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Another Victory for Health Advocate

You Can Make Them Pay

New Ways to Appeal Make It Easier to Take On Health Insurers and Win

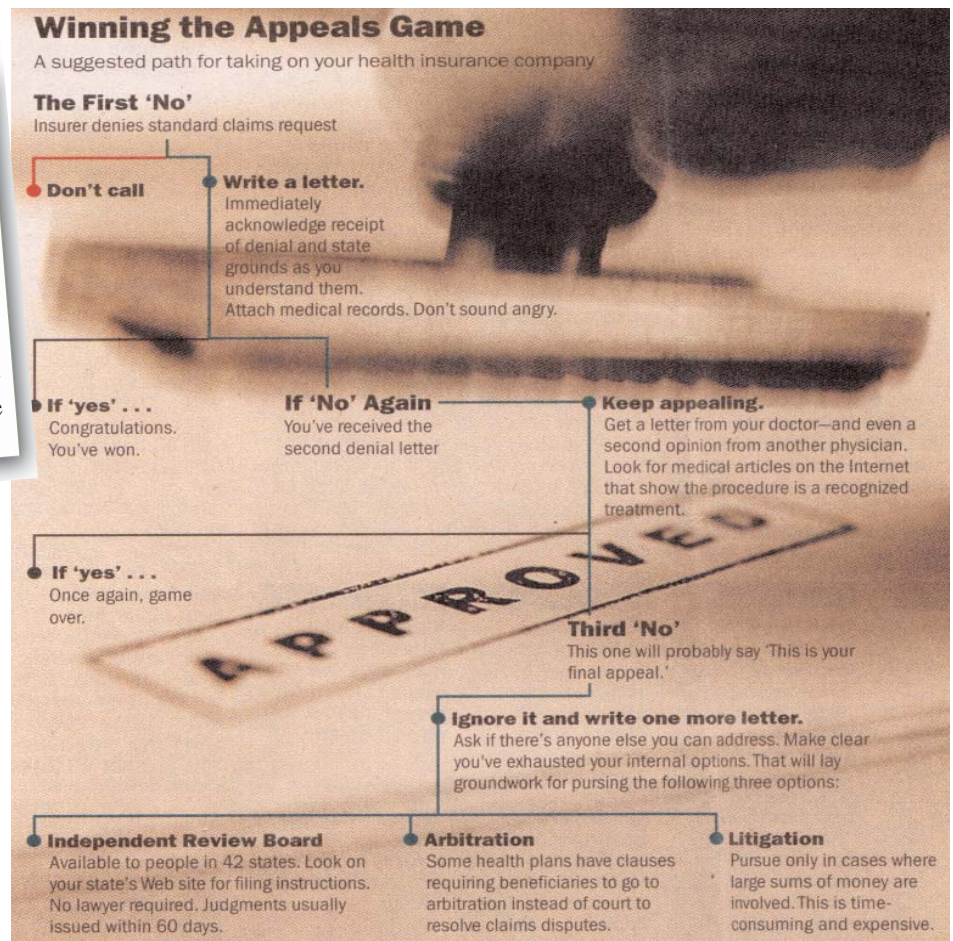
By Peter Landers
And Amy Dockser Marcus

ELIZABETH MCKENTY wanted a new treatment to fix her congenital heart defect. Her insurer said no. For most people, that would have been the end. But Ms. McKenty, a 43-year-old librarian in Philadelphia, appealed again. **With the help of a company that fight denials**, she marshaled medical literature showing why the new treatment—using a catheter to deliver a device for blocking leakage between the heart’s two chambers—would give her better odds than open-heart surgery. This time she won.

Most people take it as a maddening fact of life that health-insurance companies are programmed to say “No” – and that appealing only brings headaches, hassle and another “No.” But for all their image as heartless Goliaths, insurance companies aren’t invincible. Increasingly, it’s possible to challenge a health plan’s verdict and prevail.

New channels of appeal both within health plans and outside are making it easier for patients to press their case. At the same time insurers are under intense political and public pressure to soften their image. A new Rand study concludes insurers often pay emergency bills even if they think the patient was wrong – in part because they don’t want to alienate employers who are their customers. Rand found that patients at two big HMOs in California won appeals over denied emergency care payments 95% of the time.

Such victories are a part of a recent power shift in patients’ favor. When managed care took off in the 1990s, health plans had the upper hand, cracking down



on experimental treatments and keeping a tight lid on anything that raised costs, such as an extra day in the hospital for a new mother.

But a backlash against health insurers has led many states to pass laws setting up external review panels and requiring insurers to adopt in-house appeal procedures. Forty-two states have independent review boards, with the power to overrule insurers.

Nevertheless, as the health-care system grows ever more complex, only a handful of people are taking advantage of their appeal rights, and many still pay bills they don't have to. Ultimately, the biggest problem for consumers is the time and energy it takes to pursue complaints.

"A certain percentage of appeals drop off because people are tired, they're confused, and they may be dealing with a family

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Continued From Page D1

health crisis that doesn't give them the wherewithal to figure this out," says Gerry Martens, a Connecticut state official who helps represent consumers in insurance disputes.

Recent data, however, show the chances of winning an appeal are surprisingly good. Nationwide figures aren't available, but a Kaiser Family Foundation review of 1999 and 2000 data from four states – New Jersey, Pennsylvania, Arizona and Rhode Island – showed that patients had a 52% chance of winning their first in-house appeal. Many who lost gave up after that.

