



The CLRC is a joint program of the Disability Rights Legal Center & Loyola Law School

How to Ensure Your Healthcare Gets Paid For - California

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BEFORE TREATMENT

Tips to avoid getting medical bills

1. Check which providers and services are covered by your health plan before making an appointment

If you are in a Managed Health Care Plan (HMO or PPO), read your Evidence of Coverage (EOC) booklet that explains the rules of your health insurance plan. Also look at any preferred provider lists to see which providers are covered by your plan. Before you make an appointment, make sure that your health insurance plan will cover the services you need. You should have a Summary of Benefits from your plan which tells you which services are covered. Some services require “pre-authorization” from your health insurance company before you receive services, which can take some time.

2. Tell your doctor if you have health insurance

Tell your doctor, hospital, and other providers if you have health insurance. If you have more than one kind of insurance, be sure to let them know. Some people have both Medicare and Medi-Cal, for example. Another example is supplemental insurance. (These are additional health insurance policies that some people purchase to cover services, co-pays, deductibles, etc. that are not covered by the person’s primary health insurance.) It’s a good idea to take the initiative to ask your doctor if they will pass on your insurance and contact information to secondary providers like laboratories or imaging facilities.

3. Take your insurance card to doctor appointments and to the pharmacy

Always take your insurance card to doctor appointments and to the pharmacy. Make sure you give your card to the staff when you check in for your appointment or pick up your prescription. This is how they will know to send your bills to your health plan. Ask the person who is assisting you to make a copy of your insurance card, if they don’t ask to do so.

4. Keep your contact information current

Make sure that your health care providers have your current contact information, including your address and a phone number where you can be reached. Your health care providers include your doctor, your pharmacy, your Medi-Cal worker (if you are on Medi-Cal), and your health insurance plan. Ask your health care provider to pass your contact information along to secondary providers like laboratories or imaging facilities.

5. Look into getting your medical costs covered by an outside source

Medi-Cal

If you do not have health insurance, look into getting your medical costs covered by an outside source. Find out if you are eligible for Medi-Cal or Medicare. To qualify for Medi-Cal you must have limited income and limited resources, and be over 65 or have a disability. If you are receiving Supplemental Security Income (SSI) you are also eligible for Medi-Cal. Eligibility for Medi-Cal can be retroactive for up to three months, beginning in the month before you file your application. However, you must have been financially eligible for Medi-Cal for each month you are requesting retroactive eligibility. In addition, if you do not qualify for Medi-Cal, California has a “share of cost” program that requires you to pay a certain amount of money out of pocket before Medi-Cal will pick up your medical costs. You can call the California Department of Health Services at 800-952-5294 to see if you qualify for Medi-Cal or Medi-Cal’s “share of cost” program.

Medicare

You qualify for Medicare if you are 65 or older and entitled to Social Security retirement benefits. In addition, people who have been receiving Social Security Disability Insurance Benefits for over 24 months are eligible for Medicare even if they have not yet reached age 65.

COBRA

If you recently lost health insurance coverage through an employer, you might be able to get COBRA coverage. COBRA lets you keep your health insurance plan after you leave a job or after you lose insurance you had through your spouse's or parent's job if you elect this within 60 days. If you choose to elect COBRA coverage, you will have to pay the health insurance premiums. These are often expensive, but may be less than paying a large medical bill.

MRMIP

California's Major Risk Medical Insurance Plan (MRMIP) is available to people who do not qualify for other insurance due to a preexisting condition. Although people with MRMIP coverage are responsible for paying premiums for the coverage, the premiums are often much cheaper than the full cost of all of the person's medical expenses, particularly if they have a serious illness.

Other options

If you were hurt on the job or while you were doing something for your work, you should talk to your employer about filing a Workers' Compensation claim. Workers' Compensation pays for medical care to treat injuries that happen while you are doing something for your employer. You may also want to consider speaking with a Worker's Compensation attorney. Your local or state bar association may be able to refer you to an attorney in your area.

Is the medical bill from injuries caused by someone else? If so, be sure to talk to a lawyer who does "personal injury" cases. You may have a right to get money from the person who injured you. Your local or state bar association may be able to give you a referral to an attorney who takes personal injury cases.

There may be other programs available to assist with paying the costs for your medical treatment. You should look into what programs might be available before you need to seek medical treatment, if possible.

6. Apply for free care or charity care

Hill-Burton

In 1946, Congress passed a law that gave hospitals, nursing homes and other health facilities grants and loans for construction and modernization. In return, they agreed to provide a reasonable volume of services to persons unable to pay and to make their services available to all persons residing in the facility's area. This is known as the Hill-Burton program. You can check the U.S. Department of Health & Human Services (HHS) Health Resources and Services Administrations website, <http://www.hrsa.gov/hillburton/default.htm>, to find a Hill-Burton facility near you. You may be eligible for Hill-Burton reduced-cost care if your income is up to two times the 2007 HHS guidelines (or three times for nursing home care).

