A top-down view of various medical supplies on a grey surface. The items include several blister packs of pills in different colors (yellow, orange, white, silver), several syringes with different colored plungers (pink, purple, clear), a pair of surgical scissors, a stethoscope, a blue glucose meter, a purple insulin pen, a pair of white gloves, and a small container of orange pills. The background is a plain, light grey surface.

ADVOCATING FOR YOUR DIABETES NEEDS

By Melissa Lee and Martin Wood
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Diabetes is expensive. The costs of diabetes-related therapies, drugs, and accoutrements keep many people from taking care of themselves as well as they could. In the United States, affordable access to health insurance that covers pre-existing conditions, including durable medical equipment like diabetes supplies, is an essential part of living well with diabetes. For people with insulin-requiring diabetes, the costs of disease maintenance can be astronomical.

A study published in the Journal of the American Medical Association in 2016 indicated that the price per milliliter of insulin increased by 197% between 2002 and 2013 [1]. Since then, insulin prices have continued to rise, and members of the diabetes patient community have called for fairer pricing of this medication that is imperative to their survival. There is no middle ground when it comes to living well with diabetes. Either people have access to the medications and therapies that they need, or else they develop serious and life threatening complications as a result.

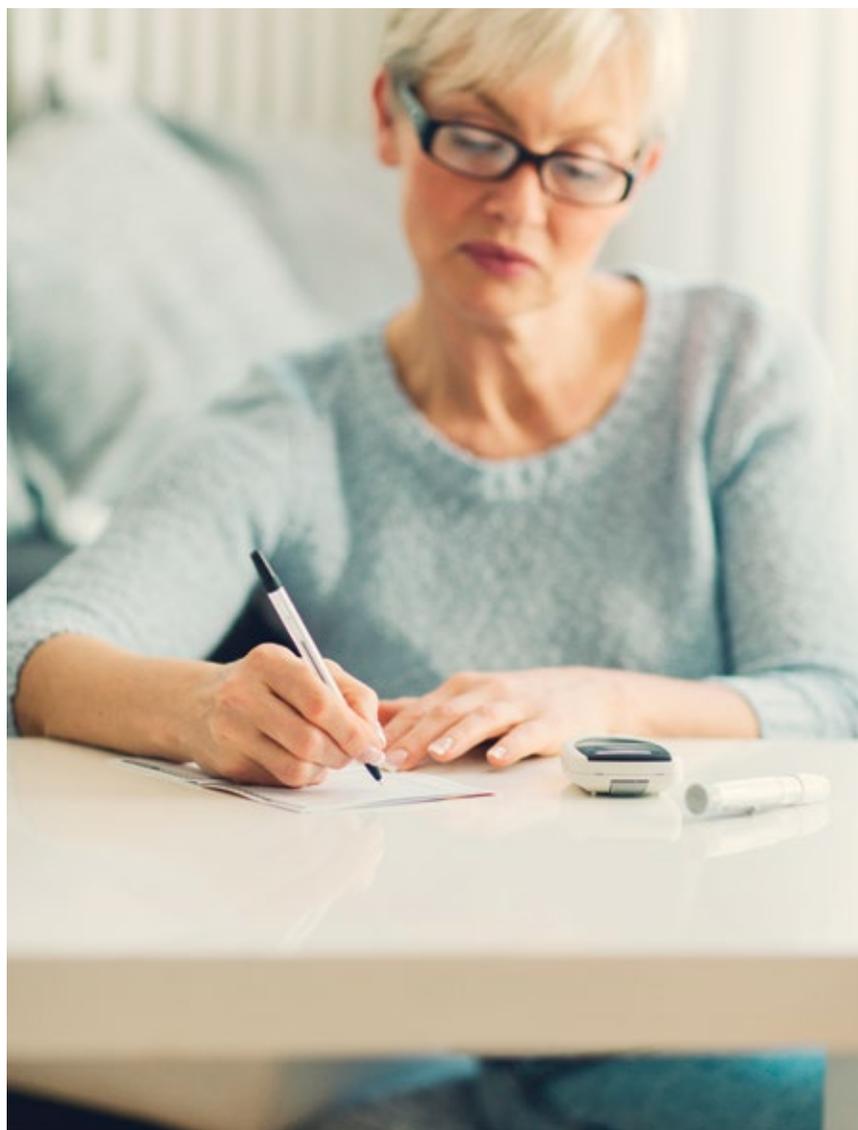
Getting these expensive medications, and the devices to deliver them such as insulin pumps and insulin pens, along with blood glucose monitoring equipment such as meters, strips (in the brand and quantity required), and continuous glucose monitoring systems, can be a test of one's ability to advocate for themselves, even with health insurance coverage. Barriers include supply quantity limits, complicated and restrictive formularies, and high deductibles. Below are some experience-driven tips to guide people living with diabetes on how they can advocate for themselves before, during, and after visiting with their healthcare provider.

