Hereditary Cancer: Insurance Challenges
Pat Jolley, R.N., Director, Clinical Initiatives

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Today’s Agenda

• Terms to Know – How it Impacts Care
• What the ACA Doesn’t Require
• Prior Authorization Process
• Crafting your Appeal - What to Expect
• Resource links
Today's World of Medicine

Genetic Counseling

Mutation

Inherited Mutation

BRCA1
BRCA2
MLH1
RAD51C
PALB2
CDH1

Genes

Breast Cancer
Medical Decisions
Screening
Disease Treatment
Inheritance
Chromosomes
Ovarian Cancer
Clinical
Prophylactic Mastectomy

PAF
Patient Advocate Foundation

P: 800.532.5274
www.patientadvocate.org/gethelp
Insurance Terms to Know

• **Covered Services** – the healthcare services that your insurance agrees are eligible for reimbursement under your plan language.

• **Excluded Services** – services that your health insurance will not pay for or cover.

• **Prior Authorization** – approval from a health plan that may be required before you get a service or fill a prescription in order for the services to be covered by the health plan.

• **Coinsurance** – your share of the cost of a covered health service, calculated as a percent of the allowed amount.

• **Summary of Benefits** – an easy-to-understand summary of a health plan’s benefits or coverage.
Genetic testing is eligible for reimbursement with flexible spending accounts (FSA), health savings accounts (HSA), health reimbursement accounts (HRA) with a letter of medical necessity.

DIRECT-TO-CONSUMER genetic testing, 23andMe was authorized in March 2018, to check for three mutations in the BRCA1 and BRCA2 genes.

**This is not considered a medical genetic test and is not covered by insurance**

Limitations to Note

Look under Exclusions and Limitations or Not Covered in your plan language for specifics, such as:

- Charges for genetic testing, except that genetic testing to assist in the treatment of an existing illness or as preventive care required by law will be covered.
- Charges for prophylactic surgery or treatment, except that preventive care required by the Affordable Care Act will be covered.

**This is not considered a medical genetic test and is not covered by insurance**
What the ACA Does Not Require

- Coverage of genetic **screening** for:
  - Heritable syndromes or mutations other than BRCA
  - Women with history of cancer not in active treatment
  - High risk men
  - Early, more intensive cancer screenings and/or risk reducing interventions

- Grandfathered plans, self-funded plans, short term or temporary health plans and church ministry benefit plans. May offer coverage but not without cost sharing

- Does not require coverage / no cost sharing unless delivered by in-network provider

- Does not require that Medicare cover the cost of genetic testing in individuals who do not have a personal history of cancer

- Did not require Medicaid coverage of screening in states that did not expand Medicaid
Pre-Authorization for Hereditary Cancer Testing

- Each insurance plan has its own requirements; coverage determinations are made based on clinical review of medical documentation, personal and family history submitted with testing.

- Provide documentation of affected family members, diagnosis and blood relationship to patient:
  - 1st degree relative (mother, sister, daughter)
  - 2nd degree relative (aunt, grandmother, niece) on same side of family
  - 3rd degree relative (great-grandmother, great aunt and first cousin)
  - 1st, 2nd, 3rd degree male relative with breast cancer

- Prior authorization or a procedure or testing is **not a guarantee** of benefits or payment by insurer.

- Review plan-specific medical policy for genetic testing for hereditary cancer or genetic testing or specific test – e.g. BRCA or multigene panels.
What is an Insurance Denial?

Insurance plans are contracts based on your plan language.

A denial occurs when the insurance company makes the decision that a submitted claim or request for services is not covered under the language and provisions of your plan language and is thus outside of the contract.

What is an Appeal?

Appeals are contract disputes initiated by patients or providers when they disagree with the plan’s decision to deny or limit care.

An appeal is a formal request for an additional review of an adverse coverage decision by an insurance company.

Rules for the appeal process are outlined in plan language, similar to guidance for disputes that would be included as part of a business contract.
Next Steps

• When you receive notice that something is denied, review the codes on the EOB or denial letter for specifics and instructions.

• Call your health plan's customer service line to clarify, many times denials can be up at this level.

• If denial is a result of improper coding, missing documentation, or other billing issues that require a resubmission of claim, these may be handled in a simpler and faster manner, that will most likely be paid upon correct processing.

