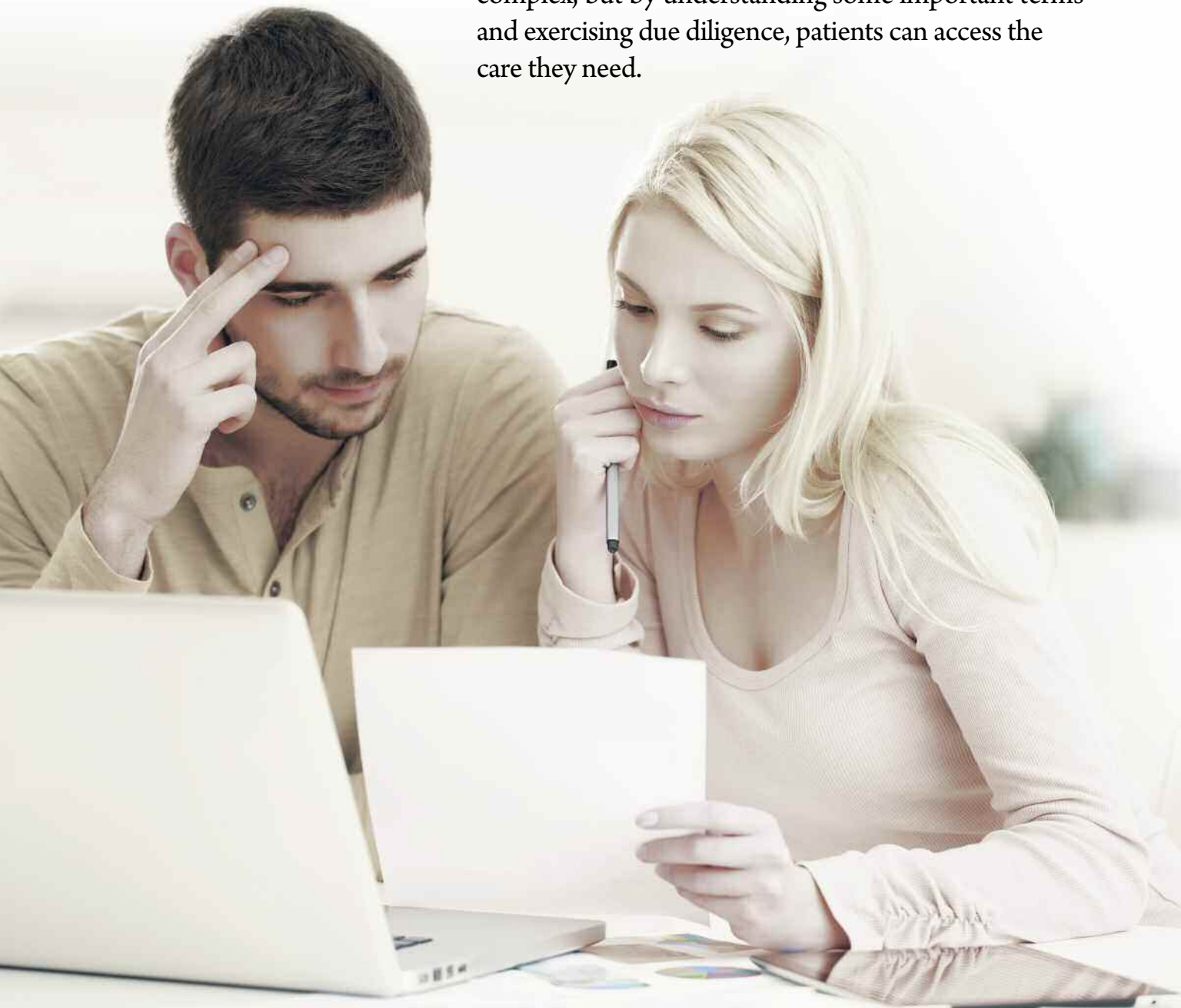


# A Guide to Health Insurance Terminology and Appeals

By Abbie Cornett and Ronale Tucker Rhodes, MS

Navigating the world of health insurance can be complex, but by understanding some important terms and exercising due diligence, patients can access the care they need.



