Navigating Insurance after Transplant

Celebrating a Second Chance at Life Survivorship Symposium

July 11-17, 2020

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LegalHealth

New York Legal Assistance Group

NAVIGATING INSURANCE

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About NYLAG

The New York Legal Assistance Group (NYLAG) is a leading non-profit that provides free civil legal services, financial counseling, and engages in policy advocacy efforts to help people experiencing poverty.

DISCLAIMER

The information and materials made available in this presentation are for informational purposes only and not for the purpose of providing legal advice. You should contact an attorney to obtain advice with respect to any particular issue or problem.

Areas Of Discussion

- Enrollment
  - Private Coverage
    - Group policy through employment, union or association
    - Individual policy
    - Insurance Marketplace
- Government Insurance
    - Medicaid
    - Medicare
- Legal Protections
- Understanding Your Policy
- Claim Denials
- Appeals and External Review
- Complaints and Grievances
- Losing Coverage

Getting Insured

Marketplace

- A Health Insurance Marketplace operates in every state
- One stop shopping for subsidized and unsubsidized coverage and Medicaid
- Easily compare health plan options and enroll in qualified health plans, all with Essential Health Benefits

Helpful BMT Infonet Webinar on Enrollment and Shopping for Coverage
https://www.bmtinfonet.org/category/health-insurance

General Insurance Principles

- **Health insurance is like a contract.** Insurance policies are partially governed by contract law.
- **Contra preferentum.** This Latin phrase means that vague language in your health insurance policy will be interpreted in your favor.
- **Public policy overrules health insurance plan language**. There are certain requirements mandated by law that you are entitled to, even if your health insurance policy says otherwise.
- **State laws require insurers and insurance-related businesses to be licensed before selling their products or services**.

Federal Laws Relevant to Private Health Insurance

Patient Protection and Affordable Care Act

Who's affected: All individuals and groups of employers and employees, whether currently covered, seeking coverage or previously not interested in coverage

COBRA

Who's affected: Employers who offer group medical coverage.

Employee Retirement Income Security Act of 1974 (ERISA)

Who's affected: All private sector employers or sponsors (such as labor trusts or associations) that provide group health benefits, whether through the purchase of insurance or otherwise.

Health Insurance Portability and Accountability Act (HIPAA)

Who's affected: Governs employers with two or more employees, healthcare providers and insurers.

How Does the Affordable Care Act Protect Me?

- All policies provide essential health benefits
- No more denials for preexisting conditions
- Limits on coverage amounts: lifetime and annual caps eliminated
- No co-pays for preventive care
- Creates State Consumer Assistance Programs
- Cannot keep patients from joining a clinical trial; limit or deny coverage of routine costs to patients who join an approved clinical trial; Increase costs because a patient joins a clinical trial
- Better access to appeals for all with external review
- Medicaid expansion for more low income people-will discuss
- Children can continue on parent policy until age 26

https://www.healthcare.gov/health-care-law-protections/rights-and-protections/

Employee Retirement Income Security Act of 1974 (ERISA)

