I have AFTNA and

I want a home birth

August, 2020



AETNA and home birth

AETNA plans, as a rule, do not allow home birth coverage even for remote patients who struggle with facility or hospital access. It's been their policy for quite some time and Alaskans are not exempt. Home birth is a planned delivery outside of a licensed facility in a patient's residence or home. Insurance companies identify the place of delivery or the POS by the code on a claim. Most common codes for delivery include inpatient hospital stays, freestanding birthing centers and patient's home. So what can you do to ensure your care is covered?

1. **Contact your plan's member service department.** There is a member service phone number listed on the back of your insurance card. This department answers patient benefits questions, helps patients locate participating providers in their area and coordinate planned procedures and care such as maternity care. They can also inform the patient about deductibles, copays, coinsurance and out of pocket maximums. Calling this number can be the first step to identifying whether or not your plan is truly an AETNA plan, or just managed by AETNA. The difference can mean whether or not your home birth will be covered or not, making this an important first step.

- 2. **Contact your HR department.** If home birth is not covered by your plan, having your Human Resources department help you contact your insurance plan and request a coverage exception for extenuating circumstances such as a) lack of facility, provider or hospital access in remote locations; b)No network providers in your area; c)state regulatory limitations of VBACs (Vaginal Birth After Cesarean)in birthing centers or d)personal grievances or preferences for a home birth.
- 3. **Get a letter from your provider stating medical necessity.** If a hospital or birth center birth is not a feasible option for you for any reason, a letter describing medical necessity from your provider can help your HR department in filing an exception for your care.
- 4. **If you get an exception**, make sure to get a reference number or prior approval number in writing. Your provider will need this information before your delivery to make sure the information is included on your medical claim.
- 5. **If your requests are denied**, you still have options that can help with the financial strain of having a non-covered homebirth.
 - a. You can appeal the decision. This means you can request that your decision be re-reviewed because you disagree with how the request was handled. This may or may not result in an approval.
 - b. Your prenatal, postnatal and newborn care before and after the delivery may still be covered. Just because the delivery is not covered at home, does not mean that regular office or home visits would not be covered. Make sure to ask your member service department if home health services are covered by your plan.
 - c. <u>Cash pay or Self Pay.</u> Ask your provider if they offer a cash or self-pay discount for services not covered by your insurance. Some providers may offer a discount for services when a claim is never sent to insurance. The amount you pay as a cash paying patient will not be applied toward your plan benefits such as your deductible, copay, coinsurance or out-of-pocket maximums because a claim will not be filed to your insurance but for non-covered services, this can sometimes save patients thousands of dollars in costly procedures (such as delivery).

When calling your insurance, it is important to take detailed notes about your call and make a list of questions you want answered. An example for your calls notes is included below.

Date: 08/01/2020, I called 1(800)000-0000 and spoke with JACK. Call Reference# 000123456

Questions:

Is home birth covered by my plan?

Is my midwife covered? If so, what is my maternity deductible, coinsurance and out of pocket maximum?

Is an exception possible and how do I start the process?

If a home birth is not covered, are prenatal or postpartum visits at home covered?