

PRIVATE INSURANCE ISSUES: Managed Care & Advocacy

Where the system often breaks down & basic health advocacy

Managed care has gained increased popularity in the last ten years. The primary reason for this was the significant growth in health care costs. Managed care companies believe that the only way to control costs is to monitor services being provided to their members. This is called, "utilization review" or "utilization management." There are a number of options to health plans who need more money. They can set up gate keepers, they charge higher copays (for example many plans charge higher copays who visit the ER but are not admitted. The plan wants their members to visit their provider during normal business hours, if they can. They do not want to pay the higher costs to see members in the ER, if they are not having a life threatening event.)

Health plans want to pay to keep people well. When they have more sick people than well people that they are at risk for, they start to lose money. Managed care is often reluctant or may entirely refuse to pay for services that will improve daily life but not "cure." This is especially true for services that are needed for chronic conditions. Physical, occupational, some respiratory therapies, as well as mental health services are usually very limited by health plans. Health plans often view these services as an ongoing expenditure with limited benefits.

Medical Necessity

Medical necessity refers to the basis by which a health plan determines if a particular procedure, product, treatment, or other service will be covered by the plan. This is one way for the health plan to limit costs.

Case managers play a key role in determining first what procedures are covered according to the contract (benefits package). If a procedure is deemed "not covered" by the case manager, an appeals process is available. The health plan's medical director must use all available information to determine whether a medical procedure being submitted for payment is necessary for the health and well-being of a patient. It is during this appeals process that the medical director for the insurer examines the information provided and determines whether it meets the qualifications for medical necessity. The National Policy Center for Children with Special Health Care Needs has developed a document on medical necessity that could assist insurers with defining medical necessity for persons with special health care needs.

Advocating for Coverage

A health plan must be responsible to its consumers. There are all kinds of avenues for recourse, if a health plan treats their members unfairly. These are some things you need to know, so that you can take charge of your health care, or advocate on behalf of others.

It will be important for individuals and advocates who work with clients to identify key

players within a health plan. Several individuals and departments have already been identified but let's reiterate.

Claims Department-these people are the first to respond to a claim. They begin the history of the claim. Their number appears on the explanation of benefits (EOB) you receive.

Medical Director-the person with ultimate responsibility to assure payment for your claim
Case manager-a person who may be hired directly by the health plan or who is contracted by the plan to monitor claims and assure that beneficiaries are using the most cost efficient methods to monitor their health status. Case managers are to respond directly to the Medical Director of the health plan.

Benefits manager-the person at the company you work for who is responsible for negotiating the contract with the insurer.

It is critically important to keep good records of any conversations with these people. Always note the persons name, the date and time contacted and the information they provided. Ask the benefits manager and/or the insurance company to fill out the questionnaire provided in the resource list. This questionnaire will enhance your understanding of services available under the health plan; and, the amount, duration, and scope of the services allowed. It will also explain your plan's reimbursement procedures.

Member Responsibility

It will be important to do good record keeping about the health care services received. Know how to read an explanation of benefits. Match your records to those of the health plan. Know how to appeal a claim denial. Most importantly know what the future medical needs might be for everyone in the family, or for those you are helping. Learn to evaluate choices based on current health needs or reasonably expected needs in the future. Use a physician to help assess the kind of future health needs family members may have. Consistent and coordinated care helps anticipate long-range health care needs. This is why establishing a medical home is especially important for people with special health care needs.

Helping Partners

People with special health care needs have several partners who act as advocates for them. Previously we mentioned the state insurance commissioner or the state commission on insurance. These members of the state government are appointed by the governor to monitor how insurance policies are written within the state, and assuring that the laws of the state are followed. One such important law prohibits insurers from denying a claim based on the claimants eligibility for Medicaid. If a citizen believes that he/she has been denied benefits that are stated to be covered by an insurer the commissioner or his department is bound to review the contract to settle this dispute. If other discrepancies are



found, the health plan may not get additional Medicaid contracts from the state government.

The state insurance commissioner's office works closely with the state attorney general to monitor activities of those operating businesses within the state. The attorney general can provide legal assistance to citizens of a state who have been denied covered benefits if the insurance commission believes it is warranted.

Two other agencies can provide legal assistance to citizen of a state:

- *Legal Services who work on behalf of the poor have assisted in numerous cases involving denial of services and coverage.*
- *Protections and Advocacy is the legal organization for persons with disabilities. Most often their background is in special education law but there have been state programs who have involved themselves with denial of benefits claims.*

Finally, Business Coalitions made up of small businesses that join forces to try to leverage power in various arenas can often be an ally to add to the list. Health coverage is a huge item on the minds of small business. These coalitions use their buying power to search out affordable health care for their members.