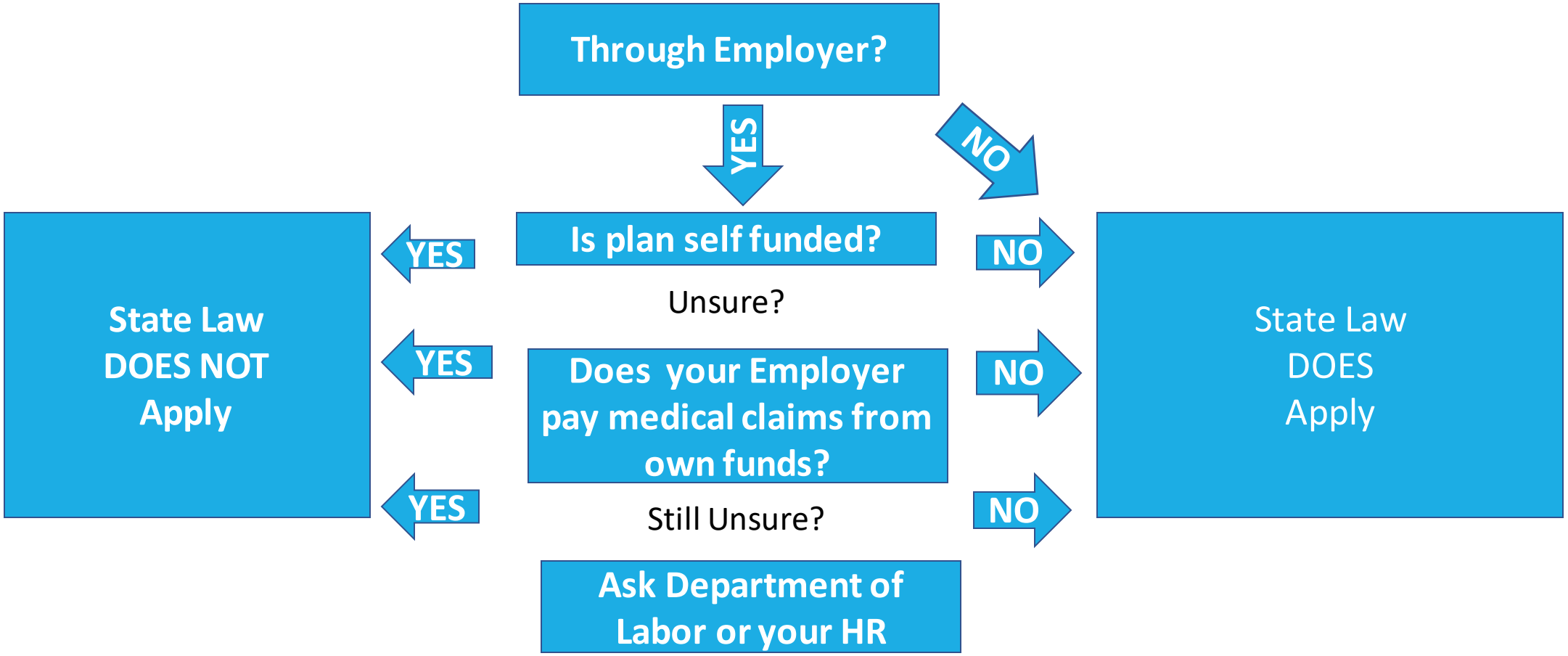
ERISA is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals in these plans.

Any health insurance coverage policy offered through employment is considered an ERISA plan. The most important thing to know about these plans is that how the policy is funded impacts if the policy needs to comply with both state and federal insurance laws or just federal laws.

Is Your Health Plan Self-Insured or Fully Insured?

SELF- FUNDED	VS.	FULLY INSURED
Pays claims from general assets ,administrative fees for "TPA", and stop loss premiums	FUNDING	Monthly premiums to insurance carrier
Employer, TPA, Stop loss carrier	ADMINISTRATION	Insurance Company
Greater flexibility in plan design	PLAN DESIGN	Limited to insurer's limited plan designs
Federal regulation, but ERISA preempts state laws	COMPLIANCE	Plan must comply with state and federal regulation

Does State Law Apply?



Why Does State Law Matter?

- Federal law generally applies across the board to all types of insurance.
- Your State may offer greater appeal protections then federal law so follow the directions in your policy for the appeal process
- If any aspect of your policy is regulated by State law then you should check to see if you qualify for greater consumer protections.

