Call Us Today 202-742-1500

PATRICK MALONE & ASSOCIATES

Better Healthcare Newsletter from Patrick Malone

For Americans and their health coverage, October and November will be a time to remember. And act.

Dear Jessica,

The season is upon us when it pays to learn the critical facts about your current health insurance coverage and your options for next year. November 1 is the start of the open enrollment season for those seeking coverage through the Affordable Care Act (aka Obamacare). For seniors, October 15 opens a window to make Medicare coverage changes.

With many companies also matching these sign-up periods for their workers' health insurance, now is a key time to gather information and think through how you and your loved ones might best protect

IN THIS ISSUE

BY THE NUMBERS

19.3 million

Fewer Americans are uninsured in 2017 compared with 2010, when Obamacare passed Congress.

$28,166

Annual cost of health

yourself with your most affordable, effective, and accessible health coverage.

Important developments are occurring. Let's explore them.

With health insurance, 'skinny' isn't good

Let's start with one of the biggest changes now on the horizon, so-called "skinny" health insurance policies. They may look attractive because they're easier on your wallet than traditional plans that comply with the ACA's standards about the coverage they must provide. But these "skinny" policies are fat in fine print: many pages of exceptions and limitations that truly undercut the whole purpose of health insurance.

What's the point of having health insurance? It protects the policy holder and their family against unexpected and ruinous medical costs, by spreading the costs of medical care among a bunch of people, some healthy, some very sick. Insurance coverage also qualifies you for lower rates than the hospital or doctor would charge if you were paying with cash or a credit card. Insurers negotiate these lower rates on your behalf.

But political partisans argue that too many health plans cost too much because the ACA demanded too much, such as wiping out lifetime caps on benefits, or barring insurers from excluding customers due to pre-existing conditions. So enter, stage right, the new "skinny" plans.

This means that if you're younger and healthier, insurers and brokers may hard-sell you to sign up for health coverage with nicknames — "short" or "skinny" or "skimpy" or "association" plans. They will be sold as costing you less, with monthly premiums as low as $100. The short plans cover you for less time, typically under a year, though the Trump administration wants this stretched longer. (This was how the plans started — as a short-duration bridge or to span coverage gaps.) These plans also contain pages of fine print, describing limits, what makes them "skinny" in what they will pay for and what they won't, if

care for a typical American family of four covered by average employer-sponsored preferred provider organization (PPO) plan

39%

Percentage of large employers offering only high-deductible plans, up from 7 percent in 2009.

$700 billion

Total Medicare benefit payments in 2017, up from $425 billion in 2007.

76 million

Number of low-income Americans who get health coverage via Medicaid, the nation's largest public health insurance program. It covers 1 in 5 Americans.

QUICK LINKS

Our firm's website

Read an excerpt and order Patrick Malone's book

The Life You Save

Nine Steps
to Finding the Best Medical Care —
and Avoiding the Worst

you go to your doctor or hospital. Many aren't "ACA compliant," meaning that protections consumers have grown accustomed to will be absent.

These plans are not new. They were around before Obamacare tried to put them out of business. During that time, too many patients learned too late that they had thrown away even the lesser sums they paid for short-term plans because, when needed, they covered next to nothing. Companies that peddled these policies not only had a propensity to deny all but a few claims, they also had bad habits of disappearing when patients and watchdogs chased them for services and sums owed.

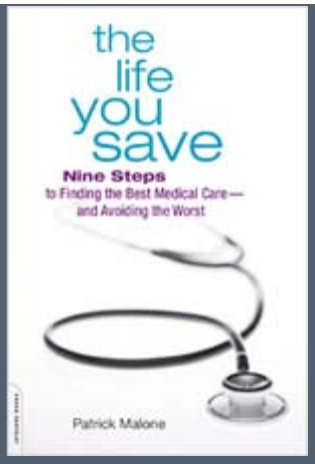
Caveat emptor, shop carefully, and know, by the way, that no matter how carefully customers read their short-term policies, experts like Andy Slavitt — who headed the Medicare and Medicaid programs in the Obama Administration — have warned that insurers and brokers always are ahead in figuring ways to get the most money while providing the fewest services. As Slavitt noted on Twitter: “Let me repeat: You will never know what’s in a Trumpcare Insurance plan for the simple reason that you will never be as good at reading fine print as insurance companies will be at writing it.”

