Life & Health Insurance Advisor

eHummel InsuranceServices

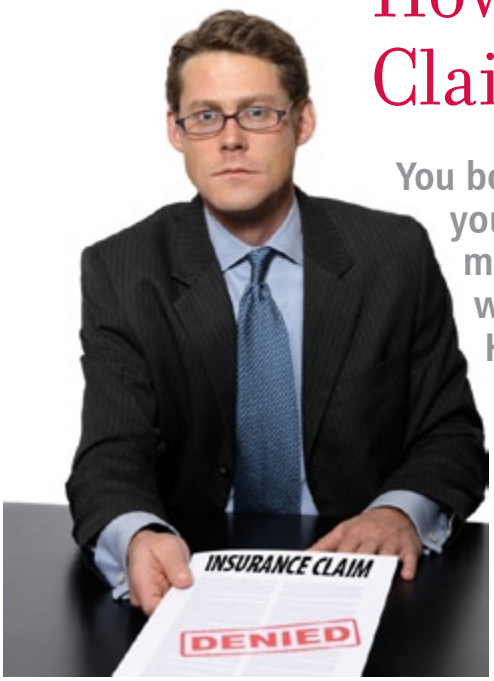
Eric B. Hummel, Agent Broker, info@erichummel.com
4995 Somerset Drive, PO Box 1538, Cornville, AZ 86325
Business: (928) 634-2123 • Toll-Free: (800) 452-9261

Health & Life Insurance Specialists Since 1989

Health Insurance | December 2008 | Volume 1 • Number 12

How to Handle a Claims Denial

You bought health insurance to protect your family from the high costs of medical care. So what should you do when your insurer denies a claim? Here is a step-by-step guide.



You can avoid denied claims in the first place by taking a few simple steps.

1. Know what your insurance covers. For any non-emergency situation, make sure your policy covers the treatment you receive, or be prepared to pay for it. Don't rely on what your doctor's office manager says—the only way to know for sure what your policy covers is to read it. If you have an individual plan, check the Evidence of Coverage booklet.
2. Get pre-authorization where necessary. Many plans require pre-authorization for any non-emergency surgery or procedure or referrals by your primary care doctor before they will pay for services from specialists. If you have coverage through an HMO or PPO, you may need authorization before the plan will cover services you obtain from a healthcare provider that is not a member of the plan's network. If you need care from an out-of-network provider in an urgent or emergency situation, contact your health insurer as soon as possible to protect your coverage.
3. Provide accurate information. Make sure all information on claims or pre-authorization forms is accurate. This includes your personal information (name, date of birth, policy numbers, etc.), along with diagnostic and procedure codes. Ask your doctor to check these for accuracy.
4. Keep records, including bills from your insurer and medical providers, Explanation of Benefits forms (more on this later) and other correspondence from your insurer. Take notes on conversations you have with your insurer regarding your claims or pre-authorizations, including names and titles of those with whom you speak. Take notes on your office visits and conversations with your doctor regarding your condition.

After you (or your healthcare provider) submit a claim to your insurer, the insurer should provide you with an Explanation

DENIAL—continued on Page 3

This Just In

Don't miss out on a tax deduction! If you have a Health Savings Account (HSA), you may be able to deduct your contributions from your state income taxes. States that do not allow these deductions include Alabama, California, District of Columbia, Indiana, New Jersey and Wisconsin. The states of Alaska, Nevada, New Hampshire, South Dakota, Tennessee and Washington have no state income taxes, so the deduction would not apply.

Cash-squeezed consumers are cutting healthcare costs, according to the 2008 Health Confidence Survey by the Employee Benefits Research Institute. The survey found that more than half of Americans (55 percent) with health insurance experienced an increase in their health care costs. Those who have had cost increases are more likely to say they use generic drugs more often (74 percent vs. 60 percent), talk to the doctor more carefully about treatment options and costs (63 percent vs. 52 percent), and go to the doctor only for more serious conditions or symptoms (62 percent vs. 48 percent).

Term vs. Permanent?

You may have heard the phrase "Buy term and invest the difference." That works if you have the discipline for a regular investment program. But for some, a permanent life insurance policy will provide better returns.

There are two categories of life insurance: term and permanent. Term coverage provides death benefit coverage only. Permanent, or cash value, programs provide some additional benefits, including the tax-deferred accumulation of cash. Term insurance provides financial protection for a specific time (one to 30 years), and gives a death benefit but no cash savings. If you have employer-provided life insurance, it is probably term insurance.