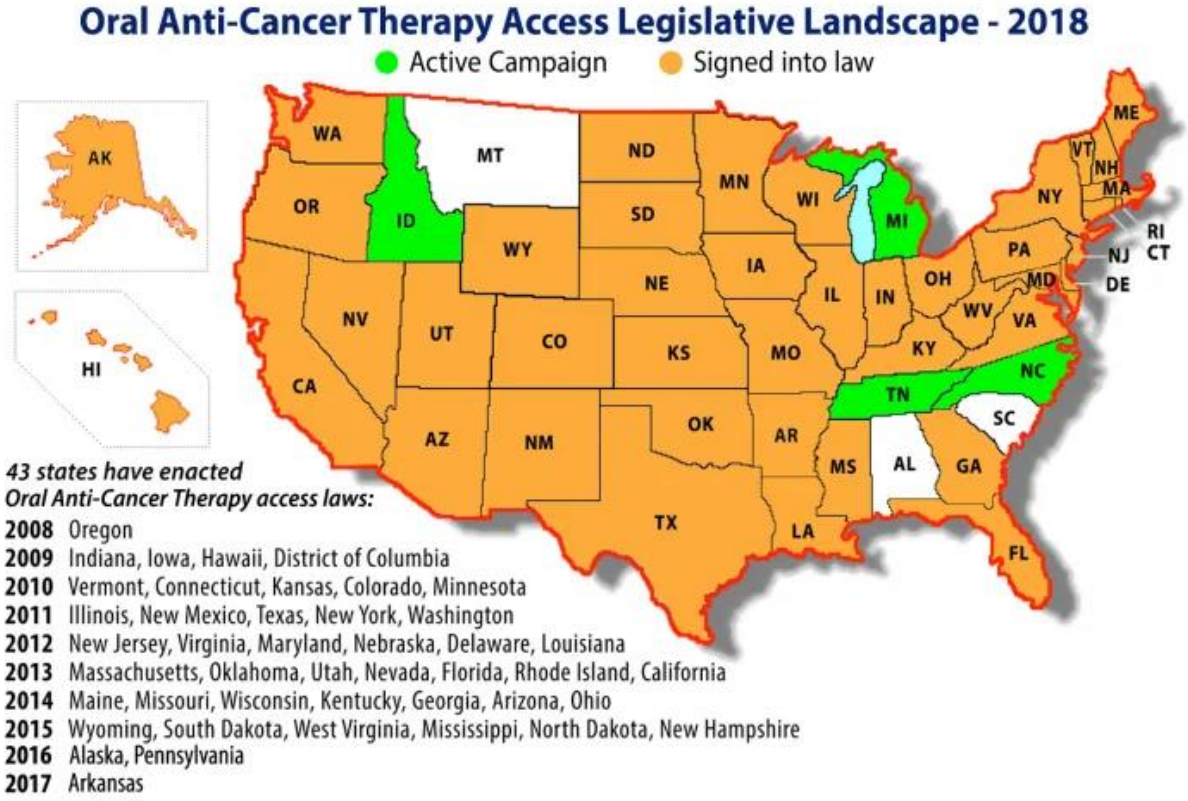
Oral Parity

Typically, cancer medications administered intravenously are covered under a health plan's medical benefit, but cancer medications taken by mouth are covered under a health plan's pharmacy benefit.

Pharmacy benefits typically require the patient to cover a percentage of the drug's overall cost.

This type of cost-sharing can create barriers to care for patients taking oral chemotherapy.

43 states and the District of Columbia have oral parity laws limiting patient out-of-pocket costs for the oral medications used to treat cancer.

