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THE TONIC GUIDE TO HEALTHCARE

WRITTEN SO YOU CAN ACTUALLY UNDERSTAND IT.

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0001: HEALTHCARE IF YOU'RE PREGNANT

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- **WHAT ELSE DO I NEED TO DO ONCE THE BABY ARRIVES?**

IF YOU'RE PREGNANT

BY JESSICA MIGALA

So, you're pregnant and excited to be a mom! Aside from peeing on about 10 more sticks to make absolutely sure it's real, your future will now be filled with tons of doctor's appointments—and, possibly, rogue insurance bills for your prenatal care.

It's easy to assume if your OB/GYN recommends a test or tells you to come in for an appointment that it'll be covered by your insurance. But as many women have found out, that's not necessarily the case.

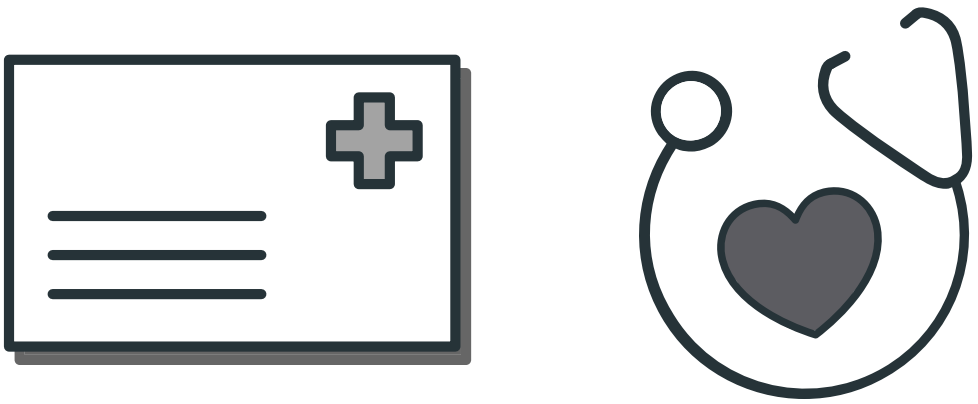
Ask a group of moms for their insurance horror stories and you'll get flooded with responses, like $1,000 bills for lab work, "routine" ultrasounds that had to be paid out of pocket, charges for an out-of-network anesthesiologist who administered their epidural, and the list goes on. The struggle is thanks to the labyrinth of insurance rules that differ depending on the multitude of plans out there.

However, despite all this, one thing is for certain: Things are better for women today than they were before the passage of the Affordable Care Act (ACA). "The ACA was a game-changer for coverage of maternity services. Before, plans routinely excluded maternity care or it was available for an additional fee. Now most coverage must cover it," says Stephanie Glover, senior health policy analyst for the National Partnership for Women & Families (NPWF). It was an unfortunate reality that women purchasing insurance on their own before the ACA struggled to find plans that covered maternity care, which is a critical service for women. (You know that, but some lawmakers still disagree that it should be guaranteed.)

If you consider that 45 percent of pregnancies every year are unintended, women who didn't have the special coverage might have been caught without proper insurance for prenatal care, which plays a critical role in health outcomes for mom and baby. Today, ACA-compliant insurance plans must cover pre-existing conditions, which include pregnancy, so even if your coverage starts after you get pregnant, the plan still has to cover you. (Still, some "grandfathered" plans purchased before 2010 may defer to the old regulations, so always check with yours on the specifics.)

The ACA offers certain financial protections for women. "While it may be confusing to navigate plan options, there are some standards across the board," Glover says. Many health plans, including those people purchase themselves on the marketplace, cover certain maternity services as "preventive" care without a copayment or coinsurance—aka for free, even if you haven't met your deductible yet—but only when they're given by an in-network provider.

But first: Do you have insurance?



The first hurdle, obviously, is making sure you have adequate health insurance. "The maternity care protections we all worked for in the ACA are being undermined these days. There are more and more plans being sold that don't comply with the law," says Cheryl Fish-Parcham, director of access initiatives for Families USA. These include short-term, indemnity, and association health plans. It's likely if you have one of these, maternity care won't be covered. "Be wary about buying one of these," she says.

