



Health Plan 101 for Patients at Physician Practices

Mindful that patients commonly have questions about their coverage, this resource is designed to help patients understand the basics of their health insurance and understand important health insurance terms and definitions. This primer is intended to help patients address some of their fundamental concerns. Insurance coverage is unique to everyone, and it is important that you review the details of your plan as closely as possible, and when questions arise, connect with their insurance company's customer support.

Coverage basics¹

Health insurance is a plan or policy that covers all or a portion of the cost of medication, doctor's visits and hospital bills. It exists to help offset the costs of medical events, whether they are planned or unexpected, and sometimes prescription drugs. Both insurer and policyholder agree to pay a certain amount or percentage to cover medical expenses.

There are many different health insurance plan options available, and it is important to understand all options to understand what you as a patient are responsible for paying for health care services.

- **Government health plans²** such as Medicare, Medicaid, CHIP or Tricare are funded fully or partially by the government.
 - **Medicare** is available if the patient is over the age of 65 or if the patient qualifies due to a special situation.
 - **Medicaid** is available to eligible low-income patients or patient who fit in certain categories.
 - **The Children's Health Insurance Program (CHIP)** is available to children in families that earn too much money to qualify for Medicaid, but not enough to buy individual health insurance.
 - **Tricare** provides civilian health benefits for US Armed Forces military personnel, military retirees, and their dependents, including some members of the Reserve Component.
 - **Affordable Care Act** plans have varied options at the state level and are government subsidized. Depending on how many plans are offered in the area, patients may find plans of all or any of these types at each "metal" level. Metal categories are based on how the patient and their plan split the costs of health care. The four categories are Bronze, Silver, Gold and Platinum
- Individual health insurance, or individual/family coverage, is health insurance that is paid for fully by the patient and provides coverage for health care services for the patient and family. Plans established in the Affordable Care Act are one example of this coverage.
- Employer-sponsored health plans are health insurance options³ that are offered to employees and their dependents (and in most cases, spouses) as a benefit of employment. In this case, insurance is purchased by employers for their employees and financed through employer or joint employer-employee contributions⁴.

References

¹ <https://www.usa.gov/finding-health-insurance#item-35987>

² Center for Medicare and Medicaid Services. From Coverage to Care. <https://marketplace.cms.gov/outreach-and-education/downloads/c2c-understand-your-health-coverage.pdf>

³ <https://www.healthcare.gov/have-job-based-coverage/options/>

⁴ Wallen J, Williams SR. Employer-based health insurance. J Health Polit Policy Law. 1982 Summer;7(2):366-79. doi: 10.1215/03616878-7-2-366. PMID: 7108173.

Defining key health insurance terms

- **Deductible:** This is the amount the patient owes for health care services their health insurance covers but is expected to pay out of pocket before their health insurance begins to pay.
 - For example, if the annual deductible is \$1,000, the plan will not pay anything for care received until the patient has met their \$1,000 deductible for covered health care services subject to the deductible. Patients must pay out-of-pocket for most medical bills that help them meet their deductible. The deductible may not apply to all services. Patients should check the details of their policy carefully to understand their deductible details.
- **Copayment:** This is a fixed amount patients pay for a covered health care service, usually when they receive the service. The amount can vary by the type of covered health care service (for example, \$15 for office visits or \$30 for specialists. The co-payment for an in-network provider usually costs less than an out-of-network provider.
- **Allowed Amount:** This is the maximum insurance payment for a covered health care service. If the provider charges more than the allowed amount, the patient may have to pay the difference. This could happen when a doctor, provider or hospital is not in the health plan's network.
 - Note, there are new protections against surprise medical bills and help patients to better understand costs before receiving care. The government agencies offer additional information.
- **Coinsurance:** The share of the cost for the patient of a covered health care service, usually calculated as a percentage (for example, 20%) of the allowed amount for the service. Patients pay coinsurance plus any deductibles and copayment they owe. In-network coinsurance usually costs less than out-of-network coinsurance.
 - For example, if the health insurance allowed amount for an office visit is \$100, and the patient has met their deductible, the coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount (\$80 in this example).
- **Premium:** The amount a patient pays for their health insurance or plan each month or other increment. If the plan is provided by their employer, the employer typically shares in the cost of the premium payment. Employer-sponsored health insurance premiums are tax-exempt for both the patient and their employer. Premiums are treated as pre-taxable income by the IRS, so the patient's premium contribution is taken directly from their paycheck.
- **Network:** The doctors, hospitals and facilities a health insurer has contracted with to deliver health care services to their members. Health care services performed by an "in-network," or "preferred," provider usually cost less than services from an "out-of-network," or "non-preferred," provider. Network determinations are made by the health insurance plan, not the physician. Health insurance companies provide lists or can tell a patient if a physician or health system is in network.
- **Out-of-pocket maximum:** The most a patient must spend for covered services in a year. After they reach this amount, the insurance company pays 100% for covered services.
- **Prior authorization:** This is sometimes called preauthorization, prior approval, or precertification. It is a requirement that a physician or other health care provider receives approval from the patient's health insurance company before the health care service is performed. The health insurance company may require prior authorization for certain services before the patient receives them. Prior authorization is not a promise that health insurance will cover the cost; it simply determines if the insurance company considers the service to be medically necessary and/or meets the plan's coverage criteria.
- **Medically Necessary:** A health insurance company will use this term to describe health care services needed to prevent, diagnose, or treat an illness, injury, condition, disease or symptoms and that meet accepted standards of medicine. Physicians may recommend a service for which a health insurance company denies coverage. This does not mean the physician's recommendation is not appropriate or needed. Appeals can be made if a physician disagrees with the insurance company's determination.

