TONIC

# THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.





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# 00005: HEALTHCARE IF YOU'RE ADDICTED TO OPIOIDS

# HEALTHCARE IF YOU'RE ADDICTED TO OPIOIDS

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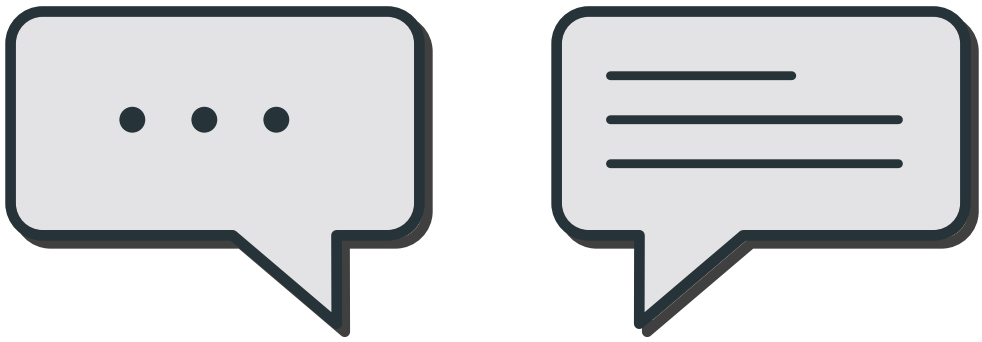
# IF YOU'RE ADDICTED TO OPIOIDS

BY MAIA SZALAVITZ

Although the Affordable Care Act (ACA) is supposed to guarantee addiction treatment to a nyone with Medicaid or private insurance, people with opioid addictions and their loved ones still face a dysfunctional system that can make it very, very hard to get help.

Here are some tips for getting around some of the biggest insurance roadblocks.

# Is rehab the best, most effective treatment for someone addicted to opioids?



The world of treatment for opioid addiction is upside down: The best treatments for cutting relapse and preserving life are stigmatized and relatively cheap, while less successful and more expensive residential approaches are featured as models in the press and on television programs like "Celebrity Rehab."

"The layperson still typically assumes that addiction treatment is residential treatment and that's a misconception," says Sam Arsenault, director of National Treatment Quality Initiatives for Shatterproof, an addiction advocacy organization. Opioid use disorder (OUD) can often be treated effectively on an outpatient basis, she says, although residential treatment may be appropriate for some.

Regardless of the treatment setting, anyone seeking care needs to know this: methadone and buprenorphine (Suboxone), used long-term and in some cases for life, are the only two treatments proven to cut the overdose death rate by half or more.

Inpatient or outpatient rehabs that don't permit the use of this medication or only use it short-term do not have this benefit—and these rehabs are less good at reducing relapse. A newer medication, long-acting naltrexone (Vivitrol) may help some, but it doesn't have the proven, lifesaving results that the two other drugs do.

Consequently, if you or a loved one is seeking care and want the best odds of recovery, choose a program that uses methadone or buprenorphine long-term, not just for a week or two of "detox."

However, if the person has only been addicted to opioids briefly or has other strong reasons for not wanting to start long-term use of one of these drugs, consider Vivitrol or drug-free programs that provide evidence-based psychological treatments like cognitive behavioral and motivational enhancement therapy. But the safest and most effective approach is to combine voluntary and appropriate psychological treatments with methadone or buprenorphine.

## Is therapy also necessary? What about other support?

No, but it's advisable. For many, a critical part of treatment is addressing problems that may have led to the addiction. At least half of people with any kind of addiction have another mental illness and most have experienced childhood trauma. For opioids, particularly heroin addiction, these rates are even higher: 90 percent have had at least one trauma exposure and a third have post-traumatic stress disorder (PTSD).

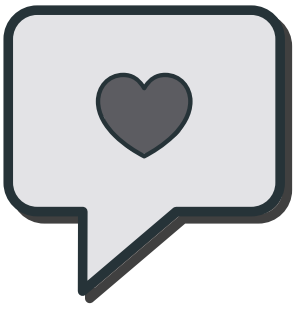
Ideally, these issues should be appropriately assessed and treated—if they aren't, recovery is much less likely. However, if the only step a person is ready to take toward recovery is taking medication, that should be encouraged: Medications offer protection against overdose even if use of other drugs isn't immediately stopped.

