

WEBINAR & TELELEARNING SERIES



Common Health Insurance Problems in Multiple Sclerosis: Solutions, Resources, and Strategies

September 12, 2017

Presented by:



Genentech | Novartis | Teva Pharmaceuticals | Acorda Therapeutics | Mallinckrodt Pharmaceuticals

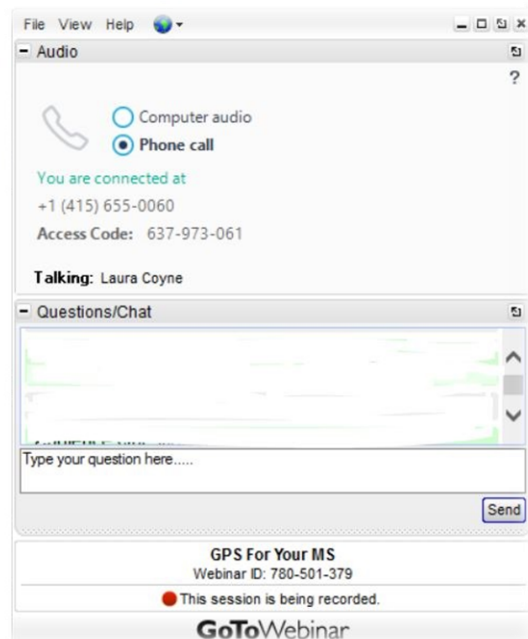


**National
Multiple Sclerosis
Society**



How to Ask Questions During the Webinar:

- Type in your questions using the **Questions/Chat** box
- If box is closed, click **+** to expand



Go-To-Webinar Attendee Support Line:
(877) 582-7011



CITRIX
GoToWebinar

Go-To-Webinar Attendee Support Line:
(877) 582-7011

Archives available at:



www.mscando.org



**National
Multiple Sclerosis
Society**

nationalmssociety.org/telelearning



WEBINAR & TELELEARNING SERIES



Common Health Insurance Problems in Multiple Sclerosis: Solutions, Resources, and Strategies

September 12, 2017

Presented by:



Genentech | Novartis | Teva Pharmaceuticals | Acorda Therapeutics | Mallinckrodt Pharmaceuticals



Kimberly Calder, MPS



**Director of Health Policy
National Multiple Sclerosis Society**

Emily Brown, BSW



**Patient Advocate Foundation
Clinical Case Manager**



Solving Insurance and Healthcare Access Issues | since 1996



Case Management

WHAT WE DO

For more than 20 years PAF case managers have been directly intervening on behalf of thousands of patients each year, enabling them to connect with and maintain access to prescribed healthcare services, overcome insurance barriers, locate resources to support cost-of-living expenses, evaluate and identify insurance coverage and manage out-of-pocket expenses associated with medical treatment.

Summary of PAF Case Management Patient Cases and Contacts in 2016

Total PAF Case Management Case Count	20,286
<i>Unique Case Management Patient Issues</i>	<i>36,173</i>



Solving Insurance and Healthcare Access Issues | since 1996

How We Help

- Debt Crisis and Cost of Living Assistance
- Screening and Enrollment in Insurance and Social Programs
- Disability Enrollment
- Appeals Assistance
- Identification of Co-Payment and Co-Insurance Assistance
- Resolution of Coding and Billing Issues
- Assistance with Prior Authorizations

Choosing the Right Plan

When you are enrolling in a health insurance plan, you should do your research before you buy....like you would when shopping for other big purchases.

