I would like to explore receiving care at Magnolia, what is the first step?

The first step is to verify your benefits. This can be done before or after you come to Magnolia for a tour and consultation. Through our verification of benefits process we are able to figure out how to best work with your insurance as an “in-network” provider with most plans and an “out-of-network” provider with others as well as your financial responsibility and coverage limits for your policy. Once your benefits are verified our Administrator can provide you with a more detailed break down of costs and if there are roadblocks offer some suggestions on where to go from there.

Once you are a client, our staff will meet with you again to discuss your specific insurance coverage and financial situation. Together, we create a payment plan with a schedule that fits your budget and completes all payments for your care by 36 weeks of pregnancy. Although it is helpful for you to know what your benefits are, the verification we complete is typically recorded (by the insurance company), reference numbers are documented and we ensure that every piece of relevant information is collected at once. There is no charge to verify benefits.

UNDERSTANDING THE COST OF CARE

HOW MUCH DOES BIRTH CENTER AND HOME BIRTH COST?

The average cost of childbirth can vary widely and there can be sigificant cost differences between giving birth at the hospital and birthing in the community at a birth center or at home. We believe in making sure we give you an amazing value for the care you receive. You’ll find our prices are comparable to other local birth centers. We accept all major insurance plans and are in-network through most carriers, including the several Medicaid Managed Care Organizations. Whether you’re in-network, out-of-network, or self-paying, we’re here to help you review all your options.

MAGNOLIA BIRTH HOUSE

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Do insurance companies cover home birth and birth center birth in Florida?

Magnolia accepts self-pay, private insurance and select Medicaid HMOs. The cost of midwifery care and the facility charge for the birth center are covered by many health insurance plans including Medicaid. All insurance plans in the state of Florida are required by law to cover midwifery services. Florida law requires that maternity care coverage include the services of certified nurse-midwives, midwives licensed pursuant to chapter 467, and the services of birth centers licensed under ss. 383.30-383.335.-- emphasis supplied. See Florida statutes, s.626.6406; s.627.6574; and s. 641.31(18). In requiring such coverage, section 467.002, f.s. specifically recognizes the need for a person to have the freedom to choose the manner, cost and setting for giving birth. The law requires that maternity coverage include midwifery services and provides that an insured or enrollee be given the option of choosing the setting for receiving such services. Therefore, no HMO contract or insurance policy may directly or indirectly deny reimbursement for midwifery services rendered in a home birth or birth center setting. Deductibles, copays and out of pocket expenses will vary depending on the specific of your individual policy.

Do midwives work with insurance companies?

