



Understanding the Insurance Process

This summary provides an overview of the health insurance process.

Health insurance falls into two major categories: commercial insurance and government insurance.

Commercial Insurance

There are a variety of commercial health insurance plans that a consumer can purchase.

Employer-sponsored group plan is one major type of commercial health insurance. These come in different models.

- **Fully-insured Plan.** This is an established plan that the employer purchases through an insurance company.
- **Self-funded or Self-insured Plan.** A self-funded or self-insured plan is one in which the employer decides the benefits and pays for the services, but the health plan is administered through an insurance company.
- **Health Maintenance Organization (HMO).** A health maintenance organization (HMO) is another type of employer-sponsored plan choice. An HMO model restricts the providers that patients see. Patients who are insured through an HMO have a list of “in-network” providers that they must choose from in order to have coverage for the services they need. If a patient intends to see a provider that is not on the HMO’s in-network provider list, then the patient must have out-of-network benefits in order to have coverage for the services being provided. It is also important to note that patients seeing a provider with an out-of-network benefit, face a higher out of pocket cost than if they had seen an in-network HMO provider.
- **Preferred Provider Organization (PPO).** A preferred provider organization (PPO) plan is a health insurance plan in which members receive more coverage if they choose healthcare providers that are approved by or affiliated with the plan.
- **Health Savings Account (HSA).** A health savings account is a savings account used in conjunction with a high-deductible health insurance policy that allows participants to save money tax-free that can be used to pay for medical expenses. Money in the HAS does not go away at the end of the [calendar] year and can be used whenever necessary.
- A high-deductible health plan is health insurance that typically requires a lower premium amount but requires that a significant out of pocket amount be paid prior to that plan paying benefits for services that are provided. These plans usually go with a health

savings account so that employees can save money to help cover their out-of-pocket costs during the year.

Individual plan is the second type of commercial plan. An individual plan is health insurance purchased by an individual consumer. Individual consumers can purchase health insurance coverage through insurance companies. These plans may be HMOs, PPOs, or point of service (POS) plans. POS plans are a type of managed-care health insurance plan that combines features of both an HMO and a PPO. Those enrolled in a POS plan are required to choose a primary care physician (PCP) from within the plan's healthcare network. This physician then becomes the patient's point of service (POS). The patient's PCP may make referrals to out-of-network providers, but the POS service plan will not cover as much of the cost, i.e., the patient's out of pocket costs will be higher for visits to providers who are out of network.

Health insurance marketplace created under the Affordable Care Act (ACA) is a third type of commercial health insurance. The marketplace offers health insurance plans for consumer to purchase, with savings in the purchase cost available to consumers based on their income level. The health insurance marketplace is required to cover 10 essential services. These services are ambulatory patient services, emergency services, hospitalization, (pregnancy, maternity and newborn care), prescription drugs, (rehabilitative and debilitative services and devices), laboratory services, (preventive and wellness services and chronic disease management), and pediatric services.

Government Insurance

The second major category of health insurance is government insurance. Government-sponsored insurance plans include:

- **Traditional (or Original) Medicare.** Patients enrolled in traditional Medicare can be seen by any Medicare provider. Medicare pays for most covered services at 80% of the allowable, but some services are covered at 100%. Since most of the Medicare-covered services require a 20% patient co-pay, many patients will have a supplemental or secondary insurance to help cover their out-of-pocket costs. Those with traditional Medicare can also choose to get prescription drug coverage by enrolling in a Medicare Part D Prescription Drug Plan (PDP).
- **Medicare Advantage (MA).** These plans are a type of Medicare insurance plan. MA plans are managed through commercial insurance companies. MA plans cover all that original Medicare does and more. These plans usually follow an HMO or PPO model. Prescription drug coverage is typically included in MA plans.
- **Medicare Savings Programs.** Individuals can get help from their state in paying their Medicare premiums. In some cases, Medicare Savings Programs may also pay [Medicare Part A \(Hospital Insurance\)](#) and [Medicare Part B \(Medical Insurance\)](#) deductibles, [coinsurance](#), and copayments if the individual meets certain conditions. There are four types of Medicare Savings Programs:
 1. **Qualified Medicare Beneficiary Program (QMB).** The QMB program can pay for Medicare Part A and/or Part B premiums. An individual can be eligible for QMB only, or for QMB and Medicaid.

