Price transparency is a critical element for ensuring not only a healthy revenue cycle, but also patient engagement and overall organizational success. With the spread of consumerism in healthcare, more patients are expecting pre-service estimates and a seamless billing and payment process. However there is one primary factor in that process that can be less than clear: insurance coverage.

As patients demand more information, particularly when it comes to financial responsibility, your front desk staff is going to have to answer more questions about benefits, eligibility, EOBs and coverage than ever before. While many medical office staff members have some training in this area, not all do.
In order to provide the best possible patient experience every person in your practice should have at least a basic understanding of the various types of insurance available, common terms, and what patients may be responsible for. After all, if they cannot explain to your patient why they owe money, the patient won't be very motivated to pay it.

In this article we will overview the various types of responsibility and insurance plans your patients may have. We have also compiled a glossary of common terms. **Get the printable list here.**

rmp
Receive More.

Patient Responsibility

Each of these costs is part of the benefit package chosen by the patient, and is part of the agreement they entered into their carrier. It is important to remember that whether the patient is responsible for these costs, and for how much, will vary by plan.

Premium

The premium is the amount that must be paid for a health insurance plan. This could be paid entirely by the patient, by their employer, or the costs may be shared. Premiums are typically paid monthly, quarterly, or yearly. If the patient's employer provides insurance and contributes to the premium, the patient's portion of this responsibility is typically taken directly from their paycheck.

Deductible

The deductible is the amount owed by the patient for services before their plan begins to pay. For example, a patient with a $2,000 deductible will have to pay for all costs out-of-pocket until they reach $2,000, after which their plan will pay the majority (but usually not all) of their expenses for the remainder of their plan period. The deductible is renewed each year.

Some plans may pay for certain services before the patient has met their deductible, but that coverage varies by plan. Others may also incorporate a copay for certain services that can apply before the full deductible is met.

Deductibles have been getting a lot of attention lately as High Deductible Health Plans (HDHPs) become more commonplace due to rising costs. Most insurance plans that have high deductibles have lower premiums. It is very important to know whether a patient has met their deductible before providing services so that you can prepare them for the responsibility of up to 100% of the cost of the services you will be providing.

Coinsurance

Under most plans, patients are still responsible for sharing in the cost of care after they have met their deductible. The patient's share of the cost, calculated as a percentage of the allowable amount, is their coinsurance. For example, if the coinsurance is 20% and the plan's allowed amount for an office visit is $100, once the patient has met their deductible they are still be responsible for paying $20 for the office visit, and the plan will pay the rest. (Prior to meeting their deductible they would be responsible for the entire $100.)

Copayment

A copay is a fixed amount owed for a healthcare service, usually due at the time of service. It is technically a form of coinsurance but is defined differently, and must be paid before any policy benefits are payable by an insurance company. The amount can vary by provider and service, and can also be required for having a prescription filled.

Collecting copays from every patient at the time of service is not only critical to a practice's financial success, it also affects reimbursement by insurance.

To learn more about improving time of service collections, get our free Collecting from Patients eBook.

Maximum Benefits (or Capitation)

Insurance plans typically set a maximum amount they will pay in a plan year, known as maximum benefits or capitation. Once a patient reaches maximum benefits the insurance company will no longer pay for care, and the patient is responsible for 100% of the costs until their plan renews. Maximum benefits can be across coverage or for specific services. For example, a plan may have a maximum benefit of $6,000 for infertility treatments, and after reaching that limit the patient is responsible for costs associated with that care, while their plan may continue to cover other services for the remainder of the year.

Insurance Plans

What costs the patient is responsible for will vary based on plan type, as well as on an individual basis within each plan. While there is no formula for each and every patient will have to pay, being able to recognize the broad categories can help you determine what the patient may be responsible for, and can give cues for what to look for when running a verification and eligibility check pre-service. With so many to keep track of, we've made you a handy comparison guide.

CLICK TO DOWNLOAD THE INSURANCE PLAN COMPARISON GUIDE

Commercial Insurance

One of the most common forms of insurance is commercial, or private payer plans. These plans include major medical coverage, qualified health plans, and catastrophic plans as well as non-major medical coverage such as short-term and gap insurance. Commercial policies can be sold individually or as part of a group plan and are categorized according to renewal provisions and benefits provided. Patients coming to your office may have any one of these, or a combination of them. With various narrow networks within these different plans, it is critical to confirm that your provider is in-network before providing care.

Major Medical Plan Alphabet Soup

Under the Affordable Care Act (ACA), all medical plans must offer minimum essential coverage; certain services and treatments must be offered on all plans regardless of the carrier. However, there are several coverage formats available based on the patient's lifestyle and health needs.

Health Maintenance Organization (HMO) Plans: Under these plans an entire network of providers agrees to offer its services, and a

primary care provider coordinates all services and care. This is one of the most popular options and is best for patients who regularly visit their family physician, but they do come with the least freedom to choose providers. These plans typically require patients to pay a monthly premium, an annual deductible, and copays or coinsurance for each type of care.

Preferred Provider Organization (PPO) Plans: Under PPOs patients can generally see any provider in their network, including specialists, without a referral. Care is coordinated by the individual rather than a PCP. People who regularly visit specialists often prefer this type of insurance. These plans typically require patients to pay a monthly premium, an annual deductible, and copays or coinsurance for each type of care, as well as higher costs for out-of-network providers and sometimes higher allowable amounts.

