A Hospital Finance Basics Series

Understanding Your Health Insurance

Kansas Hospital Association

Before understanding your hospital bill and final balance, a patient must understand some common health insurance terms and how their insurance plan pays the provider. Providers can be defined as hospitals and/or physicians. Your out-of-pocket costs for your care are dependent on the specific components of your health insurance contract, not by the billed charge from your hospital or physician. Your health insurance plan sets the rules: what is covered; how much coverage you have for each service and supply; which providers are "in-network" vs. "out-of-network;" any special rules that restrict access to coverage; and what your portion of the bill will be for each service. There are a few ways your health insurance plan shares costs with you. They include deductibles, co-pays and co-insurance. It is important to understand how these will apply with various health care services you receive.

Health Insurance Terms To Know

Contracted Payment and Write-off

An agreement made between your insurance company and provider to pay a negotiated rate for the service is a contracted payment. The difference between the provider charge and negotiated rate is a write-off.

Example:

Service	Total Charge from Provider	Contracted Write-off	Contracted payment to provider (subject to deductible, coinsurance, co-pay)
Laboratory Tests	$150.00	$100.00	$50.00

Deductible

The full amount of your health care costs you have to spend on covered health care bills before your health insurance begins to pay is a deductible. Typically, health insurance plans will have a separate deductible for in-network versus out-of-network providers. Once you've met your deductible, you usually pay a copay and/or coinsurance for covered services.

Your deductible resets each plan year. If your plan covers your family, there will probably be a deductible for each person and a separate family deductible. As soon as the family deductible is met, your plan starts paying at the coinsurance amount for everyone's care. That's the case even if some family members haven't met their individual deductible.

Example 1:

Before you have met your deductible. Your annual deductible is $1,500. If you have had no medical bills this year, and you go to your physician and lab work is ordered, a $50 contracted payment means you pay $50.

Service	Total Charge from Provider	Write-off	Contracted Payment to Provider	Applied to deductible	Patient Responsibility
Laboratory Tests	$150.00	$100.00	$50	$50.00	$50.00

Example 2:

After you have met your deductible. Your annual deductible is $1,500. If you get sick early in the year and spend $1,500 on medical bills, you have met your annual deductible. Later in the year, you go to your physician again and lab work is ordered. A $50 contracted payment means you pay $0 (if you have no co-insurance, co-pay, or other layer in your insurance arrangement).

Service	Total Charge from Provider	Write-off	Contracted payment to provider (only if there is no other layer such as co-insurance or co-pays	Patient Responsibility
Laboratory Tests	$150.00	$100.00	$50.00	$0.00

Coinsurance

The percentage of a health care bill you have to pay is coinsurance. This starts after you have met your deductible. Coinsurance usually has a maximum out of pocket. Once that coinsurance maximum out of pocket is met, your insurance pays 100 percent of the covered health care costs for the rest of the year.

Example:

After you have met your deductible if you have coinsurance. Your annual deductible is $1,500. If you get sick early in the year and spend $1,500 on medical bills, you have met your annual deductible. Your coinsurance pays 80/20 of additional services. Later in the year your physician orders lab work. A $50 contracted payment means $40 is paid by insurance (80 percent) leaving you to pay $10 (20 percent).

Co-Pay (Copayment)

A set amount you pay for a health care service is a copayment. This only applies to office visits and typically does not go toward your deductible. If you have other services such as lab tests or a splint placed on an ankle, your health insurance will apply deductibles, co-insurance or other insurance payment layers.

Examples of services that will have a copayment: (please note these co-pays dollar amounts are just examples of what you would have to pay)**:**

- Physician visit co-pay $50.
- Emergency room visit co-pay $300.
- Urgent care visit co-pay $75.
- Prescription co-pay $25.

You go to the physicians's office for a severe sore throat and fever. When you check in for the appointment, you pay your $50 co-pay for the physician to examine you. During the exam, the physician orders a swab of your throat to determine if bacteria is growing. This would help diagnose if antibiotics are needed to cure your condition. The laboratory charges your insurance for the test and culture. The laboratory portion of the bill is subject to your insurance's deductible and co-insurance levels.

Network Providers

Hospitals and physicians that your health insurance has a contract with are called in-network providers. You will pay less to receive care from network providers. Some health insurance plans won't cover services outside your network. These are called out-of-network providers. Make sure to check with your health care provider annually because network providers can change.

Out-Of-Pocket Maximum

The most you have to pay in health care costs for one year is an out-of-pocket maximum. If you reach this amount, your health insurance plan pays 100 percent as long as it's a service covered by your plan. This includes deductibles, coinsurance, copayments, but does not include monthly premiums or services not covered by your plan.

Example:

You keep getting sick during the year and pay out-of-pocket $5,000 in medical bills between the deductible payments and co-insurance payments. Your out-of-pocket maximum is $5,000 so you have reached your out-of-pocket maximum. Later in the year, you break your leg and need an x-ray. Since you have reached your out-of-pocket maximum, your x-ray would be at not cost to you.

Premium

The amount you pay every month to have health insurance is your premium. This does not include medical bills, copays and does not count toward your yearly deductible.

Example:

If you stop paying your monthly premium, your health insurance will be canceled, and you will be responsible for 100 percent of your medical bills. Plus, you won't be able to sign-up for health insurance again until the next enrollment period.

Preauthorization or Prior Authorization

A decision by your health insurance payer that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary or medically unnecessary is called a prior authorization, prior approval or precertification.

Example:

You are plagued with severe back pain for several months. Your physician has obtained an x-ray but is still unable to diagnose the problem. Your physician would like to obtain an MRI test to get a better image of what may be causing the severe pain. Your insurance company requires they approve this test before the physician can get reimbursed for the MRI test.

Non-Covered Service

Specific items or services that your insurance will not cover are called non-covered services. Ultimately, it is the responsibility of the patient to understand their health insurance coverage and what services are not covered. When a service is denied as non-covered by the insurance company, the patient is usually responsible for the full payment of the service out-of-pocket.

Frequently Asked Questions

How will I know if my health insurance policy changed? Your insurance carrier must notify you in advance of any changes in your policy. It is your responsibility to keep current on those changes.

Isn't my physician's office and local hospital responsible for knowing my benefits? No. Medical providers are not responsible for knowing your policy and what is covered or not covered. Patient insurance benefits vary widely, and Kansas hospitals handle more than 1,300 insurance plans, each having many different plan options. For instance, in the Federally Facilitated Exchange program specifically, there are approximately 120 unique insurance plans offering over 75,000 discrete health plan options leading to multiple and often unique billing requirements, authorization requirements and coverage for hospitals bills.

What are Prior Authorizations? Many health plans require permission in advance of a patient receiving particular medical services in order for the service to be covered and paid. Your medical provider usually will call to obtain authorization on your behalf, but it is your responsibility to know if your insurance requires prior authorization.

How can I find out if something is a covered service? You can review covered benefits in your policy handbook or contact a customer service representative at your health insurance carrier. They are responsible for helping you understand your policy. Additionally, review the explanation of benefits that your health insurance carrier sends you after you have received medical services. This will explain your charges and how it was reviewed and paid according to your policy by the health insurance carrier. Any dollar amounts the explanation of benefits displays will match the statement you received from the medical provider.

Resources

Visit the **Kansas Insurance Department** Consumer Complaint Online Portal.

Download the **KHA Finance Series Issue Briefs** to learn more.