NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

INSURANCE PLAN CHANGES – NOW WHAT?

With another year coming to a close, it's time again for insurance plans to begin open enrollment, and to make plan changes and amendments. As in previous years, even the most seasoned veterans are left confused and frustrated by changes and new requirements.

It's natural to feel stressed out over navigating through the unknown, but you are not alone. There are many resources available to help you identify steps you can take to minimize the impact these changes can have on your treatment plan and your health.

While ignoring correspondence from your insurance plan may seem to be the least stressful approach, the implications can be costly to your health and wallet in the New Year. So follow these steps to stay on top of insurance issues:

- **OPEN** all communications from your insurance plan.
- **READ** the entire notice, even if you think it does not apply specifically to you.
- **RESPOND** if action is requested.
- **ACT** if action is required. Most insurance plans changes include one or more of the following and should be identified and acted upon quickly:
    - Changes to your premium rate
    - Changes to your out-of-pocket costs
    - Changes to the drug formulary or preferred drug lists
    - Changes to provider networks

Each of these changes can have a direct impact on the amount of money you pay out of pocket, and can affect where you receive your treatment andcare.

FIRST and **FOREMOST,** time is of the essence, so make sure you act quickly.

Below, are samples of common language used in insurance change announcements, a summary of their meaning and what steps can be taken, if appropriate, to get an exception.

DENIAL OF PRESCRIBED TREATMENT

- The notice is a denial of the factor dosage prescribed by your provider and reads:
    - Coverage request for the drug, XXXXX, at a dosage of 3,000 units dosed four times weekly (i.e. Mon, Wed, Friday & Sun or Monday Wed with a double dosage on Friday) is denied for not meeting the definition of medical necessity.
- What does this mean? Do you have to change your treatment plan?
    - Not necessarily, so ask about your options, such as:
        - Appeal
        - Peer-to-peer review

FORMULARY CHANGE

- Your coverage is changing
    - Effective 1/1/2017 the drug formulary under your health plan will be changing. Our records indicate that you are currently taking a medication that will become "non-preferred" as of 1/1/2017. We encourage you to talk with your physician and ask if a preferred alternative is right for you. Please note that if you choose to continue to take a non-preferred drug after 1/1/2017, you may be subject to a higher copayment based on your plan design.
- Does this mean you have to change products? Potentially, but not always.
    - What steps must be taken for you to remain on your current medication?
    - Do you have to obtain a prior authorization?
        - What type of supporting documentation, if any, is required?

EXCLUDED/NONFORMULARY

- Your medication is no longer included on the plan's formulary
    - Effective 1/1/2017 the drug formulary under your health plan will be changing. Our records indicate that you are currently taking a medication that will become "non-formulary" as of 1/1/2017. We encourage you to talk with your physician and ask which formulary medication is right for you. Please note that if you choose to continue to take a non-formulary medication after 1/1/2017, you may be responsible for the entire cost of the drug.
- Can you continue to take your current medication? Technically yes; however, you may be required to pay the full cost for the drug.
    - Are there any options that would allow you to remain on your current therapy AND have it covered by your health plan? Maybe.

- Does your health plan have a process in place allowing you to request a medical exception?
- What documentation is required to prove medical necessity?
- Can your physician request a "peer-to-peer review"?
- Do you have the option to obtain your medication under the medical benefit?

PROVIDER NETWORK CHANGE

- Your physician is no longer contracted with the health plan
  - Effective 1/1/2017 Dr. John Smith is no longer a participating provider in the XYZ insurance network. Please visit xyz.com/providernetwork for a list of network providers in your area.
- Do you have to switch to a different physician? Potentially, but not always.
  - Do you have out-of-network coverage under your health plan?
  - If your plan does not offer out-of-network coverage, you may still choose to use that physician; however, you may be responsible for the full cost.
  - If your physician is a specialist, is there another specialist in the same field within the provider network?
    - If not, is it possible to obtain a referral from your primary care physician to see an out-of-network physician?

REMEMBER, it is vital to ALWAYS PURSUE COVERAGE for the services and treatments you or your child's physician believes is the most appropriate. Remember, while an approval may not always be possible, a denial left unchallenged will always remain a denial.