Demystifying Insurance

Healthcare has changed since the days of family doctors and house calls. Today, there are lots of paths to insurance coverage, often meandering and confusing. If you find yourself in need of understanding your health insurance and are feeling overwhelmed, you are not alone. Even experts can become confused when discussing all the variables surrounding health insurance.

Receiving a homecare product or device and paying for it are realities we all might face at some point.

This section tries to demystify insurance, Medicare, co-payments, and other components of the process. You can be covered in many different ways: employer sponsored plan, retiree coverage, Medicare, Managed Medicare or through the subsidized state Medicaid exchanges.

The coverage of compression garments, in particular, is a major source of confusion, so we included a section to focus on insurance coverage for category in particular. Compression Garments >> More.

Our goal is to help you understand how your healthcare insurance works and how it covers the products and devices we specialize in providing you.

Our commitment is to you…so you can live your life.

Private, Commercial Healthcare Insurance

Traditional Indemnity Plans

In the past 20 years, so many insurance plans have evolved that it is difficult to draw a dividing line between them anymore. Rather, it is helpful to see them as two ends of a continuum of options: On one end of this continuum is traditional indemnity insurance (fee-for-service), or unmanaged care. On the opposite end are the most managed types of organizations, called Health Maintenance Organizations (HMOs).

Traditional indemnity insurance was common before the advent of Managed care and the Affordable Healthcare Plan. Today, indemnity plans rare. None-the-less, it is instructive to understand how they work. First, they are relatively simple as compared the more common plans that are far more common today. They reimburse medical providers for each service you receive on a case-by-case basis. With an indemnity plan, you can use any medical provider (such as a doctor and hospital). You or they send the bill to the insurance company,

which pays part of it. Usually, you have a deductible, the amount of the covered expenses you must pay each year before the insurer starts to reimburse you.

Once you meet the deductible, most indemnity plans pay a percentage of what they consider the cost of covered services (Usual and customary, or UCR). The insurer generally pays 80 percent of the usual and customary costs and you pay the other 20 percent, which is known as coinsurance. If the provider charges more than the usual and customary rates, you will have to pay both the coinsurance and the excess charges.

Indemnity plans are were the norm 40 years ago. But as healthcare cost have increased, fee-for-service has been replaced with cost containment plans, generally referred to as Managed Care Plans.

Managed Care

As you move along the continuum from indemnity insurance plans to Health Maintenance Organizations (HMOs), you find that organizations have progressively greater control over the delivery of care. A parallel continuum goes in the same direction - more control usually limits the choices that providers and members are able to make. Providers are subject to utilization management policies and members are more limited in their choice of providers.

When managed care organizations began, their approach was to managing both the financing and delivery of healthcare. This was very different than that of traditional indemnity insurers, which only handled the financing of healthcare. In these organizations, physicians of the managed care organization work closely with other physicians to control healthcare delivery decisions. In an HMO, utilization management becomes a global, organizational concern, which starts the minute the member enrolls in the plan.

In between these extremes are many other types of insurance plans and managed care organizations. The following is a brief description of the typical managed care plans found today.

Health Maintenance Organizations

HMOs are responsible for both the financing and the delivery of comprehensive healthcare to their enrolled members. They can be viewed as a combination of an insurer and a healthcare-delivery system. These two functions are usually more tightly integrated in a HMO than in other managed care organizations.

Preferred Provider Organizations

Preferred Provider Organizations fall between indemnity insurance and HMOs. PPOs evolved to address a major concern consumers had with HMOs: limited provider choice. PPOs offer the feature of provider choice found in indemnity insurance, yet maintain some of the managed care provisions found in HMOs. PPOs are organizations that assemble a large panel of providers, called Preferred Providers.

Point of Service Plans

Point of Service Plans, or open-ended plans, are transitional managed care products that can be viewed as hybrids of HMOs and indemnity insurance. They were developed to combine the effective management features of HMOs with the provider choice found in indemnity plans.

