

Monitoring Your Health Insurance Coverage

By Jacques Chambers, CLU

Dealing with health insurance and how it covers your medical bills can be a complicated and stressful issue, but it is not something that can be ignored. You may have an Indemnity or Preferred Provider Organization (PPO) Plan that pays medical bills after they are incurred. Or you may be covered under one of the many varieties of Health Maintenance Organization (HMO) Plans that “pre-authorize” certain treatments and disallow others. However, under either type of health plan, problems can arise in how the claims are handled, and, unless caught early, they can grow into major financial and legal dilemmas as well as affect your medical care and your health.

It’s tempting to ignore the whole medical payment process and assume that the insurance company and the doctors are handling everything satisfactorily, and many times they are.

However, a rude awakening often occurs when you receive a large bill from a medical provider for charges because insurance coverage was reduced, denied, disallowed, or just not processed.

Whether it is a claims payment or pretreatment authorization, most billing and precertification communication between a doctor and the insurance company is done in codes, and one misplaced digit can make a substantial difference in what is allowed or how much is paid. It is important to catch those small errors early, and you, as the claimant, are the best person to do it.

You do not have to become an insurance expert to be able to oversee just how your insurance company is processing the medical bills you are incurring. At the least, you can get minor errors corrected quickly; at worst, you will build a solid file of documentation that will save the attorney or benefits counselor you hire a lot of billable time. It will take some time and effort on your part to understand how the process works and how you can affect it, but it will be well worth it.

The first step is, of course, “Know Your Coverage.” Easy advice to give, but this is often the biggest problem in overseeing your coverage. Insurance contracts are scary; they’re hard to read; they don’t make a lot of sense if you’re not a lawyer. But you don’t need to memorize your plan or know every single provision to understand how the plan works and how it pays your medical bills.

Get a copy of your coverage. It may be an insurance policy, a booklet of coverage, a Summary Plan Description, or a chapter in an employee benefits manual. However, a paragraph or two in an announcement or even a couple of pages in the enrollment

material is not sufficient for your needs. A complete description of your health plan will cover twenty to thirty pages or more.

If your health plan comes through your employer, they are required under a federal law called ERISA to provide you a Summary Plan Description of all of your benefit plans. If you have misplaced your copies, you should request one from your Human Resources or Benefits Department.

If you're concerned about disclosure, just tell your employer that you are doing some financial planning with an insurance agent or estate planner, and that they have asked to you get the information for their analysis.

Don't try to sit down and read your plan all the way through. That would put anyone to sleep. But, look through it. Note the different parts. There is usually an overview or Summary of Benefits at the front that will give the details of your specific plan, what the dollar amounts are. Then there will be sections that describe different provisions of the plan.

Don't try to understand and remember everything in every section. Just get familiar with where things are so you can refer to specific parts as you deal with the insurance company.

Things you should try to find are:

- **The Schedule of Benefits** – This is often at the front of the plan. It's the part that tells what the insurance company pays and what you pay. It lists the deductibles, the insurance percentages they pay, the co-pays you are expected to pay at each doctor's visit, etc.
- **Covered Benefits** – Often separate from the schedule of benefits, this will be a listing of what is covered. In some plans this will be a fairly long list; others will give a short list of a broad range of benefits covered. This section will also give greater detail about what and how things are covered.
- **Definitions** – There is usually a separate section that defines terms used in the plan. If your plan has one, watch for words throughout the plan that are capitalized, italicized or in bold, as that usually means it is a term that has a special meaning and is defined in the definitions section. Other plans will define terms throughout the document as the terms are used.
- **Exclusions and Limitations** – This lists the things that the plan will not cover, such as experimental treatment, or cosmetic surgery. It also lists the things that it will cover but puts special limits on, such as mental health, or convalescent home care, or treatment for conditions that existed when your coverage started – pre-existing conditions. You may want to paperclip this section, as you may need to refer to it more frequently, especially if you plan to appeal a denial.
- **Eligibility** – This is important only if you are a relatively new employee as it tells just when your coverage actually begins. Also if you are a new employee, look for limits on coverage for **Pre-Existing Conditions**. A similar section, usually in a different part of the book is the **Termination of Coverage** that describes when

coverage ends. This section will usually include a description of how to extend coverage under COBRA and possibly other means.

- **Claims Procedures** – This will be a couple of pages that describes the claim filing procedure. The important section here is the part that tells you how to appeal denials. You may want to read that through, as there are usually some important time limits and other information there.

Mark up the book. This is the rulebook that the insurance company must play by so don't hesitate to use paperclips, "dog ears," highlighting, underlining and margin notes to make it easier for you to use. Gummed tabs that label important sections are especially helpful.

Once you realize that the plan has different parts and you only need to focus on the part that fits your particular situation, learning what the plan does and doesn't do becomes much more manageable. As an abstract description of provision, it may not seem so helpful, but you will find it valuable as you work with the insurance company and your medical provider when there are claims questions since it must contain the basis of their denials or cutbacks. To put in terms of sports: it is the rulebook and you're at a disadvantage trying to "play" without knowing the rules.

How you watch the medical claims depends on the type of plan under which you are covered. If you have coverage through an **Indemnity** Plan including **Medicare** or a **Preferred Provider Organization (PPO)** Plan, the insurance company will process the claims and pay their portion after you have received the treatment.

With these plans you will receive an Explanation of Benefits (EOB) every time they process a medical bill. Medicare calls it a **Medicare Summary Notice**. Review each EOB or MSN carefully. Was everything "allowed" in full even if only a percentage was paid? If not, a code by the charge should lead to a reason for the denial or reduction.

If it is not clear, call and ask for an explanation. There will usually be a toll-free number on the EOB. Note down to whom you talk and what they say. Don't be bashful about asking for more clarification. Follow the appeal procedures to challenge their decision, if you disagree. Ask for your doctor's help in supporting your appeal.

It is important that you match the EOB or MSN with the bills the doctor gives you. Sometimes matching up the two can be daunting as every billing company seems to use a different format which makes them hard to read. But if the EOB or MSN is not reflected in the doctor's bill, you need to contact the doctor. Many times computer generated billings contain higher charges that don't reflect the limits on those charges by PPO contracts or Medicare assignment.

For **Health Maintenance Organization (HMO)** Plans, most of the claims work is done between your doctor and the HMO and consists of authorizing treatment before it is given, not in paying the bill after the treatment is received. Learn about your medical condition. Know what alternatives to treatment are available. However, even those

plans usually have out-of-pocket limits so you should track all of your co-payments and other out-of-pocket costs.

You need to spend some time with your doctor (or your doctor's insurance clerk) to understand when and what has to be pre-authorized by the HMO. How successful are they in obtaining approvals? How often are they denied? Can you be notified of denials and participate in appeals?

Health insurance is not maintenance free. It can't be just "turned on and forgotten." Just as you must take an active role in your health care and treatment as a patient, you must also stay alert and active as an insured individual with respect to how your medical care is authorized and paid for.