2. ***Specified Low-Income Medicare Beneficiary (SLMB) Program.*** The SLMB program can pay for Medicare Part B premium only. Individuals can be eligible for SLMB only, or for SLMB and Medicaid (with a spend down). The patient must have Medicare Part A in order to be eligible in the program.
3. ***Qualified Individual (QI) Program.*** The QI program pays for the Medicare Part B premium only. States are allotted money for this program on a yearly basis. Patients must apply every year for QI [benefits](#). QI applications are granted on a first-come, first-served basis, with priority given to people who received QI benefits the previous year. Individuals cannot get QI benefits if they qualify for Medicaid.
4. ***Qualified Disabled and Working Individual (QDWI) Program.*** The QDWI program pays for the Medicare Part A premium only, not Part B. The patient must be a disabled worker under age 65 who lost Part A benefits because of return to work.

Learn more about the Medicare Savings Programs on the CMS website at www.medicare.gov/your-medicare-costs/help-paying-costs/medicare-savings-program/medicare-savings-programs.html.

- **Medicaid.** Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits not normally covered by Medicare, like nursing home care and personal care services. Each state has different rules about eligibility and applying for Medicaid. Medicaid standard plans cover children, pregnant women, low-income families, aged, blind, and disabled patients and their families that meet the criteria.
- **Medicaid Spend Down.** Even if a patient’s income exceeds Medicaid income levels in your state, the patient may be eligible for Medicaid under Medicaid spend down rules. Under the "spend down" process, some states allow individuals to become eligible for Medicaid as "medically needy," even if they have too much income to qualify. This process allows the individual to "spend down," or subtract, their medical expenses from their income to become eligible for Medicaid. To be eligible as “medically needy,” individuals’ measurable resources also have to be under the resource amount allowed in their state.
- **County Medical Programs.** County medical programs are not available everywhere. These programs are not health insurance programs; however, they are set up by local governments, so they are included under the “government” category. These programs fund medical care for uninsured indigent adult county residents through a network of community health centers, private physicians and hospitals.
- **TRICARE.** TRICARE is the healthcare program for uniformed service members (active, Guard/Reserve, retired) and their families. The program encompasses TRICARE Standard, TRICARE Extra, and TRICARE Prime. TRICARE for Life is available for all Medicare eligible uniformed services retirees, Medicare-eligible family members, Medicare eligible widows/widowers, certain former spouses, and beneficiaries under age 65 who are also entitled to Medicare Part A because of a disability or chronic renal disease.

- **Veterans Administration (VA).** The VA may require a patient to receive services within a VA facility; patients may be permitted to be seen elsewhere, but payment for these services must be authorized. Some VA facilities do not have enough resources to keep up with the number of patients needing to be seen and so will work with outside providers to help with providing services.
- **Indian Health Service (IHS).** The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services (HHS), is responsible for providing federal health services to American Indians and Alaska Natives. The IHS provides medical service and coverage, but requires a purchase order for the services to be covered by non-IHS providers. All non-emergent services need to be preauthorized before proceeding.

Insurance Terminology

The following section will cover definitions to help understand some of the verbiage used in insurance processing.

- **Deductible.** Most insurance plans have an annual deductible which is a flat dollar amount that is to be paid prior to the insurance plan paying any of the services being provided to the patient. There may be some exceptions from a deductible depending on the type of insurance plan a patient has. For example, preventive services, such as flu shots or even well physical exams, are often at paid 100% and do not fall under the deductible.
- **Co-pay.** The co-pay is a fixed dollar amount that should be paid at the time of service. An everyday example is for an evaluation and management (E & M) code, which has a patient co-pay amount. Some insurance companies will apply the co-payment to the hospital facility fee (E & M) instead of the physician professional fee (E & M), and so you want to ensure that you are collecting for the correct entity should there be different tax ID numbers.
- **Co-insurance.** This is the dollar amount that a patient is responsible for after the insurance has paid its amount. Many times this is a percentage of the allowed charges. This amount is applied towards the patient's out-of-pocket maximum.
- **In-network Provider.** This is a provider who has contracted with the insurance plan and is paid at the contracted benefits.
- **Out-of-network Provider.** This is a provider who has not contracted with the insurance plan. Typically, when patients enrolled in a health insurance plan see "out-of-network" providers, the patients' out-of-pocket costs will be higher. It is important to know whether the patient has out-of-network benefits under the insurance plan in order to be paid for services that are provided by out-of-network providers. Under some insurance plans, even if the patient does not have out-of-network benefits, if authorization was obtained, the services will be paid for.
- **Maximum out-of-pocket.** This is the annual amount that a patient must pay before benefits will be covered at 100%. Most plans have two separate out-of-pocket maximums; one amount is for the individual and the other amount is for the entire family.

