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THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

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IF YOU HAVE A MENTAL HEALTH ISSUE

BY CINDY KUZMA

Chicago therapist Rachel Kazez understands exactly how challenging navigating the mental health system can be. In addition to providing therapy to families, couples, and individuals—with a speciality in young adults—she founded and operates a service called All Along, which specifically helps people sort through the confusion to find the right services for them.

While she knows how overwhelming the hunt for psychological care can feel, she's optimistic that anyone can manage it with some basic prep. "It might take work, but it's possible for everybody to find good mental health treatment that they can afford," she says.

Here are a few of the most important steps to take.

Where do I even start?

Recognizing you have challenges you can't handle on your own is really all the information required to start reaching out. Sure, it might be helpful beforehand to put some thought into what kind of therapy or therapist you're looking for, Kazez says, but starting your search can lead you to answers you didn't even know existed.

"You don't have to figure this out all by yourself," she says. Even if the first place you call or visit doesn't treat the types of issues you're dealing with—for instance, if you find out they specialize in veterans or younger children—the staff might still be able to recommend other resources.

And once you find a practice or clinic that can offer you a slot, they'll offer even more guidance: "Often the process of doing an initial assessment or intake or whatever it's called at the place you're going, that process is about clarifying your needs and preferences for treatment and even referring you out somewhere else if that's what you need," she says.

What kind of therapist should I look for?

While you don't have to get hung up on it in advance, it may help to understand that when it comes to mental health, there are a wide variety of providers. Psychiatrists are physicians—MDs or DOs who can prescribe medications—while therapists who have PhDs or PsyDs can't write prescriptions (though they might team up with a doc who does to manage your care).

People with master's degrees in psychology, counseling, or social work can also practice on their own after about two years, provided they have the correct licensing in their state. They might be called licensed clinical social workers (LCSW), licensed mental health counselor, licensed clinical professional counselor, licensed marriage and family therapist, or some combination of those terms—all indicating they've met state standards for education and experience. At some clinics, Kazez says, a case manager might help you connect with a therapist and also provide some supportive counseling.

I have insurance. Does it cover therapy?

Most employer-based health insurance plans cover mental health services, and all plans purchased through the Affordable Care Act's marketplace must include it (it's what the government considers an essential health benefit). So if you have coverage that does, that's often a good place to start, says Angela Kimball, national director of advocacy and public policy at NAMI, the National Alliance on Mental Illness. Check your insurance company's website or call the number on the back of your card and ask for a list of mental health service providers in your network.

Websites like the American Psychological Association and Psychology Today offer online directories where you can search for therapists by area, speciality, and types of insurance accepted. Often, there's a brief profile, too, which can help you gauge whether you might click with this person and their approach, Kazez says. For instance, do you want a therapist who'll direct you through a series of steps toward an end goal, or someone who's more likely to listen and reflect back to you as you sort through your issues?

Of course, you'll want to call and double-check that they take your specific plan—they might take some plans offered by your insurance company and not others, or the information the company gave you may be outdated. Be especially cautious if you have Medicaid for insurance, Kazez says. Often, Medicaid plans are organized by what's called a managed care organization. To be covered, the provider you see not only has to accept Medicaid, but also work with your specific managed care organization. Again, the staff at the offices or clinics you contact can help you sort through all this.

One note: Just because something's covered doesn't mean it's free. You'll typically have a flat fee called a copayment for each visit. Depending on your plan, coverage for therapy visits and also for bigger expenses like inpatient stays might not kick in until you meet a yearly minimum called a deductible, meaning you'll have to pay more out-of-pocket at first before the flat fees per visit kick in. Your insurance company can provide specifics.

Do schools or employers offer therapy?

If you don't have insurance, your plan doesn't cover mental health services, you can't find a therapist in your network accepting new patients, or you can't afford the copayments or deductibles, you still have options. One way to start is checking out the resources immediately around you. If you're still in school, visit your campus counseling center; services there are usually available at little or no cost to students. Working? Some employers offer employee assistance programs (EAP) that include confidential counseling—ask your human resources department.

