KNOW YOUR RIGHTS

There are things you can do if your health plan won't pay for your medical treatment or delays your care.

www.CoverageRights.org

Health insurance companies can take a number of steps to control their costs. This can mean your health plan won't cover certain treatments prescribed by your health care provider or the plan requires you to take a number of steps before your treatment is approved.

The good news is there are state and federal laws in place that may protect you from these practices.

To find out if your insurer or PBM may have acted improperly, ask yourself these questions:

Step Therapy

Did my insurer make me try a different treatment before covering the medication that my health care provider prescribed?

This practice is called "step therapy" or "fail first" because it requires patients to try other treatments first and show they don't work. This action may be against federal or state laws if the insurer treats you and others like you differently because of your health condition.

Adverse tiering

Do I have to pay either a percentage of the costs or a very large co-pay for my medication?

This practice is called "adverse tiering." It can be used by insurers to shift a lot of the costs to patients for newer drugs to treat chronic conditions like cancer, HIV, and rheumatoid arthritis. However, this action may also violate certain federal and state laws if used in a discriminatory way.

Nonmedical switching

Is my insurer forcing me to take a different medication, even though my current medication works well, by refusing to cover it any longer or increasing my co-pay?

This practice is referred to as "nonmedical switching." It occurs when your insurer forces you to switch from your current medication to a different (but not a generic) drug by either refusing to cover the drug any longer or increasing the out-of-pocket cost of the drug. It can violate certain state consumer protection laws.

Prior authorization

Before I can fill or refill a prescription, do I need to get approval from my insurer?

This practice is called "prior authorization." It happens when the insurer requires you or your health care provider to get approval before the treatment is covered. This step can delay or interrupt care, waste time, and complicate medical decisions. As such, it may also violate state and federal laws.

My insurer refuses to cover a treatment that my health care provider prescribed to me. **What can I do?**

If you answered yes to any of these questions, there are three steps you can take to change your insurer's decision:

- Appeal the decision;
- Request an external review; or
- File a complaint.

How do I appeal the decision?

If your insurer denies your claim, you have the right to an internal appeal. This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

- **Review the determination letter.** Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.

- **Collect information.** Collect the determination letter and all other documents the insurer sent you. This includes your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.

- **Request documents.** If you didn't receive the determination letter or don't have your policy, the medical necessity criteria, or the instructions and forms for filing an appeal, call your insurer's customer service representative and ask for these documents. The company website will list the toll-free telephone number to call.

- **Call your health care provider's office.** The health care provider's office or clinic has people on staff to help with the appeals process. They will tell you how to fill out the forms to request an appeal, write an appeals letter on your behalf, or handle the appeals request for you.

- **Submit the appeal request.** It is important for you or your health care provider's office to submit the appeal request as soon as possible along with the letter from your health care provider and all additional information the insurer requested.

  Once you file an appeal request, expect to wait up to 30 days to hear back from the insurer regarding a treatment you hope to receive. It can take up to 60 days for a response if you received the treatment and are waiting for reimbursement.

- **Follow up.** Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

What if my insurer denies my coverage on appeal?

Under law, you are entitled to take your appeal to an independent third party for an "external review," which means the insurance company no longer gets the final say over whether to approve a treatment or pay a claim. The situation applies if the insurer denies your appeal or if your medical situation is urgent and waiting would jeopardize your life or ability to function.

You can skip the internal appeal process and request an expedited external review in urgent situations. Your situation is urgent if waiting 30 to 60 days would seriously jeopardize your life or your ability to regain function.

How do I file for an external review?

To trigger an external review, file a written request with the independent organization within 60 days of the date your insurer sent you a final decision. The process should take no more than 60 days.

However, in urgent situations, you can ask for an expedited review. The expedited process should take no longer than four business days. To find out whom to contact in your state to request an external review, please go to www.CoverageRights.org.

How do I file a complaint?

If there are still problems after the external review process, you can file a complaint with the insurance commissioner or attorney general in your state. To determine whom to contact and how to submit the complaint, please go to www.CoverageRights.org.

Your complaint should include the following information:

- The name, address, email address, and telephone number of the person filing the complaint ("Complainant");
- The name of the insured individual, if different from the Complainant;
- The names of any other parties involved in the claim (for example, the plan administrator or pharmacy benefit manager);
- The name of the insurance company and the type of insurance;
- The state where the insurance plan was purchased;
- Claim information, including the policy number, certificate number, claim number, dates of denial, and amount in dispute;
- The reason for and details of the complaint; and
- What you consider to be a fair resolution.

You should also submit the following documents as supporting information:

- A copy of your insurance card;
- Copies of coverage denials or adverse benefit determinations from your insurer;
- Copies of any determinations made by internal and external reviewers;
- Any materials submitted with prior appeals and complaints;
- Supporting documentation from your health care provider;
- A copy of your insurance policy; and
- All responses from your insurer.

What happens after the insurance commissioner or attorney general receives my complaint?

The insurance commissioner or attorney general will assign someone to research, investigate, and resolve your complaint. That person will examine your account, records, documents, and transactions. He or she may question witnesses, request additional documents from other parties, and hold a hearing. If the insurance commissioner or attorney general determines that the insurer violated laws or regulations, he or she may order the insurer to give you the requested coverage or compensate you.

Whom should I call if I have any questions about filing a complaint?

To determine whom to call in your state, please go to www.CoverageRights.org.

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