IF YOU'RE UNINSURED: In 2010, two-thirds of unintended births, and half of births overall, were paid for by public insurance programs like Medicaid, according to the Guttmacher Institute's most recent analysis. If you don't have insurance and have a lower income (based on the federal poverty level), check if you qualify for Medicaid, which is insurance paid for by states and the federal government.

"Medicaid income guidelines may be fairly generous depending on your state," Fish-Parcham says. For instance, some states count the unborn child as a household member, which can increase what your need looks like and qualify you for the program, she says.

A final word on insurance—yes, you need it. If you don't have it through an employer, a marketplace plan you purchased, or Medicaid and you get pregnant, you're still on the hook for your medical bills. You'll have to pay out of pocket for your appointments and will receive a hefty bill from the hospital after delivery.

According to one study from the University of California in San Francisco, women could be charged between $3,000 and $37,000 for a vaginal delivery, and $8,000 to $71,000 for a C-section in California. That is not a bill you want, and one that can only go up exponentially if you or your baby has complications and requires an ICU or NICU stay.

I have insurance. What prenatal services will be covered in full?

SUPPLEMENTS

Prenatal vitamins and folic acid supplements and are covered. You may need a prescription from your doctor or you can pay for them using your tax-free flexible spending account (FSA), health savings account, (HSA), or health reimbursement account (HRA). These vitamins have been shown to prevent birth defects, primarily neural tube defects, which compromise the growth of the brain, spine, or spinal cord (spina bifida is one example of this kind of defect). If you're looking to become pregnant, it's important to take either or 400 to 600 mcg of folic acid alone or a prenatal multivitamin that contains folic acid.

HEALTH SCREENINGS

Covered tests include those for anemia, gestational diabetes, Rh incompatibility, gonorrhea, syphilis, hepatitis B, UTIs, and preeclampsia (for women with high blood pressure). These screenings either happen on a routine basis during prenatal visits or are a one-time occurrence depending on how far along you are in your pregnancy.

TOBACCO INTERVENTION AND COUNSELING

Twenty percent of pregnant moms on Medicaid smoke, which can lead to preterm births and sudden infant deaths. Plans offer options for helping women quit.

BUT: IT'S NOT A PERFECT SYSTEM

A 2015 report by the National Women's Law Center (NWLC) found numerous violations of the mandatory ACA maternity coverage, like limiting the number of ultrasounds or prenatal visits—which your plan may not cover in full, though Medicaid programs in most states do cover ultrasounds—or imposing restrictions on a woman receiving emergency maternity care outside of her area.

If you're pregnant, the best way to protect yourself from surprise bills is to do your homework. So, take a deep breath and read on.

What steps should I take before I give birth?

CALL YOUR INSURER TO TALK COSTS

When you know you're pregnant, call your insurance company. They can give you an estimate of what additional services are covered beyond the ACA requirements (like chromosomal screenings, ultrasounds, the copay for office visits, etc), as well as provide an estimate of how much the birth will cost, which can vary widely. For instance, when I had my first son in 2013, we paid about $2,000 in hospital bills. This year when I had my second son, we had the same insurance company but a different plan and we paid nothing.

SPECIFICALLY, HERE ARE THE QUESTIONS YOU SHOULD ASK YOUR INSURANCE COMPANY:

- What's the estimated cost of a vaginal birth? C-section?
- What services are covered under my plan?
- How do these services fulfill my deductible? (That's the amount you need to pay out of pocket before your insurance starts footing the bill.)
- Is my preferred doctor and hospital in-network? Again, those fully covered services listed above are only free when performed by a doctor in the insurance company's networks.
- Are delivery services like anesthesiology or visits from additional staff going to automatically be billed in-network (even if they're technically out-of-network)?
- When the baby is born, will the baby itself be charged separate fees? That can easily double your burden for hospital services.
- Do I need to call the insurer for pre-approval/ prior authorization before I go to the hospital to give birth? Yes, sadly, this is sometimes a thing.
- How late in my pregnancy can I order my free breast pump?
- Is the 6-week postpartum checkup covered?
- If you're interested in a home birth, ask if it's covered. But you may be out of luck. For example, Aetna says they consider planned deliveries at home "not medically appropriate," deferring to the American College of Obstetricians and Gynecologists' recommendations. In some states, however, Medicaid will cover a home birth.
- If you're interested in hiring a doula or a midwife, ask if they're covered. Medicaid reimbursement for doulas differs by state but has been difficult to implement, notes a 2016 report from the NPWF. Minnesota is one such state that offers this benefit through the Minnesota Health Care Programs. Midwife services, on the other hand, are more likely to be covered under insurance, and are allowed through Medicaid.