Term insurance comes in several varieties:

- **Renewable** – Policy owners can renew coverage at the end of their policy term without having to submit new medical information, though the premium rate will generally rise with each renewal.
- **Convertible** – A convertible policy allows the insured to convert term coverage into a permanent policy without providing evidence of insurability (usually a medical exam). This type of term policy costs more, but the premium remains fixed after conversion.
- **Level** – Level-premium policies have a fixed premium for a certain number of years (usually 10 or 20), while the death benefit remains unchanged. Although the rate locks in for the policy period, it can jump considerably upon renewal.

Permanent insurance provides lifelong protection and includes a savings element that grows on a tax-deferred basis and may become substantial over time. Premiums are generally higher than for term insurance, but they remain fixed.

All permanent insurance has a face value and a cash value. The face amount is the money that will be paid at death, while cash value is the amount of money currently available to the policyholder. Permanent life offers other benefits — purchasers can withdraw some of the money, obtain a loan using the cash value as collateral or use the cash value to pay premiums, provided there is enough money accumulated.

The different types of permanent life policies include:

- **Whole or ordinary life.** The face amount of the policy is fixed, while premiums remain level and must be paid on a regular basis. It offers a death benefit and a savings account, which grows based on insurance company-paid dividends.
- **Universal or adjustable life.** More flexible, insureds can pay premiums at any time, in virtually any amount, and may change the amount of the death benefit, although an increase usually requires a medical examination. After accumulating sufficient funds in the cash value account, insureds can change premium payments, a useful feature if your economic situation suddenly changes.
- **Variable life.** This policy combines death protection with a savings account that a policyholder can invest. The death benefit and cash value vary with the performance of the underlying investments, although some policies guarantee a minimum death benefit.
- **Variable-universal life.** The policyholder has the investment risks and rewards of variable life insurance, coupled with the ability to adjust the premiums and death benefit available under universal life.

Many insurance experts advise purchasing life insurance equal to five to eight times the individual's annual income. Life insurance needs will vary greatly according to your assets and liabilities, income potential and expenses, both current and future.

For assistance in determining how much and what kind of insurance you need, please call us.

DENIAL—*continued from Page 1*

of Benefits (EOB). This form details what the insurer paid and how the payments were allocated. It should show type of healthcare service or product; date(s) you received it; the provider's charges; any adjustments the insurer makes to those charges (such as discounts for network members); your copay, deductible or amount not covered; amount eligible for benefits and the amount you're responsible for.

Let's say that you had elective surgery. You read your plan's Evidence of Coverage carefully and thought it was covered. You followed any pre-authorization requirements to the letter. Your doctor submitted the claim—and an EOB showing zeroes under the section "total benefits from your plan" arrives in the mail, leaving you responsible for thousands of dollars in medical bills. What do you do?

1. Read the EOB carefully. Have you fulfilled your policy deductible? Your claim might still fall under the policy's deductible amount, particularly under a high-deductible policy.
2. Act quickly. Many plans limit the time they allow for appeals—you may have as little as 60 days after receiving notification to begin the appeals process.
3. Make an informal appeal first. If you believe the claim falls under your policy's provisions, call your health plan's customer service department to tell them you disagree with the denial. Some denials result from simple error and can be resolved quickly and easily. If not, ask the representative for an explanation of the denial.

If the representative can't resolve your problem immediately, ask when you can expect a response. If your claim involves an urgent medical condition, ask what special rules apply for expedited review. Document your conversation(s), including dates, name and title of any representative you speak with, and an outline of your conversation, including any agreed-upon deadlines for responses.

4. Follow up with the insurer if you don't get a response by the expected time.
5. If the insurer denies the claim, the letter should provide a reference to the specific policy provision that excludes your treatment or a specific medical reason for the denial, along with the name, title, license number and state of licensing of the person reviewing your claim (usually the plan's medical director).
6. Ask your doctor for help. Your doctor can explain to the insurer why you need the treatment, why it is appropriate for your condition and how it will save money (more cost-effective, lower incidence of complications, etc.).
7. If this doesn't work, you can file a written appeal with your insurer (an internal appeal). The Explanation of Coverage and/or claims denial letter should tell you how to do this, or where to find more information. Follow instructions to the letter, heeding any deadlines.

