

Getting the Most from Your Health Insurance

By Jacques Chambers

If you have health insurance, you are indeed fortunate given the cost of health care today. However, too many people seem to believe that once they have health insurance they don't have to concern themselves further about the cost of their care. If you are assuming that the insurance carrier and your medical providers are handling all the bills properly, you are seriously misjudging the accuracy of their staff and computers.

Too many people assume that, when the doctor sends a bill for what the insurance did not cover, they actually owe what they are being billed for. A perfect illustration of the fallacy of that belief came to light this week when one of my clients showed me a bill from her medical provider. It stated that there was a balance due of \$38 after a partial payment by the insurance company. The bill stated, "*XYZ Insurance denied remainder without explanation.*"

Fortunately, this client kept good records. On her copy of the Explanation of Benefits insurance statement, it clearly said, "*Provider has agreed to accept our payment as payment in full. You are not responsible for the remainder.*"

So the bill from the doctor for \$38 was incorrect; she did not owe a dime. Of course, when contacted, the provider apologized for the "computer error." All she had to do to correct this mistake was to return the bill to the doctor with a copy of the EOB highlighting the statement about no responsibility.

Would you have paid that doctor's bill without questioning it? Too many people do. Even if you have insurance, you still need to be watching the bills and payments to make sure everything is handled correctly, because if they are not, the medical providers will be looking to you for payment of any outstanding balances. And you don't want to pay anything you don't actually owe.

If you have an HMO, most of your out-of-pocket costs are paid directly to the provider in the form of co-pays, so bookkeeping is not a major issue. However, you still should be keeping track of all payments. To make sure there is a paper trail on your payments, you should pay all co-pays by check, noting on the check what the co-pay is for. If you need to pay by cash, make sure you get a receipt and you file them all in one place.

Often the handwritten receipts you get have only minimal information. Make sure you add all the information necessary so you will know not only when and how much was paid, but to whom and for what kind of medical care.

The reasons for keeping records of those co-pays are that you need to have your own records of payments as not all doctor's offices and fewer HMOs keep careful track of them. In addition, you may need the total of your payments for income tax purposes.



Also, many HMO plans put a cap on the amount of money you need to pay out-of-pocket in any one year, often called a “stop-loss” or “out-of-pocket cap.” After that cap is reached, you don’t pay any more co-pays for the remainder of the year. However, a lot of those same HMOs do not track your out-of-pocket expenses since they are paid directly to the various pharmacies and doctors, not to the HMO. Instead, it is your responsibility to notify them when you have reached the cap, and they will want to see the receipts to prove it. If you reach the cap and do not inform them, you will keep paying co-pays for the remainder of the year.

If you have a PPO or POS or indemnity plan, paperwork gets a little more complicated, but it still needs to be watched over by you. Since most health plans now contract with many providers either under a PPO or POS type of program, it is even more important to watch to make sure the doctor does not attempt to collect charges from you that are in excess of the amount agreed to with the insurance company, as in the example above.

Every time the insurance company processes a claim, they will send you a notice. These forms are called Explanation of Benefits or EOB for short. Medicare calls theirs a Medicare Summary Notice or MSN. You should receive an EOB or MSN for every medical charge submitted to the insurance company.

It is important that you match the EOB from your insurance company with your doctor’s bills. First, this assures you that the insurance company has processed your claim. If you don’t have an EOB, the claim may not have been sent or got lost in transit. Follow up with the doctor to make sure it was sent for payment, then follow up with the insurance company to make sure they have the charge and are processing it.

By comparing the medical bill with the EOB, you can also make sure that either everything was covered or you can understand why it wasn’t. Possibly, a deductible needed to be satisfied, or the plan only pays a certain percentage of the bill.

In addition, by comparing the two forms, you can see whether the doctor’s bill properly credited the insurance payment. If the insurance company has not processed the claim at the time your doctor sends the bill, you should consider not making a payment, or making only a small payment, until the claim is processed by the insurance company.

The Explanation of Benefits (EOB)

Too often, EOBs look confusing at first glance so future ones are not opened or studied. But this is the best tool you have for making sure the insurance plan is paying as it is supposed to. You need to learn how to read them; it is not that difficult.

An EOB does contain a lot of information, and it often takes a little study to understand exactly what is on your company’s EOB. However, you do not need to understand every code and column to know that your claim was properly processed. You should be aware that many times the insurance company will list more than one charge on the same EOB.



Typically, an EOB will include:

- The claim number and the date the claim was processed
- The name of the doctor or other provider submitting the charge.
- The date the charge was incurred. This is important because insurance companies frequently file claims by Date of Service and Amount Charged.
- The full amount charged by the provider.
- There will be additional columns showing either amount disallowed or denied or the “Covered Amount” which is often less than the full amount charged.
- Frequently there will be columns showing what, if anything, was applied to the deductible, how much the insurance company is actually paying, and how much you are expected to pay.
- Footnotes – There will always be footnotes explaining the various amounts and how they were arrived at. Typical codes will tell you: why an amount was denied or disallowed; how the insurance company arrived at the “Covered Amount;” why you don’t owe what the insurance company did not pay; etc.

Most important on the EOB is the toll-free telephone number for questions. If you do not understand the EOB or a part of it, you should call the toll-free number and ask for a more complete explanation. If you are just starting the process of checking EOBs, take two or three EOBs, call the customer service number and ask for help going through them so that you will understand them better.

Be sure to have pad and pencil with you to take notes. Also, be sure to note the representative’s name.

It is not uncommon to find billing or calculation errors in both EOBs and doctor bills. The longer you wait to question the charges, the more difficult it will be to get any errors corrected, so you should review every bill and EOB when they arrive.

A simple filing system is to have three folders, one for newly arrived EOBs, one for newly arrived medical bills from the providers, and one for EOBs attached to the medical bill which have been reviewed and you are satisfied with the calculation.

If there is an underpayment by the insurance company or an overcharge by the provider, you will be the person who is expected to pay for the error unless you are watching the bills and EOBs and can point out the errors.