BEFORE THE VISIT:

- ➔ Write down all of your prescriptions, how many refills you have left, and which prescriptions you need refilled or changed.
- ➔ Download your meter and insulin pump data. Print out data reports so you can identify trends and take notes during your visit.

➔ For the month leading up to your visit, make sure you have a solid amount of data points to share with your healthcare provider. Aim for 4-6 finger pricks per day. Don't just capture the good numbers. IT'S ONLY DATA. Keep it real, whether those numbers are high, low, or normal. Your numbers are to help you see where you can make adjustments and fine tune your diabetes management for better results. It's not a report card. No one is going to punish you.

➔ Write down any questions you have. Don't rely on your memory alone. You spend 3-6 months waiting to spend approximately 16 minutes with your physician[2]. Make those minutes count.



DURING YOUR VISIT:

→ Ask your physician to note anything in your record that could later help to have documented. For example, you could include a note in your patient record about how you struggle to read the screen of that particular meter/pump due to your vision, or how those lancets on your formulary are too painful, or how you check glucose frequently due to hypoglycemia unawareness. If it is in your written record, your provider can use it to your advantage when negotiating with your payer.

→ Get the specific name and contact information for who your insurance company can call if they need information from your healthcare provider. This could be the general office number for your physician's practice, it could be a Certified Diabetes Educator on staff, or it could be the direct line to a physician. Getting this information while your healthcare team is immediately accessible to you can save you from having to track it down later.

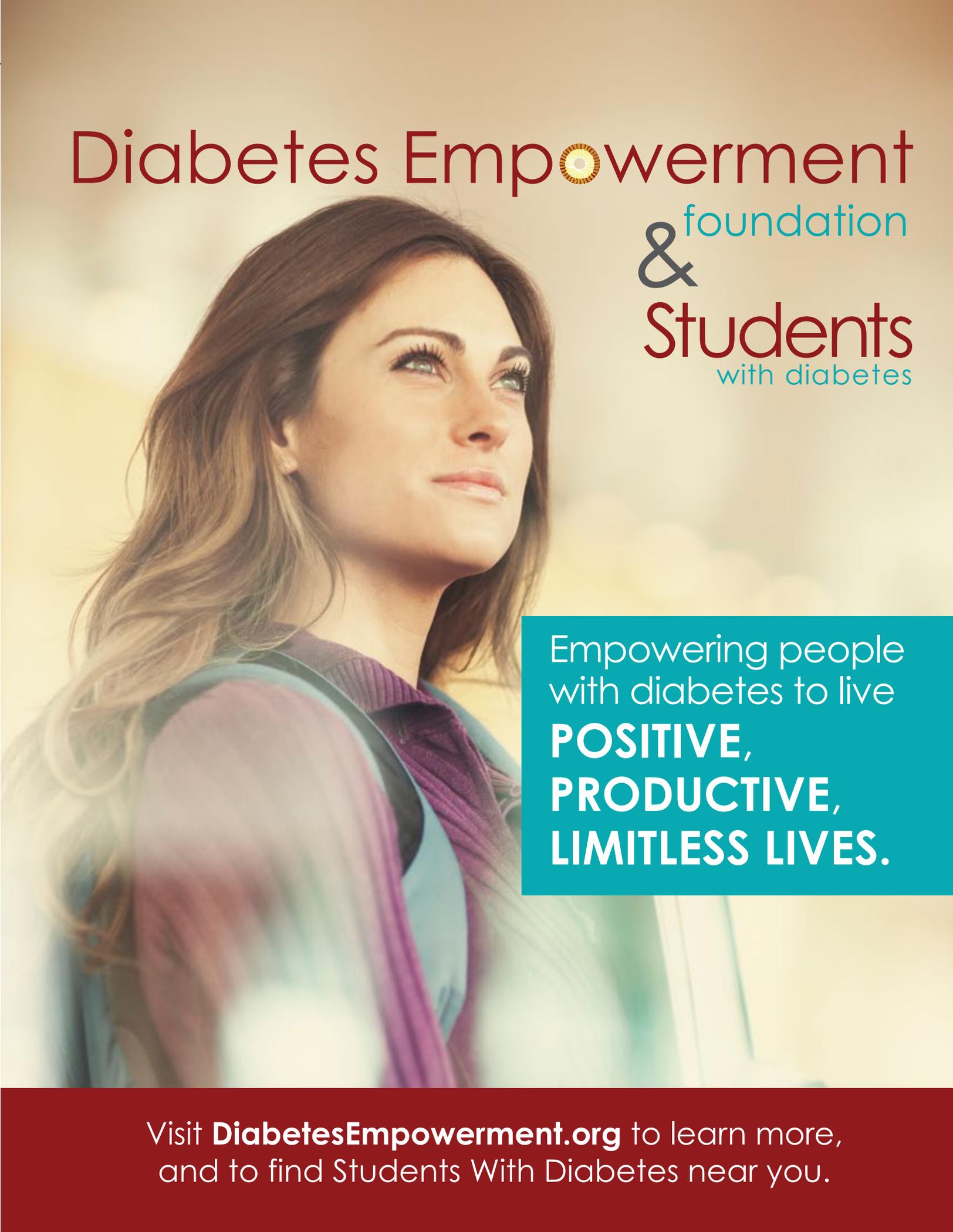
AFTER THE VISIT:

