

Find tips for
talking about
healthcare
costs and
the appeal
process
inside.

Common Roadblocks to Care

*Advice to prevent and deal with the most
common insurance-related hurdles*

The Doctor I Need Is Out of My Network

If you need care that is not available within your provider network, contact your insurance plan to learn what your options are and how to request prior approval before seeing an out-of-network provider.

You must be able to show there are no in-network providers able to provide the specialized care you need. Ask the provider for an estimate showing the amount you may be responsible for if you receive care outside of the plan's network.



*You may be
required to
try other
medications
in the same class
before you can
be approved for
a name brand
drug, also
known as step
therapy.*

*Selecting and enrolling in a comprehensive insurance plan
eliminates the obstacle of accessing care when uninsured.
However, there are still many potential barriers that you may
face when you go to utilize your plan benefits.*

Medication-Related Barriers

Navigating the Plan's Medication List and Drug Formulary

Medications can be a large financial barrier for patients, especially if dealing with a chronic or life-threatening condition. To protect yourself, when prescribed a medication, compare the medication to your insurance plan's drug formulary to ensure the medication is on the approved covered list. Be aware of the costs that need to be paid in order to receive the prescription.

If your prescribed medication is not covered on the plan formulary:

- Consider switching to the generic version of the drug if possible.
 - Formally request an exception to the formulary list. Your request will be processed in conjunction with the prescribing provider and should include documentation supporting the medically necessary reason for you to take a non-formulary medication to treat your condition. *If your exemption request is not approved, you will be responsible to pay the full cost.*
 - Seek out co-payment programs, charity assistance or financial help from the drug manufacturer to help pay for medications.
- Talk to your doctor about whether a different medication on the formulary is an option in your situation.



Accessing “Experimental” or “New” Care



Clinical trials provide additional treatment options for care beyond today’s standard of care

When you enroll in a clinical trial, the trial sponsor is responsible for the services or medications directly related to the trial, or that are not considered routine care for your treatment protocol. This may provide an avenue for you to access medication, testing or care not available outside of a clinical trial, which you may not have otherwise been able to afford or that would not have been covered in your plan language.

As of 2014, insurance companies can no longer deny or limit the coverage of routine patient costs for items or services in connection with approved clinical trials for the prevention, detection or treatment of cancer or other life-threatening conditions.

Routine costs are defined as medical services that would typically be covered under your plan for patients with the same diagnosis undergoing treatment. Examples include follow-up doctor visits, imaging scans or lab work by in-network providers that you would have received had you not been participating in the clinical trial.

You will want to ask for a detailed listing of trial details, including the trial’s covered services and non-covered services, to make an informed decision on participating. This will also ensure you are aware of your responsibilities.

Dropped Coverage

Issues with premium payments

If you miss a payment, your insurer has the right to deny your claims or cancel your policy. Consider setting up an automatic payment plan ensuring timely payment and a record of payment of your premiums.

If you are enrolled in a Marketplace plan and cannot afford the premiums, contact the Marketplace to see if you qualify for additional support. If you are having trouble keeping up with your premiums, search for charity or non-profit programs that offer financial help with premiums.

Paying an overdue balance will not necessarily reinstate your policy.

Preparing for Costs

As a good consumer, it is important to become familiar with the cost-sharing and out-of-pocket amounts described in your plan language for each type of medical services including routine care, specialty care, emergency care and prescription drugs. This means you need to review the policy language or your plan summary description to know how much you can expect to pay for your care.

Ideally, consumers should plan an annual budget or savings account that allows payments up to the annual deductible and out-of-pocket maximum associated with your plan. Even when this is not possible, staying aware of your financial responsibility is important so that you can be proactive in seeking out help.

Addressing Financial Challenges



Medical bills and out-of-pocket costs can add up quickly. If you have a bill you cannot pay, take time to speak with the billing representative or financial counselor from the provider’s office. These people are a great source of information about eligibility for affordable payment plans, prompt-pay discounts, or other financial assistance given by that provider.

Tips for talking about costs

- Initiate this conversation without assuming your provider will volunteer the information about costs.
- Be sure to investigate your options for all facilities, medical providers and medical services billed, as they each may have separate programs in place.
- Be polite and respectful, but also persistent. Call back or follow up as needed.
- Take notes and document conversations and options. Use a recorder if necessary.
- Do not ignore medical bills. If you need help, there is information on the back of the bill advising you how to request assistance.
- Try to negotiate an affordable payment arrangement, but do not agree to something you cannot afford just to avoid being sent to collections. This will ultimately cause more problems.
- Look for alternative forms of funding from non-profit and charity organizations to help offset costs and give you a better opportunity to afford negotiated payments. Help is available in areas such as housing, utilities, medications, food, transportation needs, childcare during treatment, and more.

