THE INSURANCE PRIMER

TWELVE INSURANCE TERMS YOU MUST KNOW

Health insurance policies are complicated and confusing. It can be especially difficult for patients to decipher health insurance policies because they are written with complicated terms and legal jargon.

Here are 12 health insurance terms that every patient needs to know.

ALLOWED MAXIMUM BENEFIT

Allowed Maximum Benefit or "maximum dollar limit" is the maximum amount of money that your health insurance company will pay within a certain period of time. That could refer to a lifetime maximum benefit, or an annual maximum benefit.

COPAYMENT, COPAY

A copayment or "copay" is the amount you pay each time you use a health care service. Not all services require a copay, but most do. For example, a doctor's visit usually requires a patient to pay a copay. Some insurance policies do not require a copay for an annual physical exam.

Copays can vary based on the service. Emergency room visits frequently have a higher copay. Copayments are not usually counted towards your out-of-pocket limits.

COINSURANCE

Coinsurance is the amount of money you pay out-of-pocket after you have met your deductible. Usually, coinsurance is a percentage of a services cost. The amount you pay in coinsurance is applied towards your out-of-pocket maximum. That could be 70 percent for the patient -- while the insurance covers the remaining 30 percent.

DEDUCTIBLE

Before health insurance pays anything, the patient is required to pay a deductible. Different plans set different deductible levels. If you have a $2,500 deductible, you must pay $2,500 out-of-pocket before your insurance covers any health care services.

There are often exceptions to the deductible for certain preventive services, immunizations and health screenings.

ESSENTIAL BENEFITS

Essential benefits are covered by your insurance, regardless of whether you have met your annual deductible. Under the Affordable Care Act, essential benefits are defined as services that every health care plan must cover.

Essential Benefits include the following ten services:

- Ambulatory patient services (aka, outpatient care)
- Emergency services

- Hospitalization
- Pregnancy Care (including maternity and newborn care)
- Mental health and substance abuse
- Prescription Drugs
- Habilitation and Rehabilitation (includes devices)
- Laboratory services
- Preventive and wellness services
- Pediatric care (includes dental and vision for pediatric patients)

HEALTH SAVINGS ACCOUNT (HSA)

A health savings account (HSA) allows patients to set aside pre-tax money into a special account that can be used for health care expenses. Money in a health savings account can go towards copayments, hospital fees, prescriptions. Unused funds in your health savings account can be rolled over to the next fiscal year.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An HMO is a type of health coverage insurance that restricts patients access "to care from doctors who work for or contract with the HMO."

If you decide to see a physician outside of the HMO, it likely will not be covered by the HMO, meaning you may be responsible for 100% of the cost. Under an HMO, all services must be funneled through your Primary Care Physician. In other words, you cannot see a cardiologist without a referral from your PCP.

MAXIMUM (OUT-OF-POCKET MAXIMUM)

A "maximum" is just what it sounds like – the limit on how much either you will have to pay out-of-pocket in an "out-of-pocket maximum." Maximums can apply to what your insurance will cover for you in a year or a lifetime.

If you see the word "maximum," pay close attention to the what counts towards the cost.

MEDICAL NECESSITY

Insurance companies frequently deny patients access to a medication, service or treatment by claiming it's not a medical necessity. When an insurance company denies a treatment, the burden of proof falls on the patient to provide proof of medical necessity from their doctor or specialist.

To challenge an insurance denial, a physician will provide a letter of medical necessity.

OUT-OF-POCKET

Out-of-pocket costs are the amount that the patient pays for a service, treatment or medication. If a service is not paid by your insurance, the patient pays for that service entirely -- with no amount paid by insurance.

Out-of-pocket applies to any healthcare cost you have to bear, including coinsurance or uncovered services. Some health insurance plans include out-of-pocket maximums, or out-of-pocket limits, which cap a patient's costs during a period of time.

PREMIUM

Every month, a patient pays an insurance premium as the cost of obtaining health insurance.

If you get your health insurance through your job, your employer may pay a portion of the premium. If you have insurance through a state health insurance marketplace, you pay the full premium yourself.

POINT OF SERVICE (POS)

Point of Service plans, like HMOs, require a patient to see a Primary Care Physician before visiting a specialist. Point of Service plans differ from HMOs in that there is usually a larger network of contracted doctors and providers.