How Your Costs Work

While patients typically pay a monthly fee to the insurance company—referred to as the premium—there are other costs associated with having insurance. In addition to copayment, coinsurance, and deductibles, another important term for patients to keep in mind is total anticipated medical care.

Patients should be aware of high-deductible insurance plans. These plans normally have lower monthly premiums, so the patient's monthly health care expense can be low if they are not using a lot of health care. However, patients will be responsible for more payments to health care providers for services received. For example, the patient might have a monthly health care premium of \$100, but a deductible of \$7,000 per year. This means that the patient needs to pay the \$100 premium every month to keep their health insurance and pay \$7,000 in health care services before insurance will begin covering a portion of services.

Picking a plan should be based on the estimation of medical services for the upcoming year. While it is impossible to anticipate the exact amount, patients should select a plan and coverage based on what care is likely to be needed over the course of the next year.

Patients should also consider if their current health care providers are “in-network” with insurance plans under consideration. In general, health care services provided by the insurance plan's “in-network,” or “preferred,” providers will cost less than services from an “out-of-network,” or “non-preferred,” health care provider. Networks are determined by the plans and so it is important for patients to be aware of who is in or out-of-network.

Waiver of Copay

Health care providers will occasionally waive a patient's copayment under certain circumstances, such as when the patient faces financial difficulties. But providers can be fined or become the subject of litigation if they routinely waive copays or coinsurance.

Health insurance plan & network types

The first step is understanding provider networks. A network can be made up of doctors, hospitals and other health care providers that have agreed to offer health care services at negotiated rates for services to patients in each health insurance plan.

Examples of plan types include:

- **Exclusive Provider Organization (EPO):** A managed care plan where services are covered only if patients use doctors, specialists or hospitals in the plan's network (except in an emergency). It is important to note that there are no out-of-network benefits, and patients are more likely to have to get prior authorization before having certain health care services with this plan.
- **Health Maintenance Organization (HMO):** A health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. The primary care physician acts as the patient's “gatekeeper” of sorts, referring them to others within the network. Premiums and coinsurance tend to be lower with this type of health insurance due to the defined network that helps control costs. It will not cover out-of-network care except in an emergency. It is important to note that patients normally need prior authorization, handled by their primary care physician, before having certain medical services performed.
- **Point of Service (POS):** A type of plan where a patient pays less if using in-network doctors, hospitals and other health care providers. Like an HMO plan, a POS plan requires patients to get a referral from their primary care doctor to see a specialist.
- **Preferred Provider Organization (PPO):** A type of health plan where patients pay less if they use in-network providers. Patients can use doctors, hospitals and providers outside of the network without a referral for an additional cost. This plan typically comes with higher premiums but gives patients more flexibility to receive services from providers who work best for them.