

Understanding Your Insurance Plan

Many parents of our patients have questions regarding their insurance coverage of certain services. Our office accepts many plans and many are underwritten between a person's employer and the insurance company, so even two contracts might be different, and we are unable to know every patient's specific plan.

Most insurance companies today share costs with the patient. There are many cost-sharing options:

Deductible: The total amount of covered medical expenses that must be paid by the patient before the insurance company begins paying benefits. After this requirement is reached, the insurer will begin paying according to terms of the contract (often 75%-85%) of covered medical costs. The patient is responsible for any remaining balance.

Flat-rate copayment: The patient pays a share of covered medical costs and the insurance carrier pays an amount based on the policy. For example, when the patient pays \$15 of any office visit charge or \$3 for any prescription, the insurance carrier is responsible for the balance.

Percentage-based copayment: The patient pays a percentage share of covered medical costs and the insurance company pays an amount based on the patient's policy. Examples are: 20% of the office visit charge - \$10 of a \$50 charge, \$12 of a \$60 charge, etc. Typically this copayment arrangement includes a deductible and may have other variations.

Other: The patient may be required to pay the full or partial cost of non-covered services, services provided at an out-of-network hospital or a hospital using an out-of-network radiologist, surgeon or anesthesiologist, by an out-of-network PCP (primary care provider), for mental health and dental health services, for pharmacy benefits (prices vary according to tier benefits), physical, speech or occupational therapy, and Emergency Room visits.

Consumer-driven health plans (CDHPs) are the fastest growing plan type currently across the country. Employers are shifting financial responsibility to their employees by offering health plans with high deductibles and coinsurance to reduce cost to the business. Most of these plans cover wellness services such as immunizations, well-child visits and periodic check ups more than sick services. They usually have a high deductible, but when the deductible is met, the plan pays for services at a percentage (such as 80%) of a defined reasonable and customary fee schedule.

Health savings accounts (HSAs) are tax-favored savings accounts funded with pretax dollars by the individual or the employer. Money can be withdrawn from the account at any time with no penalty or taxes to pay for qualified medical expenses. An HSA can be established only along with high-deductible health insurance plans that meet Internal Revenue Service rules that set the amount of the individual and family deductible. The amount an employee can put in an HSA is capped at the amount of his or her annual deductible of his or her health insurance policy. Any unused funds each year remain in the account, accumulate tax-free and can be used for future medical expenses.

Health reimbursement accounts (HRAs) are funded by the employer and can be used by an employee as pretax dollars. These accounts can be set up independent of any specific health plan or benefit design. Money can be used to pay for medical expenses. HRA funds can also be carried over from year to year. The amount of the contributions to the HRA varies based on the employer. The employer owns the fund and any unused amounts may or may not be transferred on termination of employment depending on the terms of the fund. Medical spending accounts (MSAs) and flexible spending accounts (FSAs) are versions of HRAs with particular features.

Understanding the fine print of your plan:

Your health insurance policy is an agreement between you and your insurance company. It is generally negotiated by your employer if it is an employee benefit. The policy lists a package of medical benefits such as tests, medications and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services." Coverage does not guarantee full payment and your insurance company may require partial coverage by the policyholder. Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive.

Be aware that a medical necessity is not the same as a medical benefit. A medical necessity is something that your provider has decided is necessary based on clinical presentation and standard of care. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your provider might decide that you need medical care that is not covered by your insurance policy. Common examples of this might be a splint for a sprain or a spacer device to use with an inhaler for wheezing.

Since we are unable to know the specifics of every insurance plan, we hope that families understand their own coverage and that families read their insurance information to make an informed decision of which plan to choose (if more than one is offered by the employer). By understanding your insurance coverage, you can help your doctor recommend medical care that is covered by your plan.

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get a lab test or x-ray or fill a prescription.
- Some medication, tests or hospitalizations may have to be approved by your insurance company before your doctor can provide them. This prior approval or prior authorization is obtained by the physician's office, but it is not always granted.
- If you have coverage under more than one plan it is important to know which plan is primary and which is secondary. Some services may not be covered by one and may be covered by the other (coordination of benefits).
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.
- Remember that your insurance company, not your provider or the physician's office, makes decisions about what will be paid for and what will not.