I need something a lot cheaper. What else can I try?

Online searching can also yield a wide range of options. Plug in "community mental health clinic" or "low-cost counseling" and the name of your town or a nearby city. "You might be surprised by what pops up," says Paul Fugelsang, a licensed professional counselor in Asheville, North Carolina, and executive director of the non-profit Open Path Psychotherapy Collective. You can also search for the chapter of the National Alliance on Mental Illness (NAMI) in your area; staffers there may be able to connect you to providers.

Another search term worth trying: "sliding scale." This means a therapist has a standard rate, but offers at least some slots at a lower fee for people who fall below certain income levels. You may have to provide some level of documentation about your financial situation, but doing so can result in a substantial discount.

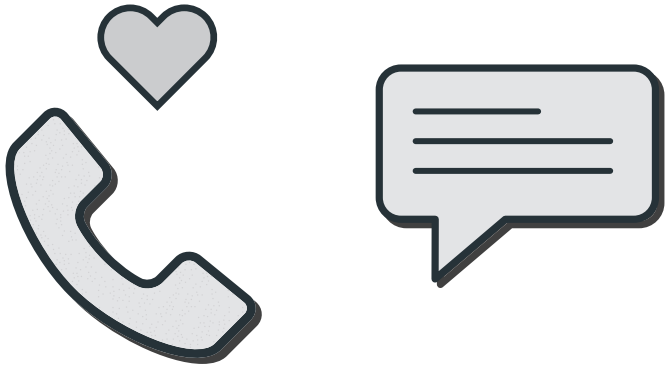
"Many therapists consider it an ethical responsibility to see at least a couple of clients that are pretty low-fee," Fugelsang says. His Open Path Psychotherapy Collective has gathered about 5,000 such providers who've pledged to offer treatment for $30 to $50 for individual sessions, after people pay a one-time, $49 membership fee.

The site lets people search by ZIP code before they join—and the therapists don't have to be as close by as you might think. "Luckily the way it works in most states is that as long as the therapist and the client are sitting in the same state, it's legal for the therapist to do online work," he says. So even if you're in a far-flung rural area, you can chat remotely with your therapist, a method he's found works very well for many of his clients. You can also ask for recommendations for therapists from your doctor or from friends and family members you like and trust, then call to inquire about their rates and sliding scales, Alibrando says.

You can also call your closest hospital or university with a medical school or psychology department. Often, they'll offer lower-cost or even free counseling with trainees or students. Of course, experience counts when it comes to therapists, says Sam Alibrando, a clinical psychologist in Pasadena, California. Experience, however, isn't the only indicator of quality, he says.

In some cases, there may even be upsides to seeing a trainee, Kazez says. "Even if they have fewer years of experience doing the work, they're also much closer to their education. They're getting the most up-to-date education about how to do good counseling and they're usually getting a lot more supervision and consultation than people who've been in the field for a while."

I have really specific issues. Do I need to see a specialist?



If you're coping with common complaints like anxiety and depression, nearly any therapist will have training in how to guide you. If there's an added element to your experience, however, you might find free or low-cost resources through organizations that specifically focus on it, Alibrando notes.

For instance, RAINN (Rape, Abuse & Incest National Network) works against sexual violence and offers a free hotline at 800.656.HOPE (4673), among other services. The Anxiety and Depression Association of America offers a directory of low-cost providers, as well as advice on affording care when cash is tight.

If your mental health challenges are highly specific—for instance, post-traumatic stress disorder (PTSD) or eating disorders—you may want to start there to ensure you're finding someone specifically trained in those areas, Alibrando says.

