Inflammatory Bowel Disease and Health Insurance

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What kinds of health insurance are there?

Health insurance companies offer a wide variety of plans that typically cover a portion of your medical costs in exchange for payment of a monthly premium. The 2 most common types of health insurance are group plans and individual plans. Group plans provide coverage for 1 or more employees of a company (depending on your state law), although not all companies offer group plans. Individual plans provide coverage if you are self-employed, unemployed, or work for a company that does not provide a group plan.

Back to top

What do I need to know about group insurance?

Group insurance is typically less expensive than individual insurance. Group insurance plans can be self-funded, which means your employer pays for your healthcare and the insurance company acts as a third-

party administrator, or fully funded, which means your employer purchases coverage from an insurance company that pays the claims. Fully funded plans are governed by state law; self-funded plans are governed by a federal law called the Employee Retirement Income Security Act (ERISA). There are also self-funded plans sponsored by non–federal governmental units, like school districts. These plans are governed by a combination of state and federal laws. Finally, there are plans offered by associations, like chambers of commerce and the National Association for the Self-Employed. These plans are largely unregulated.

Back to top

What do I need to know about individual insurance?

Unlike group insurance, which offers the same premiums to all participants in the group, individual health insurance rates are determined based on your age, geographic location, and health status, depending on state law.

Back to top

What is the difference between an HMO, a PPO, and a POS?

An HMO (health maintenance organization) contracts with specific doctors, hospitals, pharmacies, and other healthcare professionals to form a "provider network" for plan members. An HMO pays for health services only from providers in the network, and you need a referral from your primary care physician to see an "in-network" specialty provider. Like an HMO, a PPO (preferred provider organization) contracts with specific doctors, hospitals, pharmacies and other healthcare professionals to form a "provider network." Members of a PPO can choose to use an "out-of-network" provider, but be careful if you do so. Most insurers cover a percentage of usual and customary costs or a percentage of a maximum allowable amount, leaving you responsible not only for your percentage of that amount, but also for the difference between the total charges and what the insurer considers appropriate.

There also are POS (point of service) plans that do not have provider networks, so you can go to any doctor you wish. Point of service and PPO plans usually have higher premiums than do HMOs.

Back to top

What is a health savings account?

A health savings account (HSA) is an account in which you and/or your employer can deposit pretax dollars that you can use to pay your deductible and/or other healthcare expenses. To open an HSA, you must be enrolled in a high-deductible health plan.

Back to top

What are some important features to consider if I have a choice between several different types of health insurance?

Be sure to evaluate each plan's flexibility with respect to choosing specialists for both inflammatory bowel disease (IBD) and other related issues. If your plan has a provider network, confirm that your current doctors and hospitals are in-network, paying special attention to whether your plan allows you to see out-of-network physicians. Also make sure each plan's formulary, or preferred drug list, includes the drugs you need. (Note that some medication that is delivered by an infusion, like infliximab, will be covered under your plan's medical benefit rather than the pharmacy benefit.) Finally, compare costs related to deductibles (a fixed dollar amount that you have to pay before your insurer will cover anything), co-pays (a fixed dollar amount you pay per visit), and coinsurance (a percent of the cost of your care).

Back to top

What insurance is available to me despite my preexisting condition?

A preexisting condition is any physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month period prior to the enrollment date in a health plan or for which a prudent person would have sought medical attention. If you receive health insurance through your employer as part of a group plan, you can't be denied enrollment due to a preexisting condition, although there can be a waiting period of as long as 12 months before the group plan covers preexisting conditions if you have had a break in coverage of 63 days or longer.

Therefore, if you have a chronic condition like IBD, it may be important for you to make employment decisions based, at least in part, on whether your employer offers health insurance. If you are switching from 1 employer-based plan to another with a break in coverage between the 2, make sure you take advantage of the Consolidated Omnibus Budget Reconciliation Act (COBRA), which allows you to continue to buy group coverage (at full cost) for 18 months with no more than a 2% administrative fee to avoid a preexisting condition waiting period.

Note that, as of September 23, 2010, insurance companies can't deny coverage to children under age 19 due to a preexisting condition. Also, young adults up to age 26 can remain on a parent's insurance plan unless the young adult is offered insurance at their place of employment. (These provisions of the Affordable Care Act do not apply to "grandfathered" plans, that is, plans that have been in effect without significant changes since March 2010.)