- ✓ Plan Type (HMO, PPO, POS, High Deductible plans, etc.)
- ✓ In Network Providers (includes available doctors, labs, facilities, and pharmacies-and mail order)
- ✓ Deductibles (medical care deductibles, pharmacy deductibles or combined)
- ✓ Cost Sharing Rates and limits (copayments and coinsurance, max out-of-pocket)
- ✓ Formulary (identify expected medication costs and covered drugs)
- ✓ Review Non-Covered Benefits or Exclusions
- ✓ Premium

*****Keep in mind that your annual total cost of care goes beyond the monthly premium***



Tips for Controlling Costs



- Talk to you doctor about various treatment and medication options. Be honest about cost concerns.
- Ask your doctor if its still necessary to take all previously prescribed medications?
- Are there **other facilities**, outpatient, or stand-alone **network** locations that provide services at more affordable rates?
- Research advocates or possible allies that can help. Be friendly with billing representatives. Ask for suggestions.
- Avoid collections when possible to reduce potential interest and fees.
- Consider Negotiating. Ask providers for prompt-pay or cash discounts for larger balances. Ask about discounts or financial assistance options.
- Look for financial assistance in **other family budget areas** to offset costs and free up money for healthcare expenses



Transitioning to Medicare

- Things to consider and review or research:
- Do you have other current health insurance coverage?
- Do you have current creditable prescription drug coverage?
- How does your current coverage work with Medicare?
- Could joining a plan affect your current employer coverage?
- Does your current medical provider participate with Medicare?
- Do they participate in Medicare Advantage plans?
- What are your current prescription drugs needs?
- Do you have a preferred pharmacy?



Access to “Covered” Treatments

- “Covered” vs. authorized or approved -- prescription drugs as example
- Subject to restrictions, such as “prior authorization” or “fail first” requirement?
- On a tier you can afford?
- Financial assistance available for MS drugs –if you qualify (income-based, generally not for Medicare beneficiaries)
- Call the National MS Society for help re: MS treatments

If Your Drug is NOT on the Formulary

- Sometimes the medications you need will not be part of your plan's published covered drug list.
- Is your drug on the formulary, at the correct dose? in the right quantity?
- Submit a formal exception to the formulary to request coverage for the treatment as prescribed.
- Research alternate insurance plans and consider uncovered medication costs during the next round of open enrollment for a better option.
- Call the National MS Society for guidance or info about drug discount programs if you have to pay out of your own pocket. (Needy Meds, GoodRx)



Legal Precedent - Jimmo vs. Sebelius

When Services Can Be Covered

- The Jimmo vs. Sebelius Settlement Agreement provides for the re-review of certain Medicare claims under clarified maintenance coverage standards for the SNF, HH, and Outpatient Therapy benefits
- Applicable when a patient has no restorative or improvement potential
- Allows patients to qualify for home health care just to maintain their condition or to slow deterioration of their clinical condition
- Revisions were published by the Centers for Medicare & Medicaid Services (CMS) on 12/6/2013

The important issue is whether the skilled services of a health care professional are needed, not whether the Medicare beneficiary will improve.



Maximizing Your Benefits: Accessing All of Allowed Home Health Benefits

- Patient's doctor needs to be kept updated on patient status
 - Have a physician continue to certify need for services or adjust plan
- Patient and/or family members need to be honest with home health staff about any changes or declines in function
 - If there is a change in functioning, the patient may be entitled to increasing and/or continuing services
- Become familiar with Medicare or private Long-Term Care policy guidelines
- Speak w/ social worker or hospital advocate regarding eligibility for benefits
 - Apply for Medicaid if not already done
 - Qualifying for both Medicare and Medicaid Special Needs Program (QMB/SLMB) can result in no coinsurance and no balance billing
 - Eligibility for Medigap policy
- Become familiar with "Coordination of Benefits" to help understand who pays first if covered by more than Medicare



Outpatient Therapy

- May Be Provided Concurrently With Home Therapy
- After the Part B deductible (\$183), responsible for 20% of the cost of therapy services
- Responsible to pay 20% for durable medical equipment such as wheelchairs, walkers and oxygen
- Medicare Limits- “Therapy Caps” on Services for 2017
- \$1,980 for physical therapy & speech-language pathology services combined
- \$1,980 for occupational therapy services



Outpatient Therapy Benefits

- How to qualify for an Exception to the Therapy Cap limits
- The therapy provider must:
- Establish the need for medically reasonable and necessary services and document this in the medical record
- Indicate on the Medicare claim for services above the therapy cap limit that ongoing therapy services are medically reasonable and necessary
- Threshold or additional limit amounts:
- \$3,700 for physical therapy & speech-language pathology services combined
- \$3,700 for occupational therapy services

What is an Insurance Denial?