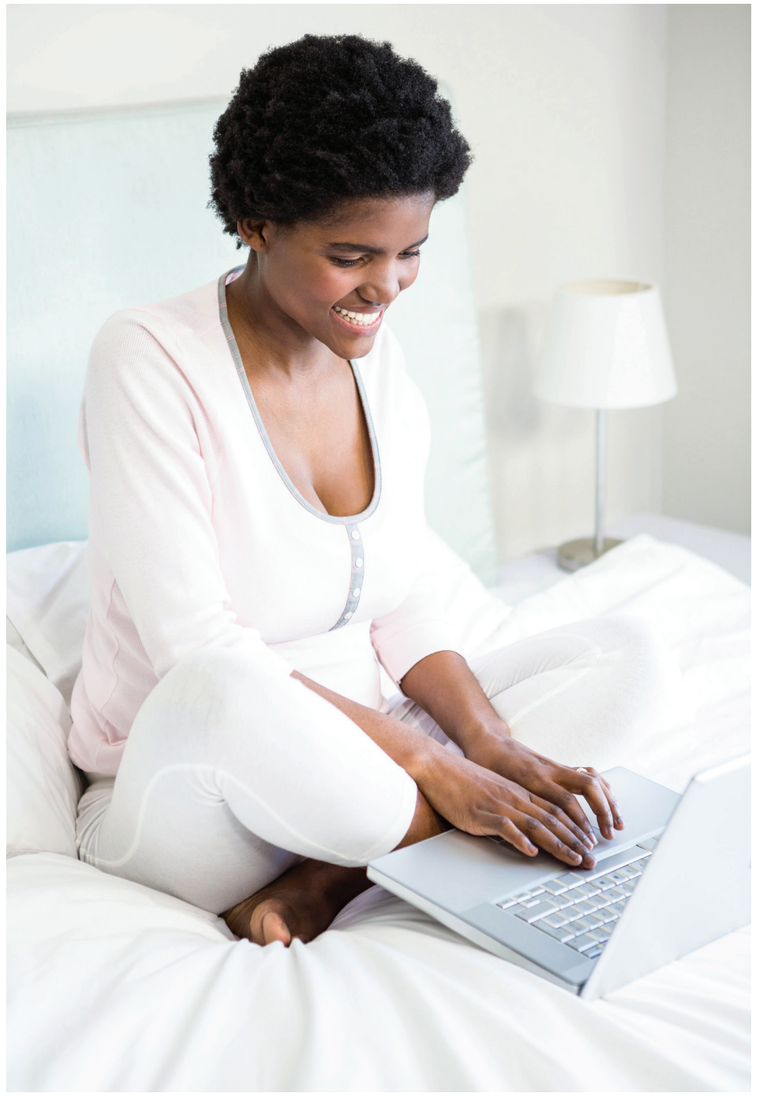
Independently practicing licensed midwives offering homebirth services are not in network providers. Many insurers don't contract with independent midwives and many independent midwives don't want to be contracted. The reason midwives may not want to be contracted in network providers is that insurance companies don't pay providers their actual fee for service. Insurance companies reimburse what they consider to be 'fair and customary'. For a business like a hospital, or a busy OB practice their volume of overall clients is so high that having their rate reduced/undercut is negligible or there are enough clients so that what they lose is made up in quantity. Unfortunately for a midwife who is doing only 3-4 births per month being paid $2900 for example (the amount the insurance thinks is 'fair') versus their actual rate ($5000-5900 in our area) is a substantial loss. When a midwife is in network once she excepts their reduced "fair and customary" fee, she cannot bill you or your insurance for the difference. If she is out of network she can 'balance bill' you for the amount between what her rate is and what your insurance thinks is 'fair'. Local rates for homebirth tend to be $5000-5900. Your insurance may pay some of that, but as out of network providers independent midwives can balance bill, which means that you are responsible for 100% of the difference between what your insurance pays and what their rate is. That's why some people opt to choose a birth center even when planning a homebirth. As in network providers we can't balance bill. So even if our 'market rate' is $6500, we have to accept the contracted rate outlined in our agreement with your insurance company. You are still responsible for your deductible, co-payments and co-insurance and the costs of any exclusions. Let's say for example our contract with your insurance says they will pay us $4000 for your care and you have a $2000 deductible. You pay us your deductible ($2000) and the cost of any exclusions and your insurance pays us the remaining $2000. We can't collect the $2500 difference between our market rate of $6500 and our contracted rate of $4000. For those who can sustain the higher out of pocket costs, an independent midwife may still be a better fit for more deeply personalized care and certainty a specific midwife will attend your birth. It's just a question of what works for your family.

Is your practice an in-network provider with any insurance companies?

Yes, several. We are dedicated to ensuring all families in our community have access to comprehensive and patient centered midwifery and birth center services. We fundamentally believe that everyone who wants access to midwifery care and birth center delivery should be able to have it. We are choosing to work with insurance companies as "in-network" providers so they can understand what we do, which we hope will help with getting better reimbursements down the road for birth centers and wider access to this type of care for families everywhere. Additionally although Medicaid reimburses 1/3 of our market rate for the services we provide we have made a commitment to continue to accept Medicaid clients and also to provide care to un-insured individuals who need financial assistance through a reduced rate program. We are in network providers with United, Aetna, Blue Cross Blue Shield / Florida Blue and Cigna. We are in network providers with a few Medicaid Managed Care Organizations (MCOs) including Molina, Simply, Prestige and Sunshine Health. Additionally we are in-network with some plans that are part of the Affordable Care Act health insurance exchange including: AmBetter, Molina, Oscar & Florida Blue.