If you're wondering why ACA foes might be eager to promote skinny coverages, that's easy to answer: They hope to undercut Obamacare by draining out of its "risk pools" healthier and younger Americans, who share in coverage costs but tend to rack up fewer expenses. The administration, according to critics, has made clear this goal, by saying it will cut money for outreach programs to increase ACA plans, while pushing skinny policies.

California, by the way, had such poor experiences with short-term plans for consumers in one of the nation’s largest markets that state lawmakers voted to ban them, and Gov. Jerry Brown has signed their bill to do so. New York state earlier had barred these policies, and Maryland and Hawaii have put limits on their length of coverage.

The three-S plans (short, skinny, and skimpy) have a close cousin, consumer advocates say. They may seem sound and even a good idea. They’re called association plans. They’re premised on the idea that like-minded groups of people, including multiple businesses or groups of churches or schools or the like, might band together to take advantage of their numbers to find and provide individuals cheaper and better health insurance.

This, too, is an old idea. It hasn’t worked before. Indeed, Americans need only look at the nation’s corporate titans to see how rich, savvy,



LEARN MORE

Read our Patient Safety Blog, which has news and practical advice from the frontlines of medicine for how to become a smarter, healthier patient.

Join our Mailing List

PAST ISSUES

What the new research on alcohol really means
Be wary of getting buffaloed into one of these medical herds
Dispelling the silence and shame around suicide
Summer-proofing your kids from the year's '100 deadliest days'
The rising toll of hepatitis, and what each of us can do to protect ourselves and our families

giant enterprises — including those in the Fortune 500 — sweat and bleed while trying to deal with their employee health insurance plans. Health care is complex and fraught, so much so that even an outfit as legendarily tight (efficient) as Wal-Mart couldn't find a path to cut medical costs, stymied by backroom deals among providers, particularly hospitals.

States, employers and groups nationwide have expressed frustration that the president and his allies will roll out association plans in 2019, without dealing with critical details that could make or break these.

If you're looking for an indicator as to what confidence might be placed in association plans, the National Federation of Independent Businesses, which had been a big and noisy advocate for more than a decade, making a counter-factual argument for how this health insurance would be far superior to Obamacare, quietly has slunk away. The group won't offer its own association plan, it has said. What does that say?

High stress with high deductibles

Tens of millions of American workers — 55 percent of us, in fact — get health insurance through our employers, a quirk of history that makes neither companies nor their employees happy these days.

With CEOs under constant fire to increase returns for stockholders and investors, U.S. businesses have responded to the skyrocketing costs of prescription drugs, medical services, and health insurance by shifting them onto their workers' backs.

Even as stock prices sit at peaks and many companies are reporting major profits, most workers have seen whatever pay raises they've won devoured by rising costs for health coverage, prescription drugs, and medical services.

Although companies are forking over more to employees in benefits and less so in wages (which are harder to roll back, if and when economic times turn tough), Americans emphasize in surveys and

More...

news stories that they're crushed by payments for health care and coverage. That annual cost for a typical American family of four, covered by an average employer-sponsored preferred provider organization plan (PPO), hit $28,166 in 2016, according to one expert estimate.

To cope with soaring costs, embattled families have struck an ugly bargain, signing up — with company encouragement — for high-deductible health plans. Their monthly premiums may be lower. But, in turn, their out-of-pocket expenses can be steep, running into hundreds or thousands of dollars that consumers must pay first, before their coverage kicks in. More than half of Americans say they're trapped in health coverage nightmares, facing average deductibles of $1,000; 39 percent of large employers offer only high-deductible policies, up from just 7 percent in 2009.

This problem is acute because studies show typical Americans already have such weak finances that they and their families, if hit with an emergency expense of $400, could not afford it without borrowing or selling something they own.

The economic realities of workplace-provided, high-deductible health insurance means that too many Americans simply forgo important medical services, skipping prescribed drugs, and praying a lot that their kids, in particular, don't get sick or injured, as the young are wont to do.