Just like any other kind of network of care, if you go out of the POS network, your out-of-pocket costs will be higher.

PREFERRED PROVIDER ORGANIZATION (PPO)

PPOs differ from HMOs in that, you do not need to have a Primary Care Physician. You can see a cardiologist without a referral. You can also see doctors and get services outside of the PPO, though you will pay more out-of-pocket for those services. Services within a PPO network are normally covered with a copayment.

DEALING WITH HEALTH INSURANCE

So many aspects of health insurance can be confusing

- figuring out what type to get
- knowing how to use it once you have it
- learning what to do if your claims are denied

FAIR Health, a national, independent, nonprofit that aims to bring transparency and clarity to healthcare costs and health insurance information, provides a comprehensive series of guides and videos to explain health insurance. They have information on health plans from employers, an exchange/marketplace or a union, or one that you bought directly from an insurer.

Their website explains many common insurance questions, including:

- What do the terms in my Explanation of Benefits (EOB) mean?
- How are in-network and out-of-network care different? How do they affect my costs?
- What are co-pays, co-insurance and deductibles?
- What should I think about before I choose a medical or dental insurance plan?
- I saw an in-network doctor. Why did I get a bill?

- What do I do if my claim was denied?
- How can I use my Flexible Spending Plan to pay for my healthcare costs?
- What to Do When Your Insurance Company Says No

INSURANCE DENIALS

Insurance denials come in many forms. The Alliance for the Adoption of Innovations in Medicine has identified four of the most common insurance roadblocks:

- Adverse Tiering: a method used to discourage patients with certain conditions from enrolling in a health plan by placing newer drugs for diseases like cancer and HIV on the highest copayment tier. A 2015 study in The New England Journal of Medicine found that some insurers participating in the state health exchanges placed all HIV therapies on the highest tier, meaning enrollees in these plans paid more than twice as much for their drugs as those in other plans.
- Non-medical Switching: a practice where the health plan switches patients who are stable on a medication to different treatment for non-medical reasons by refusing to cover the therapy any longer or significantly increasing the copay. While insurers use this practice to control costs, patients may experience negative side effects of the new treatment regimen or become less responsive to treatment even if returned to their original medication.
- Prior Authorization: a process requiring physicians and other health care providers to obtain advance approval from a health plan before a procedure, service, device, or medication is given to a patient and qualifies for payment coverage. Prior authorization can lead to delays in treatment. In a 2010 American Medical Association survey of 2,400 physicians, two-thirds reported waiting several days to receive authorization for drugs, while 10 percent waited more than a week.
- Step Therapy: a policy sometimes referred to as “fail first” that requires the individual to try one or more less-expensive treatments first and “fail” on them before the health plan will cover the one prescribed by the provider. Step therapy not only delays effective treatment, but multiple studies show the practice increases the costs to the healthcare system, particularly for hospital and emergency-room care.

There is also:

- Co-Insurance
- High Deductible Plan
- Out-of-Network Charges

If your insurance company denies your claim, you have rights to fight back.

KNOW YOUR RIGHTS

Aimed Alliance has launched “Know Your Health Insurance Rights”—a website that offers specifics steps to take if your insurer improperly delays or denies your coverage. That can include: filing an

appeal directly with the insurance company, requesting an outside review by an independent third party, or filing a complaint with the insurance commissioner or attorney general in your state.

Your odds of reversing your insurance company's decision are better than you think. That goes for internal appeals directly with your insurance company and external appeals with an outside government agency.

According to a 2011 report by the Government Accounting Office, patients who fled internal appeals directly with their insurance company saw insurance companies reverse their initial denial 39 to 59 percent of the time. In 2009, 54 percent of patients in California succeeded in reversing or revising an insurance denial through the external appeal process.

In other words, it pays to fight your insurance company and file an appeal.

