Patient Advisory Council

Insurance Toolkit

In this resource you will find information about insurance compiled by members of the Patient Advisory Council with input from members of the ImproveCareNow community. Topics include an overview of insurance types, plans, and scenarios; guidance on choosing an insurance company; and information about your rights as a patient regarding insurance.

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The Patient Advisory Council (PAC) is a community of 14+ pediatric patients with Inflammatory Bowel Disease (IBD) who come together to advocate for pediatric IBD patients and support each other. For more information, and to join the PAC, please visit *improvecarenow.org/patients*

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"This toolkit was originally authored by Leela Maitra and Justin Hwang, with contributions from members of the ImproveCareNow Patient Advisory Council (PAC) and community. To learn more about the PAC, view the original toolkit, or share your feedback, visit *improvecarenow.org/patients* or contact us at *pac@improvecarenow.org*"

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Introduction to Insurance

What is Insurance?

Insurance is a contract/policy in which an insurer compensates someone for harm/loss against damages from specific contingencies or perils. Another way to say it is that *insurance is a legal agreement where a company (the insurer) agrees to pay you money if something specific goes wrong, like an accident or getting sick*. The most common forms of insurance policies are life, health/medical, homeowners, and auto. According to the Affordable Care Act (ACA), you are allowed to stay on your caregiver's insurance until you turn 26 years old.

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Types of Health Insurance

Medicare

A federal health insurance program for people over the age of 65 or people under the age of 65 with certain chronic medical conditions (e.g., people on dialysis). The Medicare Program was created to ensure that the elderly population has secure access to health insurance, as this population is more likely to not receive health insurance through an employer (due to being retired).

Medicaid

A joint federal and state program that provides free or lower-cost health insurance to individuals and families who make under a certain amount of money. This is different from Medicare; while Medicare mainly targets older populations, Medicaid also targets those who would normally not be able to afford health insurance. Medicaid is administered separately by each state, meaning that different states have different eligibility criteria and benefits.

Dental Insurance

Typically separate from main health insurance plans, dental insurance plans cover medically necessary dental work. Some may also cover routine cleanings and orthodontics. Different states have different rules regarding dental insurance coverage.

Vision Insurance

While vision-related health (i.e., treatment of eye diseases) is covered under standard health insurance, vision insurance may cover some additional eye exams as well as glasses/contacts. An individual can purchase a vision insurance plan if needed. For children, all plans cover vision insurance (for adults, not all plans are covered).

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Insurance Plan Types

HMO *(Health Maintenance Organization)* - a type of health insurance plan from a private company that only covers care from doctors and healthcare providers who are in-network. HMO is a cost-effective plan for patients, offering lower premiums and a low to no deductible. HMO plans generally require a referral from your primary care physician to be seen by a specialist.

PPO *(Preferred Provider Organization)* - a plan that provides several select health care providers for patients who are in-network and may also have some coverage for out-of-network providers. PPO plans do not always require a referral to have specialty care covered. Although PPO plans have higher premiums, they give patients greater freedom in choosing an in-network or out-of-network provider. Furthermore, there is no need to choose a primary care physician.

POS *(Point of Service)* - a plan that enables you to receive cheaper professional medical care from doctors, providers, etc., who are within the plan's network, but out-of-network care may be covered with a referral. Individuals within the plan's network are offered copays for every visit. Those with small medical expenses may find this plan fitting.

EPO *(Explanation of Payment)* - stemmed from the PPO plan, combining the low costs of the HMO with the flexibility of the PPO. Similar to an HMO plan, EPO plans only cover care from in-network providers but often have a larger list of providers that are in-network and may allow you to see a specialist without a referral.

	HMO	EPO	POS	PPO
Primary care physician required?	Yes	Sometimes	Yes	No
Referral required for a specialist?	Yes	No	Sometimes	No
Out-of-network coverage?	No	No	Yes	Yes
Cost?	$	$$	$$	$$$

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Insurance Scenarios

These are patient scenarios. Please also talk to your insurance company/provider and physician to determine what applies to your individual situation.