Also keep in mind that treatment that is warm and welcoming is much more effective than confrontational, coercive, or disrespectful counseling: Avoid authoritarian or humiliating programs. Calling the program and asking them about rules and discipline will usually unmask such providers; if something feels punitive, rigid or cold, avoid it if possible.

Since addiction is often chronic, it's important to plan for both ongoing care that reduces in intensity as the person recovers and, particularly, social support. This can take many forms: family, friends, 12-step groups, other self-help, gym memberships, volunteer work, church—basically, whatever the person finds most appealing and sustainable and keeps them occupied without substances. Exercise can be especially helpful as the "high" from exercise can help restore the brain's pleasure and motivation systems—if people engage in activities they actually enjoy. (Note, though, that you don't have to love every second of it.)

## How do I find a provider that's covered by my insurance?

It's time to take a good look at your insurance documents and search their website for addiction treatment providers that are covered "in-network," meaning they will be the least expensive. "Rather than go through their insurer, many people go to Dr. Google and locate treatment that way," Arsenault says. "That can result in a higher price tag." Staying in-network will be cheaper and easier to get covered—go "out-of-network" only if you can't find care of sufficient quality.



# What does insurance have to cover? Do they cover it without a fight?

This part is tedious but critical. "The great thing about the Affordable Care Act is that addiction treatment [must be] covered," says Michelle Katz, a healthcare consumer advocate and nurse. The federal "parity" law, which is part of Obamacare, requires that no limits be placed on treatment for addiction and other mental illnesses that aren't placed on coverage of physical illness. But the devil, of course, is in the details, which will vary from state to state and from insurer to insurer.

Consequently, reading your policy and learning about these details is essential. (You can find the covered benefits on your insurer's website or in a document you probably stashed in a drawer and forgot about.)

In addition to the specifics on addiction care, the document will also include sections on what are known as "internal" and "external" appeals, or the processes to go through if (and when) a claim is denied.

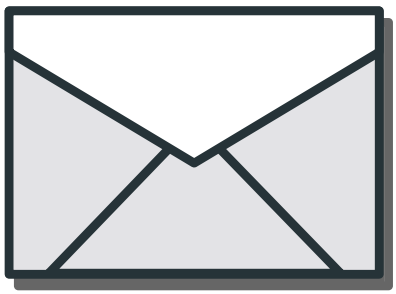
"Many times, the first time you submit a claim, you will be rejected," Katz says. You'll need to know the nature of the appeals processes, which allows you to fight denial of coverage. If you're denied, immediately demand a review, which will first be done by a doctor who works for the insurance company (internal appeal). If you lose in the internal review, go for an external review, which has to be done by a doctor who isn't employed by the insurer.

Some insurers have "fail first" policies, which mean that people have to try less-intensive treatment and fail at it before more comprehensive care will be covered. This is less likely to be a barrier to getting medication treatment covered, but it is often used to fight against paying for inpatient care.

Consequently, be sure that inpatient care truly is the best option in your case if you are going to fight for it. For people who aren't homeless and not living with drug dealers or in other dangerous environments, outpatient treatment can often work just as well. (If you're convinced that a change of setting is necessary, a new safe living space far from known dealers and drug-involved friends doesn't necessarily have to be in a treatment program).

Write down what you're told in phone calls—immediately, so you don't forget. (In many states, it is legal to record calls without the knowledge of the other party—and many insurers are already recording you as they state in their phone systems.)

# Is there a way to avoid getting care denied outright or get appeals approved faster?



As you can probably tell already, dealing with insurance coverage for addiction is often a hassle. If you have a primary care doctor who knows you and is familiar with your insurer and the genuine need for treatment, that doctor may be your best weapon in the fight, according to Katz.

What you want to find is someone who knows the specific language to use in documenting the need for care that opens the door to coverage with that particular insurer. "You need to put language in the chart that emphasizes the desperation of the situation," Katz says, "Ask for expedited approval because it is a life-threatening condition." Given the overdose crisis affecting people with opioid addictions, this is not an overstatement—but it needs to be stated starkly.