→ Fill your prescriptions immediately. Don't wait until you need them. Medications are subject to the same rules of supply and demand as everything else.

→ When trying to acquire new diabetes technology, such as a new insulin pump or a continuous glucose monitor, it's important for you to realize that insurance companies make decisions based on a wide variety of concerns, which may include:

- Your insurance company's current drug formulary
- Medical necessity
- Preferred provider deals with select medical device companies
- Precedent of other patients acquiring the technology successfully
- Evidence that the technology makes a positive difference in living well with diabetes





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IF AT FIRST YOU DON'T SUCCEED:

→ You will likely receive a letter stating that your request was denied. It may or may not give a reason. Follow up. Ask for a detailed explanation as to why your request was denied, and specifically what the insurance needs in order to cover the device.

→ Imperative to the insurance approval process is to identify your plan's medical policy for that specific benefit. You can usually search for the name of your insurer (Aetna, Blue Shield of California, etc.) on Google, and include the words "medical policy" to retrieve the results you need. Your plan's medical policy outlines exactly what the payer needs to see in order to approve the request.

→ Call your physician for assistance. This is necessary. Sometimes all that is needed is a letter of medical necessity, which your physician can provide, along with data to back it up and make the case even more compelling. Those 30 days of data you worked so hard for can now go to work for you! Your physician can also request a peer-to-peer conversation with an insurance company's physician to argue for the benefit you are trying to get approved and why you need it. This is not a route available to patients, so use your physician as your advocate.

→ If you have an insurance plan through your employer, enlist the help of your company's Human Resources or benefits manager. They are trained to help you negotiate for your benefits and uniquely situated to select plans for the coming year based on the needs of their employee population. Make sure they are aware of your needs. The more employees a company has, the greater the likelihood that others have similar and complementary health insurance needs.

→ Ask your health insurance company if you can speak with an advocate on their end. Many payers have advocates internally who can be assigned to your case and follow up with you like a case coordinator.

→ If you continue to be denied, keep trying. Don't take "No" for an answer. According to the U.S. Government Accountability Office, 39-59% of denials are approved after their first appeal [3]. Insurance companies may only give you one reason at a time as to why they won't cover your diabetes needs, but if you and your physician determine your request is medically necessary, then keep fighting for it.

Having the tools that you need to manage your diabetes effectively is not only good for you, it is also good for your insurance company. In 2012, over \$14 billion dollars was spent on emergency room visits by people with diabetes [4]. Working together to prevent complications that are a result of poorly controlled diabetes is an easy way for both you and your insurance company to save money in the long term. Use your resources, rely on your data, and make the case for what you need to live well with diabetes.

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