DO SOME READING

Also, it's worth noting that the insurance rep you talk to may not have all the information, depending on how well they're informed, and it's smart to double check their word against your plan. ("So-and-so agent told me that ultrasounds were covered" will not fly when disputing a charge.)

Health plans are required to have a Summary of Benefits and Coverage. Page 7 of most summaries will explain coverage for childbirth and how much you will likely owe for the birth, and your plan may also have a separate document spelling out maternity coverage. They may even provide an online cost estimate calculator that can give you a picture of what you might owe.

PREPARE FOR MONEY QUESTIONS

From there, many doctor's offices encourage you to appropriately save for the cost of prenatal bills and delivery. My doctor for my first child had us pay a deposit at 28 weeks to defray costs not covered by insurance. My doctor for my second baby, at a different practice, simply sent home a flyer encouraging us to call the insurance company to plan for the possible financial burden. Another option is maxing out a health savings account, or HSA, (if you have a high-deductible plan) or socking money away in a flexible spending account, or FSA, to help cover some costs.

What benefits are covered after delivery?

Here's what should be covered without a copay or coinsurance:

NEWBORN SCREENINGS

Before you're allowed to leave the hospital, your newborn will receive a bilirubin test (to check for jaundice), a blood screening, hearing screening, and more. These tests are all covered by plans thanks to the ACA. It's important to know this, should you incorrectly receive a charge for them. (Had I known that these were covered, I could have fought back against the hearing test that was denied by my insurance, which I ended up paying for out-of-pocket.) Note that the 6-week postpartum check-up isn't required to be covered under the ACA, but most Medicaid programs cover postpartum visits.

BREASTFEEDING NEEDS

Breastfeeding support and counseling (such as a lactation consultant), as well as breastfeeding equipment and supplies are all covered. The biggest perk from ACA-compliant plans is a free breast pump, which can normally run in the hundreds of dollars. Each plan has its own rules about exactly when you can order one, so If you want to breastfeed, ask your insurance about your benefits. Alternatively, the company Aeroflow Breastpumps will also contact your insurance for you to verify coverage, give you qualifying options, and allow you to order one. (In my experience, Aeroflow has saved a lot of time and confusion.)

What else do I need to do once the baby arrives?

GET YOUR BABY ON YOUR HEALTH INSURANCE

In most cases, you have a 30-day window to add your baby to your insurance. (If you have an HMO-type plan, you'll also have to formally declare a doctor for the little one.) You can do this by calling them or going online. However, some insurers will ask for a social security number for the baby, something they won't receive until they're five or six weeks old. Helpful! Ask your insurer what you should do to get around this.

If you bought a plan on the Marketplace, you don't have to wait until the next "open enrollment" to add your baby: Pregnancy qualifies you for a special enrollment period when you can enroll your baby in your plan or change your coverage.

CONTRACEPTION

After you give birth, you'll likely want to talk to your doctor about birth control. With the exception of employers who have a religious exemption, the ACA requires that insurance plans cover all FDA-approved methods of contraception and sterilization for women without a copay.

REVIEW YOUR BILL

Anyone who's looked at a hospital bill—especially for a delivery—knows how batshit crazy they can be. If you're in doubt about a bill, one option is to check with your state's insurance department, which regulates insurance companies, Fish-Par-cham advises. If you were denied coverage you feel you were entitled to, you're also able to appeal to your insurance company, says Glover, though she acknowledges that competing demands on time and resources with a newborn can make this, uh, challenging. It's easier said than done, but doing what you can up front to make sure you're covered and know what your plan entails can save you a lot of grief in the end.

WHAT ELSE CAN I DO IF I THINK I'M BEING INCORRECTLY CHARGED?

The National Women's Law Center also notes that many insurers fail women by not complying with the ACA coverage requirements. If yours is giving you trouble, you can contact their hotline, CoverHer, for help.

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).