

Chapter 6

Paying for Healthcare

In this chapter:

- Working with the Insurance Company
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As a caregiver, you will confront many choices about treatments, home care, and therapies. You may even find that personal finances and health insurance are the obstacles preventing you from selecting the best care for your loved one. At the point that your loved one requires a particular treatment, it is likely that you will do whatever you can to provide that care, including sacrificing personal finances and compromising your family's stability. But there are ways to avoid having to make these painful choices.



As medicine and health care improve, people are living longer with serious and chronic illnesses. Long-term care has become a part of modern living, and there are resources available to help you plan for this. Start by familiarizing yourself with your loved one's health insurance plan, as well as government entitlements and public assistance.

These are confusing systems to navigate through, but inquiring early on will empower you to obtain the care your loved one needs, when it's needed, at a reasonable price or perhaps for free.

If you approach these important administrative tasks of caregiving early on, you may prevent unnecessary financial pressures and compromises regarding work, housing, and education. Once you get insurance benefits and government assistance in order, you can better attend to your loved one's needs at home and make quality care available. This chapter outlines the basics you should learn about when planning for, and purchasing care. It will also give you tips for advocating for your loved one to secure medications, treatments and services if payment is denied.

Working with Your Loved One's Insurance Company

The two basic categories of insurance are public (government-sponsored insurance) and private (insurance plans purchased by you or provided by an employer). You may have one of the following types of government sponsored insurance plans: Medicare or MediCal; or a private plan such as fee-for-service or managed care. Managed care plans include: Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), and Point of Service plans (POS).

Insurance plans have their own distinct systems that may control your choice of health care providers and the services you can obtain. Contact your insurance company or your employer's health benefits manager to learn what the benefits are. Your loved one's coverage plan will determine what treatments will be covered in full, and what portion of the cost you will be responsible for paying.

If your coverage is Medicare or Medicaid, read the free consumer materials that explain your coverage and your rights. You can also contact an advocacy organization such as the American Brain Tumor Association (1-800-886-2282) and the National Brain Tumor Foundation (1-800-934-2873). These organizations provide educational materials, resources for care, and helpful support networks online and by telephone.

It is common for insurance companies to cover treatments that the doctor prescribes as "medically necessary" or "required medical events." The care prescribed by the doctor may be a combination of services, and is based on the complexity of the patient's needs.

Services the doctor prescribes as "medically necessary" may include:

- **Therapies:** speech therapy, occupational therapy, physical therapy
- **Treatments:** radiation, chemotherapy, medications
- **Interim treatment facilities:** rehabilitation hospital, skilled nursing facility
- **Home care services:** professional nursing, social work, nutritional care

Because many tests, procedures and treatments require authorization by your insurance company, it is best to verify that the service will be paid for by the insurance carrier before receiving it.

Review a copy of your loved one's policy and review it carefully. Find out exactly what services are covered and how the payment system works. Be aware of annual limits and lifetime limits (often \$1 million), and research purchasing additional coverage. Also make sure that you are aware of the policy's regulations on the following:

- Co-payments
- Deductibles
- Referrals to physicians and other clinicians
- Services covered (follow up appointments, MRIs, medications, therapies, treatments, clinical trials, home care, reimbursement for complimentary and alternative services)

The Children's Brain Tumor Foundation recommends taking the following steps in dealing with the insurance company¹:

- Educate yourself. Know about your loved one's illness and why referrals to specialists are needed.
- Many insurance plans and HMOs require that specialized tests, procedures and treatments must be pre-approved and authorized by a primary care provider. You may need this "authorization" when you call to make an appointment with a specialist.
- Ask for one "case manager" at the insurance company who will always handle your case and answer questions. Ideally you will find someone who is sympathetic to your case and time constraints.
- Document every phone call. Write down the name of the person you speak to, the date and time, and the topic discussed.
- Fill out every form completely. Payment may be delayed or denied if information is missing. You may want to send in claim forms "Return Receipt Requested." Someone of authority will have to sign for it.
- Develop a good working relationship with your loved one's primary physician's office staff because authorizations must come from there.
- Keep a copy of each authorization you receive. Follow up on authorizations and never assume that they are being handled. You may want to tell the specialists that you will get the necessary authorizations yourself.
- Sometimes the referral process to specialists or therapies is slow. You may have to emphasize the serious nature of your loved one's illness in order to get an earlier appointment or referral.
- Don't wait for the doctor's office or insurance company to call you back. Call every day if necessary. Be polite but persistent.

