Understanding Your Insurance Plan

Most insurance companies share costs with the patient. There are many cost sharing options:

- **Deductible:** The total amount of covered medical expenses that must be paid by the patient before the insurance company begins paying benefits. After this requirement is reached, the insurer will begin paying according to terms of the contract of covered medical costs. The patient is responsible for any remaining balance.

- **Flat-rate copayment:** The patient pays a share of covered medical costs and the insurance carrier pays an amount based on the policy. For example, the patient pays $15 of any office visit charge and, the insurance carrier is responsible for the balance.

- **Percentage-based copayment:** The patient pays a percentage share of covered medical costs and the insurance company pays an amount based on the patient's policy. Examples are: 20% of the office visit charge - $10 of a $50 charge, $12 of a $60 charge, etc. Typically this copayment arrangement includes a deductible and may have other variations.

- **Consumer-driven health plans: (CDHPs)** are the fastest growing plan type currently across the country. Employers are shifting financial responsibility to their employees by offering health plans with high deductibles and coinsurance to reduce cost to the business. Most of these plans cover wellness services such as immunizations, well-child visits and periodic check-ups more than sick services. They usually have a high deductible, but when the deductible is met, the plan pays for services at a percentage (such as 80%) of a defined reasonable and customary fee schedule.

- **Health savings accounts: (HSAs**) are tax-favored savings accounts funded with pretax dollars by the individual or the employer. Money can be withdrawn from the account at any time with no penalty or taxes to pay for qualified medical expenses. An HSA can be established only along with high-deductible health insurance plans that meet Internal Revenue Service rules that set the amount of the individual and family deductible. The amount an employee can put in an HSA is capped at the amount of his or her annual deductible of his or her health insurance policy. Any unused funds each year remain in the account, accumulate tax-free and can be used for future medical expenses.

- **Health reimbursement accounts: (HRAs)** are funded by the employer and can be used by an employee as pretax dollars. These accounts can be set up independent of any specific health plan or benefit design. Money can be used to pay for medical expenses. HRA funds can also be carried over from year to year. The amount of the contributions to the HRA varies based on the employer. The employer owns the fund and any unused amounts may or may not be transferred on termination of employment depending on the terms of the fund. Medical spending accounts (MSAs) and flexible spending accounts (FSAs) are versions of HRAs with particular features.

Understand the fine print of your plan:

Your health insurance policy is an agreement between you and your insurance company. It is generally negotiated by your employer if it is an employee benefit. The policy lists a package of medical benefits such as tests, medications and treatment services. The insurance company agrees to cover the cost of certain benefits listed in your policy. These are called "covered services." Coverage does not guarantee full payment and your insurance company may require partial coverage by the policyholder. Your policy also lists the kinds of services that are not covered by your insurance company. You have to pay for any uncovered medical care that you receive.

Be aware that a medical necessity is not the same as a medical benefit. A medical necessity is something that your provider has decided is necessary based on clinical presentation and standard of care. A medical benefit is something that your insurance plan has agreed to cover. In some cases, your provider might decide that you need medical care that is not covered by your insurance policy. Common examples of this might be a splint for a sprain or a spacer device to use with an inhaler for wheezing.

Since we are unable to know the specifics of every insurance plan, we encourage families to read their insurance information to make an informed decision of which plan to choose (if more than one is offered by the employer).

- Take the time to read your insurance policy. It's better to know what your insurance company will pay for before you receive a service, get a lab or x-ray or fill a prescription.
- Some medications, tests or hospitalizations may have to be approved by your insurance company before your doctor can provide them.
- If you still have questions about your coverage, call your insurance company and ask a representative to explain it.

Remember that your insurance company, not your provider or the physician's office, makes decisions about what will be paid for and what will not.

What if something isn't covered by my plan?

Most of the things your provider recommends will be covered by your plan, but some may not. When you have a test or treatment that isn't covered, or you get a prescription filled for a drug that isn't covered, your insurance company won't pay the bill. This is often called "denying the claim." You can still obtain the treatment that is recommended, but you will have to pay for it yourself. Some companies will pay a percentage and the patient is responsible for the remainder. This is in addition to your co-pay. If more than one issue is covered at a single visit (such as a hurt finger and asthma or a well visit and ear infection) separate co pays may apply, depending on an insurance plan.

If your insurance company denies your claim, you have the right to appeal (challenge) the decision. Before you decide to appeal, know your insurance company's appeal process. This should be discussed in your plan handbook. Not all appeals will end in your favor, but some challenged claims will be covered eventually by the insurance company.

Most insurance companies have different levels of co-pays for the primary care office, specialist, urgent care, and emergency room. These are often printed on your insurance card and can change yearly with new contracts. Some insurance plans require a referral to see any provider other than your primary care provider on your insurance card.

Why does the front desk always ask for my card?

Bring your insurance card with you to each visit. Although you have the same plan as last year, the copays might be different. Sometimes the insurance billing address has changed. We cannot file your claim properly without the correct information.

How do I know what medicines will be least expensive?

