

# **The Basics of Health Insurance and Appeals**

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# Types of Health Insurance

- Medicaid
- Medicare
- SCHIP
- Private insurance

# Medicaid

- Medicaid: a federal and state program
  - Many people who are eligible are not enrolled
- Eligibility varies by state.
  - Categorically eligible AND
  - Financially eligible
    - In some states, you can “spend-down” through medical bills to be financially eligible.
- Services covered can vary by state.

# SCHIP

- SCHIP (State Children's Health Insurance Program): a federal and state program
  - Some states use SCHIP money
    - to have a separate SCHIP program,
    - to expand Medicaid, or
    - to do both
- Services covered vary by state and are generally not as wide-ranging as Medicaid.

# SCHIP (cont'd)

- Many people whose income is too high for Medicaid are eligible for SCHIP.
  - Sometimes parents of eligible children are eligible for SCHIP coverage.
  - Many people who are eligible for SCHIP are not enrolled.

# Medicare

- Medicare is a federal program
  - Part A
    - primarily in-patient hospital stays
  - Part B
    - primarily out-patient care
  - Medicare Advantage (Part C and formerly called “Medicare+Choice”)
    - a combination of Part A and B and sometimes D
  - Part D
    - prescription drug coverage

# Medicare (cont'd)

- Eligibility is set by the federal government.
  - At age 65
  - 29 months after being considered disabled by the Social Security Administration

# Medicare (cont'd)

- In 2007, some Medicare beneficiaries in Medicare Advantage plans will be able to try Medicare Savings Accounts (MSAs).
  - MSAs are similar to Health Savings Accounts (HSAs) and are generally thought to give people with chronic diseases less benefit.

# Medicare *and* Medicaid

- Some people have both Medicare and Medicaid.
  - Full duals
  - Partial duals (Medicare Savings Programs or MSPs)
    - Qualified Individual 1 (QI1)
    - Qualified Medicare Beneficiary (QMB)
    - Selected Low-Income Medicare Beneficiary (SLMB)

# Medicare *and* Medicaid (cont'd)

- Medicare Savings Programs (MSPs) vary by state.
  - To see if you are eligible, contact Medicare or your state's SHIP (State Health Insurance Assistance Program) which helps Medicare beneficiaries and their caregivers.
    - 1-800-MEDICARE
    - [www.shiptalk.org](http://www.shiptalk.org)

# Private Health Insurance

- Private health insurance: generally obtained through an employer or on your own
  - Group fully funded plans
  - Group self-funded plans
  - Individual policies
  - Consumer-directed health plans (Health Savings Accounts or Health Reimbursement Accounts/High Deductible Health Plans)
  - High-risk pools (organized by a state)

# Getting Private Health Insurance

- Employment (through your employer or possibly your spouse's or parent's)
- HIPAA
- COBRA
- Individual policies
- High-risk pools, particularly for people with pre-existing conditions

# Employment

- When first hired/after probationary period
- With certain events such as a birth or divorce
- During the annual open season

# HIPAA

- Health Insurance Portability and Accountability Act of 1996
  - Protects consumers from coverage exclusions on pre-existing conditions when they go from one group plan to another
  - Limits the amount of time coverage exclusions can be imposed on those newly insured through a group plan to a maximum of 18 months

# COBRA

- Consolidated Omnibus Budget Reconciliation Act of 1986
  - Allows certain employees to continue their group health insurance when they would otherwise lose coverage under the terms of the plan because of certain life changes (“qualifying events”)

# Individual Policies

- Typically the cost-benefit ratio (deductible and premiums: benefits) of individual policies is not as good as that of group policies.
  - Still an option for coverage

# Individual Policies (cont'd)

- Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs) + High-Deductible Health Plans (HDHPs) are a new option but may not be good for people with RSD and other chronic conditions.
- Discount cards are not health insurance but may help some.

# High-Risk Pools

- Individuals who have problems getting affordable health insurance on their own because of significant health care expenses may find a high-risk pool policy to be the best option.
- Not every state has a high-risk pool, but the number is increasing.

