



Navigating and Understanding Health Insurance Issues



This guidance is intended to assist people looking for help when accessing care and when insurance denies coverage for treatment of eating disorders. The information here was compiled from research by ECRI Institute and the experience of parents and treatment providers who have had experience obtaining coverage for eating disorders care.

In a separate document are sample letters to adapt to various insurance situations related to obtaining appropriate care. This information has not been prepared by attorneys and is not intended as a legal document. This information does not guarantee success. If you have suggestions, feedback, or personal additions to share (e.g., submit a sample letter you've used with your insurance company with all identifying information removed), please email National Eating Disorders Association at info@nationaleatingdisorders.org with "Insurance Issues" in the subject line.

The National Eating Disorders Association fields many questions every day that focus on how to gain access to care and navigate insurance issues. While there is little argument that early intervention offers the best chance for recovery, insurance and the healthcare system can pose barriers to accessing prompt, comprehensive treatment.

Accessing the full benefits a patient is entitled to under his/her health plan contract requires understanding a few things about all the factors that affect access to care, coverage, and reimbursement. Navigating the system to find out what the patient is entitled to receive also takes a lot of energy. While parents can legally act on behalf of children younger than age 18, they need permission from a child older than age 18 to act on his/her behalf.

Because treatment usually involves both mental healthcare and medical care aspects, a well-rounded care plan must address both types of care. The overall healthcare system has long treated medical care and mental healthcare separately. The result of that care model is that health insurer benefits plans have often followed suit by separating mental health benefits (also called behavioral health benefits) from medical benefits. This split has created great difficulty for people with an eating disorder because they need an integrated care plan. Ways to steer through these difficulties are offered here in an 8-step plan.

Another issue is the level of benefits for mental healthcare. For years, many health plans provided few or no mental health benefits. When they did, most subcontracted those benefits through "mental health carve-out" plans. Such plans are administered by behavioral health service companies that are separate from health plans. This approach made well-rounded care by a multidisciplinary team very difficult to achieve. Even when a psychotherapist and medical doctor want to integrate services and case management to treat the patient as a whole person, the healthcare delivery system in the United States poses barriers that prevent that from happening.

For example, when a service is provided by a doctor or facility, a billing code is needed to obtain reimbursement for services. Certain rules and regulations govern how services must be coded and who can perform those services. Different types of facilities and different healthcare professionals must use codes

that apply to that type of facility and health professional. Also, if codes don't exist for certain services delivered in a particular setting, then facilities and health professionals have no way to bill for their services. Codes used for billing purposes are set up by various entities, such as the American Medical Association, U.S. Medicare program, and the World Health Organization's International Classification of Diseases. Thus, even a patient with good health insurance may face barriers to care simply because of the way our healthcare system is set up.

The system is slowly changing. Sporadic improvements have come about as a result of lawsuits and state legislation prompted by individuals, legislators, clinicians, support groups, and mental health advocacy groups. The U.S. federal government and most U.S. states have passed some form of mental health parity law. Generally these laws require insurers to provide benefits for mental healthcare that are equivalent to benefits for medical care. These laws do, however, vary widely in their provisions.

Landmark lawsuits brought by families of patients with bulimia nervosa and/or anorexia in two states—Wisconsin in 1991, and Minnesota in 2001—were watershed events that set legal precedents about what insurers should cover for eating disorders. These lawsuits also raised public awareness of the problems faced by people seeking coverage for treatment of eating disorders. Nonetheless, the system today has a long way to go to improve access to care and adequate reimbursement for care for a sufficient period for a patient with an eating disorder.

Given that appropriate well-integrated treatment for eating disorders can easily cost more than \$30,000 dollars per month, even with insurance, an insured individual is usually responsible for some portion of those costs.