National Underinsured Resource Directory

www.patientadvocate.org/underinsured

*Find the resource you need quickly by searching through any of the 35 different categories of assistance. Unlimited searches. Also available via free mobile phone app, called **My Resource Search**.*





Where to Start if Insurance Has Denied Your Service and Will Not Pay



If your insurance plan refuses to approve or pay for a medical claim, including tests, procedures or specific care ordered by your doctor, you have guaranteed right to appeal. These rights were expanded as a result of the Affordable Care Act.

Review your denial letter carefully as it outlines your next steps for appealing the decision.

Your insurer must provide to you in writing:

- Information on your right to file an appeal
- The specific reason your claim or coverage request was denied
- Detailed instructions on submission requirements
- Key deadlines to submit your appeal
- The availability of a Consumer Assistance program in some states

It is important to remember, that prior authorization does not guarantee payment of the claim.

There are multiple levels of appeal. Even if the first appeal is denied, you have additional levels of appeals that will be outlined in your denial documents.

If you have overdue medical bills on services that have already been completed, work with your providers so the bill is not sent to collections while the appeals process takes place.

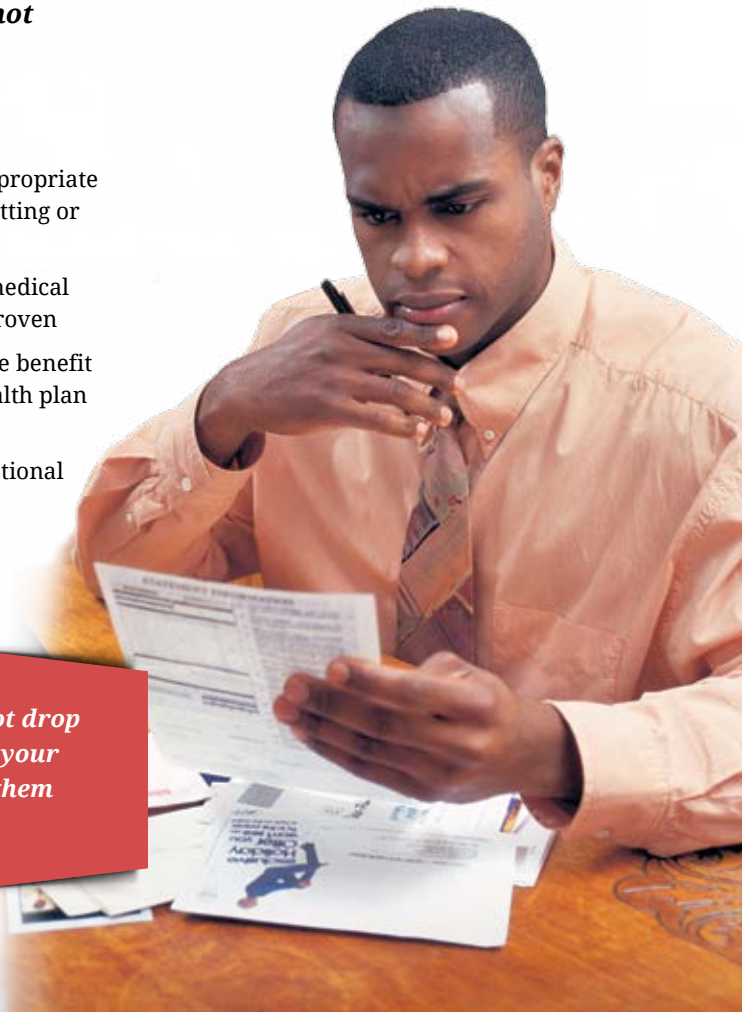
Think of an appeal as a contract dispute over the interpretation of the plan coverage details. Your health plan language defines your contract.



Reasons your insurance may deny payment or not approve a request:

- Services are deemed not medically necessary
- Services are no longer appropriate in a specific healthcare setting or level of care
- The effectiveness of the medical treatment has not been proven
- You are not eligible for the benefit requested under your health plan
- Services are considered experimental or investigational for your condition
- The claim was not filed in a timely manner

Your health plan cannot drop your coverage or raise your rates because you ask them to reconsider a denial.



Insurance is Unable to Process Your Claim

Errors that may delay the claims process

Sometimes your medical claim is unable to be processed at the time of the submission, which is different than a full denial. In this case, the insurer will identify a reason why the claim cannot be processed and include instructions on how to resubmit. Cited reasons may include:

- ✓ Insurance information submitted with claim was incomplete
- ✓ Lack of pre-certification or prior authorization, if required

- ✓ Diagnosis and/or procedure codes were missing or incorrect
- ✓ Incomplete or inaccurate information on claims
- ✓ Lack of medical documentation showing necessity of service

During the process of dealing with a resubmission or completion of claim paperwork, take careful notes on who you speak to and what action is taken. Follow up through the entire process to ensure completion and that your claim is paid without undue delay.



Starting the Appeal Process

As a plan member, you have the right to the full-length version of the plan's medical policy or a copy of the information used to make the denial decision. You should request this documentation for your records.

Your best documentation and evidential support for your appeal will come from your plan language. Most likely this information will be within the plan definitions for Covered Benefits, Non-Covered Benefits and Exclusions.