But those who appealed a second time won 44% of the time. Those who went on to the next step – independent state review boards – won 45% of the time, according to data the foundation compiled this year from the 42 state boards.

In recent years, health-insurance companies have retreated from aggressive strategies to deny permission for treatment or paying claims – in part because the savings simply weren't significant enough. In 1999, UnitedHealth Group, the big Minnetonka, Minn., managed-care company made headlines with its decision to end routine second-guessing of doctor treatment decisions, closing a \$128 million division that performed that task. The company concluded that savings from the division's work didn't exceed those costs.

Kinder, Gentler?

Still, many companies continue to review cases for such reasons as making sure the procedures are covered by a particular patient's health-benefits policy, but a number of people in the industry say they've found it isn't worth their while to fight in borderline cases. They might have strict policies on the surface but if someone comes forward with a reasonable complaint they're likely to grant it rather than waste money fighting. Some industry watchers wonder whether the kinder, gentler approach is a factor in resurgence of health-care costs.

The rules of appealing health-plan decisions vary of course, but knowing how to navigate the bureaucracy is key. Most plans have an 800 number for queries, but Rhonda Orin, an attorney at Anderson Kill & Olick, who specializes in battling insurance companies, says don't call. Instead, write a letter immediately acknowledging receipt of the denial, and stating the grounds as you understand them. Attach medical records and don't sound angry. Draft a reasoned argument, backed up by evidence, as to why the procedure is "medically necessary."

If you get a second no, appeal again. The company's first letter may offer several

reasons why it doesn't want to give you the coverage. Its second letter will likely focus on its key reason for refusing the coverage. Reappeal, focusing on that specific reason. Get a letter from your doctor – and even a second opinion from another physician – showing why the procedure was a medical necessity. Look for medical articles on the Internet that show that the procedure is a recognized treatment in the medical profession.

If you get another denial, chances are you'll get a letter stating, "This is your final appeal." By now, most people will have long given up. But if the dollars involved are big enough, it's worth another step. Write one more letter, asking if there's anyone else in the company you should talk to. Also use the letter to establish that you've exhausted your internal options. This will pave the way for pursuing outside options such as litigation or going to a state board.

By a recent U.S. Supreme Court ruling, these review boards generally have the final say in insurance disputes. But most patients are unaware they even exist; by some estimates, only about 4,000 people use them each year.

The boards are made up of doctors who are specialists in the area of medicine under dispute. They usually review records from the case and medical literature, but don't call witnesses.

No Lawyer Required

The process is usually fairly swift: A verdict should come within 60 days or less of filing, depending on the state – and much faster if you can show you have an emergency case. The appeal is either free or costs a nominal filing fee. You don't need to hire a lawyer, but many people will find it difficult to navigate the process without some expert help – and getting the documentation together could require weeks or months. Most states give full information and forms for the process on their Web sites.

People who work at big companies that directly pay all their employee medical costs aren't eligible to apply to these state boards. The federal government is in charge of regulating these big-company plans.

But employees of companies that "self-insure" have other protections. New federal rules that are being phased into effect during the second half of this year require insurers' in-house appeal boards to give speedy judgments – within 30 days or 60 days, depending on whether the patient files the appeal before or after the medical procedure is finished.

There are other weapons. It's worth checking how Medicare, the government

insurance program for the elderly, treats the case. Medicare hires private contractors to process claims. These contractors are often units of big private insurers so their rules influence how insurers act even in non-Medicare cases.

David Stone, an executive at a Nashville, Tenn., company that does back-office work on behalf of doctors, recalls a case where a woman received two kinds of ultrasound on the same day. The insurer refused to pay for both, but Mr. Stone reversed the decision by showing that a Medicare contractor would have covered the two ultrasounds.

Importance of Record-Keeping

As with any big bureaucracy, it's important to keep good records and to start early when dealing with your insurer. Cathie Hebbler of Allen, Texas, found that out when she was scheduled to give birth to her third child by Caesarean section in November 2000. She wanted a tubal ligation at the same time, but just a week before the big day, she found out that her insurer was rejecting payment for the tubal, reasoning it was an incidental add-on to childbirth. This is known as "bundling." Ms. Hebbler, unwilling to foot the \$500 bill, kept her tubes untied.

If Ms. Hebbler could do it again, she would insist on getting an answer months before her child was due so she could appeal. "They would have to kick me out of their office before I let it go," she says. She could have explained that the tubal would prevent unwanted pregnancies – and considerable additional expense.

This so-called bundling is a common but little-known source of disputes. Many insurers use software that automatically chops off some claims for procedures performed on the same day. For example, if a woman visits her gynecologist and gets a regular checkup plus a biopsy, the software will pay for the biopsy but reject the checkup. The rationale is that a biopsy includes a bit of looking around, so the checkup shouldn't be billed separately.

Many doctors fight back by refusing to perform multiple procedures on the same day, instead making patients return on a later date. Doctors are afraid they won't get reimbursed – and if you're on the hook for charges insurance doesn't cover, the doctor's precaution might save you money too. Cynthia Baily, a dermatologist in Sebastopol, Calif., says her staff puts a big red "Stop" sign on her charts so she will remember to make patients come back for a second appointment.

—Anne Marie Chaker and Ron Winslow
contributed to this article