Back to top

What if I have a preexisting condition and lose my group insurance?

If you lose your group insurance, you must be "HIPAA eligible" to get coverage of your preexisting condition under an individual plan. The abbreviation HIPAA refers to the Health Insurance Portability and Accountability Act. To be HIPAA eligible, you must 1) have had 18 months of continuous coverage, the last day of which was under an employer-based group plan (including COBRA); 2) have exhausted your COBRA benefits; and 3) have had no break in coverage of 63 days or more. If you qualify as HIPAA eligible, you are entitled to 1 of 2 "guaranteed issue" options that must be offered in your state regardless of preexisting conditions. In many states, a guaranteed issue option is a high-risk pool, which is designed specifically for people with chronic illness. Although people who are not HIPAA eligible may join state high-risk pools only if they have been uninsured for 6 months, if you are HIPAA eligible, you are not subject to this requirement.

Back to top

What if I have a preexisting condition and have been uninsured for more than 63 days?

If you have been uninsured for more than 63 days, you may have no choice but to wait 6 months before you can purchase insurance through a state high-risk pool or the Pre-Existing Condition Insurance Plan (PCIP). Some states have other options. For example, in New York, all plans are guaranteed issue, which means you can purchase insurance even if you have a preexisting condition. Connecticut has a relatively low-cost plan called Charter Oak that is available to people with preexisting conditions, and many counties in California have plans for individuals with low incomes who do not qualify for Medicaid.

Back to top

Do I have to disclose a preexisting condition when I apply for health insurance?

Yes, you are legally obligated to provide complete, honest information. Keep in mind that insurers are allowed to *retroactively* cancel your policy for fraud or misrepresentation. The good news is, as of January 1, 2014, the healthcare reform law will prohibit insurers from denying you coverage or charging you more because of IBD or other preexisting conditions.

Back to top

What if I can't get insurance due to either a preexisting condition or cost?

Federally qualified health centers allow you to pay what you can afford for healthcare based on your income. These centers are located in most cities and in many rural areas. Patient assistance programs are administered by pharmaceutical companies and provide free medication to those who can't afford it. Free ostomy supplies can be obtained from Ostogroup, and limited free tube feeding and other supplies can be obtained from The Oley Foundation. Finally, in 2014, there will be expanded Medicaid for adults with low incomes, as well as subsidies to help pay insurance for people earning up to 400% of the federal poverty level.

Back to top

What happens if I was enrolled in a group insurance plan through my spouse's place of employment, but I am getting divorced or my spouse becomes Medicare eligible?

In either instance, you can continue to buy the group coverage (at full cost) for yourself for 36 months at the same price the group pays with no more than a 2% administrative fee.

Back to top

Do I need permission from my insurance company before receiving diagnostic tests or medical treatment?

Prior authorization is usually required for major surgery, hospitalization, and expensive medication and/or tests. Because insurance policies differ, be sure to understand your plan's requirements. Keep in mind that if prior authorization is required and you proceed without it, your claim will not get paid. It's a good idea to check your plan's eligibility so you know in advance if a test or treatment will be covered. When you see a healthcare provider who is not in your insurance company's network, ask for an estimate of what will be covered. This is very important because your plan may cover a percentage of what the plan considers to be “usual and customary” and not a percentage of what your out-of-network doctor actually charges.

Back to top

What is the best way to appeal if my request for treatment or claim is denied?

Start by identifying the reason for the denial. If you suspect it's a clerical or coding error, you or the billing person at your provider's office can try to resolve the issue by phone. But if the denial questions medical necessity or indicates that a treatment is considered experimental or investigational, it is important to respond in writing (eg, by certified mail or priority mail with delivery confirmation), keeping a copy of your letter and any enclosures for your files.

To prove medical necessity, your appeal will need to include relevant medical records that confirm your diagnosis, your need for the treatment, and the treatments you have already tried. It's important to emphasize objective clinical information (eg, test results and your doctor's office notes), with less emphasis on subjective symptoms, such as pain, which is difficult to measure. If your claim is denied because a treatment is considered experimental or investigational, you will need to submit peer-reviewed, published studies that support the use of the treatment in addition to medical records establishing the diagnosis, the treatments you have already tried, and your need for the treatment you now seek. The following figure lists important information to include in your appeal.

