Say the Right Things About Health Care Plans

by Dennis R. Ackley

Clarifying a few concepts and rewording some key phrases in your health care plan booklet won't double the organization's profits or help it win the Baldrige Award. It might avoid a few problems, however, and clear up some misunderstandings. If that sounds like a reasonable goal, read on.

Part of the problem stems from employers' reliance on phrases that no longer apply, as well as their use of benefits jargon. Employers that use out-of-date phrases and benefits jargon are not trying to fool or trick employees. Yet employees who read the words come away with a meaning that wasn't intended and gain or have reinforced expectations that will not be met — a classic communication problem.

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Fortunately, this communication problem has a simple solution: Employers **need to say what they mean, bust the jargon, and use plain English when communicating health care coverage.**

The following list of words and phrases may best be avoided or, in some cases, emphasized in health care benefits communication materials. The list also contains some concepts that may need to be clarified for employees.

Comprehensive — A plan that does not cover every expense cannot be comprehensive. The term is jargon left over from the days when plans were redesigned from "Basic and Major Medical" into a single "Comprehensive" benefit design. Unless the plan pays for every medical expense, don't imply that it does.

Quality — Health care plans that reimburse expenses (such as any indemnity plan) cannot provide or ensure the quality of care. Only health care providers have control over the quality of care. Rarely do you hear doctors or hospitals making any guarantees about quality. Quality care is a wonderful concept that everyone wants, but don't imply that your plan controls or ensures it.

Medically Necessary — A plan booklet cannot be a medical textbook that clearly describes which medical treatments are necessary and which ones are not. A few years ago, this phrase was used to deny medical claims for vacations and diamonds mounted in teeth, clearly not medically necessary. But technology has made huge leaps, and the line between what is and is not medically

necessary has blurred. The same is true for what is and is not "experimental." When issues blur, particularly when a lot of money is involved, the courts are called upon to make the judgments. Because plan administrators are not doctors, the doctors who are working with the patient and recommending care usually win the court disputes. Rather than try to intensify the battle by throwing more words at the definition, health care plans probably are on firmer ground when they identify specific procedures (such as sex change operations, autologous bone marrow transplants, in vitro fertilization, etc.) that will not be covered by the plan, regardless of their medical necessity. Employees need to know that not every medical procedure prescribed by a doctor is covered. The plan has the right to exclude certain procedures, within the bounds of applicable laws, even if they are medically necessary.

Purpose of the Plan — When the comprehensive ... ensures quality ... for medically necessary treatment" statement is removed from the first page of the booklet, there's room to describe the actual intent of the plan: financial protection against high medical bills. Unless employees understand the plan's purpose, they will question why the plan has a deductible and why it does not pay 100 percent of all the expenses until they reach the out-of-pocket expense protection level.

Control of Treatment — Employees and their doctors have complete control over what medical treatments and services employees and their family members receive. Health care plans only control the reimbursement of expenses. Even when an employee follows the plan's utilization review program and the proposed medical treatment is "certified," it should be made clear to the employee that what has been approved is the *payment* of a benefit. The program's certification (or non-certification) does not mean the plan has given medical advice about the medical need for the treatment. Later, if problems arise and the employee looks for places to put blame (i.e., sue) the plan does not want to be viewed as a source of recommendation for or against the treatment.

Precertification — Unless there's a 100 percent guarantee the plan will cover a treatment, service, or length of hospitalization that's been precertified by the utilization review program, this bit of jargon can be problematic. Anyone who has been told something is "precertified" or "certified," but later finds out the plan denied part or all of that expense, will likely become a bit upset. This can happen when the certified expenses exceed certain dollar limits of the plan, the person receiving the treatment becomes ineligible (a student drops out of college due to illness), or the specific course of treatment that was agreed upon was not followed. If certified activities can be denied, the utilization program should make it clear. One way is to say, "Although the proposed services appear to meet the program's guidelines, the payment of benefits will be determined by the plan's provisions." This requires more words than "precertified," but it's also more accurate.

Lifetime Limit — The fine print sometimes is the location of the apologetic statement regarding the lifetime limit of the plan. Why not be positive about it? It's a key highlight of the plan that should be emphasized on the first page of the booklet to help reinforce the thousands of dollars — sometimes a million dollars or even unlimited amounts — of financial protection offered by the plan.