A formulary is a list of medications that your insurance company will help you pay for. It puts medications in two or three categories (tiers) based on co pay. The first tier is usually generic medications, the second more expensive medications and the third the most expensive medications. Each tier has a higher co pay. This list is reviewed and changed by the insurance company every few months, so your cost might go up or down. Be aware of the formulary before you begin any medication, especially one that will continue long term. Learn if your insurance gives a discount for using their mail in prescription service. Insurance companies, not the pharmacy, decide on the cost of the co pay. They might contract with particular pharmacies and your cost will be lower at those pharmacies. We are happy to write for prescriptions with lesser co pays if they will treat the condition properly and you know your formulary. Because we see hundreds of plans and formularies change, we do not know what your plan prefers. Know your formulary!

What if I have a question about a bill?

If you do not understand a bill or explanation of benefits (EOB), please call your benefits administrator or human resources administrator, or our office billing department.

I received a bill that I don't think I should have to pay.

Sometimes insurance companies believe that a test, procedure or therapy is warranted, but they will not cover it and require the patient to pay. For example, our office has received several complaints from parents about the charge for the autism screen we recently started performing. In October 2007, the American Academy of Pediatrics initiated a new standard of care that all children at 18 and 24 months be screened for autism with a standardized test. Prior to this, our office asked screening questions for both motor and verbal development at each well check. According to the new guidelines, questions that are not part of a standardized evaluation are not sufficient. We chose to use the MCHAT (Modified Checklist for Autism in Toddlers) because of its ease of use, validity and reliability.

We use numbered codes to submit services to insurance companies. These codes vary from the visit itself to diagnoses made and tests performed. We are encouraged to use codes for everything we do to document to the insurance company what care was given at a visit. Insurance companies use these codes to monitor practice patterns and optimum care.

When there is a new standard of care, such as the Autism screen, it takes time for the insurance companies to recognize the new code. Sometimes a company never pays on that code. Unfortunately, in order for us to able for us to provide the standard of care, which we strive to follow for all patients in all instances, we must provide this service and submit the code to the insurance companies. The service may seem minimal, but it does incur a cost to our business. With the MCHAT, we must print the forms, monitor inventory, and assure that each child at the appropriate age has a completed form.

How can I help my insurance company begin to cover costs of currently allowable but not covered benefits?

We encourage parents to call their insurance companies and talk with their Human Resources personnel to discuss billing disputes. When insurance companies review the concerns of consumers, they may change policies.

If your insurance company is one that does not recognize the value in any medically indicated service, please call your insurance representative to demand coverage for recommended services. Every call they receive may or may not immediately change their benefits, but if enough concern is raised with a particular issue, there is a better chance it will at least be discussed.

Key Terms

Billing Statement: A summary of current activity on an account.

Birthday Rule: To determine which parent carries primary insurance and which will be secondary if both parents have insurance, a birthday rule is generally accepted. Under this rule, the plan of the parent whose birthday occurs first in the calendar year is designated as primary. The date of birth is the determining factor — not the year — so it doesn't matter which spouse is older. Like most rules, the birthday rule has exceptions:

- If both parents share the same birthday, the parent who has been covered by his or her plan longest provides the primary coverage for the children.

- If one spouse is currently employed and has health insurance through a current employer, and the other spouse has coverage through a former employer (e.g., through COBRA), the plan belonging to the currently employed spouse would be primary.

- In the event of divorce or separation, the plan of the parent with custody generally provides primary coverage. If the custodial parent remarries, the new spouse's coverage becomes secondary. And finally, the non-custodial parent's plan would provide a third layer of insurance

protection. This order of payment can be altered by a court-issued divorce decree or by agreement, but the insurance companies must be notified.

Claim: Information billed to the insurance company for services provided.

Copayment or Coinsurance: The balance due by the policyholder as determined by the insurance company. If separate issues are covered at one visit, more than one copay may apply based on insurance company contracts.

Deductible: Amount the policyholder needs to pay for covered health services before a health plan will begin to pay benefits. Usually a new deductible is met each calendar year.

EOB (Explanation of Benefits): A detailed explanation from the insurance company that identifies the amount due for services provided. This includes any payments made by the insurance company and any listed co-payment, coinsurance or deductible due from the policyholder.

Guarantor: The person responsible for paying the bill.

Primary Insurance: Designation given to the insurer that your claim will be submitted to them first for payment of services you received. For dependent children, the primary insurance is the parent with the first birthday of the calendar year. For example, if Dad's birthday is July 1972 and Mom's is January 1973, Mom's birthday is first and would be the primary insurance. See also "Birthday Rule".

Secondary Insurance: Designation given to the insurer that your claim will be submitted to them second for payment of services you received. For dependent children, the primary insurance is the parent with the first birthday of the calendar year. For example, if Dad's birthday is July 1972 and Mom's is January 1973, Mom's birthday is first and would be the primary insurance. See also "Birthday Rule".

Prior Authorization/Pre-Certification: A formal approval obtained from the insurance company prior to delivery of medical services. Many insurance companies require prior authorization or pre-certification for specific medical services, procedures or medications.

Subscriber: The person who holds and/or is responsible for the medical insurance policy.