How Health Insurance is Supposed to Work: A Step-By-Step Guide

Wondering how your doctor or hospital gets paid when you use your health insurance? And what kind of privacy you have when you use your health insurance? Here we will follow a typical health insurance claim from the time the claim is filed to the time the claim is paid. It applies no matter if the health insurance plan is self insured or fully insured as well as if you have a private insurance policy or a group policy from your employer.

1A. The patient sees the doctor, whether it may be a primary care physician, specialist or mental health care professional.

1B. The patient goes to the hospital for an outpatient procedure[1] or an inpatient stay or to the emergency room (the ER).

1C. The patient goes to an urgent care clinic for after hours medical treatment.

2. The patient presents his or her health insurance card which contains the patient name, the member identification number and the group number. The health insurance card shows the applicable copays relative to the situation and a toll free number to the health insurance company in case the provider has a question or needs clarification.

3. The provider collects the appropriate copayment. The service to the patient is rendered. It can be as simple as an office visit to a doctor or as complex as either an outpatient diagnostic colonoscopy or an inpatient hospital stay to remove an appendix.

4. At the conclusion of the service a medical diagnosis is rendered by the physician. This diagnosis is placed on the patient's paperwork and is entered into the patient's permanent health record.

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[1] Or a freestanding day surgery center.

5. The patient's permanent health record is transmitted to the provider's billing staff. A member of the provider's billing staff receives the patient's diagnosis and applies a code that can be understood by a health insurance company. These codes are represented as a five digit code known as a Current Procedural Terminology code, or CPT as it is known in the health insurance industry. It is the CPT codes that determine payment from the health insurer.

4. The staff member uses the information that was collected from the patient (when the patient presented his or her insurance identification card) to go to the patient's health insurer and open a health insurance claim. Once the claim is opened a claim reference number is given which identifies the claim to both the provider and the insurance company.

5. Next, the staff member enters the CPT codes as part of the claim. Once all CPT codes are entered the claim is reviewed by the medical provider's billing staff for accuracy before it is submitted to the health insurer.

6. Once everything is in order the claim is submitted electronically to the patient's health insurer. Staff members with the patient's heath insurer begin to review the submitted claim.

7. The CPT codes are reviewed to see if the diagnosis is covered by insurance. It is checked against the policy's list of exclusions – in other words, what the health insurance plan will not cover.

If the diagnosis is on the policy's list of exclusions, the claim is reviewed once more by the health insurer's senior management staff – including a physician that is on the health insurer's staff – before making the decision to deny the claim. If the decision to deny the claim is favorable, then the claim becomes denied and notification letters are sent to both the provider and the patient.

Most of the time wrong CPT codes can cause a claim to be denied. The provider can resubmit the claim with the correct CPT codes to get the claim approved.

8. If the diagnosis is a valid and payable claim, then the claim proceeds to the next stage: Has the patient met his or her yearly deductible?

If the deductible is not met yet or is partially met: The provider and the patient are informed that part of the claim requires payment of a certain amount to meet the deductible.

Let's say you have a $1,000 deductible for your health insurance. You have met $200 of this deductible amount. $1,000 minus $200 equals a remaining deductible amount of $800. The amount billed to insurance would be minus the remaining $800 deductible you would have to pay.

If the deductible is met for the plan year: The claim is processed as usual.

Keep in mind, certain CPT codes such as a screening colonoscopy indicate that the claim will be fully paid irrespective of the deductible. How a CPT code is paid in relation to the deductible is up to the health insurer.

9. Have the appropriate co-pays been collected? This is usually taken care of at the time of the visit or service.

10. Is there a co-insurance involved? Usually found on PPO health insurance plans, co-insurance is the amount of money not covered by your health insurance that you have to pay for. For instance, if your health plan covers 80% of the cost of a service you are responsible for 20% of the cost.

11. If the claim is favorable, then the claim is paid according to the schedule of fees that are agreed upon between the provider and the health insurer.

Here is an example of a paid claim:

Total amount billed of $1,494.00: This is the amount the provider billed the patient's health insurer for a particular service.

Plan discount of $1,071.37: This is a discount that is agreed upon between the provider and the patient's health insurer.