**FOR THE CHRONICALLY** ill, access to care can be challenging, frequently the result of misunderstanding health insurance language, benefits and appeals. Without full understanding of terms commonly used in policies, patients may have difficulty choosing a plan that best meets their individual needs or comprehending what a plan covers. And, because chronic illnesses often require expensive medications and more than one specialist, an uninformed choice regarding insurance could cost patients a lot of money or, worse yet, leave them without care. So, while taking the time to learn the language of health insurance and appeals is time-consuming, it will save money and stress in the long run.<sup>1</sup>

## Understanding Commonly Used Terminology

Becoming literate in the language of insurance is the first step toward making the best decision about plan coverage and care. The following are the most common terms chronically ill patients should be familiar with and how they can affect access to care:

A *premium* is the amount paid each month for health insurance. Most people, when looking for a plan, focus on less-expensive premiums. But, that isn't always the best choice for individuals with chronic illness. Oftentimes, policies with lower premiums have higher deductibles, greater out-of-pocket expenses and frequently include coinsurance. By choosing one of these plans, patients might end up spending more on medication, doctor visits and equipment than if they had invested in a more comprehensive plan with a higher premium. Before selecting a plan, a cost-benefit analysis should be conducted to determine the best option.<sup>2</sup>

*Out-of-pocket expense* refers to the charges for medical treatment that patients are financially responsible for until the plan pays the cost of covered benefits. This includes deductibles, copayments and coinsurance, but does not include the premium or services the plan doesn't cover. The maximum limit for out-of-pocket expenses for 2018 is \$7,350 for an individual and \$14,700 for a family.

*Deductible* is the amount patients pay before the plan will pay for treatment.

*Specialty tiers*, also known as specialty tiering, entail a cost-saving method employed by payers that places prescription drugs into different categories for payment. Depending on the plan, there may be three to five tiers. Medications placed in any of the lower tiers have a fixed copay (for example, a flat rate of \$20 per prescription). However, for medications placed in the top tier, patients are usually switched from traditional copay to coinsurance.

*Copayment* (or copay) is a fixed amount patients pay for doctor visits, medication or lab work after the deductible is met. Many plans have different copays for services. The required copayment is something patients need to consider when choosing a plan. As a rule, plans with lower premiums have high copays.<sup>3</sup>

*Coinsurance*, or cost-sharing, comes into play when the patient pays a percentage of the cost of a treatment instead of a flat rate or copay. This percentage can range from 20 percent to 50 percent. A study conducted in 2013 by the Kaiser Family Foundation on employer health benefits found that 81 percent of covered workers are in a plan with three or more tiers, and that coinsurance is the most common form of cost-sharing in the highest tier. There are many consequences to this policy, but the most notable is that while the policy reduces the cost to the payer, it can be devastating to the patient.<sup>4</sup>

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*Formulary* refers to a list of prescription drugs covered by a health plan, including both generic and brand-name medicines. Understanding what is covered under a formulary is very important for patients who require medications for which there are no generics. A formulary is used to encourage doctors to prescribe less-expensive medications. It's important to be aware that many plans require prior authorization for medications on a formulary.<sup>5</sup>

*Prior authorization* is the process of obtaining approval for coverage from the patient's insurance for a medication listed on a formulary.

*Step therapy*, a practice also known as fail first, is another cost-saving method employed by insurers. Step therapy mandates patients fail on a less-expensive medication before they can be prescribed a different drug that is more expensive but that may be more appropriate to their condition or that has a higher rate of effectiveness.<sup>4</sup>

## Understanding the Explanation of Benefits Report

An Explanation of Benefits (EOB) report shows how health plan benefits are applied to healthcare services received. Specifically, it explains how an insurance claim from a healthcare provider was paid. Claims can include bills for hospital or clinic treatment, lab work or diagnostic charges. An EOB is sent to the patient after an insurer receives a bill from a provider.<sup>6</sup>

An EOB will include the following:<sup>7,8</sup>

1) The name of the provider who performed the services for the patient, which may be the name of a doctor, laboratory, hospital or other provider.

2) The amount the provider billed the insurance company for the service.

3) The allowed charge for the service. Each insurer has its own list of allowed charges, which includes discounted fees an insurer negotiates with doctors, hospitals and other healthcare providers in its network. Unlike providers outside the network, in-network providers have agreed to accept discounted fees as full payment for services rendered. Insurers create incentives for patients to see in-network providers by charging more for services provided by out-of-network providers. Negotiating charges reduces costs for patients and insurance companies.

