The Ins and Outs of Group Health Insurance Plans

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Price is generally the driving factor for the customer when buying a group health insurance plan. Companies are trying to buy the most comprehensive coverage for the price they can afford. So you recommend what looks like the best plan for your client, and all is right with the world. Once your client's employees actually start using it, however, the problems begin. One of their employees finds out that his new wife isn't eligible for benefits. Another finds out that she owes more than the $20 copayment when she goes to a network provider for a colonoscopy. Another gets a bill in the mail for $4,350 for knee surgery performed by an out-of-network surgeon who billed a total of $7,500.

Your client, let's call her Mary, calls you, and the resulting conversation is not very pleasant. Does any of this sound familiar? Or has the fear of these things happening prevented you from sticking your toe into the health insurance pond?

The following are important items you should know about group health insurance plans. Knowing these would have enabled you to help Mary and her employees understand what to expect from their plan, in addition to other issues that have yet to arise but could.

Enrollment
This is not normally a problem, but adding and terminating employees during the policy year can create issues if not done timely. Typically, enrolling a new dependent must be done within 31 days after they are acquired. Most insurance companies follow these rules to the letter, so it is very important to know these rules and educate your client.

Referrals
While it is generally true that if you go to a network provider, you are eligible for network benefits, in most point-of-service plans, visits to a specialist such as a surgeon must be recommended by a network provider for the visit to be considered in-network. This is true for hospital visits, as well. In most point-of-service plans, you need to be admitted by a network provider before the hospitalization can be considered in-network. If a non-network provider admits you, then the entire claim, including the hospitalization, may be considered out-of-network.

Usual, customary, and reasonable (UCR)
Out-of-network services are generally subject to UCR fees. In general, these are the fees most often charged by practitioners of a particular specialty in a geographic area. UCR fees are expressed in percentile ranges. For example, in the not-too-distant past, most carriers paid at the 90th percentile. This means that a carrier would allow a fee that exceeded the fees charged by 90 percent of the practitioners in the geographic area. Today, many carriers offer different levels of UCR for different premium increments. You may be able to purchase out-of-network benefits at the 70th, 80th, or 90th percentiles. As in the above description, if your plan is at the 70th percentile, the carrier would allow a fee that exceeded the fees charged by 70 percent of the providers in a geographic area.

The practical application of UCR is that not only will the out-of-network benefit be paid at, for example, 70 percent, but the fee the percentage is based upon may very well be less than what the doctor charged. In the scenario described above, because UCR is at the 70th percentile, the carrier only allowed $5,500. This means that the claim is calculated using the $5,500 fee. If the deductible is $1,000 and the out-of-network benefit is 70 percent, the claim would be paid using the following formula: $5,500 – $1,000 = 4,500 x 70 percent = $3,150. Mary's employee was responsible for the difference.

Pre-certification
Most employees are accustomed to pre-certification of hospital stays. However, many non-hospital procedures may also require pre-certification. These are usually expensive procedures such as MRIs or expensive drug regimens. It is important to know these.

Out-of-network claims
If there are out-of-network claims, policyholders must send them to the carrier in a timely fashion. Insurance policies have time limits for submission of claims. If they are submitted after that period, they can be denied for late filing.

Network providers
Doctors are often involved with different practices in different locations. They do not always participate at all locations. It is prudent for policyholders to check this out prior to seeing the physician. Also, not all doctors in a practice participate in the same networks. One provider may and another may not. This should be checked, also.

Labs
Physician offices generally use their preferred lab — it is not always the lab that the insurance carrier covers. While network providers are generally required to use only the carrier's labs, the lab being used should be verified with the provider.

Drug plans
Most people are familiar with the way the drug plans work — generally in a three-tiered system of generic, preferred brand, and non-preferred brand copayments. However, what may be considered preferred brand today may be non-preferred next month, or, even worse, may not be included in the formulary at all. Carriers periodically change their formularies, and different carriers recognize the same drugs in different ways. It is important that policyholders understand where specific drugs fall into the carrier's formulary.

Plan limitations
People are not always aware that carriers put limitations on certain services. Some examples of limited benefits are chiropractic, physical therapy, and treatment for mental and nervous disorders. This often comes up when the provider being used is out-of-network and the claim is denied because the maximum benefit was already allowed.

Exclusions
Your client should advise their employees to read their benefit booklet to learn what exclusions are listed. Carriers have different exclusions and it is prudent to at least review them.

Don't let your clients' employees be surprised by the actions of their new insurance carrier. Understand these limitations and guidelines and help your clients understand them, as well, to ensure quality customer service and happy clients that keep coming back.

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