- **Covered Benefits.** These are services that will be reimbursed by the insurance plan.
- **Exclusions.** These are services that are not covered by the insurance plan. For example, searching for a blood and marrow transplant match might not be a benefit covered by a patient's insurance plan. This means that the patient would have to pay for this service out of pocket.
- **Prior Authorization.** This is a requirement from the insurance company to get approval for a service *before* it is provided. It is important to understand what the insurance company requires for prior authorization. For example, the company may require the CPT/HCPCS codes for approval. If that is the case, and different CPT/HCPCS codes are used on the actual insurance claim, they can be denied because the codes on the claim itself were not prior authorized. The insurance company will give a number that must be placed on the claim so when the claim is filed, the insurance company can use this number to look up what was approved.
- **Pre-determination.** This is a process in which you ask for advance approval of coverage even though the insurance company does not require prior authorization. Why would a Financial Advocate ask for a pre-determination? An example would be when a specific treatment plan includes drugs not listed in the compendia, and it is not clear whether the insurance company will cover the drugs. Getting a pre-determination decision, will help the Financial Advocate decide whether the patient will need to sign a self-pay waiver, get assistance from one of the patient assistance programs available, set up a payment plan, or work with the provider to find another treatment that would be available for the patient and covered by the insurance plan.

Process for Patients Who Will Receive Treatment

Insured Patients

Developing a financial advocacy process for patients who will receive treatment is part of understanding the insurance process. Examples of how this process might work are described below.

Once it's determined that the patient is a candidate for treatment, the provider then identifies the treatment regimen that would be best for the patient. After the treatment regimen is determined and the patient has consented to the treatment, this information is communicated to the patient financial team so that they can verify benefits and obtain authorization if necessary. This communication can occur by providing a paper order or placing an electronic order in the electronic medical record (EMR) and sending it to the patient's financial team.

At this stage in the process, it's important for the clinical team to understand the time frame needed to get the authorization from the patient's insurance plan before the patient can start treatment. This window of time gives the patient financial advocate time to get an authorization if required and also to identify any assistance programs that might help the patient with the out-of-pocket costs.

Uninsured Patients

It's important to have a process in place for instances when the patient has no insurance benefits to help pay for medical services. Often, the first step is to evaluate whether the patient is eligible for Medicaid, especially since some states have expanded Medicaid coverage. If the diagnosis and recommended treatment regimen will leave the patient unable to work for an extended period of time, there should be an evaluation of disability to see if the patient might qualify for Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), short-term disability (STD), or long-term disability (LTD). If the patient does not qualify for any of the previously described programs, he or she should be considered for charity care if this is available within your program. If the patient qualifies for your charity program, also explore qualifying the patient for free drug from the manufacturer drug-replacement programs. This will help reduce some of the drug costs. Each manufacturer has its own qualifications for free drug/drug replacement. Depending on whether the patient qualifies for any programs of these programs, the final step is to discuss a payment plan and the financial expectation you have for that patient.

Access a flow chart of the insurance process for insured and self-pay patients [here](#).

Verification of Benefits

Verification of benefits is the most important piece to understanding the patient's financial responsibility. The more you know about the patient's benefits, the easier it is to help determine what the patient will need to pay. There are several ways to verify a patient's benefits:

Insurance plan website. Verifying benefits through the insurance company's website can be helpful, but these sites do not always have the most current information. **Tip:** Use your computer's "print screen" function to show the date you viewed the information and save the benefits screen. This can be helpful when there is a dispute over benefits.