The first-line of decision making about health plan benefits is typically made by a utilization review manager or case manager. These managers review the requests for benefits submitted by a healthcare provider and determine whether the patient is entitled to benefits under the patient's contract. These decision makers may have no particular expertise in the complex, inter-related medical/mental healthcare needs for an eating disorder. Claims can be rejected outright or approved for only part of the recommended treatment plan. Advance, adequate preparation on the part of the patient or the patients' support people is the best way to maximize benefits. Prepare to be persistent, assertive, and rational in explaining the situation and care needs. Early preparation can avert future coverage problems and situations that leave the patient holding the lion's share of bills.





Steps to maximize insurance benefits

1. Educate yourself.

Read the other information in the Parent Toolkit to learn about eating disorders, treatment, current clinical practice guidelines, and how you can best advocate for and support the family member who has an eating disorder. Refer to the latest evidence-based clinical practice guidelines in this toolkit and have them in hand when speaking to your health plan about benefits. Be prepared to ask your health plan for the evidence-based information they use to create their coverage policy for eating disorders.

Find out if your state has a mental health parity law or mandate and what the terms of that law or mandate are. Mental health parity simple means that your insurance company must not limit mental health and substance abuse healthcare by imposing lower day and visit limits, higher copayments and deductibles, and lower annual and lifetime spending caps than they do for medical care. The website www.bulimiaguide.org has detailed information about which states have mental health parity laws or mandates and what those laws and mandates cover. See the Eating Disorders Coalition for Research, Policy & Action web site for how to get involved in the effort to influence federal policy at: www.eatingdisorderscoalition.org.

2. Get organized.

If a patient's first encounter with the healthcare system is admission to an emergency room for a life-threatening situation with an eating disorder, whoever is going to deal with insurance issues on the patient's behalf will need to get organized very quickly to figure out how to best access benefits. Patients who are seriously medically compromised will likely be in the hospital for a few days before discharge to outpatient care or a residential eating disorder center. Those few days are critical to negotiating reimbursement for the longer-term care.

If the situation is not an acute emergency and you want to find a treatment center, consider whether you have authority to act on the patient's behalf or whether the patient must give you written authority to act on his/her behalf. If a child is 18 years of age or older, parents will need the child's written permission to act on the child's behalf. Healthcare providers have forms that require signatures to allow free flow of communication and decision making. A spouse, partner, friend, or other person who wants to act on behalf of the patient will need to have the patient sign appropriate authorizations. Medical confidentiality is discussed later in this section.

3. Read the patient's entire insurance benefits manual carefully to understand the available benefits.

Obtain a copy of the full plan description from the health plan's member's website (i.e., the specific plan that pertains to the insured), the insurer or, if the insurance plan is through work, the employer's human resources department. This document may be longer than 100 pages. Do not rely on general pamphlets or policy highlights. Read the detailed description of the benefits contract to find out what is covered and for how long. If you can't understand the information, try talking with the human resources staff at the company that the insurance policy comes through, with an insurance plan representative (the number is on the back of your insurance identification card), or with a billing/claims staff person at facilities where you are considering obtaining treatment. If hospital emergency care is not needed, make an appointment with a physician you trust to get a referral or directly contact eating disorder treatment centers to find out how to get a full assessment and diagnosis. The assessment should consider all related physical and psychological problems (other documents in this toolkit explain the diagnostic or assessment process and testing). The four main reasons for doing this are:

- to obtain as complete a picture as possible about everything that is wrong;
- to develop the best plan for treatment;
- to obtain cost estimates before starting treatment; and
- to obtain the benefits the patient is entitled to under his/her contract for the type of care needed—for example, many insurers provide more coverage benefits for severe mental disorder diagnoses. Some insurers categorize anorexia and bulimia nervosa as severe disorders that qualify for extensive inpatient and outpatient benefits, while others may not.

Medical benefits coverage also often comes into play to treat eating disorder-associated medical conditions, so diagnosing all physical illnesses present is important. Other mental conditions often coexist with an eating disorder and should be considered during the assessment, including depression, trauma, obsessive-compulsive disorder, anxiety, social phobias, and chemical dependence. These coexisting conditions can affect eligibility for various benefits (and often can mean more benefits can be accessed) and eligibility for treatment centers.