When Insurance Won't Pay

Your options for obtaining services that are not regularly covered by your insurance include:

- Paying out-of-pocket
- Submitting claims to your insurance company
- Fighting denied claims by making appeals with the support of your health care provider (see “Appealing a Decision,” at right)
- Using state and non-governmental agencies to help assist insurance complaints
- Applying for social services (county- or state-run) to provide you with services (see “Seeking out Government Entitlements and Private Financial Assistance,” on the next page)
- Obtaining health care services that are offered by charitable or non-profit organizations at reduced or no cost
- Engaging the help of a professional advocate (see “Professional Advocates,” below)

Appealing a Decision

You may find over time that there are services your loved one needs or wants that are not covered, or are denied, by your insurance carrier. Sometimes a denial occurs because of incorrect documentation or other logistic issues. At other times a service may be denied because your policy has exclusions. However, you may appeal to your insurance company to pay for the services that may have been denied. Your insurance company can tell you how to appeal a decision. In trying to make an appeal, you can ask your doctor or health insurance advocacy organization to help you obtain the services you need by submitting letters of medical necessity. Your local state legislator can also intervene with your insurance company so that your loved one receives the service for which they are paying insurance premiums.

Professional Advocates

If a service you request is denied, you can obtain the help of an advocacy service to work with your family and doctor to assist you through the appeal process. Examples of professional advocates who are responsible for representing the patient's interest include:

- **Patient Advocate** — assist patients, and concerned families and friends. They can get involved in nearly any facet of patient care and are available in most hospitals.
- **Ombudsman** — advocate for residents of nursing homes, board and care homes, and assisted living facilities. They can be called for any concerns around care, or for a referral to a patient advocate. Ombudsmen provide information about how to find a facility and what to do to get quality care. Under the federal Older Americans Act, every state is required to have an Ombudsman Program that addresses complaints and advocates for improvements in the long term care system.
- **Payment and Billing Advocates** — can investigate and resolve problems concerning insurance payments or Medicare/Medicaid. They are available in the finance departments of medical clinics or hospitals.
- **Social Workers and Discharge Planning** — help patients get in-home support services, equipment, transportation, financial benefits, and community services. They may be available in your medical clinic and are available privately.

Seeking out Government Entitlements and Private Financial Assistance

As a result of illness in your family, you may find that you need to cut back on work hours to give care and help your loved one adjust to life changes. If you are making changes to your employment, inquire with the Human Resources department at your work to learn the policies on sick leave, paid time off, the Family Medical Leave Act, or your flexibility of work hours.

Changes to your employment status can mean lost income and changes to your health benefits. But these changes may also make you eligible to receive entitlements through government programs.

Be aware that there are both government programs and privately sponsored services in place that you may financially qualify for, to help provide your loved one with the needed care.

The following lists are examples of government and non-government programs that offer entitlements, income supplements, low-cost health care services, and financial subsidies. These services may be controlled by the city, county, state or federal government, or non-governmental organizations. Be sure to speak with a case manager at the hospital or clinic, or a health care advocate at an organization such as the National Brain Tumor Foundation, to help you apply for these services.

Government Departments and Programs

- Department of Rehabilitation
- Department of Developmental Services
- Department of Social Services :
 - Social Security Disability Insurance (SSDI)
 - Supplemental Security Income (SSI)
 - Medicaid (Medi-Cal)
 - In Home Support Services (IHSS)
- Department of Aging
- Department of Housing & Community Development

State Pharmaceutical Assistance Programs

Non-Government Programs

- Clinics or health care providers with sliding scales
- Pharmaceutical programs with discounted prescription programs
- Utility companies offering utility subsidies (based on support of your physician or financial status)
- Food banks, Meals on Wheels, Salvation Army, local churches/synagogues

¹ Children's Brain Tumor Foundation, <http://www.cbtf.org>, retrieved 2007.