# Other Sources of Assistance

- Pharmaceutical manufacturers' drug assistance programs
- Discount cards (drug and medical)
- Veterans Administration
- Charity care
- State Pharmacy Assistance Programs (SPAPs)

# State Pharmacy Assistance Programs (SPAPs)

- SPAPs provide some drug coverage to eligible residents.
- SPAPs are available in more than 30 states.
- You can get help applying for an SPAP in your state.

# If You Must Pay Out-of-Pocket for Health Care...

- New Jersey, New York, Maryland, Illinois, and Florida sponsor web sites with information on places to get the best price for certain drugs.
- Sometimes you can negotiate a lower price with your health care provider (often what he/she would receive if you did have insurance).

**What do you do when you have trouble getting the insurance coverage you expect?**

# Types of Difficulties with Health Insurance

- Coverage exclusions
- Formularies for prescription drugs and payment structure for different tiers of drugs on the formulary
- Provider networks
- Billing
- Charges (usual and customary)
- Denials of care (with or without pre-authorization)

# But First...

- Know that there is often something you can do when you don't get the care or coverage you expect.
- Don't give up—appeal if necessary.

# Coverage Exclusions

- These are more difficult to address but still possible to fight, especially with private insurance.
  - Is exclusion still valid? Check laws and current FDA approvals.
  - Appeal with research, cost calculations, and physician's letter.
  - Find another source of coverage (e.g., SPAP).
  - Negotiate reasonable charges and payment schedules if you have to pay on your own.

# Formularies

- File an appeal with the insurance carrier.
  - Research current FDA label for the drug and current scientific evidence for other off-label uses.
  - Make cost calculations specific to you.
  - Get support from health care professionals.
- Find another source of coverage (e.g., pharmaceutical program).

# Provider Networks

- Be aware of any network restrictions and current members.
- Be aware that you may need referrals to specialists.
  - Referrals can expire; make sure your referral is current and valid.
- Know when and how you can go outside the network.
  - The rules are usually different for PPOs and HMOs.

# Billing Problems

- This is a frequent complaint of health care consumers.
- You often need to resolve it with the provider and/or insurer.
  - CPT codes
  - ICD-9 codes
  - Appropriateness of charges
  - What the insurer pays for (80-20 of UC&R charges, deductible, etc.)

# Charges (Usual, Customary, and Reasonable)

- How are they calculated?
- Can you find out what the charges are in advance?

# Denials of Care: Preliminary Thoughts

- You don't always need to make a formal appeal in order to reverse the denial of care.
- The appeal process depends on
  - The type of insurance you have (Medicaid, Medicare, self-insured private plan, fully insured private plan), and
  - The state where you live.

# Denials of Care

- Document all actions in one file.
  - Record dates and times of conversations with all parties (including your health care professionals and customer service representatives at the insurance carrier).
  - Summarize all conversations.
  - Keep all correspondence received and copies of all correspondence sent.
- Always keep deadlines in mind.
- Prepare, prepare, prepare.

# 1.

- You are notified of a denial of care. (If the denial is not given in writing, request that the denial be put in writing and sent to you.)

*Note: If you have already received the care, first re-submit the claim with more information on the necessity of the treatment.*

## 2.

- Examine the reason for the denial.
- Determine if the denial is based on medical grounds or on plan rules.
  - Plan rules include limitations and exclusions and are stated in the summary plan document which you get each year from the employer (if insured through an employer) or plan (if self-insured).

## 2. (cont'd)

- Unsupported therapy?
- Experimental therapy?
- Not a covered service? (e.g., the plan does not cover durable medical equipment)
- Not “medically necessary”?
- Improperly filed paperwork?

### 3.

- Ask your health care provider to speak informally, on your behalf, to the medical director or other appropriate personnel at the carrier responsible for the denial.

## 3. (cont'd)

- If your plan is self-insured, the administrator can help reverse a denial of care.
  - The administrator can consider indirect costs to the employer (such as longer sick leave, replacement costs, etc.).
- Speak to the benefits administrator (who must protect patient confidentiality) about your situation.
  - If that fails, ask your health care provider and/or other advocates to speak to him/her.

## 3. (cont'd)

- If your plan is not self-insured but is provided through your employer, your employer may still be able to help.
  - Ask the human resources director to contact the plan on your behalf.
  - He/She may be able to persuade the plan, which views the company as a customer, to reverse the denial.