4. Keep careful and complete records of communications with the insurance company and healthcare providers for future reference as needed.

From the first call you make, keep a complete record of your conversation. Treatment often occurs over a long period of time. Maintaining a log book—whether computerized or in hard copy—can be important for future reference if there are questions about claims. Decide where all notes and documentation will be kept for easy access. Create a back-up copy of everything, and keep it in a safe and separate place. The record log of conversations should contain the following:

- notes taken of each conversation with an insurer or healthcare provider
- date, time, name, and title of person with whom you spoke
- person's contact information

As a courtesy, you may wish to let the people you talk with know that you are keeping careful records of your conversations to help you and the patient remember what was discussed. If you decide to tape record any conversation, you must first inform and ask the permission of the person with whom you are speaking.

5. Call the insurer to discuss benefits options.

With documentation of the patient's diagnosis and proposed care plan in hand, it's a good idea to call the insurance company before the patient formally enters a treatment program. Quite often, preauthorization for a treatment facility or healthcare provider is needed. Ask for a case manager who has credentials in eating disorders. This will improve your chance of getting one contact person to talk with over the longer term of treatment who better understands the complexities of treatment. Confirm with the insurer that the patient has benefits for treatment. Also ask about "in-network" and "out-of-network" benefits and the eating disorder facilities that have contracts with the patient's insurance company, because this affects how much of the costs the patient is responsible for. If the insurer has no contract with certain treatment facilities, benefits may still be available, but may be considered out-of-network. In this case, the claims will be paid at a lower rate and the patient will have a larger share of the bill.

You may also want to consider having an attorney in mind at this point in case you need to consult someone if roadblocks appear; however, avoid an adversarial attitude at the beginning. **Remember to keep complete written records of all communications with every person you speak with at your insurance company.** Other things to remember:

- Thank and compliment anyone who has assisted you. You're more likely to receive friendly service when you are polite while being persistent.

- Send important letters via certified mail to ensure they can be tracked and signed for at the recipient location.
- Set a timeframe and communicate when you would like an answer. Make follow-up phone calls if you have not received a response in that timeframe.
- Don't assume one department knows what the other department is doing. Copy communications to all the departments, including health, mental health, enrollment, and other related departments.
- Don't panic when and if you receive the first denial. Typically, a denial is an automatic computer-generated response that requires a "human override." Often you need to go up at least one level, and perhaps two levels, to reach the decision maker with authority to override the automated denial.
- Your insurance company only knows what you and the treating professionals tell them. Make sure they have all information necessary to make decisions that will be of most benefit to you or your loved one.
- Make no assumptions. Your insurance company is not the enemy – but may be uninformed about your case. Treat each person as though he/she has a tough job to do.

Be aware that if the patient is a college student who had to drop out of school to seek treatment and was covered by school insurance or a parent's insurance policy, the student may no longer be covered if not a full-time student. While many people will continue working or attending school, some cannot. If this is the case, it's important to understand what happens with insurance. Most insurance policies cover students as long as they are enrolled in 12 credit hours per semester and attend classes. Experts in handling insurance issues for patients with eating disorders caution that patients who have dropped out of school should avoid trying to cover up that fact to maintain benefits, because insurance companies will usually find out and then expect the patient to repay any benefits that were paid out.

If coverage has been lost, the student may be eligible to enroll in a Consolidated Omnibus Budget Reconciliation Act (COBRA) insurance program. COBRA is an Act of Congress that allows people who have lost insurance benefits to continue those benefits as long as they pay the full premium and qualify for the program. See www.cobrainsurance.com for more information. A person eligible for COBRA has only 30 days from the time of loss of benefits to enroll in a COBRA plan. It is critical that the sign up for COBRA be done or that option is lost. Be sure to get written confirmation of COBRA enrollment from the plan. If the student is not eligible for COBRA, an insurance company may offer a "conversion" plan for individual coverage.