Navigating Pre-Authorizations

Simone has ulcerative colitis, and her doctor has prescribed her adalimumab. Simone is supposed to take adalimumab biweekly to prevent flares. After sending the prescription to her local pharmacy, she received a call that insurance requires a prior authorization, meaning additional paperwork is needed to assess for insurance coverage of adalimumab. Simone's doctor's office needs to complete this paperwork. The pharmacy has contacted Simone's doctor's office on her behalf to start the paperwork. It can take days to weeks to receive the decision from insurance regarding coverage once the paperwork is submitted. Oftentimes, the provider's office is notified of the insurance's decision, and Simone should receive notification as well. The pharmacy will only know based on trying to fill the medication and filing a claim.

Navigating the Denial Process & Ensuring Treatment at Intervals

Ryan recently received a call from his pharmacy that informed him of a denied medication by his insurance provider. It is Ryan's first time switching to this medication, so he is not familiar with his insurance's policy on it. To attempt to get his medication, Ryan decided to first look at the claim that was submitted and try to figure out why it was denied. Specifically, he wanted to see if there was a coding error on the claim that was filed, if his insurance plan does not cover the medication, or if the medication was deemed not medically necessary. Success! Ryan discovered that his medication is not covered and is considered non-formulary. With this newfound knowledge, Ryan called his doctor's office to figure out the next steps (file an exception to formulary medication request, pursue patient assistance program through manufacturer, or treatment with a covered medication). After talking to his doctor, Ryan discovered that a medication that is preferred on his insurance formulary will just as effectively treat his disease as the denied medication. His provider sent a prescription for the covered medication, and Ryan was able to fill the prescription.

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Insurance Scenarios

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Navigating the Appeal Process

Jane was recently diagnosed with Crohn's disease, and her doctor has prescribed her infliximab infusions, but Jane's insurance company refuses to cover the cost of the drug. Fortunately, Jane had heard about the appeals process in which her insurance provider must reconsider their decision not to cover the infliximab. The first thing Jane does is call her insurance company to figure out why her medication was not covered. After she figures that out, she will submit her appeal. She will need to give her insurance company proof that her medication was not covered, information about doctors' visits, and any other necessary documentation that can prove why she needs to be on infliximab. With the help of her physician, Jane files the appeal. This type of appeal is known as an internal appeal since it is reviewed by her insurance company, and they will decide whether or not to cover the medication. If this is unsuccessful and her insurance still chooses not to cover the medication, Jane can file an external appeal, which can be done through a government website. Now, an independent third party of healthcare professionals will review Jane's case and ultimately have the final say on whether the medication will be approved. Fortunately, Jane was able to get her insurance company to approve her appeal and is now able to start her infusions.

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Insurance Scenarios

These are patient scenarios. Please also talk to your insurance company/provider and physician to determine what applies to your individual situation.

Navigating Peer-to-Peer Reviews

Hannah, a 22 year old with ulcerative colitis, currently lives at home with her parents and receives a letter from her health insurance company. The letter states her upcoming infusion of infliximab has been denied due to clinical criteria that Hannah doesn't meet. She tells her parents about the letter, given that she is due for her infusion the following week on a Tuesday. She's nervous she won't get her treatment on time now. Her parents tell her to contact her GI provider; she emails him, telling him she's been denied her infliximab at her next infusion. Her doctor, Dr. Patel, returns her email telling her he will submit for a peer-to-peer review with her insurance company, as he has medical records that indicate she does meet the clinical criteria for infliximab. Last year, Hannah had tried adalimumab (e.g., Humira), but it didn't work. Because one of the clinical criteria involved attempting Humira before infliximab and the medication caused Hannah to flare, Dr. Patel argues her inadequate response to Humira warrants that she meets the clinical criteria. He calls the insurance company on the same day as it is required to complete a peer-to-peer (up to 72 hours from the denial of coverage). Dr. Patel speaks with Dr. Hammond around 3:00 p.m. the following day. He summarizes Hannah's history on infliximab and remission, whereas Humira, the previous summer, didn't yield remission, and the patient flared. He explains that Hannah has been on infliximab for 14 years, and she was in remission entirely during that time. He reiterates that because of this history, Hannah's case merits this peer-to-peer call, requesting Dr. Hammond to complete the review. Dr. Hammond tells him that she will get back to him the following day. On Thursday, Dr. Hammond reaches out to Dr. Patel, notifying him that a prior authorization was approved for the infliximab. Dr. Patel tells Hannah the good news, and she goes ahead and schedules her in-home infusion and delivery of the medication.

