AVOIDING UNEXPECTED COSTS

By Ed Gaelick CLU, ChFC

How can those covered by a health plan protect themselves from unexpected out of pocket costs? Two ways immediately come to mind – prior authorization and usual, customary and reasonable fees.

Prior authorization, also known as pre-certification, is the approval an insurance carrier gives a member and provider in order for certain services to be considered covered charges before they are performed. Without prior authorization, a member may be subject to greater out-of-pocket expenses because benefits could be reduced or even denied.

What services require prior authorization?
Generally speaking, non-emergency hospital related services, behavioral health, alcohol/ substance abuse, advanced radiology/ imaging services and some prescriptions require prior authorization. However, each carrier's guidelines are different. Members should refer to their Benefit Booklet/ Certificate or call Member Services for verification before services are performed.

Who is responsible for obtaining prior authorization?
If a member uses a network participating provider, that provider should get the necessary authorization. If a member chooses to seek services from a non-participating provider, the member is responsible to comply with all applicable procedures. Many out-of-network providers may be willing to help with the process. However, the ultimate responsibility always lies with the member whether using a participating or non-participating provider. It is up to the member to ensure pre-authorizations are obtained and the member would suffer the financial consequences if not.

What can be done if a prior authorization request is not approved?
In most cases, a service or medication on the carrier's prior authorization list will be approved. If it is not approved, the member will receive a letter explaining the decision as well as whom they can contact to ask questions or obtain additional information that may help to understand the decision or resolve the issue. This letter will also include instructions on how a member can pursue a formal appeal. A member can certainly choose to receive the service or obtain the medication if prior authorization is not approved; however the total cost could become the member's responsibility.

Usual, customary and reasonable (UCR) is the maximum amount an insurance company will consider eligible for reimbursement under a health insurance plan and only applies when using non network providers. UCR is determined based on a survey of charges for a particular health service within a specific geographical area. Commonly, UCR is set at a certain percentage of all charges made by providers of similar services such as the 80th percentile.

For Example: 100 doctors are surveyed in a given zip code for a specific procedure. Results show that the charges range from $100 to $250. The 80th highest priced doctor charges $200. This would establish UCR at $200. Any charges above the $200 would not be considered when the claim is processed. Since it is the insured's choice to use non-network providers, they would be responsible for any amounts over UCR in addition to any applicable copays, deductibles, coinsurance.

For example: A member is enrolled in a plan that pays 70% out of network (assume no deductibles apply). The member uses out of network services and total charges are $4,000. The carrier determines that the UCR for the surgery is $3,000 (80% of providers in the members geographical area charge $3,000 or less for this type of surgery). The insurance carrier will reimburse the member 70% of $3,000 (or $2,100). The member will pay 30% of $3,000 ($900), PLUS the $1,000 difference between the billed charged of $4,000 and UCR of $3,000. This additional $1,000 cost to the member is called "balance billing" and does not apply to any maximum out of pocket limits!

It is always advisable to question whether your out of network provider(s) will accept UCR as applied by your insurance carrier. If they will not, you will have these options:

1. Pay balance above UCR
2. Ask provider to forgive balance above UCR
3. If they won't, get additional information from provider why they are above UCR and submit to insurance carrier under an appeal for reconsideration
4. Negotiate with provider to reduce balance

By addressing UCR before treatment, you could avoid unexpected expenses and headaches by having to appeal the balance billing. It is ALWAYS more difficult to argue the point after a claim is processed.

In 1985, Ed Gaelick established PSI Consultants, LLC where he specializes in company sponsored employee benefits, business planning and personal insurance. Throughout his career, Ed has received many of the highest professional honors awarded in the insurance industry. His dedication, integrity and fortitude have earned him great respect from his clients, staff and peers.

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