If the patient is in the hospital and will be discharged to a residential treatment center, discuss how the medical and behavioral health components of benefits will work. Although a patient may be "medically stable" at discharge, he/she may not be nearly well enough to participate fully in psychotherapy at the residential



center. The patient's medical condition, though not life-threatening at this point, affects mental health and ability to participate in treatment. Restoring physical health may take days or weeks. Therefore, before the patient is admitted to a residential eating disorder center or placed in outpatient treatment, contact the patient's health plan or employer (if applicable and the health plan is self-funded by the employer) and ask for the early claims for psychotherapy to be paid under the medical benefits instead of the behavioral health benefits. The language to use is: "Will you intercept psychotherapy claims and pay them under medical benefits until the patient is stable enough to participate fully and assist in her treatment?" Not all health plans will do this, but some do, so it's worth asking. Going this route can save the behavioral health benefits for the time when the patient is better able to take part in the psychotherapy.

Another way to get the most out of benefits is to find out whether chemical dependency or substance abuse benefits are included in the mental health day allotment or if it is a separate benefit. If it is separate and the patient does not really need this benefit, find out whether the insurer will "flex" the benefit to apply it for treating an eating disorder.

6. Find out the authorizations for care that the insurer requires for the patient to access care.

Once insurance benefits are confirmed, be sure to obtain the health plan authorizations required for reimbursement for the care the patient will receive. Sometimes authorizations and referrals are sent electronically to the concerned parties. Always confirm that they have been sent and received by the appropriate parties. Ask for the level-of-care criteria the patient must meet to be eligible for the various levels of benefits. Again, keep a record of the authorizations received.

7. Communicate with key caregivers to give any needed input and devise a treatment plan.

Obtain the names of the people who will be providing care and having daily interactions with the patient (including lower-level staff such as aides). Try to meet with, or talk by phone, to each caregiver on the team. Discuss the diagnosis (and whether there is more than one primary diagnosis) and treatments options, and ask whether there is clinical evidence to support the recommended treatment and what that evidence is. This information can be useful when talking to the insurance company about benefits, because insurance companies value evidence-based care. Also, ask how the treatment plan will be coordinated and managed, and who will coordinate the plan. In the case of bulimia nervosa, the patient often has close to normal body weight. However, serious, but less obvious medical conditions may also be present (e.g., osteoporosis, heart problems, kidney problems, brain abnormalities, diarrhea, reflux, nausea, malnutrition, heartburn). Tests that are used to diagnose medical symptoms and criteria for levels of care are listed in **First steps to getting help** in this toolkit. Ask for "letters of support" from the healthcare team. See *Sample letter #6* in **Sample letters to use with insurers** in this toolkit. Using language that is used by insurance companies is helpful to have common ground. For example, it's important to point out care that is considered by the doctors to be "medically necessary" for the patient's recovery. Documentation like this is useful to provide to the insurer when discussing reimbursement, because it gives both you and the insurer a framework for discussion. With regard to the healthcare providers, ask them how to and who can obtain copies of the patient's medical records, who will provide progress reports, how often they will provide them, and to whom. Ask the healthcare provider (whether a facility or individual therapist) for an itemization of the estimated costs of care, which costs will likely be paid by the insurer, and which costs will be paid by the patient. Also ask how billing for reimbursement will be handled—ask whether you have to submit claims or whether the healthcare service provider submits the claims on the patient's behalf.

8. Enlist support from family members and friends you can count on.

Make a list of people you can count on for moral support throughout the course of treatment. Keep their names, phone numbers, and email addresses handy. For this list, identify people who can help the patient remain focused and provide helpful emotional support and encouragement while navigating the system to obtain care and while receiving care. Find out from each of them their availability (i.e., times, dates) for support and the kind of support they can offer. Also consider distributing that list among key people on the list so they know who is in your support network. Also, list key healthcare provider (facilities and healthcare providers) contact numbers on that list in the event of an emergency.