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These steps can help keep your medical bills from getting out of hand

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Certified financial planner Susan Sylvest says it's crucial to understand what your insurance covers. Sylvest speaks from experience, having dealt with health care providers for her own surgery as well her family's health needs.

By: Pamela Yip

No expenditure can hurl you toward financial ruin as quickly as medical bills.

Medical debt is a major factor in the filing of consumer bankruptcies. And it often invades your life when you least expect it. But you can take steps to keep your medical bills from getting out of hand.

“The best thing to do is to be prepared to the best of your ability,” said Susan Sylvest, certified financial planner at Murphy & Sylvest in Dallas. “Understand what your insurance will and will not cover.”

Sylvest speaks from personal experience, having dealt with health care providers for her own surgery as well her family’s health needs. She learned firsthand how to deal with medical bills.

Here’s what Sylvest and other experts say you need to know:

Stay in network

Your insurance plan contracts with a wide range of doctors, hospitals, labs, radiology facilities and pharmacies. These health care providers are part of your plan’s network and have agreed to accept your plan’s contracted rate as payment in full for services.

The rate includes both your insurer’s share of the cost and your share. Your share may be in the form of a co-payment, deductible or co-insurance.

For example, let’s say your insurer’s contracted rate for a primary care visit is $120. If you have a $20 co-payment for primary care visits, you’ll pay $20 when you see a doctor in your network and your insurer will pick up the remaining $100.

If you go outside of your network, you pay more because those providers haven’t agreed to a set rate with your insurer. Your plan may require higher co-payments, deductibles and co-insurance for out-of-network care.

“For somebody who’s been going to a particular doctor and may now have new coverage, they really need to be certain that the doctor they have a long-standing relationship with is part of their network,” said Mark Rukavina, principal at Community Health Advisors LLC in Chestnut Hill, Mass.

“If their doctor, who is part of the network, refers them out to a specialist or to a particular hospital for care, they need to make sure those providers are also in the

network because that unpleasant surprise of co-insurance trips up lots of people," Rukavina said.

Sometimes, asking the network question may be the last thing on your mind. In an emergency, you may not have the ability — or the desire — to ask for such details.

But in non-emergency situations, ask whether all your providers are in your network.

Ask about costs

Before undergoing a procedure, ask how much it will cost and how much your insurance company will cover. Much of that will depend on whether you've met your deductible and annual out-of-pocket maximum.

Your insurance company can help you with this.

"The biggest thing that I have found is that when I've called the insurance company, there is usually something called either a case advocate or a nurse advocate," said Sylvest. "They are generally nurses who understand insurance as well."

She said the questions you should ask are: What do you know about my diagnosis?

Should I get a second opinion? How much is this going to cost? Who's going to be involved? "When trying to judge medical expenses, the biggie is trying to figure out who all will send you a separate bill," Sylvest said. "That is by far one of the most challenging things to discover. Call the insurance company and ask, 'How many people could I possibly get a bill from?'"

Blue Cross and Blue Shield of Texas, the largest health insurer in the state, offers a "benefits value adviser" to help guide plan participants through health care decisions.

The adviser helps consumers with provider-specific cost and quality information for common procedures, clinical educational support, appointment scheduling, help in understanding benefits, locating in-network providers and requesting pre-authorization for a procedure.

"Many times, consumers can choose between different providers or facilities and receive the same procedure at a lower cost," said Margaret Jarvis, a Blue Cross spokeswoman.

Know the rules

Your insurance company may require pre-authorization for a procedure. For example, one employer's plan under Blue Cross and Blue Shield of Texas requires participants to call the insurance company before non-emergency outpatient MRI and CT imaging procedures to receive full benefits.

"So many insurance companies force you to call them for approval for something that they would deem elective or not time-sensitive," Sylvest said.

Ask about financial aid

The Affordable Care Act requires nonprofit hospitals to have written financial assistance policies.

"This only pertains to nonprofit hospitals," Rukavina said. "But many for-profit hospitals do have financial assistance policies as well, so people should ask whether the hospital has any form of financial assistance they offer to patients."

Many nonprofit hospitals have their financial assistance policies structured in a way that they provide help to both insured and uninsured patients, he said.

"Even if somebody is insured, they might have a lot of first-dollar costs in front of them like for a deductible, significant co-pays or co-insurance," Rukavina said. "They should ask and see whether or not there's a financial assistance policy and whether it covers people with insurance, as well as the uninsured."

You should also ask your doctor or the hospital if they have extended payment plans.

"Many providers also offer prompt-pay discounts to people, so if you pay at or near the time of service, or within 30 days, they'll oftentimes offer a prompt-pay discount," Rukavina said.

Get itemized bills

"The first and foremost thing any patient has got to do is get a detailed itemized statement," said Pat Palmer, chief executive of Medical Billing Advocates of America.

"What hospitals provide them is something like a summary deal. It will say, 'OR: $20,000,' 'Miscellaneous supplies: $30,000.' You have no clue what you're being asked to pay for."

Once consumers get the itemized statement, they should analyze each charge, she said. “Prior to any payment, you want a detailed itemized statement of every item you’ve been charged for so you can see if you feel it’s justified,” Palmer said.

Be your own advocate

It’s important to speak up and fight for your rights.

“The key points for consumers to recognize are that health care’s expensive and many of us are shocked when we get those bills,” Rukavina said.

“But silence or not responding is typically not helpful. I’ve found that providers are willing to work with patients if they hear from them.”

IN THE KNOW: Key terms

Deductible: The amount you owe for health care services before your insurance company begins to pay.

Co-payment: A specific charge that your health insurance plan may require that you pay for a specific medical service or supply, also referred to as a co-pay. For example, your health insurance plan may require a $15 co-payment for an office visit or brand-name prescription drug, after which the insurance company pays the remainder of the charges.

Co-insurance: The amount that you have to pay for covered medical services after you’ve made any co-payment or deductible required by your health insurance plan. Co-insurance is typically expressed as a percentage of the charge. For example, if your insurance covers 80 percent of the allowable charge for a specific service, you would be required to cover the remaining 20 percent as co-insurance.

Out-of-pocket maximum: The most you pay during a policy period — usually a year — before your insurer begins to pay 100 percent of the allowed amount.

SOURCES: UnitedHealthcare, eHealthInsurance.com

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