Government Entitlement Healthcare Programs

Medicare

Medicare Part B provides coverage for Durable Medical Equipment (DME). DME includes items such as: wheelchairs, walkers, oxygen therapy, prosthetics and orthotics and compression devices. Coverage for these items is strictly limited to those cases that meet the coverage criteria defined in the Local Medical Review Policy (LMRP) for the applicable Durable Medical Equipment Regional Carrier (DMERC).

Medicare pays for Durable Medical Equipment in different ways, depending on the item or service and whether you buy or rent the equipment. Medicare pays the same amount whether the supplier "takes assignment" or not. If the supplier takes assignment and if you have already met your deductible for the year, Medicare pays 80 percent of the Medicare approved charge and you're responsible for the remaining 20 percent. You may pay more if the supplier does not take assignment.

You Must Pay Medicare Copayments. After you have met your deductible, you're still responsible for paying directly, or through supplemental insurance, at least 20 percent of the Medicare approved amount. This copayment may not be dropped by the supplier except in very special hardship situations and only on a case-by-case basis.

Offers by suppliers to drop copayments or deductibles or to give discounts, coupons, rebates, or other "special offers" -- eliminating the need for copayments on Medicare-approved items -- are illegal. Report such offers to your Medicare carrier.

Special "offers" may seem like a good idea at the time because they appear to be saving you money. But such practices lead to increases in your Medicare Part B premiums and deductibles and unwarranted increased costs to the Medicare program.

Reputable suppliers do not resort to these kinds of incentives. They will provide a reliable product at a reasonable cost to you and the Medicare program.

Compression Garments

Compression garments are relied on as the first and primary treatment option for edematous conditions just as aspirin is called on to treat a headache. Compression garments (sleeves and stockings) are by far the most commonly prescribed medical product for the treatment of lymphedema, edema, venous disease and the prevention of Deep Vein Thrombosis (DVT).

Then why does Medicare not offer a coverage benefit for compression garments?

This is a great question, the answer to which lies tangled deep in the language of the Social Security Act. Of course, for those who suffer from these condition, the reality challenges common sense. The good news is that the vast majority of private healthcare plans do offer coverage for compression garments. Exclusions and limitation may apply as specified by your plan's coverage policy, so verification of benefits is the logical first step. Never assume coverage, or lack of coverage. Always have your benefits verified - specifically for compression garments - by a qualified compression garment provider.

Why does Medicare cover knee-high compression stockings and wraps?

For those who suffer from chronic venous insufficiency (CVI) which has resulted in a venous stasis ulcer, Medicare provides a coverage benefit for compression garments (Coverage Policy L11460). The coverage benefit is limited to two types of garments:

- Elastic Compression, Knee-high Stocking (30-40mmHg & 40-50mmHg). Elastic Knee-high >> More
- In-elastic Compression Wraps, Knee-highs. In-elastic Knee-high >> More

However, Medicare's Coverage Policy (L11460) limits coverage to cases where there is a current venous stasis ulcer, and only for the affected extremity. Therefore, patients who have bilateral, lower extremity edema or lymphedema, with a venous stasis ulcer on one leg but not the other, would be covered for only the affected extremity, and only for one garment. The edematous extremity without an ulcer would not be covered. This is the case even if the edematous extremity without current ulceration has a history of recurrent ulceration,

and even if that history is recent. This highly restrictive coverage policy, in effect, requires that the patient wait to ulcerate before the coverage benefit can be realized, again, defying common sense. The bottom line is very clear - there is not allowance for preventative care, even with a well-documented medical history of repeated and chronic venous ulceration.

Why does Medicare cover compression stockings for wound care and not lymphedema?

Medicare Coverage Policy described these lower extremity compression stocking as a secondary wound care dressing, required to treat the wound alone, not the edema/ lymphedema. The benefit does not extend to treatment of lymphedema separate and apart form a venous stasis ulcer.

How does Medicare avoid offering a coverage benefit for lymphedema arm sleeves for post mastectomy lymphedema when the Women Healthcare Act of 1998 mandated that commercial healthcare plan must extend cover for lymphedema compression garments to treat complication caused from breast cancer such as lymphedema?

Another good question. As convoluted as it may be, the Women's Healthcare Act, a federal law, was not directed at the Medicare program. Medicare coverage can only be changed by specific legislation that addresses change to the Medicare program specifically.