Policy-makers and politicians have offered a weak response to workers' rising ire about the sky-high costs of medical services and health coverage: flexible spending accounts (FSAs) and health saver accounts (HSAs).

Both give Americans who can set aside money for specified medical costs tax advantages for doing so. Employers can contribute to these accounts. They differ greatly, however, because consumers can't qualify for HSAs unless they can show they've got health coverage with deductibles of at least $1,350 for an individual or $2,700 for a family. HSAs allow Americans to contribute more, up to $3,450 for an individual and up to $6,900 for a family. That compares with FSA contribution eligibility of $2,650 per year per employer.

It's also important to know that FSA contributions, generally speaking, must be spent in a year, while those for an HSAs can be rolled over year-to-year. HSAs follow you if you change jobs, while FSAs are employer-specific. You can change your contribution levels throughout the year with HSAs, while, generally, with FSAs, the sums are set annually.

Both options can be smart and financially beneficial. But they ignore reality: These accounts take money to save. Families struggling with health insurance costs and choosing high-deductible coverages as a consequence are unlikely to have free cash to set aside.

News organizations have devoted plenty of ink and electrons to the

problems with employer-provided health insurance. But the politicians, especially partisan extremists, have shown an obsession with the ACA. Will this disconnect persist?

Problem-solving is never easy

As an early-term legislation by President Obama and congressional Democrats, the ACA has been criticized fairly for taking on too much too soon. Obamacare, critics point out, was spelled out in a bill covering almost 2,000 pages and with almost a quarter-million words — only a bit fewer than in J.K Rowling's "Harry Potter and the Order of the Phoenix."

Still, if its central goal was to help Americans access and afford health insurance, the ACA has numbers worth considering, as the New York Times has reported based on U.S. government data: "Obamacare has substantially reduced the number of Americans without insurance. … 19.3 million fewer people were living without health insurance in 2017 compared with 2010, when the Affordable Care Act passed Congress."

Although assailed by critics, the ACA has grown popular among Americans in an array of opinion surveys. It wins more voter support than a signature, early-term action by the Trump Administration and congressional Republicans: Giving wealthy corporations and the richest Americans more than $1 trillion in tax cuts.

November will be a key time — a decisive one — not only for Americans in deciding about their individual health insurance but also about who they want in Washington, D.C., steering crucial matters about their health coverage and the health-care system that takes up 18.5 percent of the U.S. GDP.

The White House and Congress both will have significant sway over big issues — like the funding and future of Medicare and Medicaid, the government support programs that provide health coverage to tens of millions among us. Elected officials also will play determining roles in grittier coverage problems, including the fate of protections against "surprise" and "balance" medical bills and insurer bias on pre-existing medical conditions.

Uncovered: 'surprise' and 'balance' bills

Profit-seeking insurers, as part of the protections for their own interests that they put in place after the passage of Obamacare, narrowed patients' health care networks. This has constrained Americans' choices of doctors and hospitals, forcing the insured to roll through huge phone books of medical providers to find those participating in their health plans.

At the same time, insurers have stepped up the penalties for out-of-network treatment, hitting patients with big, surprising, and much-dreaded medical bills, notably for emergency care. Who, after all, stops anyone in scrubs from caring for you when you're so sick or injured that you've been rolled into an ER? We're really supposed to make them tell us which insurer network they're in before they administer care? Who, before going under, grabs a syringe from an anesthesiologist to ask if she's in a given insurer network?

Media organizations, rightly, have shamed doctors and hospitals for balance billing (providers seeking big sums from patients whose insurers already have made "fair and reasonable" reimbursements). This coverage included a recent story about a 44-year-old Texas teacher and father of two. After he suffered a heart attack, his insurer paid a hospital $56,000 for his stay and treatment. But the hospital demanded $108,951 more. Public outrage led the institution, which defended its actions to the hilt, to eventually settle the dispute for $332.39.

States also have stepped in to bar sneaky and unacceptable billing practices. But with public sentiment polling high for federal legislation to address this mess, will politicians in the nation's capital not only campaign on but act on safeguards for patients?