Advocacy groups for families with addiction like Shatterproof and the Partnership for Drug-Free Kids have useful resources and can help connect you with others who've been there to help you fight your way through the system.

Depending on the state where you live, the attorney general's office and the state agency that regulates insurance may also be helpful. Since these officials deal with bad behavior by insurers, they know the relevant state law and how patients can get the benefits they're owed. The names of the agencies involved vary by state, but searching for "health insurance consumer protection" or "health insurance regulation" and the name of the state should bring them up.

While it's almost never helpful to be impolite, it's critical to be persistent. The more you complain and the more you show that you know what should be covered, the harder it is for insurers to deny benefits.

Bombard them with studies (some useful research is linked in the online version of this guide at tonic.vice.com/healthcareguides) that show what works to fight opioid addiction, call frequently, and let them know you aren't going to stop until you or your loved one gets the treatment they need to get better. Endless paperwork and slow bureaucracy are huge deterrents to getting your claims paid, but don't let it stop you.

# Are there things I can do now to be ready when someone wants treatment or if there's a crisis?

Fighting to get the coverage you're owed can sometimes be a full-time job in itself—and this is hardly what a person with addiction or their family members need to deal with while in crisis or when a person who previously resisted help finally decides to go for it.

Consequently, try to do your research and have as much of the paperwork ready as possible (like medical and insurance records) before there is a crisis or recovery opportunity—either of which is hard enough to manage without having to deal with insurance companies.

# Should I also have naloxone?

Regardless of where you or your family member is in the recovery process, keep the overdose antidote naloxone on hand—it's better to have it and not need it than it is to need it and not have it. Some insurers will cover this medication with no copay and many harm-reduction programs distribute it and train people to use it for free. There's more info on how to get naloxone on tonic.vice.com and at hopeandrecovery.org.

# What about people who don't have insurance or their coverage isn't enough?

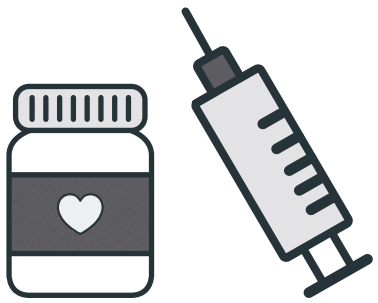
Most states have publicly funded treatment programs that are available to the uninsured, and nearly all treatment programs will also work to enroll patients in Medicaid so the facility can get paid for the care. Calling a treatment center that seems like a good fit and asking if this is an option at their facility is generally the best way to find out about these slots. Some private programs also have "scholarships" for people who cannot otherwise afford to attend; again, call and ask.

Be aware, however, that some rehabs and treatment programs will "balance bill" for services that aren't covered completely; people have been hit by surprise bills for thousands of dollars. Ask about exactly what is covered and what isn't, especially with regard to "scholarships."

Further, don't pay any unexpected bill just because it is sent to you. Call and challenge it, and find out about your specific rights via your attorney general or insurance commissioner's office. In some states, it's actually illegal for programs to accept insurance payments and then bill the patient for more than the insurance rate for a given service. Your insurance will send you documents known as an explanation of benefits (EOB), which will spell out how much a provider is allowed to charge for a specific service. If the provider tries to bill you for more than the "allowable amount," challenge it.

# Any final words of wisdom?

America's medical system is not patient-friendly in general, and it is even less so when it comes to addiction. However, most people with opioid addiction do recover—provided they can avoid overdose. Always have naloxone, try to keep on top of your insurance coverage (both maintaining coverage and fighting for benefits), and reach out to organizations like Shatterproof and The Partnership for Drug Free Kids for support from others who have been there.