If something isn't covered by your plan:

Most of the things your provider recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim." You can still obtain the treatment that is recommended, but you will have to pay for it yourself. Some companies will pay a percentage and the patient is responsible for the remainder. This is in addition to your copay. If more than one issue is covered at a single visit (such as a hurt finger and asthma or a well visit and ear infection) separate copays may apply, depending on an insurance plan.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook. Not all appeals will end in your favor, but some challenged claims will be covered eventually by the insurance company.

Most insurance companies have different levels of copays for the primary care office, specialist, urgent care, and emergency room. These are often printed on your insurance card and can change yearly with new contracts. Some insurance plans require a referral to see any provider other than the primary care provider on your insurance card.

Bring your insurance card with you to each visit. Although you have the same plan as last year, the copays might be different. Sometimes the insurance billing address has changed. We cannot file your claim properly without the correct information.

How much you will have to pay for medicines: A formulary is a list of medications that your insurance company will help you pay for. It puts medications in two to four categories (tiers) based on copay. The first is usually generic medications, the second and third are more expensive medications and the fourth the most expensive medications. Each tier has a higher copay. This list is reviewed and changed by the insurance company every few months, so your cost might go up or down. Be aware of the formulary before you begin any medication, especially one that will continue long term. Learn if your insurance gives a discount for using their mail-in prescription service. Insurance companies, not the pharmacy, decide on the cost of the copay. They might contract with particular pharmacies and your cost will be lower at those pharmacies. We are happy to write for prescriptions with lesser copays if they will treat the condition properly and you know your formulary. Because we see hundreds of plans and formularies change, we do not know what your plan prefers. We cannot continue to write new prescriptions until one is found that is least expensive, so please do not call the office multiple times for another medication because "this one is too expensive also". Know your formulary!

If you have a question about a bill:

If you do not understand a bill or explanation of benefits (EOB), please call your benefits administrator or human resources administrator, or our office billing department.

Key Terms:

Billing Statement: A summary of current activity on an account

Birthday Rule: To determine which parent carries primary insurance and which will be secondary if both parents have insurance, a birthday rule is generally accepted. Under this rule, the plan of the parents whose birthday occurs first in the calendar year is designated as primary. The date of birth is the determining factor – not the year – so it doesn't matter which spouse is older. For example, if Dad's birthday is July 1972 and Mom's is January 1973, Mom's birthday is first and hers would be the primary insurance. Like most rules, the birthday rule has exceptions:

- If both parents share the same birthday, the parent who has been covered by his or her plan the longest provides the primary coverage for the children.
- If one spouse is currently employed and has health insurance through a current employer, and the other spouse has coverage through a former employer (e.g., through COBRA), the plan belonging to the currently employed spouse would be primary.
- In the event of divorce or separation, the plan of the parent with custody generally provides primary coverage. If the custodial parent remarries, the new spouse's coverage becomes secondary. And finally, the non-custodial parent's plan would provide a third layer of insurance protection. This order of payment can be altered by a court-issued divorce decree or by agreement, but the insurance companies must be notified.

Claim: Information billed to the insurance company for medical services provided

Copayment or Coinsurance: The balance due to the healthcare provider from the policyholder as determined by the insurance company. If separate issues are covered at one visit, more than one copay may apply based on insurance company contracts.

Deductible: Amount the policyholder needs to pay for covered health services before a health plan will begin to pay benefits. Usually a new deductible is met each calendar year.

EOB (Explanation of Benefits): A detailed explanation from the insurance company that identifies the amount due for services provided. This includes any payments made by the insurance company and any listed copayment, coinsurance or deductible due from the policyholder.

Guarantor: The person responsible for paying the bill

Payment Arrangement: A formal payment plan set up between a patient and our office when payment cannot be made in full

Primary Insurance: Designation given to the insurer that your claim will be submitted to first, for payment of services you received.

Prior Authorization / Pre-Certification: A formal approval obtained from the insurance company prior to delivery of medical services. Many insurance companies require prior authorization or pre-certification for specific medical services, procedures or medications.

Subscriber: The person who holds and/or is responsible for the medical insurance policy

Secondary Insurance: Designation given to the insurer that your claims will be submitted to second, for payment of services you received.