When preparing for your appeal, seek additional support from your medical provider, including a statement of medical necessity, documentation of prior treatments, and the reason the treatment or service in question was ordered.

You may be able to successfully appeal if you and your provider can show that the treatment you require is currently considered to be the standard of care by medical providers. *Standard of care* is a formal diagnostic and treatment process a doctor follows for a patient with a specific illness or set of symptoms. Also known

as "best practice," the standard follows guidelines and protocols that are agreed upon by experts in the field.

Important questions to ask include:

- Are there clinical studies or peer-reviewed journal articles that support the treatment?
- Did your doctor participate in a peer-to-peer review with the medical director of the insurance company?
- Does Medicare or any other insurance company already cover this treatment?

If you have been unable to receive the care because your insurance has denied it as being outside of *standard of care*, ask your medical provider if the treatment is available through a clinical trial that will not further delay your access to care.



Gather the Details

Review the denial letter for the specific details you'll need for the appeals process. If you need more information, call your insurer directly.

- 1 What is the specific reason behind the denial?
- 2 May I have a copy of the file which supports the denial?
- 3 Who are the people responsible for reviewing my appeal?
- 4 What are the deadlines for me to file the appeal?
- 5 What is the time frame for the health benefit plan to respond to the appeal?



Get Organized

As you begin the appeals process, gather your documents and keep them in a file organized by date of receipt so your paperwork is easier to navigate. Organization and paperwork management can be key elements in your success.





Urgent or Expedited Appeals

Urgent appeals are only considered in these situations:

- You are currently receiving the treatment and your medical provider believes a delay in treatment could seriously jeopardize your life or health, affect your ability to regain maximum functions or subject you to severe and intolerable pain
- Your issue is related to an admission or continued inpatient stay and you have not yet been discharged

You or your representative can request an expedited appeal verbally by calling the insurer directly. In expedited appeals, your health insurer must make a decision within 4 business days.

You cannot begin an expedited appeal if you:

- Already received the treatment and disagree with a claim denial, or
- Your situation is not considered to be urgent by a medical provider with knowledge of your medical condition, or the medical director of your insurance plan

Items to Include in Your Appeal Letter

One of the most important elements of your appeal packet is a clear, concise letter detailing your counter-argument that addresses the original reason for denial and citing the terms of your policy. The letter can be written by you, a medical provider or an advocate on your behalf.

Elements of the letter

- ⊕ Patient name, policy number and policy holder name
- ⊕ Accurate contact information for patient and policy holder
- ⊕ Date of denial letter, specifics on what was denied and cited reason for denial
- ⊕ Doctor or medical provider's name and contact information
- ⊕ Your detailed case as to why the plan should cover the claim
 - *State why you need the prescribed medical service and why you believe your insurance policy covers the treatment or service. Cite plan language where possible.*
 - *Ask your medical provider to prepare a letter of medical necessity explaining prior treatments and the reason the treatment in question was ordered and is necessary for your situation.*

- *Provide and reference published journal articles or treatment guidelines from recognized groups or institutions, demonstrating benefits and treatment success.*
- *Anything else that supports your request, including copies of pre-authorizations and second opinions.*

Sending Your Submission

- ⊕ Track submission. If submitted by fax, keep the confirmation of successful transmission. If submitted by mail, send the letter by certified mail with the request of a return receipt.
- ⊕ Keep a copy of the letter, all submitted materials, the delivery or submission receipt and your record of all correspondence prior to and following your appeal submission in a safe and organized place.
- ⊕ You should receive an official notice within 7-10 days that your appeal has been received. If you do not receive confirmation, contact your insurance company representative to make sure your appeal has been received and is recorded in the system.

Your insurer must respond to an expedited request within 24 to 72 hours. The plan may deliver the decision verbally, but a verbal decision must be followed with written documentation within the following 72 hours.





Your Rights in an External Review



If you are not satisfied with the insurance plan's final response, request an external review. This is when an independent third party reviews the health plan's decision, and will either uphold the insurance company's decision or decide in favor of the consumer by overturning all or part of the health plan's decision.

Health insurance companies in all states are required to participate in an external review process that meets minimum consumer protection standards as outlined in the Affordable Care Act. Requests for external review can only be made for denials related to covered services and cannot be considered for services identified under your plan's exclusions or non-covered elements. Read your plan language and the denial letter closely regarding the process and timelines for an external review when considering going this route.

Special Scenarios with Self-Funded Plans

If your health plan is sponsored by an employer, they may “self-fund” their health insurance benefits for employees. This means the employer maintains influence in the final decisions made on payment of medical claims and healthcare decisions related to plan language. Although the company has contracted with a third party organization to manage and operate the plan, your employer maintains the authority to make decisions as your insurer.

Keeping your Human Resources department updated throughout your appeal process may give you an ally if your appeal is unsuccessful. Once you exhaust internal and external appeal options, you may consider making a compassionate appeal directly to the top executives within your company. Your employer has authority to override denials in special circumstances.