# 0008: HEALTHCARE GLOSSARY

# HEALTHCARE GLOSSARY

- AFFORDABLE CARE ACT (ACA)
- ANNUAL AND LIFETIME LIMITS
- COINSURANCE
- COPAY
- DEDUCTIBLE
- ESSENTIAL HEALTH BENEFITS
- FLEXIBLE SPENDING ACCOUNT (FSA)
- HEALTH SAVINGS ACCOUNT (HSA)
- HIGH-DEDUCTIBLE HEALTH PLAN
- INDIVIDUAL MANDATE
- INSURANCE NETWORK
- MARKETPLACE
- MEDICAID
- MEDICARE
- MEDICARE FOR ALL
- OPEN ENROLLMENT
- OUT-OF-POCKET COSTS
- OUT-OF-POCKET MAXIMUM
- PREMIUM
- PREEXISTING CONDITION
- PRIVATE HEALTH INSURANCE PLAN
- PUBLIC HEALTH INSURANCE PLAN
- SINGLE-PAYER HEALTHCARE
- UNIVERSAL HEALTHCARE

# HEALTHCARE GLOSSARY

BY SUSAN RINKUNAS

Let's be honest: Health insurance is confusing, so let's start at the beginning. Health insurance is a contract you buy that requires an insurance company to pay for some or all of your medical expenses. Some employers offer (heavily subsidized) insurance to their employees, some people buy their own plans, and the government provides insurance for older people as well as for low-income people and those with disabilities. Still, some people in the US go without insurance.To help you understand how it all works, here's a list of the terms you need to know, explained in plain English.

# Affordable Care Act (ACA)

Really, its full name is the Patient Protection and Affordable Care Act (PPACA) and it was passed in early 2010 and fully implemented as of January 2014. It's also known as Obamacare, after the President who shepherded it and signed it into law.

People in the United States aren't guaranteed to get health insurance. They have to get coverage from their employer or spouse's employer, buy it themselves, qualify for a government program, or go without. The ACA sought to get more people covered by insurance and protect people from going bankrupt from medical bills. It did that in a few ways: It said young people could stay on their parents' plans until age 26, it expanded the eligibility requirements for Medicaid, and it banned insurance companies from discriminating against people for having preexisting conditions [see " preexisting conditions"], which range from having given birth via C-section to having diabetes and other very basic, common things.

The ACA required insurance companies to cover everyone, and charge them the same rates no matter their health history. It also mandated that plans cover, at minimum, the same set of essential services [see "essential health benefits"], including preventive care at no cost, like vaccines and a set of benefits specific to women. The ACA also banned annual or lifetime caps on those essential services.

In 2010, 48.6 million Americans, or 16 percent of the population, didn't have health insurance. In 2017, the number of uninsured had fallen to 29.3 million people (or 9 percent of the US). That's still a sizeable chunk of people without health insurance, and that's why people want to improve upon Obamacare or replace it with universal coverage.

# Annual and Lifetime Limits

These are caps on the benefits your insurance a company will pay in a given year or over a lifetime; after you hit the number, they stop paying and you're on the hook.

Annual limits can be dollar amounts or a number of visits. Obamacare banned annual and lifetime limits for a set of 10 essential health benefits. [see "essential health benefits"].

# Coinsurance

The percentage of costs you have to pay for a service after meeting your deductible [see "deductible"]. Your plan will either charge a copay or coinsurance, not both. Coinsurance matters a lot if you see providers that aren't in your plan's network [see "insurance network"].

Say your copay for an in-network specialist is $25 and your coinsurance for out-of-network providers is 30 percent. If your therapist charges $250 a visit and they take your insurance but are considered "out of network" (as is common with therapists), you'll first have to pay in full out of pocket until you hit your deductible, then pay $75 a visit (30 percent of $250) after that. If you see an in-network therapist, you'd owe a $25 copay, and might not even have to pay the deductible first if your plan says office visits aren't subject to the deductible.

# Copay

Short for copayment, it's a flat fee you pay for seeing a doctor or filling a prescription. Copays typically don't count toward your deductible [see "deductible"]. Usually you only pay a copay if you've already hit your deductible, but many employer plans cover things like office visits and trips to the emergency room before you meet the deductible and so, voila, you only get charged a copay. It's common to have different copays for primary care providers and specialists, so you might pay $25 to see a doctor about a suspected case of bronchitis and $50 to see a specialist like a podiatrist.

There's usually an inverse relationship between your monthly premium (the cost of a plan) and your copays: Plans with lower premiums tend to have higher copays, and plans with higher premiums usually have lower copays.