If my insurance plan (i.e. AvMed, Humana) isn't listed, how can we work with your practice and still be covered by our insurance company if possible?

If you have out of network benefits your policy will automatically pay out of network rates. If you don't have out of network benefits then we have to make even more efforts to secure coverage with your insurance company. Some insurance policies allow members to submit a request for an in-network exception authorization sometimes referred to as a gap exception. This request asks your insurance company to pay an out of network provider (us) at the same rate as an in-network provider. If it is allowable for your policy, we submit this request. It can require some leg work on your end. It may take a few weeks or even months to go through the process of approval/denial. This request can only be done by contacting member services either by phone or by letter. If the request can be done by phone, our billing specialists (Total Billing) will typically do it. If contact must be made via letter, we provide you with a sample letter on which to base your personalized request. In some cases exceptions have to be renewed every three months. In other cases they are not allowed due to the terms of the policy. We find out what the parameters are of your specific policy during the verification of benefits process.



We believe in providing an amazing value for your financial investment in the care you receive.

What can we expect our costs to be?

There are several variables at play when determining your individual out of pocket costs. These include: our rate of service and your deductibles, co-insurance, co-pays, contracted rates, out of pocket maximums and exclusions as they relate to your insurance coverage. We will explain each below.

Deductible

Your deductible is the amount of money you have to spend before your insurance starts paying. When you use an in network provider you are billed at the contracted rate, not the market rate. Usually the contracted rate is substantially lower than the market rate. Think of it as the difference between paying retail (market) and wholesale (contracted). Even if you have a deductible of say $1000, you aren't being charged the market rate for the services you use. If for example your deductible is $0 this means that from the time you get your first medical bill for any service, your insurance begins to pay.

Co-Insurance

Your co-insurance kicks in after you meet your deductible and it is the percentage of the bill (at the contracted rate) that you are responsible for after you've met your deductible. If for example your co-insurance is 25% this would means if our contracted rate for all of your prenatal care and your delivery is $2000, you are responsible for $500 of that.

Co-Payment

A co-pay is a set dollar amount you have to pay when you see a provider. For example, you could have a $50 co-pay to visit your primary doctor or a $200 co-pay when you visit the emergency room or a $30 co-pay for your first prenatal visit or a $350 co-pay for use of the birth center. Whether or not you have co-pays depends on your plan and plans can vary widely even with the same insurer.

Out of Pocket Maximum

Your out of pocket maximum is the total amount you can spend on healthcare in the course of a benefit year. So if for example your out of pocket maximum is $2800 you won't ever spend more than that in a year. Even if you have a 100,000 hospital bill and your co-insurance is 25% once you hit $2800 the insurance covers everything else.

Exclusions

An exclusion is something that isn't covered by medical insurance. Maternity coverage typically includes medical care for services billable by standard obstetrical codes. Prenatal care, lab work, ultrasounds and other medical care is what typically goes under the umbrella of a medical care. Childbirth education does not. So childbirth education classes are exclusions. Our administrative fee is an exclusion. A doula for labor support would be an exclusion. None of those things are billable to your medical policy. Are there scenarios under which dollars allocated for medical care could be used for exclusions – yes. If you have an HSA (health savings accounts) or FSA (flexible spending account) where your own pre-tax dollars are stored for use on things with things like insurance co-pays, deductibles, doula care etc. Some companies set these up for their employees and even match what they contribute.

Fees

Our fee for midwifery care and birth center delivery is $5900. This fee does not include any physician consultations, lab work or ultrasounds. All payments must be made by the 36th week of pregnancy, unless other arrangements have been made. Additionally just like hospitals and physician offices insured clients pay a minimum of their deductible, co-insurance, co-pays and any exclusions if applicable.