Pre-existing condition protections

Meantime, anxiety has run high for ACA advocates as a federal judge in Texas weighs a case brought by 18 attorneys general and two governors — all Republicans — challenging Obamacare, which is defended in the court by a similar array of ranking Democratic officials from 16 other states and the District of Columbia.

The administration, effectively, has sided with ACA opponents arguing that Obamacare should fall because Congress — in the giant tax cut bill — voted to eliminate a key element on which it was built: the requirement that Americans show they have health coverage.

The case turns on thorny legal issues, may not be decided quickly, and likely will be tangled up in appeals for some time. But this battle has potential for significant consequences, including 17 million Americans losing ACA health coverage and tens of millions of others, including those with employer-provided health insurance, seeing rollbacks in protections on essential benefits and against insurer denials based on pre-existing conditions.

The ACA's pre-existing condition protections have become some of Obamacare's most valued, opinion polls show. Americans are loath to go back to a time when big insurers left them in the cold because they survived cancer and heart disease, or because they may have a long list of pre-existing conditions — including pregnancies, allergies, and athlete's foot.

Political partisans both have counter-factually pretended, as the midterm elections have heated up, that they support the ACA and its rules on pre-existing conditions (this though they're on the record with years and dozens of "repeal and replacement" votes) or that they support a faux U.S. Senate bill. That hastily launched legislation purportedly keeps up pre-existing condition protections that voters like. But, as the New York Times reported, it still would allow, "insurers [to] refuse to cover certain medical conditions. They could also again charge more based on gender or line of work or raise rates on older Americans."

Fighting back

What are all of us ordinary folk supposed to do when medical care and health insurance have become so costly, complex, and daunting?

You might consider, at minimum, informing yourself about your health coverage, whether through the ACA or your job. Go to information sessions at work. Grab someone from the benefits area in your Human Resources department if you're unclear about details of your coverage.

Please consider getting up to speed on health care policy as it directly affects you, your loved ones, friends, and employer. It matters, as Maryland residents, for example, have found: With the costs of Obamacare policies all over the place — with many heading skyward, insurers say, because of Republican ACA attacks — Maryland's health insurance rates are going lower. Informed citizens helped make this happen.

If you haven't done so, it's an important part of being a good citizen to register and — please — vote.

Line-by-line battles

You may be sick or hurt, and it won't be fun. But you and yours also need to pore over every medical bill and insurance statement you get. Don't let your blood pressure rise or your temper flare. Be cold, calculating, skeptical, and insistent. Demand that providers send you bills, not with an aggregate sum, but with line-by-line charges detailed. Be prepared and fight every expense that you think is excessive, unfair, or inappropriate. We're all learning, sadly, how doctors, hospitals, and insurers "spitball" the nose-bleed prices they try to extract from you for your care. If that's the case, as is true with the mechanic down the street or the butcher around the corner, if so

much flex exists in medical bills, haggle them lower.

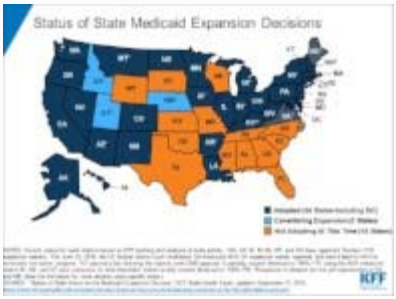
Elisabeth Rosenthal, a doctor and stand-out medical journalist, has written a book and reported extensively about how sick the U.S. health care system has become and how consumers can fight back when they're gouged. When you go in the hospital, for example, and an army of bureaucrats forces you to sign admitting papers in which you pledge to pay your medical bills, she says to take a pen and write in that you'll do so only if the providers are part of your insurance network. Her advice on another step makes sense for other reasons, too: Demand that anyone who appears at your bedside identify themselves and explain what they plan to do to or for you.

In my practice, I see the harms that patients suffer while seeking medical services and their struggles to access and afford safe, efficient, and excellent medical care. It's unacceptable that medical economics have become so fraught for so many Americans that dealing with health insurance and medical bills alone have become a draining and epic battle.

We need to muster our families and friends and good allies — in the medical profession, health insurance, public-policy making, and among politicians — to keep in control those who would exploit and divide us. As humans, we all may be moments away from catastrophic injury or illness, and it has been a hallmark of American society that we recognize this, share risks, and help each other, in sickness and health.