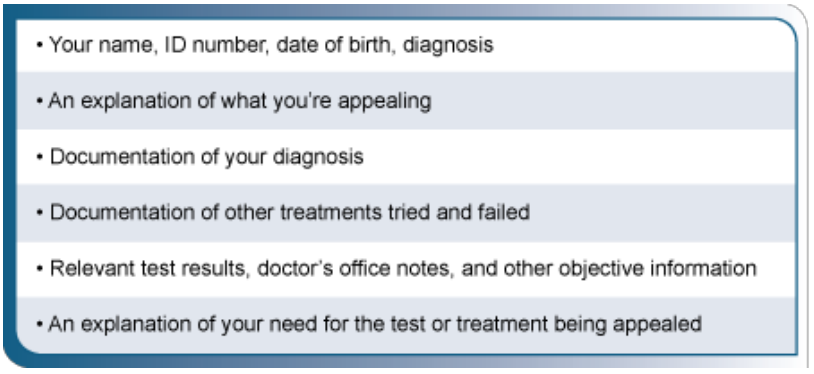

Figure. Important information to include with an appeal.

When speaking with an insurance company representative, take notes that include the person's name, the date, and a summary of your conversation. Pay close attention to any deadlines for submitting your appeal. Never appeal by phone. If your insurance company denied your claim, you will have to provide additional information for them to reverse their decision.

Back to top

Who can help me with an appeal?

Enlist your doctor's help in compiling the documentation you need. He or she may even be willing to write a letter to accompany your own. In addition, many healthcare providers have financial counselors who can help you. Organizations like Advocacy for Patients with Chronic Illness, Inc, may also be able to offer assistance if you need help with an appeal. If your doctor would like sample appeal letters, he or she can consult organizations like the Crohn's and Colitis Foundation of America. However, we strongly urge you and your doctor not to send a letter without also including copies of supporting medical records and/or medical journal

articles.

Back to top

What if my appeal is denied?

Individual insurance plans have only 1 level of internal appeal, but there are often 2 levels of internal appeal for group plans. Once you have exhausted your opportunities for internal appeal, you can submit an external appeal as described in the following table. The opportunity for external appeal is mandated for all plans other than high-risk pools and grandfathered plans.

Table. Submitting an External Appeal

If your insurance plan is...	Submit an external review to...
Fully funded	State insurance department
Self-funded	Independent review organization chosen by the plan or the US Office of Personnel Management, at the plan's option
Non-federal governmental	US Office of Personnel Management

Back to top

Is it worth trying to appeal?

Yes! Although 94% of insurance denials are never appealed, up to 59% of health insurance appeals are granted.[1,2]

If you found this article interesting, you may also be interested in our previous *Your Digestive Health newsletters*:

- Know Your Rights: IBD and Employment
- Taking Control of Your Medical Records
- Bring Out the Best in Your Healthcare Team

Readers are advised that the contents of this publication are subject to change, are to be used as guidelines, and do not constitute legal advice.

References

1. Mayer CE. The claim game. *AARP The Magazine*. 2009(Nov/Dec):31-32. **2.** US Government Accountability Office. *Private health insurance: data on application and coverage denials*. Washington, DC: US Government Accountability Office; 2011:1-37. GAO-11-268.

The next issue of* Your Digestive Health *will focus on tips for caregivers and family members.

About the authors

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Jennifer Jaff graduated with honors from Georgetown University Law Center in 1984. She was an Assistant Attorney General for the state of Connecticut for 5 years, where she specialized in health law and Medicaid fraud, bringing the first civil RICO cases on behalf of a state in US history. Ms Jaff spent a year as counsel to government relations departments at national reproductive health organizations, and in private practice, she focused on large class actions involving employee benefits. She founded Advocacy for Patients with Chronic Illness, Inc, in 2005 and has served as its executive director since

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Depression associated with metoclopramide use has occurred in patients with and without a history of depression. For those patients with a prior history of depression, metoclopramide should only be given if the expected benefits outweigh the potential risks.

In one study in hypertensive patients, intravenously administered metoclopramide was shown to release catecholamines; hence, caution should be exercised when metoclopramide is used in patients with hypertension. Any rapid rise in blood pressure associated with METOZOLV ODT use should result in immediate cessation of metoclopramide use in those patients.

Since metoclopramide produces a transient increase in plasma aldosterone, patients with cirrhosis or congestive heart failure may be at risk of developing fluid retention and volume overload. If these side effects occur at any time in any patients during metoclopramide therapy, the drug should be discontinued.

