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Guest Column: The Facts You Need to Know About Primary vs. Secondary Coverages

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Health care is not as simple as it used to be. Today, some patients have health care benefits through multiple insurance plans. I'm one of them. I have Medicare as my primary coverage and Tricare for Life as my secondary coverage. I make sure that every doctor that treats me is contracted or participating with each of my plans. If they don't, I look to find another doctor that does.

What can become complicated is when the doctor is not contracted or participating with either insurance company. Things go ballistic when the doctor works in a hospital but the hospital is contracted and the doctor isn't, but that is the subject for a future article. You can add to the confusion when you factor in the type of health plan the patient has, and the laws that have jurisdiction over that plan. Some health plans, such as a Health Maintenance Organization, may be under the jurisdiction of a state HMO insurance law and some may be under the Federal law known as the Employee Retirement Income Security Act (ERISA). More on ERISA will be found in other articles. Why? What we don't want is to provide you with information overload. We wish to keep things as simple as it can be. [Read about ERISA in Medical Billing & Collections Alert Volume 11, Number 7.]

For the purposes of this article, the scenario will show that Dr. X is of any specialty and practices anywhere in the United States. Dr. X could be the doctor at your neighborhood health clinic. Dr. X is non-participating or non-contracted with any commercial insurance company. These insurance plans are not HMOs; they are not a Medicare or Medicaid Part C plan. They are not a workers' compensation health plan, nor is it an auto accident personal injury plan, also called PIP or Med-Mal in some states. Any one of these situations can change the entire contents of this article and can change the way the scenario is processed.

The patient is a normal person living in any neighborhood in the United States. The patient could even be you. We will call the insurance company ABC. It could be Aetna, Blue Cross and Blue Shield, Cigna, Humana, United Healthcare, or it could be the insurance plan you have now. We will call the patient Sheldon. Sheldon goes to see Dr. X for a routine minor medical condition. Dr. X submits an insurance claim to ABC Insurance for a routine office visit. The charge is $100. ABC Insurance is Sheldon's primary insurance company. Again, Dr. X is not contracted with ABC Insurance.

The fact that Dr. X is not contracted means that Dr. X is entitled to be paid 100 percent of his charges. He has not negotiated with ABC to be paid less than his full charges. If ABC Insurance doesn't pay 100 percent of the billed charges, then the patient, Sheldon, is supposed to pay the difference between the insurance company payment and the doctor's charge. So, if the charge is $100, if ABC insurance pays $10, the patient owes Dr. X the balance of $90. If ABC was supposed to pay the full $100 and they didn't, it is the patient's responsibility to contact their insurance company and appeal the incorrect payment.

Now, there could be some reasons why the insurance company didn't pay 100 percent of the billed charges. One reason is that all ABC is required to pay, per their contract with the patient, Sheldon, is a percentage of billed charges. For example, ABC is contracted with Sheldon to pay 60 percent of the charges, so if the charge is $100, ABC is only contracted to pay $60. The contract with the patient may require the patient to pay the amount not paid by the insurance company.

Another reason is because the payment was applied to the patient's deducible. Most insurance companies have a deductible. This is an amount that the patient is contractually obligated to pay out of pocket before the insurance company issues a check and pays claims. The amount of deductible is per their contract with the patient. A deductible

could be anywhere from $100 to $7,000 per year. Commercial insurance deductibles start in January of each calendar year. The higher the deductible, the longer it can take for the patient to meet their deductible. A deductible could be considered an IOU to be paid by a patient. If a patient has a $7,000 deductible that starts in January, and a visit is $100 and each $100 visit is applied to the deductible, that means the patient has to visit the doctor 70 times before the insurance company issues a check to the doctor. A healthy person may never meet a high deductible if they visit the doctor a couple of times per year, but in January, a new deductible begins. So, if you have a $7,000 deductible and you went to the doctor in January 2012, February, March, up to December 2012, on January 2013, you start a new $7,000 deductible. Not only are you paying premiums each month for this healthcare, you are also paying extra out of your pocket for the medical care. This extra is your deductible. You also have an additional out of pocket expense called coinsurance and another called copays. These out of pocket expenses will be discussed in further articles. If you have coverage through more than one insurance company, each may have its own deductible, so not only do you have a deductible with ABC Insurance, you may also have a deductible with your secondary insurance we will call XYZ Insurance.

Now, let's go back to the beginning. Sheldon visits Dr. X and there is a claim for $100 that was sent to Sheldon's primary insurance, ABC Insurance. For this situation, ABC allows the full $100. ABC applies the $100 payment to Sheldon's deductible, so Sheldon still owes Dr. X the amount of $100. Sheldon says I have additional insurance to help me pay my medical bills. I have XYZ insurance. Dr. X is also not contracted with XYZ. Sheldon has a $50 deductible with XYZ insurance. The claim is sent to XYZ in the amount of $100. The documentation from ABC insurance is sent to XYZ insurance to show XYZ how ABC processed the claim sent to them. Without this document, which is called an explanation of benefit or EOB, XYZ may deny the claim or they may put the claim on hold to wait for Dr. X or Sheldon to send them the EOB. XYZ allows $100 for the visit but Sheldon didn't meet their deductible of $50, so XYZ applies $50 to Sheldon's deductible and sends a check to Dr. X for $50. Because $50 of the original charge of $100 was transferred to the patient to pay, in the form of a deductible, Sheldon is responsible to pay Dr. X the balance due of $50. If XYZ denied the entire claim, Sheldon would have to pay Dr. X the amount of $100 for the medical care that he received.

Let's vary this scenario a little bit. Sheldon now has a $40 deductible with ABC Insurance and a $40 deductible with XYZ insurance. The claim is sent to ABC Insurance. They allow $100 but because Sheldon didn't meet their full deductible, they can't pay the full $100. They can pay $60 which is the $100 charge less the $40 deductible. Dr. X receives an EOB and check for $60 from ABC Insurance. The payment of $60 is applied to Sheldon's debt owed to Dr. X. That leaves a balance owed to Dr. X by Sheldon in the amount of $40. A claim is sent to Sheldon's secondary, XYZ insurance for the amount of $40 which is the balance still due Dr. X. ABC insurance allows $100, but Sheldon still has a $40 deductible to meet. The $40 remaining charge sent to ABC insurance is applied to the $40 of Sheldon's deductible. Sheldon now owes Dr. X the $40 charge balance.

If you think this is all so confusing, imagine how a patient feels. This is something that a well trained medical biller has the knowledge to understand and how to proceed. Again, if there are any variables this whole thing can change drastically.

About the author: Steve Verno is a Certified Medical Billing Specialist, a Certified Multispecialty Coding Specialist, a Certified Emergency Medicine Coding Specialist, and Certified Practice Manager-Medical Coding Specialist. Steve's specialties are Emergency Medicine, Family Practice, Pediatrics, Urgent Care, Internal Medicine, ERISA, Appeals, Provider Insurance Contracting, Provider Enrollment and AR Recovery. Prior to his stroke, Steve was a Professor of Coding and Billing Instruction at Everest University, now on medical leave.

Steve is on the Editorial Board of BC Advantage, the Medical Association of Billers, the Professional Association of Healthcare Coding Specialists, and the Physician Office Managers Association of America. He is a retired American Red Cross Health Services Instructor Trainer and now consults and trains through Heal Your Practice in Central Florida.