Alaska Center for Pediatrics
BIRTH THROUGH ADOLESCENT CARE

Understanding Preventive Care Costs

Health care for newborns, infants, children, and adolescents begins with the well-child visit (checkup) and other services that help keep children healthy. These are preventive services. Our providers and staff deliver these services based on The Bright Future plan. The American Academy of Pediatrics (AAP) created this plan to guide providers and families on what preventive services children should receive from birth to 21 years of age. This includes screenings, lab tests, and advice about staying healthy and safe. This plan can be altered to suit each child as needed. ACP follows the AAP vaccine schedule for newborns, infants, children, and adolescents.

Because preventive services are important to keeping children healthy, the Patient Protection and Affordable Care Act (health care reform law) includes a rule stating that all preventive care screenings and services included in the Bright Futures plan and vaccine schedule must be covered by most health plans. Unfortunately, this is not always true, as some plans like grandfathered plans, cost sharing plans, etc. choose not to cover preventive services.

Health Plan Terms to Know:

- **Co-payment**: A fixed amount that you pay for certain health services before the health plan pays
- **Coinsurance**: The portion of the charge that is not paid by the health plan (usually a fixed percentage of each amount paid by the plan)
- **Deductible**: An amount that must be paid before the health plan pays for covered services

ACP does not want you to be surprised by a bill however, we are required to bill your health plan based on the actual services provided. While our billing office is happy to review our records for errors, the following are common reasons you might receive a bill after a well-child visit:

Reason 1: Your child's insurance plan is not ACA-compliant.

> While new group health plans and exchange plans are required to cover all parts of the well-child visit with no cost sharing, many health insurance plans are exempt from the ACA and, as a result, this requirement. These include existing unchanged health plans from before the ACA became law ("grandfathered" plans), federal employee plans, government plans like Tricare or ChampVA, ERISA-based self-insured plans, and membership plans like faith-based cost-sharing services.

Reason 2: Your child's insurance plan is ACA-compliant, but you received some preventive services which are not part of the ACA-recommended list.

> The list of services that ACA-compliant plans are expected to cover can be found at the US Preventive Services Task Force. For example, routine vaccines—not travel vaccines—are in the list of covered preventive services. If a child received a travel vaccine as part of a well-child visit, an ACA-compliant plan may not fully cover the cost of the travel vaccine (even though it is a preventive service).

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Reason 3. Your child's insurance plan is ACA-compliant, but you received some non-preventive services as part of the visit.

Examples might include lung function testing for asthma or evaluation of chronic headaches done at a well-child visit. While both services help promote wellness, neither are included in the definition of a standard well-child visit service and may result in an additional charge based on the rules of your insurance plan. Other non-preventive service examples might include acute illness evaluated at a well-child visit or a splinter removal procedure performed at a well-child visit. Some families only want covered preventive services at a well-child visit; other families appreciate that we can provide all needed services at the same time so you don't have to come back for a separate visit. Please let us know if you prefer to come back for a separate visit as we will typically always take care of the services needed if time allows!

Reason 4. Your child's insurance plan is ACA-compliant, but you received more frequent services than is typical.

This occurs when well-child visits are scheduled closer together than what the insurance company considers to be "annual." Some insurance companies pay for one well-child visit per calendar year. This means a child might have a check-up in September one year and July the next. Other insurance companies have more stringent rules and say that at least 365 days must pass between well exams. If not, the second well visit will be denied by your insurance company, and you will be responsible for the charge. Be sure you understand your insurance company's definition of "annual" before scheduling the appointment.

Reason 5. You received ACA preventive services, but your insurance company does not recognize the billing code(s) ACP uses for that service.

For example, vision screening for children ages 3 to 5 is an ACA preventive service. In 2017, there are three codes that are commonly used to report vision screening in children: simple eyechart and two types of electronic instruments.

Some insurance plans recognize the eyechart code as an ACA code, but not the electronic instrument code. In that case, a family would have no cost-sharing responsibility for an eye chart, but they would if their child could not use an eye chart, and ACP screened vision using an electronic instrument. Families might understandably ask the ACP to use the covered code—even if ACP used the other method. However, it is a violation of insurance contracts and federal and state laws to knowingly report the wrong code.

Other insurance plans might permit all the vision screening codes as ACA preventive, but not accept them when billed by ACP. The plan only pays for them when the family makes a separate trip to an eye doctor.

Please do not hesitate to inquire about services that may not be paid in full by your health plan. It is our pleasure to help.

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