# Deductible

The amount you have to pay out of pocket for medical care before your plan will start footing the bill. Unfortunately, the deductible starts over every year. Many plans cover office visits before you've hit your deductible, so you may only have to pay a copayment for those visits rather than the full cost. After you've hit your deductible for the year, you usually only pay a copay or coinsurance for care [see "copay" and "coinsurance"].

Similar to a lot of employer plans, Obamacare plans provide certain preventive health services for free, even if you haven't hit your deductible yet. These services include vaccines and certain medical tests for all adults, and a special set of services for women including birth control and an annual well-woman visit. (Contrary to popular belief, an annual physical with a primary care doctor is NOT one of the things that's required to be free, and it will cost you at least a copay. For many employer-sponsored plans, both the annual physical and also the well-woman visit are free.)

# Essential Health Benefits

A set of ten services that all health insurance plans on the Marketplace [see "marketplace"] must cover as a result of the Affordable Care Act. Insurers also can't place annual or lifetime limits on these services. The ten categories are: doctors' services, prescription drugs, hospitalization including surgery, outpatient hospital care, pregnancy and childbirth, emergency room care, mental health and substance use disorder services, laboratory services, rehabilitative services, and pediatric oral and vision care.

# Flexible Spending Account (FSA)

If you have employer-based insurance, you can have money taken out of your paycheck before taxes and use it to pay for approved medical expenses including deductibles, copayments, and coinsurance. It's often loaded onto a prepaid card that you can swipe at a doctor's office or the pharmacy. You can also use an FSA account to pay for other expenses like glasses, contact lenses, dental care, and health products sold on FSAstore.com, like bandaids, pain relievers, and sunscreen. In 2018, the most you could contribute to an FSA was $2,650 a year, and you can roll over $500 to the following year.

# Health Savings Account (HSA)

This is similar to a flexible spending account (FSA) in that it's pre-tax money that can be used to pay for deductibles, copayments, and coinsurance. But you can only put money in an HSA if you have what's considered a high-deductible health plan (HDHP), which is generally any plan that has a deductible of at least $1,350 for one person.

For 2019, you can contribute up to $3,500 to an HSA for individual health coverage. Some insurance companies offer these accounts, or you can open one with a bank. And unlike an FSA, you can roll over the account's entire balance from year to year and the funds may earn interest, which isn't taxable.

# High-deductible Health Plan

An insurance plan that requires you to pay at least $1,350 out of pocket for an individual (or $2,700 for a family) before the plan starts to pay its share, though the monthly premium (or cost of the plan) is usually lower than plans with lower deductibles. Some plans sold on the insurance marketplace have deductibles over $5,000 for one person.

# Individual Mandate

This is one of the linchpins of the Affordable Care Act. In order for insurance companies in the Marketplace not to be saddled with only people who have preexisting conditions—people who buy health insurance because they need to use it and cost the insurance companies more money than people who don't require a lot of care—the law required everyone in the US to either have health coverage or pay a tax penalty.

Importantly, it doesn't say that everyone has to buy a plan from the ACA Marketplace, just that they need to have coverage that meets the law's minimum standards—so getting insurance through work means you're good. The idea is that having "healthy" people in the pool of insured people helps keep costs down, but a lot of those people were mad that they suddenly had to get insurance. (Truth is, without insurance, healthy people are one accident or diagnosis away from big, big problems, physically and financially.)

Republicans effectively ended the individual mandate for 2019 in their tax bill. They couldn't erase it altogether, but they made the tax penalty for not having insurance $0. Experts believe that healthier people will be less likely to buy insurance in 2019 and premiums for others will go up as a result.

# Insurance Network

A group of providers and facilities that contracts with your insurance company to provide services at a discounted price. A doctor might accept your insurance and be considered in-network, and your insurance company will incentivize you to use providers like this by charging, say, a $25 copay for visits. Other providers may accept your insurance but are out-of-network and your insurance company may charge you more money to see them, for instance by subjecting the visit to your deductible and charging coinsurance, or a percentage of the cost rather than a flat fee.