# 4.

- If the informal routes fail, begin the formal appeal process.
  - Plot a strategy: What does the insurer need to change its mind?
  - Understand the appeal process, including timelines (e.g., 30 days for a first appeal to be filed in writing) and your rights.

# 5.

- Get letters of support from your providers:
  - Physicians,
  - Nurse practitioners,
  - Psychologists,
  - Physical therapists, and
  - Others involved in your care
- If necessary, have the letters address any risks to the therapy and, if true, how those risks are not expected to harm you.

# 6.

- Formulate your argument in response to the reason for the denial.
  - You must make a solid and focused case, based on medical necessity and/or plan rules, for why your insurance company should cover this care.

# 7.

- Research your position and compile evidence to support your argument(s).
- Put your strongest arguments first.

# 7. (cont'd)

- Use the following if they support your case:
  - Plan benefits and plan rules
  - Your medical records
  - Standards of care/guidelines/options (sometimes called practice parameters or practice guidelines) or consensus statements from professional societies

## 7. (cont'd)

- Position statements or guidelines or educational material from patient organizations, statements or publications from the National Institutes of Health
- Approvals from the Food and Drug Administration and accompanying approved labeling text (e.g., indications and usage, contraindications, precautions, adverse reactions)

## 7. (cont'd)

- Articles published in peer-reviewed scientific journals
- Medicare coverage
- Accepted off-label use as noted in certain publications
- The cost-benefit ratio of the treatment

## 8.

- Address any risks (such as high blood pressure) or other disadvantages to the care desired.

# 9.

- Understand the insurance company's argument so that you can argue against it.

# 10.

- In a professional manner, write your own statement of appeal: reference the plan rules plus the science, the clinical evidence on the expected benefits, etc. while you make your argument clear and concise.

# 11.

- Submit all of the information in the required time frame, and make sure the insurance carrier responds within the appropriate timeframe.

# 12.

- If your appeal is successful, notify your health care professionals.
- If unsuccessful, take the next allowable step.

# 13.

- Address any issues raised in denial of appeal.
- If allowed in the claims procedure, submit second appeal according to the timelines.
- If possible, submit any new information omitted in the original appeal.

# 14.

- If your appeal is successful, notify your health care professionals. If unsuccessful, take the next allowable step.

# Medicare Appeals

- Traditional Medicare Appeals
- Medicare Advantage Appeals

# Medicaid Appeals

- Grievances
- Appeals
- Notices
- Fair hearings

# For Help with Insurance Problems

- The Reflex Sympathetic Dystrophy Syndrome Association
  - Treatment Guidelines (published June, 2006)
  - [rsdsa-dc@hotmail.com](mailto:rsdsa-dc@hotmail.com)
- Consumer Health Assistance Programs (CHAPs)
  - Help consumers address all types of health insurance questions but can rarely help with questions specific to diseases like CRPS/RSD.

# Consumer Health Assistance Programs (CHAPs)

- Can answer questions about health insurance products and benefits
- Can help you
  - Understand eligibility for government and non-governmental programs and determine what income and assets are counted
  - Complete applications for assistance
  - Find coverage if you are uninsured

# State Health Insurance Assistance Programs (SHIPs)

- CHAPs for Medicare
- Created in 1992 and are in all 50 states, the District of Columbia, Guam, the Virgin Islands, and Puerto Rico
- Help Medicare beneficiaries and their caregivers with Medicaid, private Medigap plans, and long-term care options
- [www.shiptalk.org/](http://www.shiptalk.org/)

# CHAPs for Private Insurance and Medicaid

- Many states have a CHAP for private insurance and Medicaid but not all.
- [www.familiesusa.org/resources/program-locator/](http://www.familiesusa.org/resources/program-locator/)

# Workers' Compensation (WC) Claims

- Private insurance CHAPS may be able to help with WC complaints, especially if the complaint relates to provider billing problems.
- Each state has a WC official:  
[www.dol.gov/esa/regs/compliance/owcp/wc.htm](http://www.dol.gov/esa/regs/compliance/owcp/wc.htm)

# Sources of Help When There Is No CHAP

- State insurance commissioner
- State legislators
- State attorney general's office
- Legal representation (hired or obtained through a legal services organization)