*Be sure to take notes on all phone conversations, including the date and time of the call, the names of the people you speak to and what was discussed.
Writing The Letter

• Submit a clear concise letter detailing your argument that **addresses the reason for the denial**, citing the terms of your insurance policy language.
• The letter can be written by you, a medical provider or an advocate on your behalf.
• Try to remain factual, not emotional, while you are preparing your packet—this is a business decision, not personal.
  o Submit your appeal on time and with required components
  o Track the submission—send by certified mail with a return receipt
  o If sending by fax—keep a copy of the successful transmission confirmation and plan a 48-hour follow-up
• State consumer insurance commissions can clarify your rights and provide additional guidance.
Sample Appeal Letters from FORCE

Genetics
  • Genetic counseling
  • BRCA testing for women & men

Detection and Screening
  • Breast screening MRI
  • Mammograms
  • Ovarian cancer screening (TVU & CA125)
  • PSA testing

Surgery - Risk-reducing:
  • Salpingo-oophorectomy (removal of ovaries and tubes)
  • Bilateral mastectomy
  • Reconstruction after mastectomy

Treatment
  • PARP inhibitors (Lynparza, Rubraca, Zejula)
  • Chemoprevention (Tamoxifen, Raloxifene)
You should receive an official notice within 7-10 days that your appeal has been received. If you do not receive this, contact your insurance company to verify that the appeal has been received and shows in the system.

Timeline for answers depend on which type of appeal, which level of appeal you are at and other factors defined in the appeal process and may range from 72 hours in urgent appeals to 60 days.

The answer may be provided to you via phone, but will always include a written response as well.

If the denial is upheld, the new denial letter will alert you to the next steps for any additional appeal option.
The ACA requires insurance companies to implement an effective appeal process, that at minimum:

- Plans must have an internal claims process
- Must provide notice on the internal and external appeal process
- Advise enrollees of health insurance consumer or ombudsman assistance availability

According to a 2011 US Government Accountability Office report, appeals were successful more often than not, even before the ACA stepped in and made changes to appeal rights.

Specifically, the report in question found that 39% to 59% of **appeals made directly to insurance** companies resulted in a reversed decision.

**External** appeals were nearly as successful, with 54% of appeals conducted (as part of the same GAO report) in Maryland ended with the insurer overturning their denial, and 23% in Ohio.

http://quotewizard.com/health-insurance/denied-health-insurance-claim

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**Not a Waste of Time**

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Case Example

Situation:

• Caucasian woman in her 30’s

• Diagnosed with HER2+ breast cancer, previous double mastectomy and reconstruction

• Insured

• 2 previous appeals resulted in an approval for revision of left breast reconstruction due to post-operative complications

• Denial upheld for revision of the right breast reconstruction to provide symmetry as not medically necessary
Resolution

- Reviewed previous documentation submitted with appeal
- Reviewed policy language and language of previous denials
- Researched standard of care and clinical guidelines for breast reconstruction
- Identified that the federal policy for Women’s Health and Cancer Rights Act (WHCRA) requires that insurance companies cover all stages of procedures to produce a symmetrical appearance
- Submitted expedited internal appeal packet on behalf of patient which resulted in an approval for right breast reconstruction to provide symmetry
- Coordinated with treating provider to ensure proper coding for procedure
Final Thoughts

01
Be proactive – contact insurance company before issues arise. Prior to screening, genetic counseling, before large procedures or treatments to be informed on coverage, in-network providers, or needed pre-authorizations.

02
Pay attention to changes in plan benefits and re-enrollment periods to ensure you have the plan that’s right for you.

03
Be persistent in all levels of communication and during appeal process. Even after a decision has been made, ensure that all paperwork continues to the right place. Keep copies! Re-submission/tracking is a common occurrence.
Resources

• Your Insurance Company's Website and Member Services Phone

• FORCE website & resources
  www.facingourrisk.org

• Health Resources & Service Administration
  www.hrsa.gov/womensguidelines

• US Preventive Task Force Recommendations
  www.uspreventiveservicestaskforce.org

• ACA Preventive Coverage & Essential Benefits
  www.healthcare.gov/coverage/preventive-care-benefits/

• Patient Advocate Foundation
  Case Management Services 800-532-5274
  A Patient's Guide to Navigating the Insurance Appeals Process
  www.patientadvocate.org/publications
Thank You!