# HEALTH INSURANCE BASICS

## & Advocating for Appropriate Coverage

Managing insurance can be challenging. This toolkit is designed to help sickle cell disease (SCD) warriors and advocates know the **basics about insurance coverage**. This resource can help you understand options, keep costs lower, and appeal denials of coverage.

Generally, there are **two types of health insurance:**

1. **Public health insurance** like Medicaid, Medicare, and CHIP.
2. **Private health insurance** like employer-provided insurance or through a marketplace exchange.


**While each insurance plan is different, no health insurance company will cover 100% of your medical expenses.**

## GLOSSARY OF COMMON INSURANCE TERMS

- **Covered services** are the services, prescription drugs, or supplies for which the insurance company agrees to cover some or all of the costs.
- **Non-covered services** include elective or cosmetic procedures, off-label drug use, or supplements that insurance will not pay for.
- **Preferred Drug List (PDL)** is a list of brand-name and generic medications covered by your insurance plan (also called "formulary").
- **Wraparound services** are behavioral healthcare and management services such as mental health services. Case management (care coordination), counseling, and education are examples of wraparound services.

## HOW MUCH DOES HEALTH INSURANCE COST?

There are **five important terms** to know when figuring out how much you will pay out-of-pocket for your insurance plan. Your **premium**, **deductible, co-payment,** and **co-insurance** are all expenses you pay. **An out-of-pocket maximum** helps control these costs each year.

- **Premium** = The monthly fee you owe for your insurance.
- **Deductible** = The fixed $ amount you owe each year before your insurance plan starts to pay.
- **Co-payment** = The amount you owe for each covered service or prescription AFTER your deductible is met.
- **Co-insurance** = The percentage you owe for each covered service AFTER your deductible is met.
- **Out-of-pocket maximum** = The absolute max you will pay annually.

## HOW DO INSURANCE COMPANIES CUT COST?

Insurers try to reduce and control costs through several strategies that impact patient access:

- **Prior Authorization** is a process in which insurers require **advance approval** before it will cover your medication.
- **Step Therapy** is the practice of requiring that patients try **less expensive therapies** before the insurer covers the medication.
- **Denial of claim** is when the **insurer refuses to pay** for certain medical services.

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Sometimes your health plan will say “no” to a claim, in full or in part, for benefits or services you believe should have been covered. Here are the steps you can take to file an appeal:

## ... IF YOUR HEALTH PLAN SAYS "NO"

### 3 STEPS TO APPEAL INSURANCE DENIALS

### 1 UNDERSTAND YOUR DENIAL

Insurers must tell you **why they’ve denied your claim**. Many denials can be based on billing and coding requirements. Review the claim denial letter and your Explanation of Benefits (EOB) closely, to understand the reason for your denial and what evidence may be required.

### 2 CONDUCT AN INTERNAL APPEAL

Letter writing is a great way to conduct health insurance appeals. Ask your health insurance provider how to file an internal appeal by **contacting the customer service number** provided on your insurance card /materials. Be clear and concise in your appeal letter. Ask your medical provider to assist with language. **Take detailed notes** from any phone conversations you have with your insurance company or your doctor that relate to your appeal.

### 3 SUBMIT YOUR APPEAL

There are a few different ways to submit your appeal, including by fax or by mail. The Consumer Assistance Program in your state can also file an appeal for you. Remember to **keep records** of all information related to your claim and the denial.

- Follow up after sending your appeal letter within 30 days
- If your internal appeal is denied, request an **external review or level 2 appeal.**

"I am calling to get a **status review of my appeal letter** on the denial of treatment and services provided by my provider on this date. I have reviewed my policy and believe treatment or service should be covered. My internal appeal letter was **submitted over 30 days ago."**

## TOOLS & RESOURCES

**Tips and Best Practices**
*Patient Advocates*
**Billing, Coding, and Appeals Guide**
*Novartis*
**Appealing a health insurance denial**
*Healthcare.gov*

## DON'T FORGET!

- **Medicare & Medicaid -** There are different rules for appeals.
- **Keep Records** - Keep all documented information related to your case.
- **Take notes and establish response deadlines** - Track phone calls, insurance responses, name, and date.