Electronic health systems. Your electronic health system may have the capacity to electronically verify benefits, but often these systems do not have all the information you're looking for.

Pick up the phone. Another way to verify benefits is by calling the insurance company. Most insurance companies will record the call and provide a reference number to use in case you need to go back and verify what you were told. **Tip:** Always write down the reference number, the date of the call, and the name of the person that you talked with.

Verifying Benefits: What Information Do You Need?

When verifying benefits be sure to inform the insurance plan of the place of service because benefits can be different depending on the location. You want to ask:

- What is the deductible?
- What is the out-of-pocket maximum?
- What are the co-payments?
- What is the co-insurance?
- What services need prior authorization?

It is important to verify benefits *prior to* the start of treatment and then *verify again each month* for on-going services to make sure the coverage is continuing.

Prior Authorization

Requirements of coverage for payment include getting prior authorization for any services that require it. When you verify benefits, be sure to identify with the insurance company any services that will need prior authorization. It is essential that you have the correct codes that are going to be billed for the services because some insurance companies have specific codes that need authorization and others might require all codes, and the codes must match with the authorization to be paid. If you provide one code for prior authorization and then a different code is used on the claim form, the claim may be denied. For example, IVIG codes vary depending on the brand of IVIG used. You need to know which brand will be used for the patient when you get this service pre-authorized so that the code on the claim form will match the code that was pre-authorized.

Pre-determination

Pre-determination is also necessary if it unclear whether the treatment to be provided to the patient will be covered or not. Some insurance companies do not **require** a prior authorization; however, when you bill for the treatment, you may be denied coverage for a drug that the insurer deems not to be covered for the diagnosis, experimental, or not medically necessary. Due to the high cost drugs, you need to make sure that the insurance company has agreed that the regimen you are going to use will be covered.

What about Medicare Patients?

Traditional (or original) Medicare does not prior authorize. If you think the treatment will not be covered by Medicare, the patient should sign an Advanced Beneficiary Notice (ABN). Medicare requires that you inform the patient of the cost of the treatment prior to providing that service. If you don't provide this information and have the patient sign the ABN, the patient will not be responsible to pay for the services.

Medicare Advantage plans might require prior authorization for some services. If you are not contracted with the Medicare Advantage plan, make sure the patient has out-of-network benefits to ensure that you will be paid for the services you provide. If you are not contracted with the Medicare Advantage plan and the patient you want to provide services for does not have out-of-network benefits, make sure to get prior authorization on everything you do, otherwise the Medicare Advantage plan is not required to pay for the services.

The Authorization Process

The authorization process can vary depending on the insurance company. Some require a form to be filled out with specific information. Some insurers have an online form that can be filled in. Others require that the form be faxed in. Some will let you call the information in over the phone. The best way to validate that the information you sent is approved is to get the approval back in writing. You might need to compile medical records to send in with the forms that are required to validate that the patient has met the criteria. It is important to know if the drugs are

indicated for the diagnosis or if you need to identify journal articles to also present to the insurance company.

Denial of Prior Authorization

If the insurance company denies the treatment prior to the delivery, you will want to plan for a peer-to-peer review to try to get approval of the therapy. If you still get a denial after that, you will want to check to see if you can get free drug from the manufacturer. Make sure you understand what the insurance company is approving. For example, just one of the drugs in the regimen might make the treatment not covered. Even if you plan to get the drug free from the manufacturer, you will have to bill for the drug and get the denial. However, the insurance company may deny the entire treatment rather than just the individual drug that makes the regimen not covered.

Time Frame for Verifying Benefits/Prior Auths

It is important for your program to agree on and establish an acceptable time frame for benefits verification and prior authorization before a patient can start treatment. If that time frame is 72 hours, then all patients need to be scheduled 72 hours after the treatment regimen is decided. This will allow the patient financial team the time necessary to get the authorizations that are required and gives the Patient Financial Advocate time to identify assistance programs when necessary. This window will be an average time frame, so make sure that if a specific insurance company will take longer that you communicate this information. It is important to ensure that the established time frame is communicated to all providers and staff that are involved and that they are in agreement with this time frame. **Tip:** Monitor how the process is working. If you are getting denials, did you have the agreed-on established time frame to get the prior authorizations?

