HUFFPOST PERSONAL

My Health Insurance Company Is Trying To Kill Me

"They are genius (and stealthy) in their tactics to exhaust me financially, emotionally and physically."

By Jonna Jerome

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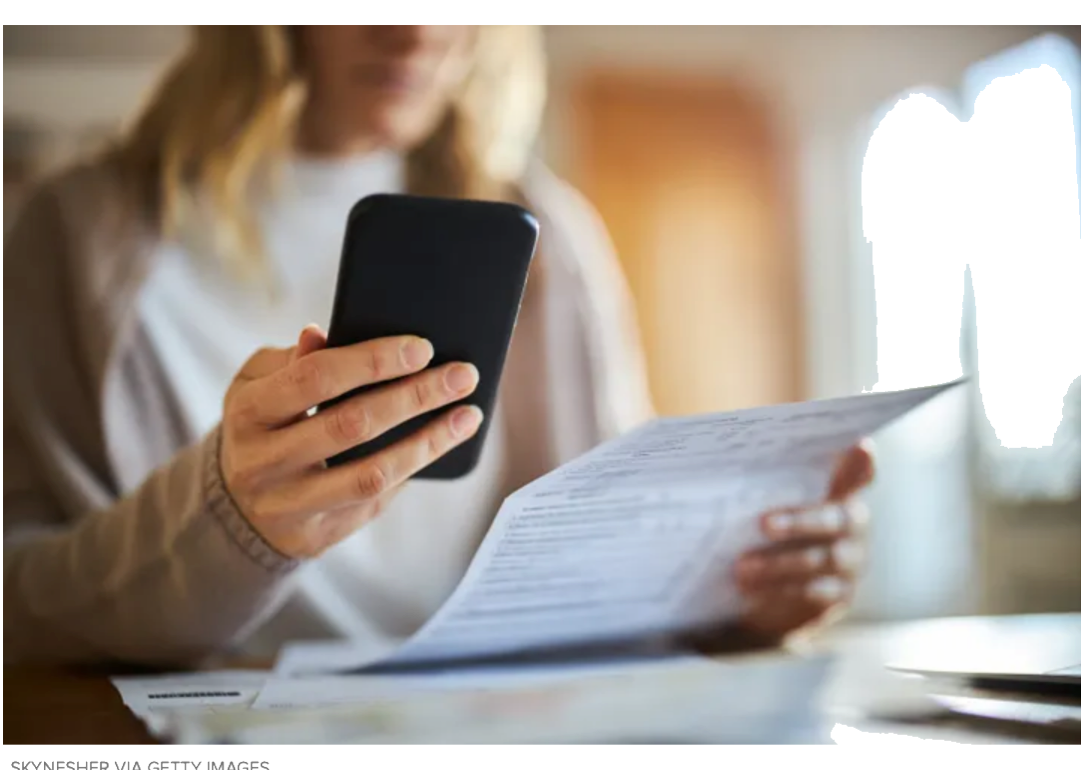

SKYNESHER VIA GETTY IMAGES

I suspect that my daughter and I are growing too costly and inconvenient for my health plan's customer profile. They are genius (and stealthy) in their tactics to exhaust me financially, emotionally and physically. The company manuals must contain strategies for this, cleverly disguised as "working together."

I have tried to be patient and cooperative. I pay the premiums for my top-tier PPO plan on time. I have accepted the fact I must cover a sizable deductible, copays, and coinsurance. It's harder to swallow the exorbitant "out of pocket maximums" we are required to pay before a health plan will cover at 100%. Not many people hit that mark, and are likely bankrupt by then.

Looking at this logically, it was silly of me to believe the health plan when it said it wanted to help me or my family. After all, this is strictly business for the company, and businesses must make money. It's nothing personal — unless we die.

I learned the hard way how to survive in this wild world. It entails reading the fine print, contending with confusing website portals, and enduring astonishingly long wait times while being serenaded by repetitive jazz when attempting to reach a live person.

Based on my decades-long journey, it appears that a health plan's modus operandi is: When in doubt, deny. Unfortunately, at times I discover that a claim has been denied only after being contacted by a collections agency. Why? Because insurance approval or denial decisions can be delayed while providers are grilled for "more information" to justify their treatment plans, and bills deemed delinquent are routinely sent to collections.

Claims are typically rejected for one or more of these reasons:

- Preauthorization forms or superbills are not submitted properly.
- The facility or doctor is not in network.
- The treatment is not medically necessary. (That one is my all-time favorite.)