Here's hoping that you and all you know, of course, stay healthy and worry-free from health coverage, medical care, costs, and bills!

Medicaid: Millions got covered. And millions didn't.



If you're living on the edge of poverty, whether you can afford to go to the doctor depends on where you live: Blue states, yes. Red states, not so much.

The ACA expanded Medicaid, with 33 states and the District of Columbia agreeing to accept federal underwriting to increase health coverage for the poor. Millions of previously uninsured

For seniors, due diligence can be key with Medicare

Here's a data point that must be considered in any discussions of the U.S. health care system, especially in any conversations about health insurance: Every day, until 2030, 10,000 baby boomers will turn 65, and with each of those birthdays, that many have new health care coverage through Medicare.

As the nation grays, Medicare will play a bigger, even more crucial role in providing coverage to

Americans got health coverage, as a result.

At the same time, millions of low-income adults in states that declined Obamacare's Medicare expansion, as one health policy group has described it, "face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Many are in fair or poor health or are in the age range when health problems start to arise, but lack of coverage may lead them to postpone needed care due to the cost."

Some conservative and GOP-voting states are reconsidering their earlier ACA decisions. Voters in Utah, Idaho, and Nebraska will decide in November whether to join the Medicaid expansion.

Maine voters approved a Medicaid expansion plan for their state, but the governor refused to implement it. He will be termed out of office in November, and Medicaid is an issue in the election campaign for his successor.

In Virginia, Medicaid will expand in 2019, with Democrats and Republicans still tussling over the program, especially with GOP-demanded requirements that recipients show they have sought work or have worked for a time, especially soon after they seek government support.

Virginia also has become a case-study state, with researchers finding disparities between the health of the rural and urban poor attributable to the state's earlier refusal to expand Medicaid. As the Washington Post described what happened in Virginia and other states like it that didn't expand Medicaid: "Rural, low-income voters who helped propel President Trump to victory in 2016 [in these areas] are less likely to have health insurance than the urban poor in states that didn't expand Medicaid under the Affordable Care Act."

This compounds health challenges that rural residents face, because they're poorer and sicker, the newspaper noted, adding, "Compared to people living in metro areas, low-income Americans in rural areas have less access to medical and social services, and are more likely to die from heart disease, cancer, chronic respiratory disease, stroke and unintentional injuries."

tens of millions of Americans.

It pays to start boning up on Medicare as soon as you turn 64, a year before you're officially eligible. Uncle Sam, AARP, and Consumer Reports provide valuable resources for this. Suffice it to say that seniors confront complex coverage choices under this program, which has different parts: A, B, C, and D.

A and B, "original Medicare," help seniors with hospital and medical coverage, while C deals with their private insurance options, and D deals with prescription drugs, a huge concern as medication prices skyrocket and program changes are afoot. Seniors may sign up for Medicare three months before they turn 65. Dig into program details, because early missteps with the federal health insurance program can cost you.

Political partisans long have battled over not only Medicare and Medicaid but, more fundamentally, whether the federal government should play any role in health care, health insurance, and individuals' well-being.

Republicans have shown in recent months that they think Americans should struggle on their own, and that collective sharing of the costs of inevitable and pricey injury or sickness is unacceptable. They've proposed trillions of dollars more in tax cuts for rich elites and wealthy companies, while promising to slash Medicaid, Medicare, and Social Security, blaming these "entitlements" for adding to the national debt and budget deficits.

Currently, 44 million Americans are enrolled in Medicare, with that figure expected to soar by 2030 to 79 million, the AARP says.

Again, as with Medicaid, the November midterm elections will hold giant sway over whether 60 million Americans 65 and older, who paid into retirement health programs, will see the $700 billion Medicare program as fungible or dispensable, as Republicans argue it and Social Security to be.

Or do they want legislative leaders to give more rigorous, methodical, open, deep, and transparent consideration? Senior advocates like AARP have suggested at least a dozen ways Uncle Sam could improve a program that already has proven

As Trump voters in non-Medicaid-expanding states support the GOP and its attacks on the ACA, they're acting against their own interests, especially their health and the well-being of their loved ones, friends, employers, and communities.