At a minimum, your letter should include your contact information, your plan number and member number, copies of your medical bills or referrals to specialists and references to the sections in your Evidence of Coverage that apply. You can bolster your appeal by including an explanation from your doctor as to why the plan should cover your treatment and any relevant information on its appropriateness for your medical condition, such as treatment guidelines or articles from medical journals. If you'd like a form letter to adapt to your needs, see www.bankrate.com/brm/news/financial_literacy/Aug07_claim_denial_procedure_letter_a1.asp

8. If the insurer denies your appeal and you are not satisfied with the decision, you can proceed to an external review program. Individual health insurance policies fall under state regulation; each state has different procedures and rules. For state-specific information, see the map provided by the Kaiser Family Foundation and Consumers Union at http://www.kff.org/consumerguide/19-statebystate.cfm.
9. Use your insurance broker as a resource. If you don't understand the benefits provided under your policy or if you need assistance with a claim, please call us. ■

LONG-TERM CARE—*continued from Page 4*

nursing home and home care, with a daily benefit of $142 for nursing home care and $135 for home care. Three quarters (76 percent) also included inflation protection—a valuable benefit, particularly for younger insureds.

In general, younger policyholders pay less; older policyholders pay more. Generally, premiums remain the same for the life of the policy, unless the insurer raises rates for an entire class of policyholders. Therefore, people with conditions such as diabetes that may worsen or lead to other health problems may want to buy long-term care insurance when they are younger.

Should you buy long-term care insurance? If you will qualify for Medicaid, or will qualify shortly after entering a nursing home, don't waste your money. Likewise, if you have enough saved to pay for four to five years of nursing home care, you probably don't need LTC. (Be sure to consider the effects of inflation when estimating how much nursing home care will cost when you are likely to need it.) All others should consider buying LTC.

For more information on long-term care insurance, please call our office. ■

Do You Need Long-Term Care Insurance?

If you make it to age 65, you'll have a greater than 40 percent chance of entering a nursing home at some time during your life, according to the U.S. Department of Health and Human Services.

If you end up in a nursing home, will you be able to afford it? According to a survey released in October by MetLife, the annual cost of care in a licensed nursing home averaged $68,985. That's for a semi-private room — a private room costs more.

Doesn't the government pay for nursing home care?

Many people assume that government programs will pay for nursing home care. However, Medicare and most "Medigap" policies cover only acute medical care for the elderly, such as "skilled" nursing or rehabilitation care, not the purely custodial long-term care that many elderly require. Medicare ends up paying only about 5 percent of all nursing home expenses.

Medicaid does cover nursing home expenses. However, because it's designed to cover health care for the needy, you must qualify. Changes in the law permit the spouse of a Medicaid recipient to retain specific assets and income levels; however, those limits are still fairly low. Do you want to jeopardize your spouse's quality of life or your estate?

Long-term care insurance fills the gap

Long-term care insurance helps pay for nursing home care. It can cover qualified long-term care services, including diagnostic, preventive, therapeutic and rehabilitative services, as well as maintenance or personal care services. The services must be required by a chronically ill individual and prescribed by a licensed health care practitioner. The level of long-term care varies from skilled nursing care, or round-the-clock nursing and rehabilitative care provided under the supervision of a registered nurse or doctor; to intermediate care, or less than 24-hour daily nursing or rehabilitative care; to custodial care, or "assisted living," which provides assistance with daily living tasks but does not require nursing skills.

In 2005, the cost of a long-term care policy averaged $1,918, according to a survey by America's Health Insurance Plans, a trade group. The vast majority of these policies (90 percent) included coverage for both

LONG-TERM CARE—continued on Page 3

Here are some things to look for in a long-term care policy:

- **An adequate daily benefit.** Policies pay from $20 to several hundreds of dollars a day. Compare this to the average daily cost of nursing homes in your area.
- **An adequate benefit period.** A policy with a shorter benefit period will costs less, but might not provide enough coverage. Ten percent of people who require nursing home care stay five years or more.
- **A realistic elimination period.** Every policy has an "elimination period," which begins when you first enter a nursing home or first begin receiving home care. You must pay expenses during this period, which can range from 0 to 100 days. A longer elimination period will lower your premiums; just be sure you can afford this out-of-pocket amount.
- **Flexibility.** Does the policy cover home health care, hospice care, respite care and assisted living facilities, in addition to nursing home care?
- **Inflation guard.** Protect your benefits from being eaten up by inflation. Some policies automatically increase the benefit level each year. Others cover a specific percentage of "reasonable and customary" charges, while some allow you to periodically increase your coverage without proof of insurability.
- **Guaranteed renewable.** Without this, an insurer can cancel your policy if you become ill or develop a chronic condition.
- **Definition of eligibility.** To receive benefits tax-free, your policy must meet the IRS's definition of eligibility. For information, please contact us. ■