First, dealing with paperwork and shifting protocols during a crisis doesn't help anyone's well-being. This, coupled with the medical field's reluctance to share digital files (citing privacy issues despite encryption solutions), means we are sent on a scavenger hunt for hard copies of our medical records, or must play digital hopscotch with external sites trying to transfer data into our insurance portals — which frequently malfunction. I believe these portals are programmed to crash multiple times a day. Once documents are submitted successfully, they aren't always expedited to address urgent situations.

It's mysterious how information I work so hard to obtain seems to vanish into black holes. During my quest for records from a hospital that failed to help my child, I had to revisit the scene of our trauma. Despite being sent to the wrong buildings twice, I persisted and asked another orderly for help. Without breaking stride, she rattled off complicated instructions. She might as well have directed me to follow the yellow brick road, veer left to pass a magic tree house, and then descend floating stairs, all while reciting Hail Marys and clicking my heels three times to reach the golden door.

Eventually, I found a dank basement office that matched my mood and the receptionist's. I then faxed, emailed and even visited a local post office to ensure the copious paperwork reached a grievance coordinator.

Trying to call this aggrieved individual was even more challenging. As I cannot get the same person on the phone twice, I find myself reliving the darkest hours of my life repeatedly with each new person, who inevitably offers different instructions than the last.

One such encounter went like this:

Me: "Hi. I'm calling about my daughter's ambulance and hospital charges. I haven't been able to reach my grievance coordinator about the appeal."

Representative: "I can help you."

Me: (Genuinely excited.) "Great!"

Representative: "Oh, I see your daughter turned 18. I can't discuss her information with you."

Me: "I sent a release of information form by mail, fax and email. I also faxed our conservatorship papers."

Representative: "I'm sorry, it's not on file. What office did you send it to?"

Me: (I give the information.)

Representative: "That's the wrong fax number. Let me give you the correct one."

Me: "I'm not inventing numbers out of the ether. This is the third new fax number I've been given. Are the address and email inaccurate too?"

Representative: "I'm sorry, but I can't discuss your daughter's claims with you without this information. Can you put her on the phone to give verbal consent?"

Me: "I can't put her on the phone. She's currently in a treatment center and has no access to a phone, which is why I have a conservatorship to help with her medical care."

Representative: "I'm sorry, ma'am. There's nothing I can do without the forms or her verbal consent."

Me: "Who do you think pays the insurance premium and all her providers? I'm just trying to settle her claims, and I don't know what we owe without access."

Representative: "I can only answer general questions."

Me: "OK. From the bills I've received, we're being charged out-of-network fees for the ambulance, ER, ER doctor and hospital."

Representative: "Was this out of state?"

Me: "Yes."

Representative: "Hang on, I have to transfer you."

I was on hold for another 15 minutes, and then got cut off. I called back, was transferred twice and then repeated a version of the above conversation before resuming — with a grievance coordinator!

Grievance coordinator: "The ambulance and ER facility were both out of state and out of network."

Me: "A treatment center called for an ambulance. I wasn't given a choice of who responded or where they took her."

Grievance coordinator: "They used out-of-network providers."

Me: "They dialed 911. No one stops to ask the closest ambulance what their network status is."

Grievance coordinator: "They did transfer her to an in-network hospital, but the physicians were not participating providers."

Me: "Under the No Surprises Act, insurance must cover all providers in the case of an emergency, whether they are in network or not — even if out of state."

(There was a long silence.)

Me: "Are you still there?"

Grievance coordinator: "Yes, ma'am. Once you get the conservatorship papers to us, we can look at those claims. Is there anything else I can help you with?"

Me: "Apparently not."

As for the incident in question, my daughter sustained injuries severe enough to require ambulance transportation, an emergency room visit and subsequent hospitalization. Yet, on top of the network status squabble, my insurance company disagreed with the triage physicians and determined that the hospitalization was "not medically necessary."

The hospital discharged her because the insurance would not cover her stay. The result was disastrous, and she was admitted almost immediately to another hospital. Despite this, she is still alive.

Challenging this decision initiated the next phase of the appeals process, which mandates patients' doctors to engage in peer-to-peer consultations with insurance company doctors to validate treatment plans. How can these decision-makers, who are on the health plan's payroll and may lack expertise in the relevant specialty, be impartial or make more informed decisions than the doctors in the room?

While dealing with my daughter's crisis, I faced my own when my immunologist prescribed infusions to strengthen my severely weakened immune system. The insurance company was the entity with the authority to deny this treatment. Amazingly, insurance companies also get to dictate which medications patients should take. They prefer us to stay on generic versions that often have lower success rates and make us feel sick, rather than approve a brand-name or compounded medication with a better track record. The same approach applies to recommended alternative therapies.