HOW TO REQUEST AN INTERNAL APPEAL

If your insurer denies your claim, you have the right to an internal appeal. This means you can ask your insurer to conduct a full and fair review of its decision. To appeal the denial, you should do the following:

- Review the determination letter. Your insurer should have sent you a determination letter to tell you that it would not cover your claim. Review this document so you can understand why your insurer denied your claim and how you can appeal the denial.
- Collect information. In addition to the determination letter, collect all documents that your insurer sent to you, including your insurance policy and your insurer's medical necessity criteria. "Medical necessity criteria" refers to your insurer's policy for determining whether a treatment or service is necessary for your condition.
- Request documents. If your insurer did not send you the determination letter, your policy, the medical necessity criteria, or instructions and forms for filing an appeal, call your insurer and request these documents.
- Call your health care provider's office. Contact your healthcare provider's office to ask for help with the appeals process. Someone in his or her office might help you fill out the forms to request an appeal and draft a strong appeal letter.
- Submit the appeal request. You or someone in your health care provider's office should submit the appeal forms along with the letter from your health care provider and any additional information that your insurer requested. Be sure to follow your insurer's instructions closely and make a copy for your own records of all documents you or your health care provider submitted to the insurer.
- Request an expedited internal appeal, if applicable. If your case is urgent, you should contact your insurer and ask for instructions on how to apply for an expedited internal appeal. Your situation is urgent if it jeopardizes your health, life, or ability to regain function.
- Follow up. Follow up with your insurer regularly until you hear back. Be sure to keep a record of the name of any representative you speak with about the appeal, the date and time you spoke with that person, a confirmation number for the call, and a summary of your discussion.

The Patient Advocate Foundation also provides extensive information on appealing insurance denials, including a booklet called "Navigating the Insurance Appeals Process."

KEEP TRACK OF YOUR MEDICAL BILLS

There's no one best way to keep track of your medical bills. Some people are more comfortable with paper files, while others prefer keeping electronic records. Once you decide the way you want to keep track of your medical bills, you can find many tools to help you.

Cancer.net has put together an essential list of all the information you should keep track of to help you manage payment of medical bills:

- Records of each appointment, including the date and any lab work, tests, or procedures that took place
- The name and dose of each drug prescribed and the name of the doctor
- Copies of checks and credit card receipts for co-pays and other health care costs
- A current copy of your health insurance coverage
- Bills and invoices from health care providers, such as doctor's offices, hospitals, or labs
- Insurance claims filed by you, your doctor, or your hospital
- Explanation of benefits statements from your insurance company for processed claims
- Insurance reimbursements you've received
- Insurance claim rejections you've received and appeal letters you've written

TAX DEDUCTIONS

You are allowed to deduct from your taxes the amount of your total medical expenses that are more than 7.5% of your adjusted gross income. If you think your medical expenses will reach or exceed Internal Revenue Service minimums, keep track of travel, meal and telephone expenses related to your medical care.

TOOLS FOR TRACKING MEDICAL BILLS

Calendar: Using either a paper or electronic calendar, record all your medical appointments, tests, procedures and prescription drug purchases the day they occur so you don't forget. You can refer to the calendar for insurance claims and tax purposes.

Paper Tracking: You can use a pad of paper to record the payment status for medical services. Add columns for the date of the appointment, the doctor's name, the amount paid (with the date), the insurance claim status and other notes.

Electronic Tracking: You can use spreadsheet software to track this information. There is software available that provides a template to view and manage medical data, as well as templates for writing letters to dispute rejected insurance claims. Or you can create your own spreadsheet. Update the list or spreadsheet every time you receive a bill or insurance statement, or pay a bill.

There are websites that will save your insurance information and help you manage medical bills. Examine them closely—some may charge a fee, and others may not have adequate security to protect your data and privacy.

GOING OVER INSURANCE STATEMENTS

You may get several bills for the same care. If you had surgery, you may get bills from the surgeon, the anesthesiologist and the hospital. If you had an X-ray, you may get separate bills from the imaging facility and the radiologist who read the image.

When you get the medical bill, compare it with the insurance statement. Make both have the correct date, provider and type of medical care. Make sure you understand how much of the bill you are expected to pay (the amount your insurer says you owe). If the medical bill is incorrect or unclear, call the provider's billing office. Call your insurer if you have any questions about your health insurance statement. If the insurance company won't cover a service your policy says should be covered, file an appeal (see section above).

FILING YOUR DOCUMENTS

You can set up a paper filing system with separate files for insurance statements, bills and receipts of payment, or you can scan these documents and save them on your computer. Organize bills by date of service. An insurance statement can be about more than one medical bill. Make a copy of the statement and match it with each separate bill it mentions. Include any payment receipts and updated statements about those bills. Medicare has an online tool for storing and accessing personal information: here.

Insurance is hard by design. We hope this helps.

Reach out to us if you need advice.