Insurance plans are *contracts* based on your plan language.



A 'denial' occurs when the insurance company makes a decision that a submitted claim or request for services is not covered under the language and provisions of your plan language and is thus outside of the 'contract'.

What is an Appeal?

Appeals are *contract disputes* initiated by patients or providers when they disagree with the plan's decision to deny or limit care.

An appeal is a formal request for an additional review of an adverse coverage decision by an insurance company.

Rules for the appeals are outlined in plan language, similar to guidance for disputes that would be included as part of a business contract.



Next Steps

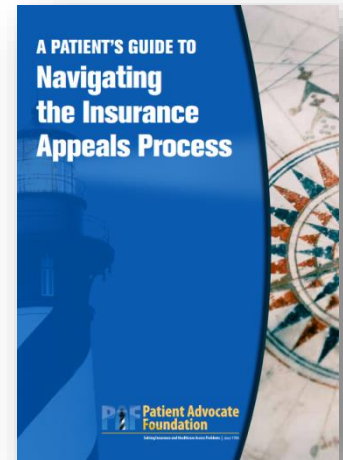
- ✓ When you receive notice that something is denied, review the codes on the EOB or denial letter for specifics and instructions.
- ✓ Call your health plan's customer service line to clarify, many times denials can be cleared up at this level.
- ✓ If denial is a result of improper coding, missing documentation, or other billing issues that require a resubmission of claim, these may be handled in a simpler and faster manner, that will most likely be paid upon correct processing.



**Be sure to take notes on all phone conversations, including the date and time of the call, the names of the people you speak to and what was discussed.*

Factors to Consider

- Understand the process and timelines.
- Keep providers office updated on status of appeal to avoid collections. (Do not pay the bill before the appeal is complete, there may be delay in getting money back).
- If still before treatment was received and approved preauthorization is necessary, are there alternate options for treatments?
- Will a delay in treatment:
 - Seriously jeopardize your life or health?
 - Affect your ability to regain maximum functions or subject you to severe pain?
- State consumer insurance commissions can clarify your rights and provide additional guidance.



Writing the Letter

- Perhaps the most important element of your appeal packet is a clear concise letter detailing your argument that addresses the reason for the denial and cites the terms of your insurance policy language
- The letter can be written by you, a medical provider or an advocate on your behalf. Advocacy organizations may offer help.
- Try to remain factual not emotional while you are preparing your packet- this is a business decision, not personal.



- Submit your appeal on time and with required components
- Track the submission- if by mail, send by certified mail with a return receipt
- If sending by fax- keep a copy of the successful transmission confirmation and plan a 48-hour follow-up

After Submission



- You should receive an official notices within 7-10 days that your appeal has been received. If you do not receive this, contact your insurance company to verify that the appeal has been received.
- Timeline for answers depend on which type of appeal, which level of appeal you are on and other factors defined in appeal process and may range from 72 hours in urgent appeals to 60 days.
- The answer may be provided to you via phone, but will always include a written response of decision.

Healthcare Reform and Your Coverage

- Term “healthcare reform” over-used
- System is constantly changing, re-forming
- ACA’s biggest impact on those previously un-insured and people who “individual” policies
- Congress and state governments likely to do more healthcare reforms in these same areas
- Most people will NOT be affected, but your insurer can make changes on their own

Open Enrollment Coming Soon!