Point of Service (POS) Plans: POS plans are a hybrid of HMOs and PPOs, so patients are required to coordinate care through a PCP, but also have the option to visit out-of-network providers if they choose, but will pay out-of-pocket to do so. These plans are a little more versatile but a little more costly, and are best for those patients who require a little more flexibility in their care. They typically require patients to pay a monthly premium, an annual deductible, and copays or coinsurance for each type of care; coinsurances and copays are higher for out-of-network providers.

High Deductible Health (HDHP) Plans: This format is quickly becoming one of the most common as costs continue to rise. These plans require patients to meet a high deductible, sometimes thousands of dollars, before any coverage takes effect. These plans are often coupled with health savings accounts (HSAs) and are the best option for people who want to save money and don't plan to use their coverage much. These plans typically have a lower monthly premium as well as copays and coinsurance. Participants are encouraged to review their benefits carefully to learn what they will be responsible for before seeking care.

Non-Major Medical/Gap Plans

Short-Term Plans: For patients who miss open enrollment and need to start coverage mid-plan period, a short-term plan can hold them over with limited benefits as a safeguard against illness or accidents. This limited coverage does not meet the ACAs minimum essential coverage requirements, so they may come with a tax penalty and carriers may refuse coverage based on pre-existing conditions. These plans can provide coverage for any length of time from 30 days to 12 months and are nonrenewable.

Catastrophic Insurance Plans: These plans are designed to provide an emergency safety net for unexpected costs. They can stand alone or be coupled with another major medical plan in case of serious health issues. Similar to short-term plans, alone they do not meet the ACA's standards and come with the same penalties and limitations.

Ancillary Dental and Vision Plans: Most major medical plans do not cover routine dental or vision care, and some patients or employers opt for additional coverage for these types of care. There are a wide array of options within these plans from discounted costs to full coverage.

Marketplace Insurance

The implementation of the ACA created the Health Insurance Exchange, or marketplace, where people without coverage can shop online for various types of insurance plans that meet the stringent requirements set forth by the Act. Each major medical format is available on the market-place and is organized by "metal" category. These categories are based on how the patient and the plan share the costs of care.

Bronze: These plans generally have the lowest premiums and the highest deductibles and out-of-pocket costs. The insurance company pays 60% and the patient pays 40% in this category.

Silver: Patients who qualify for cost-sharing reductions based on their income may be able to select a silver plan, which has a lower premium as well as lower deductible and out-of-pocket costs. In this category the insurance company pays 70% and the patient pays 30%.

Gold: As the categories grow, the costs shift to higher premiums with lower deductibles, with more coverage provided by the insurance company and less patient responsibility. The insurance company pays 80% and the patient pays 20% in this category. Gold and platinum plans are less common due to their high monthly premiums.

Platinum: These have the highest premiums but the lowest deductibles. In this category the insurance company pays 90% and the patient pays 10%.

Government Insurance

In additional to commercial plans, there are also forms of government-assisted coverage. These services include Medicare, Medicaid, and Veteran's Health Care.

Medicare Medicare is the federal health insurance program for people who are 65 or older (and is available to others in some cases) and is broken down into several parts. Coverage is based on federal and state laws, national coverage decisions by Medicare, and local decisions made by companies in each state that process claims for Medicare. Patients may have a single part or a combination, and determining what level of coverage they have is key to understanding their eligibility and benefits.

Part A: Hospital insurance that covers inpatient hospital stays, care in skilled nursing facilities, hospice and some home health care. Many people are eligible for premium-free Part A coverage, but in most cases those who have Part A also have Part B coverage and pay a monthly premium for both.

Part B: Medical insurance coverage for certain medically necessary services, outpatient care, medical supplies and preventative care. Patients pay monthly premiums for this coverage, but if they are receiving Social Security or other retirement payments the premium may be automatically deducted from their benefit payments. The current standard premium amount is $134.00 per month, but may be higher based on income.

Part C: Also known as Medicare Advantage Plans, these plans are offered by private companies that contract with Medicare to provide Part A and B benefits.

Part D: Adds prescription drug coverage from private insurance companies approved by Medicare to Original Medicare.

Medicaid A joint federal and state program that helps with medical costs for people with limited income and resources. Each state has different eligibility and patient responsibility requirements, and some people are eligible for both Medicare and Medicare. These "dual eligibles" often have most of their care covered, and there are specific processes for submitting claims to Medicare first, then to Medicaid, for reimbursement.

Veteran's Health Administration The VHA is America's largest integrated health care system and provides coverage to people who have served in active military service or are current or former members of the Reserves or National Guard who were called to active duty. Eligible veterans typically receive treatment at one of the 1,245 participating healthcare facilities nationwide, including 170 VA Medical Centers, but some care may be referred to private providers if the VA cannot provide the necessary care.

CLICK TO DOWNLOAD THE INSURANCE PLAN COMPARISON GUIDE

rmp Receive More.

1809 N. Broadway, Greensburg, IN 47240
855-831-3426 | ReceiveMoreRMP.com

Want to get RMP Insights delivered right to your inbox?
Subscribe at www.ReceiveMoreRMP.com/Subscribe-to-Insights