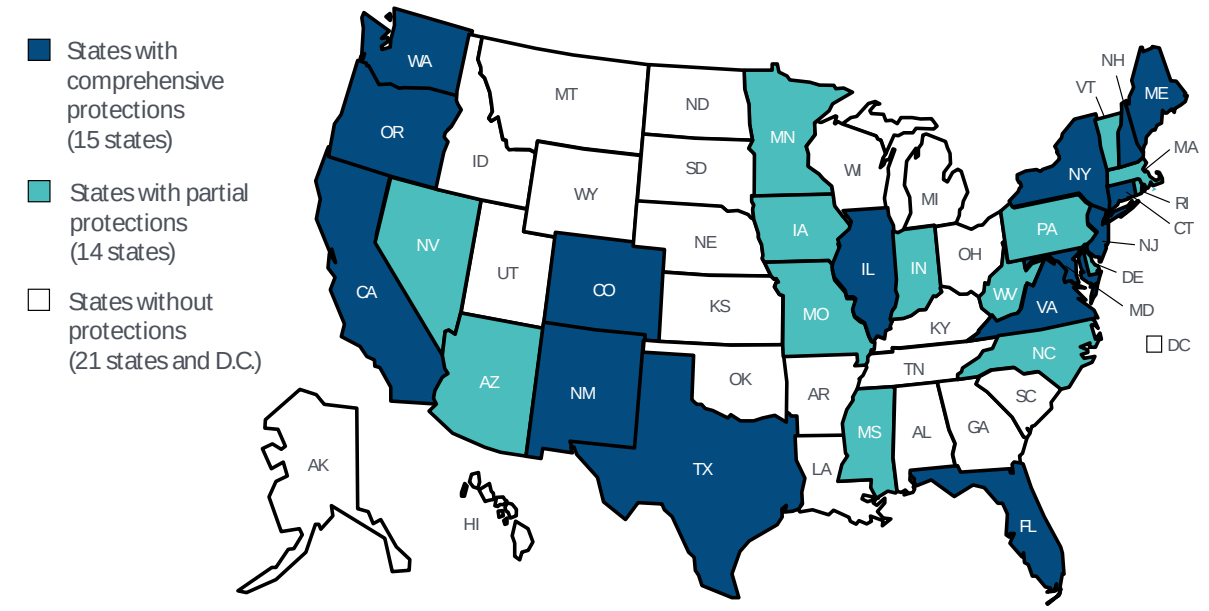


Surprise Medical and Balance Bill Laws

"Balance bills" primarily occurs when an enrollee receives emergency care from an out-of-network provider, or when an enrollee receives elective nonemergency care at an in-network facility but is inadvertently treated by an out-of-network health care provider.

- No federal law currently limits this practice.
- However, 29 states have enacted laws to protect enrollees.

State Laws Protecting Consumers Against Balance Billing, April 2020



Data collection and analysis as of April 2020 by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute.

The Commonwealth Fund

Source: Jack Hoadley, Maanasa Kona, and Kevin Lucia, "States Can Prevent Surprise Bills for Patients Seeking Coronavirus Care," *To the Point* (blog), Commonwealth Fund, Apr. 29, 2020.

What Makes Up The Terms Of My Policy?

You must be given these documents if you ask for them.

Summary Plan Description (SPD) An easily understood version of the plan document.

Summary of Benefits and Coverage (SBC) A uniform template that uses clear, plain language to summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations.

Certificate of Coverage (COC), Plan Document, Complete Benefits Policy contain the specifics of how your benefits are administered. Can be over 100 pages in length and contain tremendous detail about your policy.

Certificate of Coverage (COC)

Read through your COC and pay special attention to the following:

- Type of plan (HMO, PPO, High Deductible)
- ERISA or non-ERISA plan
- Governed by state or federal law
- Your cost sharing, deductibles, and out-of-pocket maximums
- Policy exclusions
- Appeal rights
- Pharmacy benefits
- Definitions and Glossary of Terms

Internal Clinical Guidelines, Formularies, Association Recommendations

Your insurer will rely on supplemental documents to administer your plan benefits. These guides are constantly changing and will usually be under the Provider link of your insurance website.

You have the right to review them!

Where differences exist between an Insurer Clinical Guideline and your benefit plan document, the benefit plan document rules.

Where differences exist between your benefit plan document and an applicable law, **the law rules.**

How Long For A Claim Decision?

Plans are required to pay or provide benefits within a reasonable time after a claim is approved.

CLAIM TYPE	DEADLINE FOR MAKING A DECISION
Urgent care	As soon as possible, and no more than 72 hours after receiving the claim
Pre-service	Within a reasonable time period, and no more than 15 days after receiving the claim*
Post-service	Within a reasonable time period, and no more than 30 days after receiving the claim*

Explanation of Benefits (EOB)

A statement from a health insurer addressing the extent to which a health plan participant's or beneficiary's claim for payment for plan services will be reimbursed. An explanation of benefits (EOB) may include, among other things, information about:

- the type of service provided and the date of service
- the amount a plan provider billed for the service
- any discount the participant or beneficiary received for using an in-network provider
- the amount the plan paid
- the amount the participant or beneficiary owes
- the amount applied toward the plan's deductible
- available review or appeals procedures

Adverse Benefit Determination aka Denied Claims

- A coverage denial is considered an "adverse benefit determination" under the Department of Labor's claims regulations.
- Plans and insurers MUST include specific language and detailed information about the denial in their notice.

Don’t assume the denial is correct. Carefully read the Explanation of Benefit and denial reason.