Maybe if health plan employees were with members during unspeakable ER experiences, or their company doctors thoroughly examined us, consulted expert colleagues or read our medical histories, there would be fewer catastrophic lapses in judgment. And, before dismissing our prescribed treatments, shouldn't they at least learn to pronounce our names?

Health plans are not just failing those they are supposed to serve; they are contributing to the problem of overbilling for health care. Physicians may charge more to offset the administrative burden of working with insurance companies and to account for expected negotiations on their service rates.

The health insurance industry is so flawed that around half of the insured population in the United States struggles to afford the cost of care and has substantial medical debt. Others cannot afford coverage at all and go without even basic care. I know I am not alone in my outrage. Though I can't revolutionize an entire industry overnight, I can share intel from my vast experience navigating the current structure successfully, so you can do the same.

Laws exist to protect patients, and when staggering under impossible debt, I discovered that the No Surprises Act is one of the most effective. What's surprising is how few people know it exists.

I'll review the most important bits. This act safeguards consumers from being charged more than the in-network rate for services in certain situations:

- One is when emergency care is provided at any facility, even if out of network or without prior authorization. This includes charges for ambulances, ERs, hospitals and the physicians who work there.
- Another is when nonemergency care is provided at in-network facilities. If you receive treatment involving out-of-network providers or services such as anesthesiology or radiology, they must be processed at the in-network level.
- Out-of-network cost-sharing (like coinsurance or copayments) is banned for most emergency and nonemergency services. You can't be billed for more than the in-network cost-sharing rate.
- Health care providers and facilities must provide information about billing protections with contact information so you can report any suspected violation of these safeguards.
- You must consent to be balance-billed by any out-of-network provider, and you must receive notice of this.

Two additional factors can allow you to choose an out-of-network provider and still have your insurance cover the cost at the in-network level:

- Distance: When no other qualified providers and specialists or in-network facilities are nearby or accepting new patients. "Nearby" typically means within a 100-mile radius.
- Specialty: If your specialty physician no longer accepts your insurance and you wish to remain with them, you can ask for a "continuity of care" exception. If your case is complex, your doctor can submit supporting documentation.

Reviewing and appealing these criteria-related claims have become as routine as brushing my teeth. By appealing, I've successfully overturned almost $1 million worth of denials. I may now have colorful notes about me in my member profile, but I'm rarely patronized. You deserve access to the health care you need without paying extra. Chances are, you've paid for services you're not even responsible for.

You also have the right to appeal any denied claim. Instructions and a form on how to do so accompany every explanation of benefits, or EOB. You can also file from your provider's website if your member portal is up and running. If you still need help, pick up the phone. Be patient, and don't let the canned hold music defeat you.

If you find yourself in a debate with an aggrieved person, mention the No Surprises Act and see what happens. Often, an awkward reversal occurs where you are offered assistance with an appeal to reprocess your claim.

The key takeaway: When in doubt, appeal. Even if denied by your insurance company, you still have the option to escalate the matter to its governing agency, which is responsible for supervising health plans. Each state has one.

Sure, it's annoying, and insurance companies know most members (especially the severely ill) may lack the know-how, luxury of time, or energy to fight back. This exploitation of those most in need can have devastating consequences.

There are health and medical billing advocates who specialize in these tasks and typically charge a percentage based on the amount they save or recover for you. The fact that this is a cottage industry further illustrates how badly our health care system needs an overhaul.

Yet, as more members challenge the status quo, it creates a ripple effect. Even small actions can lead to reform. I encourage those who are able to call their health plan and request assistance with the appeals paperwork. This costs time and resources. If companies see their profits dip due to employees spending more time managing grievances, they are motivated to resolve the issue.

This is how we can dissuade them from kicking back claims they are legally mandated to cover, and how we can effect policy changes, inspire new laws and hopefully keep more cash in our bank accounts.

Trust me. I want to keep everyone alive and solvent.

Jonna Jerome is a creative writer and content marketing strategist. Her forte is helping people and the causes she cares about through her writing.

After years of experience navigating the broken healthcare system and overturning more than $1 million in denied claims, Jonna founded "My Patient Voice" to help others obtain fair pricing for their medical care.

Jonna's personal blog delves into life's absurdities with a sense of humor, and her work is often featured in other publications. You can read more at janglery.com.

She is inspired by her love of family, and fueled by espresso.