range from $350 to $800 per month, depending on whether the patient is experiencing complications. "Those costs really add up."

The features of health insurance that hurt diabetes patients and others with chronic illnesses "were all adopted for reasons that were perfectly logical," such as keeping insurance companies solvent, protecting insurers from adverse selection, or being able to offer cheaper premiums.

"But those [features] tended to have been adopted one change at a time, so it was hard to step back and take a look at the big picture," Ms. Pollitz said.

She added that the perspective of chronically ill patients "is a very important one to adopt when looking at proposals to change the health insurance system, because if change won't make it better for people who are sick, then what's the point?" ■

The report is available at www.healthinsuranceinfo.net/diabetes_and_health_insurance.pdf.

Doctors Stand to Recoup Losses From Insurers

BY ALICIA AULT
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Physicians frustrated with seemingly arbitrarily denied claims will have their day in court later this year with at least six insurers, thanks to a recent Supreme Court decision to deny the plans' appeal of a class action suit.

But settlements related to improper denials by Cigna and Aetna are likely to provide vindication even sooner.

The legal actions affect almost every practicing physician in the United States—about 900,000 doctors.

A series of suits, originally filed by several state and county medical societies, was consolidated in a U.S. District Court in Florida in 2000 and certified as a class action in 2002.

The filing named Aetna, Anthem, Cigna, Coventry, HealthNet, Humana, PacifiCare, Prudential, UnitedHealthcare, and WellPoint as defendants, and alleged that the plans violated the Racketeer Influenced and Corrupt Organizations Act (RICO) by engaging in fraud and extortion in a common scheme to wrongfully deny payment to doctors.

Aetna and Cigna broke off and entered into negotiations, an enormous process involving more than 100 attorneys, 19 state and county medical societies, the American Medical Association, and the plans' CEOs.

The two insurers settled in 2003, but the other parties have vowed to continue to fight, and are scheduled for trial in September in the Florida courtroom of Judge Federico Moreno. Another suit, with 60 Blue Cross and Blue Shield plans as defendants, is also before Judge Moreno.

Still, those other insurers could possibly follow in Aetna and Cigna's footsteps.

The Aetna claims deadline has passed, and physicians had until Feb. 18 to make a claim against Cigna, with two options for recouping losses. One was to make a general claim on Cigna's $30 million settlement pot, which will be divided equally among all who make such a claim. Or, physicians could reconstruct claims and seek repayment according to either a general amount per CPT code or a more specific amount based on a complete medical record.

Physicians who did not meet that deadline will still reap the benefits of the settlement, according to David McKenzie, reimbursement director at the American College of Emergency Physicians, who explained the various options to physicians at a recent ACEP meeting in Orlando, Fla.

Aetna agreed to set aside $300 million for prospective relief, and Cigna agreed to a $400 million figure. These amounts represent what is likely to be paid to physicians now that the two insurers have also agreed to a number of changes in business practices.

For instance, both will pay for vaccines and their administration. And the insurers will no longer automatically downcode evaluation and management codes, and will separately identify and pay modifier –25, which allows physicians to bill for evaluation and management service on the same day as a procedure.

Other coding and editing changes will also lead to future income for physicians.

Both insurers agreed to disclose physician fee schedules and to change the schedules only once a year. Aetna's schedules were posted on a Web site, and Cigna agreed initially to post schedules via e-mail.

Both also said they would make a preadjudication tool available so physicians could determine in advance what they might be paid for a claim.

Clean claims have to be paid within 15 days, whether submitted electronically or on paper. Aetna agreed to pay interest at the lesser rate of prime or 8%, and Cigna agreed to 6%.

A dispute resolution process was established to ensure that Cigna and Aetna are complying with the settlement agreements—in fact, three external independent review boards are monitoring the situation.

Another result of the settlement: Cigna and Aetna agreed to endow two nonprofit foundations devoted to improving medical practice.

The year-old foundations are currently seeking grant proposals.

Aetna put $20 million into the Physicians' Foundation for Health Systems Excellence, and Cigna contributed $15 million to the Physicians' Foundation for Health Systems Innovations.

For more on the foundations, go to www.physiciansfoundation.org. ■