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4) Total patient cost for the service. This is the amount of money a patient owes as his or her share of the bill. This amount depends on the plan's out-of-pocket requirements such as an annual deductible, copayments and coinsurance. And, when a patient has received a service that is not covered by the plan, the patient is responsible for paying the full amount.

Patients need to be vigilant about what their health plan covers. Mistakes happen. They should keep track of what procedures they undergo, as well as the dates of treatment. And, those procedures and dates should match what is listed on the EOB.

In addition, patients should check to see if there is a "remark code" indicating the insurance company needs more information to process a claim. For example, it may inquire if treatment was for a work injury that should be covered by workers' compensation.

If a claim is denied, there should be a denial code that specifies the reason for denial. For example, if an out-of-network provider was inadvertently used, part or all of a claim may be denied.

"Going over your EOB without any context of what coverage you have is a wasted effort," says Sarah O'Leary, founder and CEO of Exhale Healthcare Advocates. "You must have a thorough understanding of the parameters of your insurance plan when reviewing the EOB, so if something is denied, you'll know how to appeal it. And, there may be errors — according to one estimate, 30 percent to 40 percent of medical bills have errors in them; other estimates are even higher."

## Understanding and Appealing Denials

Denials are the refusal of an insurance company to pay for healthcare services obtained from a provider. Three types of denials can be appealed:

- Denials for services, supplies or prescriptions that a patient has already received such as for a test conducted during a medical visit.
- Denials for a healthcare service, supply or prescription such as a wheelchair.
- Denials for a request to pay a discounted price for a prescription drug (for example, a discount for an expensive medication because the available lower-cost drugs are not effective for the patient's condition).

When a claim is denied, the insurer must notify the patient in writing within 15 days of seeking prior authorization for a treatment, 30 days for medical services already received or 72 hours for urgent care cases. And, it must explain why the claim is denied.

When a claim is denied, the patient has the right to an internal appeal and an external review, if necessary. An appeal is a request to the insurance company to conduct a full and fair review of its decision. And, if the case is urgent, the insurance company must speed up this process. A patient can

also file an expedited appeal if the timeline for the standard appeal process would seriously jeopardize his or her life or ability to regain maximum function.

An internal appeal must be filed within 180 days (six months) of receiving notice that the claim was denied. In urgent health situations, a patient can ask for an external review at the same time as the internal appeal.

To file an internal appeal, the patient must complete all forms required by the health insurer, or a letter can be sent to the insurer with the patient's name, claim number and health insurance ID number. Also, the patient may want to submit any additional information that he or she wants the insurer to consider such as a clarification letter from the doctor. It's also possible to have the state's Consumer Assistance Program file an appeal on behalf of the patient.

For services not yet received, the insurance company must provide the patient with a written decision within 30 days. For services already received, the insurer must provide a written decision within 60 days. In urgent situations, a final decision about the appeal must come as quickly as the medical condition requires, and at least within four business days after the request is received. This final decision can be delivered verbally, but must be followed by a written notice within 48 hours.<sup>9</sup>

If the appeal is denied, the patient can ask for an external review. And, the insurance company's final determination must explain how to ask for one.

In an external review, the insurance company no longer decides whether the claim must be paid. Instead, the decision is made by an independent third party. There are two steps in the external review process:

1) A written request for an external review must be made within the time frame specified in the health insurer's notice. In most instances, insurers require an external review be filed within 60 days of the date the insurer sent a final decision; however, some plans may allow more than 60 days to file.

2) The external reviewer issues a final decision that either upholds the insurer's decision or decides in the patient's favor. The insurer is required by law to accept the external reviewer's decision.<sup>10</sup>

## It's Up to the Patient

A study published in the *Journal of Health Economics* found most Americans don't have a comprehensive understanding of the types of cost-sharing that are at the heart of most major health insurance plans.<sup>11</sup> That is troubling, especially for those with chronic illness who need vastly more care

than those who are healthy, and who heavily rely on health insurance coverage. In addition, most patients are unsure what to do when an insurance claim is denied.

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Health insurance companies are now required to include a summary of benefits, which includes relatively simple definitions of common terms such as copay, coinsurance, deductible and out-of-pocket maximum. And, with the Affordable Care Act, national standards allow everyone who is denied treatment coverage to appeal that decision to the insurance company and, if necessary, to a third-party reviewer.