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Picking Insurance Companies

Website to Understand What Insurance Plan Can Cover

https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

- Ambulatory patient services
- Emergency services
- Hospitalization (such as surgery and overnight stays)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Mental health/substance use services and treatment
- Prescription drugs
- Rehabilitation services/devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Website for Tips on Picking a Good Insurance Plan

https://www.npr.org/sections/health-shots/2021/11/01/1050878727/6-tips-to-help-you-pick-the-right-health-insurance-plan

- Medicare if you are 65 or older
- Check coverage through your employer if you are younger than 65
- Medicaid if you have low income
- Healthcare.gov is the place to go for everyone else
- Consider either an HMO or PPO
- Take into consideration your own health before choosing your insurance, such as how healthy are you in general?
- Find local help: https://localhelp.healthcare.gov/
- Don't fall for plans that sound too good to be true—many are short-term
- Check annually what is available for other insurance plans

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Picking Insurance Companies

Website to Seek Help and Get Started When Finding a Good Insurance Plan for Individuals, Families, and People Who Seek Short-term Plans

https://www.getmehealthinsurance.org/v3/shophealth-individual/

- Marketplace, private, and supplemental plans
- You can take a questionnaire/survey to find what's best for you
- There is a common misconception that people cannot have more than one health insurance plan
- A secondary insurance plan can pay for what the primary plan does not cover. Any private insurance company offers secondary insurance; however, it may not be the best option for everyone, as it may not be as cost-effective, depending on your budget and needs. Secondary insurance can be in the forms of dental, vision, disability, prescription drug coverage, and other long-term care insurances
- You may want to look for healthcare facilities that offer wellness programs, virtual appointments, and mobile apps to monitor your health. Some plans offer helpful services like free health assessments, tobacco cessation counseling, virtual care, or nurse advice

Website to Understand Total Cost of Plan for the Year

https://www.healthcare.gov/choose-a-plan/your-total-costs/

- Monthly Premium (12 months): the amount you pay each month to have insurance
- Deductible for Every Visit: the amount you have to pay for covered services before the insurance company pays for services
- Copayments: the amount you pay to your healthcare provider each time you see them
- Out-of-Pocket Maximum: the most amount of money you have to spend for covered services in a year; after reaching this amount, insurance fully pays for covered services

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Picking Insurance Companies

Website for Tips to Compare Insurance Plans While Considering Personal Factors

https://www.healthcare.gov/choose-a-plan/plan-types/

- Health risk factors: Some people require more health care assistance than others. Those with chronic conditions likely need more specialized services and medications than those without them. Other lifestyle choices, like playing a sport or smoking, can also affect the level of regular health care you require. Consider how your lifestyle might require a more comprehensive plan.
- Financial situation: You should also consider your available budget while researching options. Determine a monthly spending amount you feel comfortable with, and use it to narrow down available choices.

Website to Understand the Options for Young Adults When Choosing Insurance

https://www.healthforcalifornia.com/blog/best-health-insurance-options-for-young-adults

- You can stay on your parents' insurance until you're 26 years old
- Student insurance through university/college is an option
- Schools can offer student health insurance that has lower premiums
- If you are working, insurance through your employer/job is an option
- Buying private insurance (Bronze, Silver, Gold, Platinum) is another option from the state/federal marketplace
- You can check through the state's database to see if you are eligible for Medicaid, as they look at income as their main requirement

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Picking Insurance Companies

Website to Understand the Categories of Health Insurance Plans Based on Your Situation

https://www.healthcare.gov/choose-a-plan/plans-categories/

- There are 4 categories of health insurance plans: Bronze, Silver, Gold, and Platinum. These categories show how costs are shared between you and your plan. You pay a monthly bill to your insurance company (a "premium"), even if you don't use medical services that month. You pay out-of-pocket costs, including a deductible, when you get care.
- These are the averages of how much each plan pays:
  - **Bronze** - Insurance pays 60%, you pay 40%
  - **Silver** - Insurance pays 70%, you pay 30%
  - **Gold** - Insurance pays 80%, you pay 20%
  - **Platinum** - Insurance pays 90%, you pay 10%

Bronze	Silver	Gold	Platinum
Lowest monthly premium	Moderate monthly premium	High monthly premium	Highest monthly premium
Highest costs when you need care	Moderate costs when you need care	Low costs when you need care	Lowest costs when you get care
Deductibles can be thousands of dollars a year	Silver deductible are usually lower than those of Bronze plans	Deductibles are usually low	Deductibles are very low

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Patients' Rights FAQ

Why is it important to understand your patient rights?