Justifying the Time Frame

Providers order treatment and sometimes treatments are ordered as same-day chemotherapy. If the patient's insurance company does not require pre-authorization and the treatment is FDA indicated or compendia approved for the diagnosis, you might agree to waive the agreed-upon benefits authorization time frame. For example, if the usual time frame is 72 hours, you would not wait that amount of time before starting treatment. However, if you do so, you want to ensure that you also consider the patient's need for assistance with out-of-pocket costs.

Communication with providers about the need for and consequences of prior authorization is important, as is ensuring that the wait for authorization will not impact the outcome for the patient. For example, does the provider know if there is an authorization for the treatment—whether same day or not? If not, do providers know what the financial consequences of not being reimbursed will be? In most circumstances, start of treatment can wait the agreed-upon time frame to obtain authorization.

Insurance Company Guidelines

An important part of understanding the insurance process is keeping up to date with insurance company guidelines. Maintain a file or database for all major insurance plans and make sure to update this information on a regular basis. The information you compile should include any policies or rules regarding medical necessity for specific drugs. Some drugs might require prior

authorization; other drugs may require that the patient fail therapy with of another drug or drugs prior to use of a specific drug. Find out if the insurance company requires the CPT/HCPCS codes for payment. Work with the insurance companies to identify the number of treatments permitted before you are required to renew an authorization. Once you have this information, put this information in the chart or EMR for all staff to see that there is a current authorization and to be aware of when they need to watch for a new authorization.

For Insured Patients

Access a [flow chart of the insurance process for insured and self-pay patients](#) [here](#).

Identification of Assistance Program

This step should occur prior to the start of treatment during the agree-upon time frame set aside for benefits verification and prior authorization (if required).

Step one: Identify the patient's out-of-pocket costs.

Step two: Research any assistance programs available for the patient.

Pharmaceutical company co-pay assistance programs are only available for commercially-insured patients. These program will help with deductibles, co-insurance, and co-pays for each specific drug. In order to register a patient for these program, you will need to get a signed consent from the patient. Once the patient's insurance pays, you will work to have the assistance program pay the share that they have agreed to. Some EMR billing systems will allow you to set up the assistance program as a secondary insurance. In order to receive payment from the assistance program, you will need to file the insurance claim and an itemized explanation of benefits. Requirements for pharmaceutical and non-pharmaceutical patient assistance programs vary. ACCC's [Patient Assistance and Reimbursement Guide](#) provides detailed information from a number of patient assistance programs, including links to enrollment forms, sample letters, and more.

Foundations

This type of assistance program is available to insured and uninsured patients. A recommended approach is to use the manufacturer patient assistance programs for commercially-insured patients and turn to foundation assistance for the government-insured patients since these patients do not qualify for pharmaceutical company patient assistance programs.

The process is similar in that you will first need to consent patients to allow you to register them for the assistance program, and you will then need information from the insurance company as to what they paid on the individual drug.

Free Drug/Drug Replacement Programs

Yet another type of assistance program can be used when there is a possibility that the insurance will deny coverage for a drug. In this instance, you will consent the patient to register so that you can apply for a manufacturer free drug/drug replacement program. These programs are also available to both insured and uninsured patients.

Filing Clean Claims

When filing a claim you want to check and double check that the claim information is correct. You want to ensure you are sending a clean claim. **Tip:** Things to look for—

- Check that the treatment matches the treatment request from the authorization
- Check that the diagnoses codes are correct
- Check that the HCPCS and CPT codes are correct.

Understanding the Insurance Process at *Your* Program

When understanding and developing the insurance process, it is important to understand that this includes having a philosophy of care regarding treatments. Some considerations:

- Do you allow patients to be treated pending verification of coverage or even before you receive prior authorization?
- What if an insurance company takes longer than your program's agreed-upon time frame for authorization and the provider wants to start treatment?
- What happens if the insurance plan denies the prior authorization?
- What process do you follow if the insurance plan denies the treatment upfront? Which staff will file an appeal to try to get the treatment covered?
- If the patient wants to move forward with treatment, will he or she be asked to pay out-of-pocket upfront?
- What staff will track denials for off-label use or no authorization in place?