Adverse reactions, especially those involving the nervous system, may occur after stopping the use of METOZOLV ODT.

In clinical studies, the most frequently reported adverse events (≥2% occurrence) were headache, nausea, fatigue, somnolence, and vomiting.

Complete Prescribing Information for METOZOLV ODT, including BOXED WARNING

Important Safety Information about OSMOPREP

WARNINGS

There have been rare, but serious reports of acute phosphate nephropathy in patients who received oral sodium phosphate products for colon cleansing prior to colonoscopy. Some cases have resulted in permanent impairment of renal function and some patients required long–term dialysis. While some cases have occurred in patients without identifiable risk factors, patients at increased risk of acute phosphate nephropathy may include those with increased age, hypovolemia, increased bowel transit time (such as bowel obstruction), active colitis, or baseline kidney disease, and those using medicines that affect renal perfusion or function (such as diuretics, angiotensin converting enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs], and possibly nonsteroidal anti–inflammatory drugs [NSAIDs]).

It is important to use the dose and dosing regimen as recommended (PM/AM split dose).

OSMOPREP® (sodium phosphate monobasic monohydrate, USP, and sodium phosphate dibasic anhydrous, USP) Tablets are indicated for cleansing of the colon as a preparation for colonoscopy in adults 18 years of age or older. Considerable caution should be advised before OSMOPREP is used in patients with severe renal insufficiency, congestive heart failure, ascites, unstable angina, gastric retention, ileus, severe chronic constipation, bowel perforation, toxic megacolon, gastric bypass or stapling surgery, or hypomotility syndrome. Use with caution in patients with impaired renal function, patients with a history of seizures or at higher risk of seizure, patients with higher risk of cardiac arrhythmias, known or suspected electrolyte disturbances (such as dehydration), or people taking drugs that affect electrolyte levels. Patients with electrolyte abnormalities such as hypernatremia, hyperphosphatemia, hypokalemia, or hypocalcemia should have their electrolytes corrected before treatment with OSMOPREP.

OSMOPREP is contraindicated in patients with a known allergy or hypersensitivity to sodium phosphate salts or any of its ingredients, and in patients with biopsy–proven acute phosphate nephropathy. In clinical trials, the most commonly reported adverse reactions (reporting frequency >3%) were abdominal bloating, nausea, abdominal pain, and vomiting. It is recommended that patients receiving OSMOPREP be advised to adequately hydrate before, during, and after the use of OsmoPrep.

For complete Prescribing Information for OSMOPREP including BOXED WARNING.

Important Safety Information about VISICOL

WARNINGS

There have been rare, but serious reports of acute phosphate nephropathy in patients who received oral sodium phosphate products for colon cleansing prior to colonoscopy. Some cases have resulted in permanent impairment of renal function and some patients required long-term dialysis. While some cases have occurred in patients without identifiable risk factors, patients at increased risk of acute phosphate nephropathy may include those with increased age, hypovolemia, increased bowel transit time (such as bowel obstruction), active colitis, or baseline kidney disease, and those using medicines that affect renal perfusion or function (such as diuretics, angiotensin converting enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs], and possibly nonsteroidal anti-inflammatory drugs [NSAIDs]).

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VISICOL® (sodium phosphate monobasic monohydrate, USP, and sodium phosphate dibasic anhydrous, USP) Tablets are indicated for cleansing of the colon as a preparation for colonoscopy in adults 18 years of age or older. VISICOL is not to be used in patients with congestive heart failure, ascites, unstable angina pectoris, gastric retention, ileus or acute obstruction or pseudo-obstruction, severe chronic constipation, bowel perforation, acute colitis, toxic megacolon, or hypomotility syndrome. Use with caution in patients with impaired renal function, pre-existing electrolyte disturbances, or people taking drugs that affect electrolyte levels. VISICOL is contraindicated in patients with a known allergy or hypersensitivity to sodium phosphate salts or any of its ingredients. In clinical trials, the most commonly observed (≥1%) adverse reactions occurring with use of VISICOL were generally transient and self-limited and included nausea, vomiting, abdominal bloating, abdominal pain, dizziness and headache.

Consult with your physician to see if this product is right for you.

Complete Prescribing Information for VISICOL, including BOXED WARNING

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