

The Appeals Process:

When cancer patients are denied coverage for treatment (called a claim) by their insurance company, patients then have to decide whether to appeal and petition their insurer to pay.

Insurers may deny coverage—that is, refuse to pay for care—for a variety of reasons, ranging from billing code errors to treatments deemed “experimental” or “not medically necessary.”

50%- 60%

OF THE TIME

Patients who appeal insurance denials actually **win coverage**.

(US GOVT ACCOUNTABILITY OFFICE, 2011)

THE REALITY, HOWEVER, IS:



Most patients don't appeal. For employers, denials rarely save them money, because the burdensome appeal process creates greater medical costs down the road by needlessly delaying care for their employees.

IN 2019,

40.4 Million

Claims were denied by insurance companies.

OF THOSE DENIED CLAIMS, ONLY

0.2% Appealed

(Kaiser Family Foundation, January 2021)

TO TACKLE AN APPEAL,

A patient (or their loved ones) must be **proactive, persistent, thorough** and able to withstand the stress and uncertainty of the process, on top of the stress and uncertainty of their illness.

“Insurance companies have built a business model around denials, knowing that people take ‘No’ for an answer... the worst-case scenario for the insurance company is that the patient actually appeals, and then it has to pay for the care it was supposed to pay for to begin with.”

~ Joanna Morales, *Cancer Rights Attorney & CEO of Triage Cancer*

EMPLOYERS CAN address this by selecting or designing health plans that **streamline the approval and pre-authorization process from the start, before appeals are needed.**