Expenses for Treatment and Services That Are Prescribed by a Physician, Covered by the Plan, and Within Reasonable and Customary Limits — This is a mouthful that some benefit booklets seem

to repeat in whole or in part in nearly every other sentence. Not only is it boring to read a booklet that keeps repeating these phrases, but sporadic use could loosen the specific intent. For example, if an expense is mentioned on page 30 without the "within reasonable and customary limits" phrase, does that mean the writer got tired of repeating it 100 times, or does it actually mean that limit does not apply to that expense? This spawns disputes.

Here's a way to make the medical plan easier to understand as well as more tightly defined. Early in the booklet, define eligible expenses to include only treatments and services that are prescribed by a doctor, determined by the claims administrator to be within reasonable cost limits, and not excluded from coverage. Then define these three elements, but never use them again to modify eligible expenses. If you refer later to "eligible expenses that are within reasonable and customary limits," you destroy the tight definition. Then all other references to eligible expenses can be questioned as to whether they too must be within reasonable cost levels.

The XYZ Insurance Company Plan Pays ... — Because some organizations use the name of an insurance company in the name of the plan, it's little wonder that many employees believe the insurance company's money pays their medical claims. For most large employers, the insurance company is simply acting as the claims processor and issuing checks based on an account funded mostly by the employer, with the balance coming from employees. Part of the impetus behind rising health care costs may be employees who believe they're spending someone else's money to buy health care, especially some "fat insurance company's money." Employers can help employees become better health care consumers simply by letting them know whose money they are spending.

Two other bits of jargon that may be perpetuating the insurance myth are "self insurance" and "coinsurance." These terms could be exchanged for plain English, "the plan pays" or "you pay." Also, referring to people covered by the plan as "insured" and the money they contribute for the coverage as "premiums," sends the wrong message.

Special Concerns for Managed Care

To employees, managed care is a strange-sounding phrase that's used to define mandated second opinions, utilization review programs, HMOs and, more often today, point-of-service programs. In fact, the term is used in so many ways that it has too many meanings to be useful in employee communication. Rather than naming a new point-of-service program managed care, it might be better to call it the "Primary Care Physician Plan" or the "Coordinated Care Plan."

Primary care physician or network providers — but not both — When introducing a point-of-service plan, don't use the jargon left over from the introduction of PPOs or other NETWORK-STYLE plans. Although it is simpler to say "when you are in the network" and "when you go outside the network," there can be a problem. The problem is that an employee who goes to a network doctor who is not the person's primary physician will get "non-network" benefits. That's difficult to explain to the employee who "went to the network" but not to the "right" doctor. In a point-of-service plan, it's better to say "when you use your primary care physician" and "when you do not use your primary care physician." Drop the use of "network" in point-of-service plans. The network is not important — the use of the primary care physician is critical.

The Plan Pays 80 Percent, 90 Percent or 100 Percent — Another bit of information

that seems to get repeated to death throughout a medical booklet is the percentage the plan pays for various eligible expenses. It's not only boring, but it can be misleading. For example, the plan may pay 80 percent of an eligible expense unless it's a service provided through a PPO, in which case it's paid at 90 percent, except of course if the employee has met the out-of-pocket expense limit when the plan begins paying 100 percent. (Don't call it "stop-loss" — whose "loss" is being stopped?) To avoid repeating the percentages ad nauseam, it can be useful to develop a flow chart that goes in the first few pages of the booklet. Throughout the rest of the booklet, all the references to how much the plan pays can be directed to the chart.

Financial Rewards — An organization that offers employees lower contributions if employees use network or HMO plans should make them aware of the general nature of the financial arrangements and incentives that the organization has with the doctors and hospitals.

The following statement could be used in the health care booklet: "The doctors participating in the XYZ Care Network are paid by the network based on the number of patients assigned to them. They are not paid according to the services provided to patients. The doctors also are given financial incentives to help control expenses by using cost-effective treatments and facilities."

If disputes arise and the organization has not disclosed this information, employees might claim they would never have selected the network option had they known how the doctors were paid.

Employees' Role in Managed Care -- Employees need to know that if they are not satisfied with the decision of a utilization review program or the recommendation of their primary care physician, there is an appeals process. And that process needs to be described. Furthermore, if an employee wants to change from one primary care physician to another, the procedures to do so need to be clearly stated.

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