- Patient rights allow for a universal expectation of healthcare practices on patients, without regard to an individual's race, color, religion, disability, sex, sexual orientation, national origin, or source of payment. In other words, patient rights ensure that all patients receive the same standard of medical care.

What information is protected?

- Information on your medical record: This can typically include information such as your date of birth, contact information, diagnoses, medications, immunization records, and insurance information.
- Conversations with doctor/care team: This is also known as doctor-patient privilege, where private conversations between your doctor/care team are protected from being disclosed. However, a doctor can break that confidentiality if information that involves harm or abuse is revealed or if revealing certain information can protect another individual from harm.
- Billing information: HIPAA (Health Insurance Portability and Accountability Act) protects billing information as it is related to payment information. It falls under protected health information (PHI).

What rights do I have to my health information?

- Can ask to see a copy of health records
- Edit/correct health information
- Receive notice on how your health information is used/shared

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HIPAA

Who must follow HIPAA Regulations?

- Health plans from health insurance companies, HMOs, and government health programs like Medicare and Medicaid
- Health Care Providers: doctors, clinics, hospitals
- Health Care Clearinghouses
    - These entities must follow HIPAA rights as they are considered covered entities. They carry an individual's health information, which is deemed private by the HIPAA Privacy Rule

Who doesn't need to follow?

- Employers
- Life insurers
- Work compensation carriers
- Most entities that don't deal with protected health information (PHI), unlike the covered entities above, do not usually have to follow HIPAA rights

What do I do if I think my rights are being denied or health information isn't being protected?

- File a complaint with the provider/health insurer
- File a complaint with the U.S. Department of Health and Human Services

Where can I find my rights? Where can you find more information?

- Google search the healthcare rights for your state
- Look at your insurance plan

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Patients' Rights Outlines

American Medical Association (AMA): Code of Medical Ethics Opinion 1.1.3

- Topics include:
  - Treatment of medical staff with respect to patient confidentiality and privacy
  - Treatment with dignity, respect, and courtesy
  - Open discussion with doctors on the cost, risks, and benefits of the treatment plan
  - Decisions on health care

Health Insurance Portability and Accountability Act (HIPAA)

- Topics include:
  - When Your Health Information Can Be Shared
  - How Electronic Health Records Protects Your Health Information
  - The Right to Receive Health Information Copy, Ensure Accuracy, Review Who Can Access Your Health Information Records

The Speak up for Your Rights Materials From the Joint Commission, part of the U.S. Department of Corporate Communications

- Topics Include:
  - Overview of Patient Rights
  - How to Be Active in Your Own Medical Care
  - How a Patient Advocate Can Help
  - Actions to Take if Something is Wrong

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Patients' Rights Outlines

The Patient Bill of Rights from the U.S. Office of Personnel Management

- Topics include:
  - **Information Disclosure:** the right to receive accurate, easily understandable information to make informed decisions about health plans, professionals, and facilities
  - **Choice of Providers & Plans:** the right to a choice of health care providers that is sufficient to ensure access to appropriate, high-quality health care
  - **Access to Emergency Services:** the right to access emergency health care services at any location and time it is required
  - **Participation in Treatment Decisions:** right to fully participate in all decisions related to their health
  - **Respect and Nondiscrimination:** the right to considerate, respectful care from the interdisciplinary healthcare team at all times
  - **Confidentiality of Health Information:** the right to communicate with health care providers in confidence and to have their individual identifiable health care record protected
  - **Complaints and Appeals:** the right to a fair, efficient process for resolving differences with health plans, healthcare providers, and institutions that serve them
  - **Consumer Responsibilities:** the right to assume responsibilities as mentioned above, and per the U.S. Office of Personnel Management website https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/bill-of-rights/

Glossary

Commonly used terms and their definitions:

Affordable Care Act (ACA): an act that provides patients with better coverage and rights to make health insurance easier to understand and more affordable.