If the matter cannot be resolved by speaking with the insurance company, patients retain the right to file an appeal directly to their insurance company.

The Internal Appeals Process:

File your internal appeal within 180 days (6 months) of receiving notice that your claim was denied.

An insurer must make a decision within the following timelines after receiving your request:

- **72 hour**s if you're appealing the denial of a claim for urgent care.
- **30 days** for treatment that you haven't received yet.
- **60 day**s for treatment you have already received.

External Review

Types of denials that can go to external review

- Any denial that involves medical judgment where you disagree with the health insurance plan
- Any denial that involves a determination that a treatment is experimental or investigational
- Cancellation of coverage based on your insurer's claim that you gave false or incomplete information when you applied for coverage

What are my rights in an external review?

Insurance companies in all states must offer an external review process that meets the federal consumer protection standards.

https://www.cms.gov/CCIIO/Resources/Files/external_appeals

What If My Care Is Urgent and I Need a Faster Decision?

- **In urgent situations,** you can request an external review even if you haven't completed all of the health plan's internal appeals processes.
- A final decision about your appeal must come as quickly as your medical condition requires.
- This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.

The Appeal Letter

Step 1	Look at your Explanation of Benefits (EOB) and make sure the information is correct.
Step 2	If you feel this is an urgent issue than in large letters write URGENT EXPEDITED APPEAL on top of your page.
Step 3	Clearly write patient name, insurance ID#, claim # (found on your EOB), provider name, date of service.
Step 4	Look at your Certificate of Coverage and find the definition of medical necessity (or denial reason).
Step 5	Explain, using facts, quotes and documents: What was denied? The exact reason given for the denial Why you disagree and think the proposed treatment meets the policy definition. What will happen if the treatment is not received in a timely manner.
Step 6	Specify any laws, regulations or guidelines that you think were not followed.
Step 7	Request copies of guidelines and records used to make the decision.

Denial Based On Medical Necessity

Medically Necessary : Health care services that a Physician exercising prudent clinical judgment would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms,

XYZ Medicine meets the definition of Medical Necessity and should be covered:

- **BECAUSE** a physician exercising prudent clinical judgment prescribed it to treat Peter's CML
- **BECAUSE** it was recommended by Dr. Smith, an Oncologist with 20 years experience at ABC Hospital
- **BECAUSE** Dr. Smith has treated Peter ever since he was diagnosed 6 months ago and knows his full medical history
- **BECAUSE** it is based on his experience with similar patients and his specific work with Peter.

Why?… BECAUSE!

In accordance with the generally accepted standards of medical practice

For these purposes, "generally accepted standards of medical practice" means:

- ***Standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community;***
- ***Physician specialty society recommendations;***
- ***The views of Physicians practicing in the relevant clinical area; and any other relevant factors***

This is consistent with generally accepted standards of medical practice :

- **BECAUSE** it is FDA approved for CML which is what Peter has.
- **BECAUSE** research shows that XYZ Medicine is less likely to cause infertility then OTHER Medicine.
- **BECAUSE** Peter is 25 and ASCO recommends minimizing infertility in young adults
- **BECAUSE** studies show fertility concerns increase depression.
- **BECAUSE** studies show depression may reduce the benefits of certain treatment.

Address Each Element of the Denial Reason

Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease,

This is clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness:

- **BECAUSE** Peter is allergic to the filler in the generic version of XYZ MEDICINE
- **BECAUSE** in the past, Peter has broken into hives when he was exposed to this filler
- **BECAUSE** … you get the idea

Appealing when State Law Might Conflict with Policy

Formulary Exception

Cathy lives in NY and has private insurance through a fully funded employer plan. Her employer recently changed insurance carriers and she is concerned about her prescription costs.

She has been stable on XYZ medicine for several months and used a manufacturer co-pay card to help with costs. Her new insurance company Prescription Drug List shows that XYZ medicine is subject to Step-Therapy. She finds the Step Therapy guidelines on their website and sees that it can be covered for continuation of therapy but she can't qualify if she received financial assistance from the Drug's Patient Assistance Fund.

What can she do?