Ultimately, patients must take the time to ensure they understand insurance terminology so they can be sure to choose the best plan that will meet their healthcare needs. And, they must exercise due diligence by keeping track of their care and standing up for their rights to ensure justifiable claims are rightfully paid. ■

**ABBIE CORNETT** is the patient advocate and **RONALE TUCKER RHODES, MS**, is the editor-in-chief for *IG Living* magazine.

## References

1. Mangan, D. Many Americans Don't Know Much About Health Insurance — And It Will Cost Them. CNBC, Nov. 4, 2016. Accessed at [www.cnbc.com/2016/11/04/many-americans-dont-know-much-about-health-insurance--and-it-will-cost-them.html](http://www.cnbc.com/2016/11/04/many-americans-dont-know-much-about-health-insurance--and-it-will-cost-them.html).
2. Fuscald, D. How to Get the Best Plan When You Have a Chronic Illness. *U.S. News and World Report*, Dec. 23, 2015. Accessed at [health.usnews.com/health-news/health-insurance/articles/2015-12-23/how-to-get-the-best-plan-when-you-have-a-chronic-illness](http://health.usnews.com/health-news/health-insurance/articles/2015-12-23/how-to-get-the-best-plan-when-you-have-a-chronic-illness).
3. HealthCare.gov. Out-of-Pocket Maximum/Limit. Accessed at [www.healthcare.gov/glossary/out-of-pocket-maximum-limit](http://www.healthcare.gov/glossary/out-of-pocket-maximum-limit).
4. Cornett, A. Understanding Access to Care Issue. *IG Living*, April-May 2015. Accessed at [www.igliving.com/magazine/articles/IGL\\_2015-04\\_AR\\_Understanding-Access-to-Care-Issues.pdf#search=%22co-insurance%22](http://www.igliving.com/magazine/articles/IGL_2015-04_AR_Understanding-Access-to-Care-Issues.pdf#search=%22co-insurance%22).
5. Birhari, M. Understanding Your Health Plan Drug Formulary. *Very Well Health*, Feb. 6, 2018. Accessed at [www.verywell.com/understanding-your-health-plan-drug-formulary-1738897](http://www.verywell.com/understanding-your-health-plan-drug-formulary-1738897).
6. Health Tradition with Mayo Clinic Health System. Health Insurance 101 — How to Read an EOB. Accessed at [www.healthtradition.com/home/health-insurance-101-read-eob](http://www.healthtradition.com/home/health-insurance-101-read-eob).
7. Health Insurance Definitions: What the Terms Mean. *U.S. News and World Report*, Nov. 14, 2014. Accessed at [health.usnews.com/health-news/health-insurance/articles/2014/11/14/health-insurance-definitions-what-the-terms-mean](http://health.usnews.com/health-news/health-insurance/articles/2014/11/14/health-insurance-definitions-what-the-terms-mean).
8. How to Read Your Health Insurance Explanation of Benefits Statement. *Ebiz*, Oct. 18, 2017. Accessed at [ccbing.com/cache.aspx?q=reading+your+eob+when+you+have+a+chronic+illness&d=4535714848703781&mkt=en-US&setlang=en-US&w=RoIFSXXJOaoOmjT8TjOaexXuaIKaoSy](http://ccbing.com/cache.aspx?q=reading+your+eob+when+you+have+a+chronic+illness&d=4535714848703781&mkt=en-US&setlang=en-US&w=RoIFSXXJOaoOmjT8TjOaexXuaIKaoSy).
9. AARP Medicare Resource Center. Appealing a Medicare Claim Decision. Accessed at [www.aarp.org/health/medicare-insurance/info-05-2011/appealing-a-medicare-claim.html](http://www.aarp.org/health/medicare-insurance/info-05-2011/appealing-a-medicare-claim.html).
10. Healthcare.gov. How to Appeal an Insurance Company Decision. Accessed at [www.healthcare.gov/appeal-insurance-company-decision/appeals](http://www.healthcare.gov/appeal-insurance-company-decision/appeals).
11. Kliff, S. Do You Understand Health Insurance? Most People Don't. *The Washington Post*, Aug. 8, 2013. Accessed at [www.washingtonpost.com/news/work/wp/2013/08/08/do-you-understand-health-insurance-most-people-dont/?noredirect=on&utm\\_term=.2b78d4740003](http://www.washingtonpost.com/news/work/wp/2013/08/08/do-you-understand-health-insurance-most-people-dont/?noredirect=on&utm_term=.2b78d4740003).