Partisans, insisting that social support programs cost too much and their costs need to be slashed, not only have resisted Medicaid expansions but also have sought to add harsh rules to the program, like forcing participants to show they've sought work or are doing so, even for short periods. Many of the restrictions, pushed in a dozen states, won't work — they can't be followed by a huge segment of Medicaid recipients like poor kids, chronically sick seniors, or the disabled. The work rules, experts also say, add bureaucratic costs without saving money, one of their major, purported reasons for existence.

Montana in November will test a novel way to deal with the costs of expanding Medicaid: Voters will decide if smokers in Big Sky country will foot much of the bill with added tobacco taxes, so 100,000 lower-income Montanans can keep their health coverage.

Big Tobacco has poured money into the state to try to bully voters off the Healthy Montanans Initiative. Considering tobacco's huge health harms, however, taxes that discourage its use and that support health coverage could be a big win for a healthier Montana.

Hooray for the folks who developed this idea, which maybe should spread widely. Just a reminder why: Medicaid is the nation's largest health care program, covering 74 million enrollees, or about one in five Americans. Some 60 percent of Medicaid's spending is for the elderly and the disabled, many of whom come from middle-class households.

to help older Americans live longer and healthier, while also keeping them in efficient ways out of costly medical care.

Recent Health Care Blog Posts

Here are some recent posts on our patient safety blog that might interest you:

- Big hospitals can't exploit patients and violate their privacy by throwing open their facilities

to Hollywood for television shows that plump institutions' reputations. And academic medical centers need to think twice before letting their leaders strike cozy deals to enrich a choice few insiders by hawking important diagnostic information collected with best intentions by medical staff from patients for decades. The roster of hospitals with black eyes from recent negative news stories about their activities includes well-regarded institutions in Boston and New York — Brigham and Women's Hospital, Massachusetts General Hospital, and Memorial Sloan-Kettering Cancer Center.

- Doctors put their patients at grave risk by failing to stay current with professional best practices, eliminating outdated and ineffective therapies and approaches and instead learning and adapting better ways of care, notably treatments to help deal with the opioid crisis. Vulnerable children can pay an unacceptable price, for example, for pediatricians' unwillingness to "unlearn" what they were taught decades earlier in medical school, reported Aaron Carrol, a professor of pediatrics at Indiana University School of Medicine, a health researcher, and a contributor to the New York Times' evidence-based column "The Upshot."

- Nursing homes, by scrimping on their staffing to maximize their profits, put their residents at grave risk for infections that too often have grisly and deadly results. Low-rated facilities run by Uncle Sam to care for elderly veterans also may be concerning. And those oft-pricey assisted living facilities may have their own response to dealing with difficult to care for elders — putting them out on the street. Kaiser Health News Service, the Chicago Tribune, USA Today, and the Boston Globe all deserve credit for their digging into problems at facilities caring for the old, focusing on issues that should be at the fore for regulators, policy-makers, and politicians as the nation grays.

- Celebrities can play an out-sized role in medicine and health care: Just consider the public attention paid to Angela Jolie or Ben Stiller and their discussions about cancer screening and the disease's risks, or Michael Phelps, Mariah Carey, and Carrie Fisher raising awareness about mental health issues, or, yes, Gwyneth Paltrow promoting a rash of wellness goop. But even with their wealth, accomplishment, looks, and social standing, public figures also can be savaged just like ordinary folks by medical errors that harm and even kill them and their loved ones, according to the Center for Justice and Democracy.

- Although Americans may be having less sex, it's getting riskier than ever, with the federal Centers for Disease Control and Prevention reporting that new cases of chlamydia, gonorrhea, and syphilis spiked for the fourth consecutive year in 2017 to a record high of nearly 2.3 million diagnoses. "We are sliding backward," Jonathan Mermin, a doctor and director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, said in a statement. "It is evident the systems that identify, treat, and ultimately prevent

STDs are strained to near-breaking point.”

HERE’S TO A HEALTHY 2018!

Sincerely,

Patrick Malone

Patrick Malone & Associates