Plain paid $422.63: This is the amount the patient's health insurer paid.

12. A check from the patient's health insurer is sent to the provider for the plan paid amount. In the example above, it would be the $422.63 amount.

13. The patient's diagnosis is entered onto the patient's permanent health record with the health insurer.

14. The health insurer sends to the patient an Explanation Of Benefits (EOB) document which shows the following:

- Patient identifying information
- Provider seen and medical diagnosis
- Deductible information
- Co-insurance information (if applicable)
- What the health insurer paid
- Any amount due from the patient to meet a deductible

15. The health insurance claim is closed. The typical health insurance claim takes 15 to 30 days to process, but it can take longer depending on the complexity of the claim.

So you see, a typical health insurance claim is seen by several people at least with a health insurer to review medical diagnosis, plan exclusion and deductible information before the claim is paid. Once a health insurance claim is begun by a healthcare provider the confidentiality of *any* medical diagnosis surrounding the claim, especially a claim surrounding a mental health diagnosis, can be potentially lost as the claim moves through the various stages of the claims review process.

Once a medical or mental health diagnosis is placed on a patient's permanent health record, it cannot be sealed or expunged. When that diagnosis is on one's permanent health record with a health insurer, that permanent health record can potentially be seen by other parties in any type of legal proceeding. For example, in any guardianship proceeding in the State of Florida under Chapter 744 of the Florida Statutes, the

attorneys representing the petitioner in a guardianship proceeding can serve a judicial subpoena on a healthcare provider, health insurer or a specialty consumer reporting agency such as MIB (the Medical Information Bureau) or Milliman to order the health records related to the Alleged Incapacitated Person released as a part of the guardianship proceeding[2]. Another example would be that of Adult Protective Services, again if a subpoena is obtained as part of a proceeding under Chapter 415 or as part of a guardianship proceeding under Chapter 744 of the Florida Statutes.

The Notice of Privacy Practices – of which any healthcare provider or health insurer must make available to you – is a notice of your privacy rights and how your health information can be used. Glance at your provider's Notice of Privacy Practices and look for the section where your health information can be used about judicial or administrative proceedings. This means that if your health care provider or insurer is served with a legal order through a judicial subpoena to release your medical records, your health care provider or insurer must comply with that request.

When your healthcare provider says no insurance accepted

There is a reason why healthcare providers – particularly mental health providers – do not want to accept any form of insurance. The biggest reason is the confidentiality of the doctor-patient relationship.

When insurance gets involved, that doctor-patient relationship is technically lost the moment a staff member of the heath care provider's practice enters insurance claim information related to a patient to the patient's health insurer. Think of it as your health care provider looking out for your interest.

There are two ways to get around the "no insurance accepted" dilemma:

[2] These records once obtained can be turned over to the three person Examining Committee as a part of the record review process. A part of the Examining Committee member report asks whether records including medical and social records were used in the course of the examination.

1. Use your Flexible Spending Account (FSA) or your Healthcare Spending Account (HSA). These are tax free monies that are set aside by your employer to help cover health care costs. More than likely if you have health insurance with a high deductible (which, according to IRS guidelines as of 2025, is $1,650 for an individual and $3,300 for a family) you have an HSA to help you with the deductibles. You get a debit card to access the monies in your FSA or HSA accounts and all you have to do is to save your receipts for services rendered. Practically no medical diagnoses are shared as opposed to when you or your health care provider files a claim on your insurance.

If you are retired, you may use an HSA until you are Medicare eligible. Once you are Medicare eligible you cannot open an HSA but any funds in an HSA before you go on Medicare can be spent on qualified expenses. On the other hand, you cannot have an FSA once you are retired – instead, you must spend down your FSA account prior to retirement.

2. See if your provider can use a sliding fee scale to help with the cost. Pair that with an FSA or an HSA and that should help you save money on your provider visits. As mentioned previously, keep receipts (scanning them is the best) to prove expenses if needed.

Finally, don't file an out of network claim with your healthcare insurer, even if your healthcare insurer will allow you to do so. These out of network claims *do* require a diagnosis and the potential of loss of confidentiality at some point during the claims process should be kept in mind.

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