Submission Checklist

- Copy of most recent denial letter from your insurance company
- Advocacy letter
- Signed HIPAA authorization form allowing Insurer to speak with anyone helping you with the appeal
- Copy of medical records to support your claim
- Copy of your policy (highlight the parts that are relevant to the denial)
- Statement from treating physician(s)
- Clinical guidelines or medical articles supporting the recommendation.
- Relevant laws or policy which support your argument.
- Proof of mailing and copy of entire complaint.
- Copies to send to Regulatory Agency or Congressional Person (if needed)

Now What?

- If you are worried that the appeal will not be properly processed based on past experience, or it is extremely urgent, than simultaneously contact the Department of Labor, Local Insurance Department and Attorney General Office.
- If you are worried that the agencies won't be helpful then also contact your State or Federal Congressional Representative and explain your concerns about the issue.
- File a Complaint!

Which Regulators Do I Contact?

Self Funded Employer plan	U.S. Department of Labor
Fully Insured Employer plan	U.S. Department of Labor State Insurance Department
Individual plan	State Insurance Department
Medicaid	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Local Health Department
Medicaid Managed Care Plan	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) Local Health Department State Insurance Department
Medicare	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)
Medicare Advantage Plan	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS)

Continuation of Insurance Benefits

- How to I maintain coverage if employment ends?
- What other options do I have?
- What can I do if I lost coverage due to COVID-19?

COVID-19 and Health Insurance

- **The Department of Labor "DOL"** has extended certain timeframes applicable to employee benefit plans and their participants and beneficiaries, including special enrollment timeframes, COBRA deadlines, and ERISA claims procedure deadlines in response to the COVID-19 emergency.
- **Centers for Medicare and Medicaid Services "CMS"** issued guidance allowing multiple temporary waivers and benefit flexibility.
- **Insurers** have voluntary waived certain prior authorization requirements and benefit limitations.
- **States** have issued emergency proclamations on insurance coverage and enrollments.

Medicaid

Medicaid is funded through a partnership between the federal and state governments. While states are required to provide certain basic services to all members, they maintain a large degree of flexibility in the administration of their individual Medicaid programs.

As a result, there are differences between states as to their services and delivery systems. For example:

- Expansion of Medicaid Eligibility following the Affordable Care Act
- Special programs for “disabled” individuals
- Different Income limits for special populations

https://www.medicaid.gov/about-us/contact-us/contact-your-state-questions/index.html

Medicaid Buy In for Working People

- Medicaid buy-in program for working people with disabilities is an option authorized under the Ticket to Work and Work Incentives Improvement Act that allows working individuals with disabilities whose income and/or assets exceed the limits for other eligibility pathways to "buy-in" to Medicaid coverage.

- This option provides people with disabilities the opportunity to work and access the health care services and supports they need, without having to choose between working and qualifying for Medicaid.

- The Medicaid Buy-In program is an optional Medicaid program that states may choose to provide. Most states, but not all, have a program.*

Department of Labor Medicaid Buy In
https://www.dol.gov/odep/topics/MedicaidBuyInQAF.pdf

Medicaid Appeals

The Medicaid Act requires states to provide a “fair hearing” for patients who have been denied eligibility or services.

More broadly, when the government takes an action that could potentially harm an individual and the reason for that action is based on a finding of fact, then “the evidence used to prove the Government’s case must be disclosed to the individual so that he has an opportunity to show that it is untrue.”

https://www.macpac.gov/publication/elements-of-the-medicaid-appeals-process-under-fee-for-service-by-state/

Am I Eligible For Medicare?

- Eligible if age 65 or have been on SSDI for 24 months
- Part A-free hospital coverage
- Part B-medical insurance which requires a monthly premium
- Part C-Medicare Advantage Plans which allow private health insurance companies, such as HMOs and PPOs to provide Medicare benefits
- Part D-prescription drug insurance, provided through private insurance companies that have contracts with the government

Medicare AND …

- How does Medicare intersect with private insurance?
- Do I have to get on Medicare?
- How does Medicaid and Medicare work?
- What is a Medicare Advantage Plan?

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30 YEARS
EMPOWERING PATIENTS
BLOOD & MARROW TRANSPLANT INFORMATION NETWORK

Questions?

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