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healthcare financial management association

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Helping Patients Through the Billing Maze

As employee health insurance plans become more complicated, Health Advocate gets busier. On behalf of some 4,000 corporate clients, the health advocacy company helps employees solve problems related to the healthcare system. Health Advocate's services include helping patients figure out hospital bills.

Arthur "Abbie" Leibowitz, MD, Health Advocate's chief medical officer and cofounder, tells what causes the most headaches for his members.

About 14 million Americans have access to your services through an employee benefit program. What are the most common problems you see?

Leibowitz: A significant portion of the reasons that people call us—at least the first call—is over a bill. For one reason or another, they didn't expect to have to get a bill or to have to pay the amount that they got billed. In today's environment, individuals have higher out-of-pocket expenses to pay for their healthcare benefits, and they have coinsurance and deductibles and covered amounts and uncovered amounts and in-network amounts and out-of-network amounts. The health benefits world is very confusing.

Our job is to take a billing question apart and look at it piece by piece. We look at what was done, what was billed, how that bill was processed by the carrier or the third-party administrator. We look at how the processing was applied to the individual's benefit plan, and then we make an assessment about whether those steps were performed correctly.

If an error has been made, we work with the party that can get it straightened out, and if no error has been made, we tell the individual that honestly, impartially, independently, "This is what you owe."

In what percentage of the complaints do you find an error in the bill?

Leibowitz: In the overwhelming majority of cases in which we get involved, nothing is wrong. The problem is usually that the individual doesn't understand the benefit plan or doesn't understand how the billing system works.

The difficulty is that, in today's world, the patient does not receive just one bill. You get the bill that says, "We've submitted this charge to your insurance company," so you know you don't have to do anything with that. You then get the statement from the insurance company that says, "We've received a charge from the hospital," and you know you don't do anything with that.

Then you get the second bill from the hospital that says your payment is overdue. That's where the problem begins, because then the individual wonders what the heck is going on. "Am I'm going to have to pay interest? Is this going to ruin my credit?" And the reality is that the process today is just slow because of the complexity of the plan and benefit designs.

What generates more confusion—inpatient stays or outpatient visits?

Leibowitz: We see more issues around outpatient services, because the benefit designs are much more complicated. And to be honest, I would say that there are more errors made on the outpatient side.

An inpatient stay is typically billed on a per diem or under a contracted relationship with the payer, while the outpatient side is far more likely to be billed on an à la carte basis, and multiple billing entities are usually involved. You've got the laboratory, radiology, the emergency department, anesthesiology, pathology, etc. You've got lots of participants in the service, any of which can bill for their part of what was done. So the individual who goes in for outpatient surgery can end up getting seven or eight bills.