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Don't take it lying down if your insurer refuses to pay

By Sandra Block
USA TODAY

A serious illness is hard on the body and the mind. If your health plan refuses to pay some of the bills, you may feel too weary to fight. But you have a right to appeal those decisions, and the odds of success are better than you may think.

Health plans deny claims for all kinds of reasons. Your insurer may argue that a surgical procedure is experimental or your medication isn't "medically necessary." Your plan may decline to pay the full amount because an out-of-network doctor performed the service. Sometimes, claims are denied because they were coded improperly. (**Health care crunch: How Americans pay medical bills**)

The problems are compounded for people with chronic illness, who often file dozens of claims, says Jennifer Jaff, author of *Know Your Rights: A Handbook for Patients with Chronic Illness*. "The system is built for people who get sick, get treated and get better," she says.

Jaff — who has battled Crohn's disease, a chronic inflammation in the small intestine, most of her adult life — says individuals with chronic illnesses often have to fight for coverage. "We are absolutely by far the most expensive bunch of people, so insurance companies will look for reasons to deny coverage."

But just because a claim is denied doesn't mean you should pay it. All states require health insurance plans to have internal review procedures, and about 70% of appeals are successful, Jaff says.

How to improve your chances:

▶ **Make sure you understand the reason for the denial.** The letter you receive from your insurer should explain the reason your claim was denied and may offer to provide documents supporting that decision. "Collect as much infor-

mation as you possibly can," Jaff says. That will help you determine how to frame your appeal.

▶ **Ask your doctor to write a letter on your behalf.** The letter should include a brief medical history and diagnosis and an explanation why the medication or treatment is necessary. If you've tried other medications or treatments, explain why they were ineffective, Jaff says.

▶ **Write a cover letter explaining the basis of your appeal.** For example, your letter may state that the insurer didn't consider all the evidence in your case or misread information provided by your doctor. Include evidence to support your contention, such as blood tests, MRIs or CAT scans, Jaff says.

▶ **Keep detailed records.** Dan Robinson's son, Zane, was born four years ago with a rare disorder that required open heart surgery when he was 2 months old. Right after that surgery, the first of several operations, "We started getting tons of bills," Robinson says. "I knew just looking at the pile of them that it was way more money than I should have to pay." At one point, Robinson was filing up to 10 appeals a month.

Robinson created a computer program to track his son's bills. It proved invaluable in filing appeals, he says. In many cases, claims were denied on the grounds that a particular doctor wasn't included in his plan's network. Robinson's record-keeping system helped him prove that the doctor in question was covered by the plan.

Robinson, who was working for software maker Intuit at the time, used his experience to develop Quicken Medical Expense Manager, a product designed to help families organize their medical records.

Whether you use a computer program or a file folder, keep detailed

records of correspondence with your insurer, medical records and bills. Take notes of phone conversations. Send letters through certified mail and request a return receipt. That way you can confirm they were received.

▶ **Pay close attention to deadlines.** If your insurer says you have 60 days to appeal, make sure you meet that deadline. Otherwise, you could lose your right to appeal. If you don't have all the information you need, state in your letter that you're expecting more information and will submit it as soon as possible. Likewise, if you're too ill to send a detailed letter, send a short letter explaining the basis for your appeal, and tell the insurer you'll provide more information when you can.

▶ **Ask for an independent review.** Many insurers contract with doctors or other outside experts to review claims disputes. Try to provide new information that wasn't included in your first appeal, Jaff says.

The next step

If your insurance company refuses to change its initial decision, you still have options. However, your rights differ depending on the type of plan you have.

Where you can go for help:

▶ **State external review boards.** Some 43 states and the District of Columbia have established independent boards to consider denials of health insurance claims. Most states won't consider an appeal until you've exhausted your insurance company's internal process.

The state programs apply to employer-sponsored insurance plans and private plans that individuals buy for themselves. But if you work for a company with a self-funded plan, you are ineligible for a state external review.

Employers with self-funded plans pay for workers' health care costs directly, rather than purchasing insurance from a company such as Aetna or Cigna. It's not always easy to tell what kind of coverage you have because many companies with self-funded plans use insurance companies to process claims. Before filing an appeal with your state's external review board, read your plan's Summary Plan Description or talk to the administrator.

If you're eligible, your insurer should be able to provide information about

your state's review process. A report by Consumers Union and the Kaiser Family Foundation also provides details about state plans; you can find it at www.kff.org. Click on the link to "Consumer Guide To Resolving Health Plan Disputes."

Don't abandon the fight just because your plan is self-funded. Dan Robinson's plan was self-funded, and when he was unable to resolve a dispute, he asked his employer's human resources department to intervene. Seeking help from your employer may not always work, but it's

worth a try.

► **File a lawsuit.** This should be your last resort, because lawsuits against health insurance plans are hard to win, Jaff says. The federal Employee Income Retirement Security Act, which governs most employer-provided group plans, requires you to show that the insurer's decision was "arbitrary and capricious," Jaff says. "That's a very high standard of truth. I can count on one hand the number of times the patient has won."