

Covered California Cost-sharing: What's the Difference Between "Co-payment" & "Co-insurance"?

Summary

Even when you have insurance, understanding how much you have to pay when you go to the doctor can be hard. This fact sheet explains the important differences between two ways you might have to pay when you go to the doctor or hospital: "co-payment" or "co-insurance."

When you sign up for health insurance through Covered California, you pay a monthly fee to your health plan, called a "premium." In turn, the health plan agrees to pay for a part of the services you need if you get sick or hurt. When you use medical services, you also usually have to pay a part of the charges. The part you pay for is called "cost-sharing."

There are different kinds of cost-sharing, including:

- The amount of money you have to pay before your insurance pays anything – called the "deductible"; and
- The amount of money you pay each time you get a service – called the "co-payment" or "co-insurance."

This fact sheet focuses on **helping you understand "co-payment" and "co-insurance."**

What is cost-sharing?

Cost-sharing is a term that refers to the amount of money **you** will pay for health care services under your health plan. It is your share of the cost of care.

Cost-sharing does not include the premium you pay to the health plan every month.

What is a co-payment or co-pay?

A co-payment (also called a “co-pay”) is a form of cost-sharing. It is a set amount of money you will pay for a service (\$3, \$15, \$40 etc). The amount is the same no matter how much the doctor or hospital charges for the service.

For example, a health plan has a co-payment of \$45 for laboratory services. If a laboratory charges \$100 for blood work, your co-payment will be \$45. If the laboratory charges \$1,000 for blood work, your co-payment will still be \$45.

Many co-payments are listed on your insurance card. All set co-payment amounts should be listed on your plan’s Summary of Benefits and Coverage (SBC) form.

TIP: For more information on the SBC form, see a [sample here](#).

What is co-insurance?

Co-insurance is also a form of cost-sharing. Unlike a co-payment, co-insurance is not a set amount of money you have to pay. It is a percentage of the insurer’s allowed amount for the service. What you will pay depends on how much the insurer allows for the service.

Let’s say your health plan has co-insurance of 20% for urgent care services. If the insurer allows \$1,000 for your visit, your co-insurance will be \$200 (20% of \$1,000).

Unlike co-payments, your cost-sharing will change depending on how much the insurer allows for the service. The SBC lists the co-insurance percentages for different services, but will not show the total allowed amount for each service.

How do I know what I will have to pay when I go to the doctor or fill a prescription?

If a co-payment applies to a service, the exact amount you will have to pay should be listed on your insurance card. You can also find the co-payment amount on your plan’s SBC form.

On the other hand, it may be hard to figure out how much you will pay when your plan includes co-insurance.

Co-insurance is a *percentage* of the allowed amount, not a set amount. It’s not always easy to figure out the amount the co-insurance applies to. In most situations, insurers don’t allow a set price. What they allow depends on the specific contract they agreed to with each provider. It may be difficult to find out what that amount is before you get

the services. Sometimes the specific amount is considered confidential. This makes it very hard to figure out how much you will pay for services with co-insurance. Ask your health plan if they can give you an estimate of what you should expect to pay

What are some examples of how co-insurance works?

Let's say a health plan requires you to pay 20% co-insurance for "Imaging" services. Imaging services are tests like an ultrasound, MRI or a CT scan. There are many kinds of imaging services a doctor might recommend. The allowed amount may be different, depending on the kind of imaging you need.

As an example, let's say the allowed amount for an ultrasound is \$180. The allowed amount for an MRI is more than an ultrasound – let's say \$600. If your plan requires 20% co-insurance for imaging, the price you pay at the time you get services will be different. Here's how it would work.

- For the ultrasound, you pay 20% co-insurance on the total of \$180 – so you would pay \$36.
- For an MRI, you pay 20% co-insurance on the total of \$600 – so you would pay \$120.

Co-insurance can make your costs hard to predict. In this specific example, "20% co-insurance" can mean you pay anywhere from \$36 to \$120. It all depends on the allowed amount for the services you receive.

Will I pay a different amount of co-insurance depending on where I get my services?

Yes. Services in a hospital or outpatient facility will likely cost more than services in a doctor's office. And different labs, facilities or doctors negotiate very different rates for the same service. This is another reason it can be hard to know in advance what you will have to pay for services using co-insurance. For example:

- An MRI at one hospital in Los Angeles costs \$1,075. If this was the allowed amount and your plan requires 20% co-insurance for imaging services, you would pay \$215 co-insurance.
- At another hospital in Los Angeles, an MRI costs \$550. If this was the allowed amount, you would pay \$110 co-insurance (20% of \$550).

So, the amount you pay might be very different based on which hospital or facility you use.

How can I better understand what I might pay?

The amount you pay depends on your health plan. Each plan has a Summary of Benefits and Coverage Form (SBC) that lists all the services covered under the plan. The SBC will tell you which services require cost-sharing and what the cost-sharing amount is for each service. The SBC should make clear if the amount you pay will be a co-payment (set fee) or co-insurance (a percentage of the charges).

You can find an SBC for each of the Covered California health plans on www.coveredca.com. Your health plan also should give you an SBC form. Below is an example of what one part of the SBC form looks like.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 co-pay/visit	40% co-insurance	—none—
	Specialist visit	\$50 co-pay/visit	40% co-insurance	—none—
	Other practitioner office visit	20% co-insurance for chiropractor and acupuncture	40% co-insurance for chiropractor and acupuncture	—none—
	Preventive care/screening/immunization	No charge	40% co-insurance	
If you have a test	Diagnostic test (x-ray, blood work)	\$10 co-pay/test	40% co-insurance	—none—
	Imaging (CT/PETscans, MRIs)	\$50 co-pay/test	40% co-insurance	—none—

Are there things that I should remember when I am comparing health plans?

Keep in mind that a low co-insurance percentage may not be cheaper than a high co-payment amount. This can be confusing. When you see a lower number, you might think it means the cost to you is cheaper. But a set co-payment amount is different than a co-insurance *percentage*.

Remember, a co-payment is a set amount that does not change, no matter the allowed amount for the service. But a co-insurance amount will change depending on the allowed amount for the specific service.

A 20% co-insurance for a lab test might seem lower than a \$45 co-payment at first glance. But if the lab test you need is expensive, even a co-payment of \$45 will be less than the 20% co-insurance. Here's how:

- Lab Test - \$400
 - Co-payment - \$45
 - Co-insurance - \$80 (20% of \$400)

Co-payments are easy to understand. No matter how much the doctor charges, if a co-payment applies, you will pay only that specific amount and no more.

If I have a deductible, do I have to pay more than just my co-payment or co-insurance amount?

Yes. For some services, your health plan will only pay **after** you have paid your deductible amount. That means the health plan won't pay for anything until you have spent a certain amount of money first. For example, if your deductible is \$500, your health plan won't pay **anything** until you've spent \$500 out-of-pocket on covered health care services. (There are exceptions for preventive services.)

There is an exception to this rule: you don't have to pay the deductible first for some of the most basic services. For example, the deductible does not apply to any preventive care doctor visits. Look closely at your plan information to find out if the deductible applies or does not apply to certain services.

This fact sheet was prepared by Geraldine Slevin & Julie Silas, Consumers Union. For more information, contact geraldine.slevin@consumer.org