- Take advantage of Open Enrollment no matter how you get insurance
- Dates vary depending on type of insurance, except Medicaid (enroll anytime)
- Medicare Open Enrollment for 2018
- October 15 to December 7, 2017
- Important information for “individual” plans
- New dates, shorter open enrollment period:
 - Nov 1st to Dec 15th only
- Healthcare.gov is starting point, but less one-to-one help -- so start early



Questions or Comments



Emily Brown, BSW



Kimberly Calder, MPS

If you are enjoying tonight's presentation, please consider donating to our programs:

Text to donate: 970-626-6232

<https://www.mscando.org/get-involved>

Can Do MS Resources

e | NEWS
your best life update

Q&A

Can Do Library

Find these resources at www.MSCanDo.org.

National MS Society Resources



The National MS Society's mission is for people affected by MS to live their best lives as we stop MS in its tracks, restore what has been lost and end MS forever. To fulfill this mission, the Society funds cutting-edge research, drives change through advocacy, facilitates professional education, collaborates with MS organizations around the world, and provides services designed to help people with MS and their families move their lives forward.

MS Navigator®
A SERVICE OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

MS
National Multiple Sclerosis Society

nationalMSSociety.org
1-800-344-4867

© 2016 National MS Society. 888987 #MS

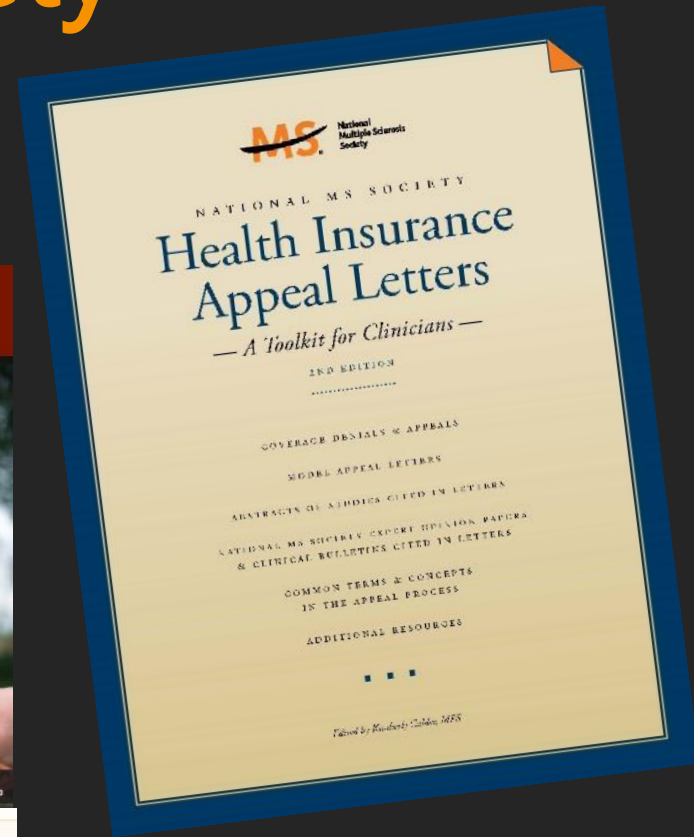
MS
National Multiple Sclerosis Society

ANTHONY (RIGHT)
DIAGNOSED IN 2003

📞 NEED MORE INFORMATION?

We Are Here

Our MS Navigators help identify solutions and provide access to the resources you are looking for. Call 1-800-344-4867 or contact us online.



nationalMSSociety.org

National MS Society Health Insurance Services

If you have a health insurance related question that was not answered during tonight's webinar, please feel free to email

HealthInsurance@nmss.org

or call 1-800-344-4867

You can also visit our website at
www.nationalmssociety.org/healthinsurance

Thank you



#KICKMS

SEPTEMBER IS CAN DO MONTH

mscando.org/CanDoMonth



WEBINAR & TELELEARNING SERIES



Discover The Invisible: Pain and Depression in MS

October 10, 2017

Presented by:



Genentech | Novartis | Teva Pharmaceuticals | Acorda Therapeutics | Mallinckrodt Pharmaceuticals

Text-to-Donate

Help support our webinars with a donation
by texting

970-626-6232

Thank you!

