

NAVIGATING PRIVATE HEALTH INSURANCE

I. COMMERCIAL OR SELF-FUNDED

- A. Distinction determines whether state or federal law applies
 - 1. Commercial - state law applies
 - a. Division of Insurance/ Insurance Commissioner has jurisdiction
 - b. Mandated benefits are decided in the state legislature
 - 2. Self-funded – ERISA law (federal) applies
 - a. Department of Labor has jurisdiction
 - b. State mandates are not required
- B. How to find out whether you're in a commercial or self-funded plan
 - 1. Ask your employer - Human Resources Manager/Department
 - 2. Look at the plan – particularly under Denials/Appeals/Complaints
 - a. Commercial plans have *external reviews* referred to in the appeals process section
 - b. Look for language re: DOI, ERISA, or Dept. of Labor
- C. Why knowing the difference is important
 - 1. State Mandates - Colorado (listed in www.dora.state.co.us/insurance)
 - a. HB99-1088 (Colo. Revised Statutes (C.R.S.6) Section 10-16-104(1.7))
 - Provides 20/20/20 sessions of OT/PT/Speech to age five (if the need is due to congenital defects)
 - b. Medical foods for inherited metabolic disorders (C.R.S.10-16-104 (1)(c)(I))
 - c. Autism is a *medical*, not a mental condition (C.R.S.10-16-104 (5))
 - d. Parity Law (C.R.S. 10-16-104(5.5))
 - Requires group plans to provide coverage for treatment of six biologically based mental illnesses-as per physical illness
 - e. Network Adequacy
 - Provides remedies if network of providers is inadequate
 - 2. Appeals Process-State Law Requirements
 - a. Mandated procedures and notification requirements
 - b. Two levels of appeal plus external review
 - c. Allows members to request a second level of appeal for coverage denials if physician deems treatment medically necessary.
 - d. Allows audio or videotaping of second level appeals for potential use in third level of appeal
 - e. Jurisdiction-DOI versus Department of Labor

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II. READ YOUR CONTRACT

- A. Benefits or Policy Manual is your contract
 - 1. Read about Covered Benefits, Exclusions, Appeals Process; using Glossary of Terms
 - 2. Understand non-compliance with terms of contract (including pre-authorization)
- B. Open Enrollment

Read insurance plan summaries (disclosures) and comparison shop based on the needs of your family members

III. PREAUTHORIZATION

- A. Insurance may not pay if pre-authorization is not obtained
- B. Do not rely solely on physician's staff—it isn't possible for them to know all the ins and outs of your contract (and every other patient's!) Be proactive and confirm anything that is told to you by getting it in writing.
- C. Referrals—ascertain that referral is complete or insurance may not pay the benefit

IV. COVERED BENEFITS AND MEDICAL NECESSITY

For a treatment to be covered, two criteria must be met

- 1. It must be approved as a covered benefit
- 2. It must be medically necessary

If challenged, garner letters of support from all professionals involved to begin preparing an appeals packet.

V. A DENIAL MAY MEAN IT IS TIME TO APPEAL

- A. "No" is not usually the final answer
- B. Denial based on "medical necessity"
 - 1. Commercial health plans required by state law to:
 - a. Notify contract holder in writing
 - b. Give medical reasons with signature of physician
 - c. Advise about appeal rights
 - 2. Provide *contract language* to your physicians and therapists to help them write letters of medical necessity
 - 3. Write a cover letter for the appeal, referring to and attaching letters of support and a copy of the denial letter
 - 4. Send by certified mail and follow up with a phone call to acknowledge receipt
 - 5. Do not allow the physician's office to do the appeal for you.
Everything needs to be all in one packet. Be sure to make your own copy!!!

VI. COMMUNICATION LOG

Keep a log by your phone

- 1. Record date, times, names and content of every call with the insurer
- 2. Request every approval or denial in writing from them and if no response, write to them

VII. WRITING THE LETTER OF APPEAL

- A. Provide your appeal in writing – tone of the letter should be assertive and factual not aggressive and emotional
 - 1. If it is urgent, request an expedited appeal by phone and follow-up in writing
 - 2. Provide a brief background of your case
 - 3. Cite relevant and helpful language in your contract (with page numbers)
 - a. Demonstrate that the treatment is a covered benefit (photocopy of page) or that you are requesting an exception.
 - b. Evidence of medical necessity

1. If treatment is a benefit exclusion, Colorado state law does not require the same appeal procedures as medical necessity, but you have the right to challenge the decision and ask for a second level of appeal
 2. Argue why the health plan should make an exception for your family
- B. Demonstrate that the treatment is medically necessary
1. Include and refer to letters provided by physicians, therapists, specialists
 2. Include second opinions, medical literature, safety and cost issues—any information helpful to your case
- C. Commercial insurance in Colorado provides three levels of appeal, including a face-to-face meeting and an independent external review. Do not give up if the first appeal does not result in a reversal of the denial.
- D. The appeals process for self-funded plans is in the contract (plan document).
Consider asking your employer to assist with the appeal
- E. Consider using **Family Voices – CO Letter of Medical Necessity Template**.
Click here. ([Christiana, please link to it on website.](#))

VIII. HELPFUL HINTS

- A. Establish relationships—ask for supervisors; send photos of the child; be respectful!
- B. Always manage your plan by reading notices; asking if the physician is still in the network.
- C. Treat every year as a new year—establish that benefits won through appeal are still available.
- D. Your physician is your best advocate—support him/her with information about your contract.
- E. Ask for help—patient advocacy is available—service coordinators have the advocacy resource contacts.