Regardless of what lies at the root of your concerns, there are many ways to find help fast in a crisis. The National Suicide Prevention Lifeline provides free, confidential support 24 hours a day, 7 days a week via chat or phone (1-800-273-8255); or text HOME to 741741 to reach the Crisis Text Line. And if the situation's life-threatening, you can also call 911.

What are my other options?

In some cases, there's no substitute for one-on-one treatment from a mental health care provider. In other situations, however, different types of services can supplement or potentially even replace therapy. "There are a lot of options that aren't just sitting down with an individual therapist in one office that are often a lot cheaper and can be really powerful and helpful," Kazez says.

Group therapy, for instance, combines the guidance of a professional with connections to others dealing with similar issues. Programs such as Alcoholics Anonymous help many with substance use disorders. Religious organizations often offer faith-based counseling or support groups. Hospitals, clinics, or non-profit organizations may offer peer-to-peer support, a link to someone who's been through what you're going through, Kazez says.

What if I hate my therapist or can't afford to go anymore?

Sometimes, a given therapist's approach doesn't work for you—and every once in a while, you might run into a mental health care provider who just plain isn't good at what they do, Alibrando says. Or maybe you find a therapist you like only to discover, over time, that you can no longer afford their fees. Perhaps you've tried a few times and just don't think therapy's your thing.

That's OK—but that doesn't mean you have to give up on feeling better. "There are a lot of different ways to get help with your mental health, and help with your mental health doesn't have to mean therapy," Kazez says.

Group or peer-to-peer options, or even something as simple as joining an art class or sports team, might improve your mood, forge beneficial relationships, and help you learn communication and problem-solving skills. Or, try telling your therapist you'd like to come in once a month rather than weekly or biweekly, and ask them if they have a workbook they'd recommend—there are many evidence-based options targeting issues such as anxiety, depression, or anger.

And if things reach the point where your concerns are more serious or troubling, you can always resume your search. "There are absolutely ways to go about finding treatment and making it affordable," Kazez says.

What kind of health plan should I get if I need therapy?

Definitely one that covers mental health treatment—though again, most do, including all of them available on the Affordable Care Act marketplace. If you're choosing between different employer-based or public plans and already have a therapist, check to make sure that person's in-network, or that you can afford to pay the out-of-network rate if not. The provider's billing department can be a crucial source of information about whether one plan's better than another, so call them with questions before you make a final decision, Kimball suggests. If you're taking medication, also check that your prescription is on what's called "the formulary," or the list of drugs your plan will cover.

If you don't have a therapist yet, you might have to go through the process of scoping out networks and potential providers for each plan you're considering. Sure, it's a bit of a pain—but if there's a big difference between plans, it might end up saving you a substantial amount of cash.

Will my parents or employer find out if I go to therapy?

If you're on your parents' health insurance plan, they'll probably receive an explanation of benefits (EOB) or similar statement in the mail or online saying that you've been to therapy. But with a few important exceptions, such as plans to hurt yourself or others, everything you say to your therapist is confidential.

If your plan's through work, your bosses won't find out unless you tell them. Companies get big-picture information about the cost of employees' health care consumption, Kimball says. However, the specifics of your medical records—including the fact that you made therapy visits—are protected by what's called the Health Insurance Portability and Accountability Act or HIPAA. They can't be shared without your consent.

What happens if I need to take extended time off from work?

The same rules apply for mental health issues as for physical health problems. "They are both medical concerns that someone can approach human resources about to discuss extended leaves of absence, for example an FMLA leave like when someone is injured," Kazez says, referring to the Family and Medical Leave Act. (It's worth noting that, in most cases, only a certain percentage of your income may be covered—not all of it.) Your therapist may need to provide documentation to your HR rep for time off, but at most companies, that person can act as a confidential go-between if you don't want to go into detail with your manager. And just as with any other health issue, if your employer doesn't provide reasonable accommodations, you can escalate things to higher-ups, get your provider involved, or possibly take legal action.

0008: HEALTHCARE GLOSSARY

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- 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).