Understanding Your Insurance and Advocating for Coverage

Many families with healthcare insurance expect to have services paid for by their plan, and are surprised or confused when this does not happen. Every insurance plan is different and there is almost always some level of member responsibility for payment. This document helps you understand what influences whether or not a service is covered by an insurance plan, and what you can do to advocate for coverage.

Your Insurance Plan Membership

Patients receiving services at PrairieCare enter both a clinical and financial relationship. The "guarantor" is the person who becomes responsible for payment for services. Most guarantors have insurance, which means they can many times rely on help from their insurance plan. However, even if insurance does not pay, for some reason, the guarantor then becomes responsible for payment. Insurance companies act as a third party benefit that can help provide financial coverage for those services. It is important to remember that although the guarantor is ultimately responsible for payment, **you are a paying member of an insurance plan**. Just as you may be a member of any other association, club of group – you have an expectation to receive benefits through that membership. We encourage all members to make contact with their insurance plan to make sure that they are fully aware of their benefit coverages and that their insurance company can identify them as an alert consumer.

Authorization for Payment for Services

Many insurance companies will require pre-authorization for initial and ongoing coverage for some mental health services. It is important to understand that the insurance companies decision on pre-authorization may be independent of whether or not the services are deemed medically necessary by the provider. In other words, a provider may deem a treatment beneficial or even necessary but **the insurance company may disagree and not provide payment coverage**. In these cases, we encourage members to contact their insurance company and exercise their rights as a consumer to advocate otherwise. This can be done by corresponding directly with the insurance company, or other regulatory agencies. It is unfortuantley common that **clinicians recommend a treatment option that an insurance company decides is not necessary and they refuse coverage**. These conflicts are a disagreement between the medical and/or therapeutic decision making of a clinician and the financial opinion of an insurance company representative or policy. The denial of payment by an insurance company does not change or supercede the decision of a clinician. However, it does create a dilemma when this creates a barrier to an individual receiving care. **An insurance companies denial of coverage shoud never be perceived as a providers refusal to provide care.**

Advocacy Support and Help

We encourage all patients and guarantors to communicate their medical needs to their insurance company at the onset of treatment. If you are experiencing unfair or unethical coverage denials, you can also contact the follow agencies to seek further assistance or file a complaint:

- **MN Ombudsman for Mental Health and Developmental Disabilities:** 1-800-657-3506
- **MN Attorney General:** 1-800-366-4812
- **MN Department of Health, Managed Care Section:** 1-800-657-3916