AB774

California's Payer's Bill of Rights now requires that hospitals provide information on their charity care and financial assistance policies to uninsured persons. They must also provide an application if requested. In addition, AB 774 requires hospitals to post notices with information about the hospital's discount programs in commonly used areas. They also must have written financial assistance policies with eligibility criteria. You should apply as early as possible for charity care programs to avoid future debt collection problems. If the bill has already gone to collections, ask the hospital to rescind it if financial assistance is granted.

CMSP & MIA Programs

County residents who have no other way to pay for health care may be able to get services through County Medical Services Programs and Medically Indigent Adult Programs. You can find information about these programs by contacting your local county health department. If you were not told about your county program prior to receiving health services, ask the hospital or clinic that is sending you a bill why you weren't screened for these programs.

Other health care providers may offer free or reduced-cost care for persons meeting their program's particular requirements. Check for providers that offer free or sliding-scale services in your area. Also, some pharmaceutical companies offer prescription drugs at reduced cost through a patient assistance program. Other ways to reduce prescription drug costs include asking for generic alternatives, and checking into mail order options.

7. Always read health forms carefully before you sign them

Do not sign anything that you do not understand. If you do, you might be agreeing to pay for services and treatments without knowing it. It is okay to ask your doctor or provider questions about any forms that you are being asked to sign.

AFTER TREATMENT

Strategies for reading and negotiating hospital bills

1. Request an itemized copy of your medical bill and review it
 - Verify the dates noted on the bill. Make sure they are the dates you actually received treatment.
 - Look for data entry errors. For example, an extra zero added to an item, so that 1 x-ray becomes 10.
 - Confirm that the services listed are ones you actually received, and are appropriate for your particular condition. For example, if you were undergoing heart surgery, there should not be charges for setting a broken leg.
 - Ask your provider questions if you don't understand your bill.
2. Request a copy of your medical record and pharmacy ledger

Compare your medical records to your bills. Look for procedures that are billed for, but not in your medical records, or billed for more times than they are listed in your records. Look for procedures or medications that were ordered and then cancelled, but are still listed on your bill. Look for medications or other items that were ordered, but that you refused prior to receiving. Confirm that any operating room time billed is not for longer than the surgery actually lasted.

3. Compare the bill to the hospital's standard charges to determine if there are overcharges

California's Payer's Bill of Rights requires hospitals to make their standard charges available to the public for all of their products and services in a document called a "chargemaster." This information must be available, either at the hospital, or through the Office of the Statewide Health Planning and Development website: www.oshpd.ca.gov/HQAD/Hospital/Chargemaster/index.htm. The pricing listed in the chargemaster should not be significantly different from your hospital bill. Also, AB 774 requires that uninsured patients with income below 350% of the federal poverty level, cannot be charged more than the highest amount the hospital would receive for the same care under a public health care program like Medicare or Medi-Cal.

4. Look for items billed due to the hospital's negligence

Generally, when a hospital makes an error, the patient is asked to pay for it. For example, if an x-ray is lost or the results of a blood test are misplaced, those procedures will be redone and the patient will be billed. You may challenge these charges. Also, charges based on delays caused by the hospital should be challenged. For example, in a non-emergency situation, sometimes the hospital's own scheduling needs for tests or surgeries will result in longer hospital stays.

5. Obtain the services of a professional bill reviewer

A professional bill reviewer can offer expertise with finding errors in standard billing practices and experience negotiating a payment plan. If you have tried these techniques on your own, and still think your bill is too high, it might be time to call a professional bill reviewer, also known as a claims assistant professional. You should take this step if lowering the amount of the bill will actually make a difference in your situation. (For example, if you are in debt and are being sued, or if negotiating a payment plan might actually be possible, but you have already done everything you can think of to lower the bill.)

If you cannot readily find errors, bill reviewers can (1) check the diagnosis codes to see if an ailment has been "upcoded" to a more serious condition than what your medical record states; (2) determine if some charges were added that are already contained in other bundled charges, and (3) have the expertise to know what is beyond the industry standard. Most bill reviewers will also assist in negotiating with the provider or testify as experts in collection defense suits, if contracted to do so.

6. Negotiate a payment plan

Setting up a payment plan with your provider can be a good option when (1) the charges are legitimate, (2) you can make the payments, and (3) the debt will eventually be paid. You may want to consult a consumer attorney for advice prior to negotiating a payment plan. You may also wish to contact a Consumer Credit Counseling Service for assistance with negotiating a plan.

If you decide negotiating with your provider is your best option, try to work out a reasonable payment plan, or if it is possible, offer the hospital a lump sum payment to settle your debt. You can write out an agreement in which both parties agree to a payment plan or lump sum settlement that includes removing any negative reports to credit bureaus, so that once the debt is paid off, the provider will send you a new statement that reflects a zero balance.

Tips for disputing a bill

1. If you believe your health plan should have paid the bill, call your plan to find out why they did not pay it

Your health insurance plan's phone number is usually on your insurance card. Your health insurance plan may have refused to pay the bill because of a mistake on the bill. If you are able to resolve the mistake, then you should call your medical provider's office and health insurance plan to make sure the bill is actually paid and that your account is cleared.