Discussing these scenarios and having procedures for handling these situations are an important part of working through your insurance process. Answering these questions is important so that you can adjust your insurance process to avoid loss of revenue.

A Process for Handling Denials

Having a process in place for handling denials is an important part of understanding the insurance process. A denial may bring into question whether you can continue a treatment for a patient or if the patient's regimen might need to be changed. The first step is to identify what the denial is for. Is it a full denial (nothing is paid for) or is it a line item denial (a specific item or items is not being paid for)? Obtaining the remittance from the insurance company will give you the specific information you need to know what the next step is. Claims can be denied for many reasons. Some denials are simply due to something being incorrect or missing in the claim. These claims can be re-filed with the corrected or additional information. However, some denials will require full appeals.

The appeals process should be used whenever a service was provided appropriately and you have information to substantiate the coverage.

Denials also reveal the need to have a process for staff education. For example, you may see denials that stem from a specific error (e.g., incorrect coding, or incomplete information on the claim form). This is an opportunity to educate, not to blame. If something was authorized and denied, re-send with the authorization information. Again, this example shows why you should always get a required authorization in writing so that you have evidence to show that the authorization was received. If a drug is denied as being investigational or not medically

necessary, obtain scientific evidence to prove efficacy and file an appeal. Make sure you know where to file the appeal and keep a copy of everything you sent to the payer for the appeal.

Try, Try Again

If the first appeal you did was denied and you have additional information that you feel will help your case, file a second appeal. This appeal will go to a different party to review. With government insurance, the third appeal is with an Administrative Law Judge. In order to move to this appeal level, the denial must reach a minimum dollar amount. It is important to continue the appeal process if you feel the services were appropriate. Many times the third appeal level is a peer-to-peer hearing where another oncologist might give an opinion or even attend the hearing to discuss and give the judge their opinion on coverage.

Following Up with Patient Assistance Programs and Foundations

Once the insurance claim has been paid appropriately, the process is to file a claim along with the explanation of benefits (EOB) to the assistance program for which the patient may be eligible. Note: You should have registered the patient prior to treatment, but some manufacturers will provide retroactive assistance coverage up to 90 days prior to registration. Each pharmaceutical company has its own patient assistance program rules and processes for filing for payment. Some programs allow you to electronically file a claim along with a copy of the explanation of benefits. Some programs require you to fax this information. Once you have sent the patient assistance program the explanation of benefits for the patient, some will allow you to make payment using a credit card that they supplied to you when the patient was registered. All patient assistance programs require a line item explanation of benefits to show what the balance is for the individual drug. It is important to track the information that you have sent to the PAP and whether or not payment was received from the PAP.

If you are applying to foundations for patient assistance, the process is similar although foundations may help with other costs besides drugs—such as transportation costs. Again, be sure to file and track the information sent and any payment received.

More information on pharmaceutical and non-pharmaceutical patient assistance program is available in ACCC's [Patient Assistance and Reimbursement guide](#).

Free Drug/ Drug Replacement Programs

These programs also require that the appeals process has been done. If there is a question as to whether the patient's drug will be covered, you will want to register for patient for the program so that if coverage is denied and the appeal(s) is denied, the drug can be replaced. Once you have shown that the drug is not being paid by the insurance company, the free drug/drug replacement program might provide the drug ahead of time for the patient. You will have to send the appeal denial to the manufacturer to show the insurance denied it more than once. Again, track the information you provide to ensure you receive the replacement drug. Ensure that you track any drug that is coming in for a specific patient so that drug is not used on someone else.

Audit and Reconciliation

Audit and reconciliation are an important part of insurance process. When billing for a new drug, make sure you audit any patients that received that drug for the first few months. You want to make sure clean claims are going through and all of the necessary information for payment was included on the insurance claim. If the claim was paid, make sure you received the expected reimbursement on that claim. Many times an insurance company may leave out a payment on the drug, but pay the other line items on the claim so that it looks like the claim was paid in full, but it was not. Make any adjustments in the insurance process necessary to ensure the clean claims are going out the first time. Continue to reconcile the reimbursement until the process has proven itself.