# Marketplace

The health insurance marketplace, also known as the "exchange," is the service available in every state that helps people shop for and enroll in health insurance. People who are buying their own coverage (i.e., not getting it through their job, spouse, or the government) can shop for plans online, by phone, or in person. In most states, the federal government runs the marketplace and you sign up at HealthCare.gov. But 11 states and Washington DC have their own sites.

# Medicaid

A government-run insurance program that provides low- or no-cost health insurance to some low-income people, low-income or uninsured pregnant women and children, people with disabilities, the elderly, and more. People can apply for Medicaid at any time; it doesn't have to be during the open enrollment period [see "open enrollment"]. Under the Affordable Care Act, more than 30 states expanded eligibility for Medicaid to include all adults below a certain income level—138 percent of the federal poverty level. (This is known as "Medicaid expansion.") The states that have resisted thus far tend to be in the South and Midwest.

# Medicare

A government-run insurance program for people 65 and older and some younger people with certain disabilities and conditions. Some politicians want to make Medicare available to more people by letting them buy into it before age 65, aka a "public option," or turn it into our nation's one health insurance program [see "Medicare for all"].

# Medicare for All

One way to achieve universal coverage is to make Medicare the insurer for everyone—not just people over 65 or people with certain conditions. Medicare allows both the government and private insurance companies to pay for care, so it's not a single-payer system. Vermont Senator Bernie Sanders has a plan that he calls Medicare for All, but if you want to get technical, his plan is actually single-payer healthcare because it would eliminate all private insurance companies, which isn't how Medicare operates now.

# Open Enrollment

The period when you can sign up for health insurance for the following year. Each employer has its own window, but for people buying their own plans, open enrollment has run from November 1 to December 15 the past two years in the 39 states that sell their plans on Healthcare.gov. (Most of the 11 states that run their own sites have longer enrollment periods.) You can sign up for or change your insurance outside of that period if you have what's known as a qualifying life event. Examples include if you get married or divorced, have a baby, lose your health coverage, or if you move.

# Out-of-pocket Costs

Also known as "cost-sharing," this is the total of what you, not the insurance company, spend for medical care. It includes deductibles, copays, and coinsurance, but not the monthly premium since that's the cost of having insurance, not for getting care.

# Out-of-pocket Maximum

Yes, there is a limit to how much the insurance company can make you pay in one year. After your out-of-pocket costs hit whatever that amount is, the insurance company picks up 100 percent of any costs for covered services thereafter. And while copays don't usually count toward your deductible, they DO count toward your out-of-pocket max.

# Premium

The amount you pay just to have an insurance plan, even if you never set foot in a doctor's office. If your insurance comes from your employer, the premium gets deducted from each paycheck throughout the year. (This isn't the true cost of the plan—your employer pays for some of it.) If you buy your own plan, you pay the insurance company directly every month.

# Preexisting Condition

Before the Affordable Care Act, people who bought their own insurance could be denied coverage for having a preexisting condition like diabetes and Crohn's disease. Some insurers would cover you if you had a preexisting condition, but they'd charge you more than other people. The ACA banned insurance companies from asking people about their health history and required them to accept everyone and charge them the same rates.

# Private Health Insurance Plan

A health plan that isn't "public," that is, paid for by the federal government. Private plans include those offered by employers and ones people buy themselves. The majority of Americans have private insurance: In 2016, 49 percent of Americans had insurance through work and another 7 percent bought their own coverage.

# Public Health Insurance Plan

A health plan that's operated by the federal government—so, Medicaid and Medicare.

# Single-payer Healthcare

One type of universal healthcare. The payer in this case is the government, rather than a for-profit insurance company. A single-payer system would make health insurance companies obsolete: You'd get health coverage from the government and the government would pay doctors a set price for medically necessary care. You, the user, would have no premiums or deductibles, but there would likely be some out-of-pocket costs, and not every country with single payer covers vision or dental care.

# Universal Healthcare

A system that guarantees that everyone in a country, or even a single state, gets health insurance, no matter their ability to pay. The system is funded by taxes. There are several types of universal healthcare, including single-payer, where the government pays for care provided by private companies (see: Canada), or socialized medicine, where the government pays for and provides the care (see: the UK).