2. Send a letter to the health provider who billed you

In the letter you should include any information that explains why you believe you should not have been billed, or why the bill you received is incorrect. Provide as much detail as possible. This is especially important if you are getting hospital bills for many services. You should include a copy of the bill you are disputing so that the provider knows which bill you are referring to.

If you had health insurance at the time you received services, make sure the provider submitted the bill to your health insurance plan. Send a copy of your insurance card to your medical provider, and be sure to show that the insurance was effective on the day(s) you were billed for. If your insurance plan needs your medical provider to fill out forms, send the forms to the provider.

If your insurance company has suggested that a treatment you have received or asked to receive is not covered by your plan because it is not medically necessary, you should get a letter from your doctor stating why the treatment is medically necessary, and send the letter to your insurance company. Keep copies of your letter and anything else that you send, so you have proof of what you sent. You may want to send your letter certified mail and ask for a return receipt so you can show that the provider received your letter. Keep a written record of the names and telephone numbers of anyone you talk to about your bill. Also note the date on which you spoke and any relevant information that you discussed.

3. File a grievance

Look at the Summary of Benefits from your insurance company to find out how to file a grievance with the company. The complaint or grievance should be in writing. If the plan does not resolve your grievance within 30 days, or if you disagree with the company's final decision, you can file a complaint with the California Department of Managed Health Care (DMHC) or Department of Insurance. (See next section for more information on how to seek external review of your health plan's decision.)

How to dispute your health insurance company's decision

If you disagree with a decision that your health insurance company has made regarding coverage, you have the right to appeal that decision. The appeals process varies depending on what state you live in. In California, you must first exhaust your health plan's internal appeals process, and then you can request an external review of the decision.

1. Understand your coverage and applicable laws

Before you begin an appeal, you should understand your coverage and applicable laws. Different laws apply to different types of health plans.

An employer-sponsored health plan is one that a person can get through their own employment or through a family member's employment. The employer usually makes a contribution toward the cost of the employee's coverage. An individually-purchased plan is one that you purchase directly from a health plan. The person purchasing the insurance pays the entire premium. Different laws apply depending on whether your plan is employer-sponsored or individually-purchased.

If your plan is an employer-sponsored plan, you need to know whether it is a self-insured plan. A self-insured plan is one in which the employer does not contract with an insurance company to insure their employees. Instead, the employer does their own risk pooling like an insurance company would, and pays directly for their employees' health costs. Since self-insurance does not involve a contract between an insurance company and an employer, it is not subject to state insurance regulations. Federal laws still apply to self-insured plans.

Know what is covered and what is not covered by your plan. Also know what procedures and deadlines are required by your plan.

2. Exhaust your plan's internal appeals process

If you have a problem with your health plan, you have the right to file a complaint with your health plan. A complaint can also be called a grievance or an appeal. You may be able to file your complaint by phone, mail, or the internet. If you need assistance finding your plan's contact information, you can go to the

DMHC's website, type in the name of your plan, and get your plan's information. Go to:
http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_contact.asp.

You must exhaust your plan's internal grievance process before you may pursue external review through the DMHC or the Department of Insurance.

If your problem is not urgent, your health plan must give you a decision within 30 days.

If your problem is urgent, meaning there is a serious threat to your health, your health plan must give you a decision within 3 days.

3. Request external review

You can file a complaint with the DMHC or the Department of Insurance (depending on which type of plan you have) if you are not satisfied with your health plan's decision, if you have not received the plan's decision within 30 days, or if the problem is urgent. The DMHC oversees HMOs and all Blue Cross and Blue Shield plans. The Department of Insurance oversees all other health plans.

In California, you have the right to receive an external review of your plan's decisions, called Independent Medical Review (IMR). IMR decisions are based on the medical necessity of the treatment and are binding on the plan. Complaint forms are available on the DMHC website at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.asp and on the Department of Insurance website at <http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm>. See the DMHC and Department of Insurance websites for more information on the types of disputes that can be appealed to the two Departments.

Financial assistance resources to help pay your remaining medical bills

1. Private financial assistance programs

There are many private financial assistance programs, such as Salvation Army, Lutheran Social Services, Jewish Social Services, and Catholic Charities. Look for programs that serve your community.

2. Local service organizations

Local service organizations like Kiwanis, Rotary Club or Lions Club sometimes provide financial assistance.

3. Non-profit programs

Non-profit organizations like the American Cancer Society, the Lance Armstrong Foundation, Patient Services, Inc., and the Patient Advocate Foundation also provide assistance.

4. Cancer-specific programs

Some programs are designed to assist people with a certain kind of cancer, such as The Leukemia & Lymphoma Society, The American Kidney Fund, and The Lung Cancer Information Line.

5. Government benefit programs

Government benefit programs include state disability insurance benefits (depending on what state you live in), Supplemental Security Income, and Social Security Disability Insurance. These programs provide you with income while you have a qualifying disability. Please note that the eligibility requirements for these programs vary, and not all programs have income and asset restrictions.

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