Billing

After the birth of your baby when we bill your insurance, we reconcile your payments to us with the payments we receive from your insurance company. In some cases you may be due a refund, in other cases you may have a balance owed. We try to put ourselves (and you) in a position not to have to worry about addressing a sizable bill after your baby arrives. Worst case you owe a few hundred dollars when all billing is complete. Best case you are due a partial refund from us. Billing is submitted by our billing service directly to the insurance company within 72 hours of your baby's birth and typically takes 8-10 weeks to be finalized. That timeline isn't based on us. It's largely based on the turn around time of your insurance company. You pay for your insurance (most people do) and we bill for everything we can in the spirit of getting as much payment from them as possible.

What are typical exclusions that will be part of my out of pocket costs?

The exclusions below are typically associated with care at our birth center and listed in our financial agreement:

Administrative Fee
Our administrative fee is intended to support administrative costs. We made the decision to be in-network providers with most insurance companies in order to assure the broadest access to midwifery care. That said, in-network rates for insurance reimbursements are anywhere from 30-70% less than of our market rate. We would never be able to run our business and keep our doors open without making some attempt to cover the intangible non-covered administrative labor that helps facilitate our capacity to provide you with comprehensive and individualized care. We could not do this unless we overbooked our clients, had long wait times and spent about 10 minutes with clients at visits – similar to what many obstetrician practices do. Administrative support by multiple non-medical staff members is required to shepherd you through all aspects of your care from things like verifying your insurance benefits and communicating with your insurance company to ensure payment, to coordinating with external providers by facilitating appointments and referrals, to providing educational materials and 24/7 extensive phone/text/email and in-person support. This fee makes a small contribution to the human cost of these tasks that are all part of ensuring you receive high quality whole person care. The actual staff time that goes into providing our wraparound approach far outstrips the $15 x 10 hour per client estimate we used to come up with this fee. $250

Childbirth Education
It is recommended that you participate in a childbirth preparation classes. Your midwife cannot adequately explain the entire scope of the physiology and process of labor and birth, birthing center/homebirth procedures, medical interventions, comfort measures, coping techniques, newborn care, etc. in the course of regular appointments. We offer a childbirth education program through The Gathering Place provided at a 45% discount for Magnolia clients. Classes provided through the center are more personal and typically smaller in size than classes offered in hospitals and are taught by knowledgeable and experienced instructors. A special package of their core classes has been created for our clients. Clients can choose to take advantage of any or all of the following classes: Preparing for Out of Hospital Birth*, Giving Birth with Confidence, Coping with Fear & Pain in Labor, Your Amazing Newborn, Becoming a Father, The Fourth Trimester and Breastfeeding Basics for a package rate. You aren't required to take classes through The Gathering Place but you are required to take classes. Documentation of classes taken will be requested of clients. *required class $99

Risk Assessment Consultation
When you enter our care we complete risk assessments that functionally clear you to receive care from our midwives at our birth center per the parameters set by Florida law. Risk assessment is ongoing. If at any point your health status changes and those risk assessment tools indicate a consultation is needed, you are referred to a medical doctor for that counseling visit and a fee is charged. During pregnancy all visits, outside of your initial visit are billed as a package under what is called a "global" fee. As a result when you have a consultation with a medical doctor for the purpose of evaluating an issue of concern that arises during your pregnancy which potentially elevates your risk factors, that visit is billed to you. $100-500

Birth Assistant Fee (home birth only)
Your primary birth team is made up of a midwife and a birth/midwife assistant. When you deliver in the birth center we bill a facility fee to your insurance company which includes the costs associated with using the space including staffing. If you have a home delivery we cannot bill that fee, because the "facility" is your home. We charge the birth assistant fee for home births only. $500

Curated Postpartum Bag
This bag contains a group of products that we have curated to aid in your postpartum recovery and welcome your little one. They include a Boba wrap, Honey Pot Postpartum Pads, Coddle Nipple Cream, Earth Mama Milkmaid Tea & Herbal Sitz Bath and other items selected specifically for our clients and offered to you at wholesale pricing. $75

Birth Pool Supplies
Currently insurance companies do not have codes specific to waterbirth or hydrotherapy in labor. As a result we cannot bill them for the disposable supplies that we use for each water birth i.e. the pool liner and hose. The cost of these supplies is provided to clients at cost. $75