Allowed Amount: maximum amount for payment of covered healthcare services.

Balance Billing: the difference a provider charges you between the provider cost and the allowed insurance amount. For example, if the provider cost is $100 and the allowed insurance amount is $70, you could be responsible for the $30 difference.

Claim: a statement submitted to an insurance company (usually by a provider) requesting payment for a medication, service, or medical procedure. For example, insurance companies will pay for a colonoscopy if the patient has insurance.

Coinsurance: it is the amount an insured individual must pay towards a health insurance claim after their deductible is satisfied. This term is usually used in various types of insurance that are sharing the risk or cost between the insurer and the insured. Coinsurance is usually given as a percentage—i.e., if the bill is $100, and you have 20% coinsurance, you pay $20 and insurance pays the rest. One of the most common coinsurance breakdowns is the insurer paying 80%, while the insured pays 20% of the total expense.

Copayment: a fixed amount you pay for a covered health care service; varies by the type. Higher copayments come with lower monthly premiums, and lower copayments come with higher monthly premiums.

Deductible: the amount you pay before your insurance starts to pay for healthcare needs and services. It is in the interest of both parties as this minimizes loss.

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Glossary

Commonly used terms and their definitions:

Drug Formulary: a list published by your insurance company of all drugs covered under the plan.

Drug Tiers: a level system that insurance providers use to classify the cost of different types of medication (i.e., generics, name-brand drugs, and specialty drugs).

Flexible spending account (FSA): an account in which your employer lets you set aside money from your paycheck, pre-tax, in order to pay for medical expenses. Money in the account is fully tax-free but usually expires at the end of each year-long period (thus, you cannot carry over funds).

Health savings account (HSA): a personal savings account in which you can put pre-taxed money in order to pay for medical expenses. Money in the account will stay in the account from year to year (thus, you can carry over funds). HSAs are typically only available to people on plans with a high deductible.

HRA (Health Reimbursement Arrangement): an employer-funded plan that allows your employer to reimburse you (tax-free) for certain medical expenses.

In-Network/Out-of-Network: when a health care provider accepts your health insurance plan, they are in-network, and services will be covered after your deductible is met. When a provider is out-of-network, the services may not be fully (or at all) covered depending on your plan and will likely be more costly.

Itemized receipt: a list provided to you by a doctor's office or hospital describing each service, medication, procedure, or supply that was provided and its corresponding charge. These bills are often provided to insurance companies and can be provided to patients as well in some cases (when care is not covered by insurance or upon request). Patients can request itemized receipts in cases where they feel that they may have been unfairly or incorrectly charged.

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Glossary

Commonly used terms and their definitions:

No Surprises Act: a federal law enacted in 2022 (was effective in some states before this) that regulates medical billing to prevent patients from being unexpectedly charged for certain types of medical care, especially emergency care (i.e., being charged for getting treated by an out-of-network doctor at an in-network hospital).

Open Enrollment: a several-month period each year where people can freely switch their health insurance plan. In some cases people may be able to switch plans outside of this window if they experience a qualifying life event (i.e., leaving/losing a job, moving).

Out-of-Network Coinsurance: coinsurance rates for out-of-network providers, which are typically more than coinsurance rates for in-network providers due to no negotiated rates. This typically comes up in PPO plans when insurance pays for part (but not all) of out-of-network care.

Out-of-Network Providers: health care providers who do not have a contract with your health insurance plan, meaning that insurance does not accept the insurers negotiated prices or rates for health services. This results in having to pay more for out-of-network care.

Out-of-Pocket Maximum/Limit: maximum you can pay yearly for in-network healthcare. Copays and coinsurance count towards your out-of-pocket maximum, as does money you pay before your deductible is met. You may still be charged for out-of-network care after you meet your out-of-pocket maximum.

Premium: the amount of money paid periodically (often monthly or yearly) by the insured to the insurer for health coverage. Insurers are required to use their collected premiums to pay for claims.

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