Electronic Explanation of Benefits (eEOB)

We help payers provide members online access to their Explanation of Benefits.

Electronic Explanation of Benefits: Drives Digital Communications and Improves Member Experience

At A Glance

Payspan has implemented digital tools that provide convenient, detailed information for members to access their **Explanation of Benefits** in digital format. These digital tools benefits payers through reduced calls to their offices, decreased printing and mailing costs, increased patient payments, and improved member satisfaction.

Payspan successfully engages and retains members/patients with innovative solutions that allow members secure access to payer portals, improve member communications, and facilitate access to medical care. Our leading payment solutions support healthcare reimbursements and provides multiple payment options for members.

The beginning of the health care journey

A healthcare patient's journey may start with an inciting incident such as medical symptoms developing suddenly (a lingering headache or stomach pain) or a medical crisis (a heart attack or an unpredictable accident). Sometimes the illness is short-lived (the headache or stomach) and rarely is the rest of the experience an episodic journey. But serious medical conditions can result in an ongoing healthcare journey filled with interactions and expectations with medical providers. When the patient leaves the doctor's office, hospital, or clinic doors, the real challenge awaits: how much did this medical event cost?

The after-seeking-medical treatment journey continues

When the patient requires follow-ups and care instructions, medical treatment becomes sources of ambiguity and frustration. In today's healthcare environment, consumers can become financially responsible for post-surgical treatment, specialist referrals, prescription fulfillment, understanding lab results, and so much more. These requests require information about the patient's insurance.

The process for payment of medical services the patient received usually begins with the healthcare facility (hospital, doctor's office, urgent care) filing a claim regarding the medical services rendered to the patient.The patient then receives an Explanation of Benefits (EOB). It is an important step in the patient journey, so it is crucial for patients to understand the details provided in the EOB.

A new option for members: Electronic Explanation of Benefits

Payspan, a leader in adopting new technologies that benefit healthcare providers and consumers, offers the paper-based EOB in a digital format: electronic Explanation of Benefits (eEOB). An EOB is a form, a statement, or document sent to the member by the payer (insurance company) explaining the medical treatment or services provided, amount to be billed, and payments made on each claim. It provides necessary information about claim payment amounts and patient responsibility amounts.

An electronic EOB contains the exact same information as a paper-based EOB. It is issued to the subscribers of a private health insurance, a health plan from an employer, or Medicare. The electronic EOB is usually available securely online to members from their payer's portal.

Along the journey: patient reviews the electronic EOB

An EOB (paper or digital format) is a statement from the patient's health insurance plan describing the treatment costs and how much the patient must pay for medical care or products. The EOB is generated when the provider submits a claim for services the patient received.

The insurance company sends patients EOBs to identify:

- The cost of the care the patient received
- Any money the patient saved by visiting in-network providers
- Any out-of-pocket medical expenses the patient will be responsible for

An Explanation of Benefits is not a patient bill. It is a statement of the medical services the patient received and provides details on how much the insurance company will pay and how much the patient will pay. The EOB is not used to pay any outstanding bill. EOBs are standard documents disseminated by insurance companies.

Patients should understand the detailed Information in an EOB – crucial data along the patient journey

EOBs have very valuable and specific information that can help patients track their healthcare expenditures and serve as a reminder of the medical services received. In today's patient-centric environment, it is important for members/patients to know how to read an EOB and understand their health insurance plans.

The information in an EOB will be displayed in different ways based on the various insurance companies. However, a typical EOB provides the following information:

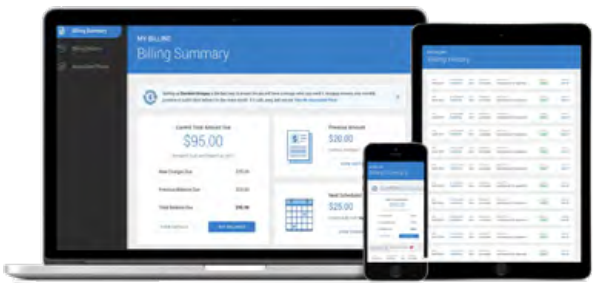
- **Patient:** The name of the person who received the service. This may be the patient or one of the patients' dependents.
- **Insured ID Number:** The identification number assigned to the patient by the insurance company. This should match the number on the patient's insurance card.
- **Claim Number:** The number that identifies or refers to the claim that either the patient or health provider submitted to the insurance company. The patient will need the insurance ID number and claim number if they have any questions about the health plan.
- **Provider:** The name of the provider who performed the services for the patient or patient's dependent. This may be the name of a doctor, a laboratory, a hospital, or other healthcare providers.
- **Type of Service:** A code and a brief description of the health-related service received from the provider.
- **Date of Service:** The beginning and end dates of the health-related service you received from the provider. If the claim is for a doctor visit, the beginning and end dates will be the same.
- **Charge (Also Known as Billed Charges):** The amount the provider billed the patient's insurance company for the service.
- **Not Covered Amount:** The amount of money that the patient's insurance company did not pay the provider. Next to this amount, there may be a code that gives the reason the doctor was not paid a certain amount. A description of these codes is usually found at the bottom of the EOB or in a note indicated on the EOB. Insurers generally negotiate payment rates with doctors, so the amount that ends up being paid (including the portions paid by the insurer and the patient) is typically less than the amount the provider bills. The difference is indicated in some way on the EOB, with either an amount not covered, or a total covered amount that's lower than the billed charge.
- **Amount the Health Plan Paid:** This is the amount that the health plan actually paid for the services you received. Even if the patient has met their out-of-pocket requirements for the year already and don't have to pay a portion of the bill, the amount the health plan pays is likely a smaller amount than the medical provider billed, due to network negotiated agreements between insurers and medical providers (or in the case of out-of-network providers, the reasonable and customary amounts that are paid if the patient's insurance plan includes coverage for out-of-network care).
- **Total Patient Cost:** The amount of money that patient owes as their share of the bill. This amount depends on the patient's health plan's out-of-pocket requirements, such as an annual deductible, copayments, and coinsurance. Also, if the patient received a service that is not covered by the health plan, the patient is responsible for paying the full amount.

The EOB will usually indicate how much the patient's annual deductible and out-of-pocket maximum have been met.

The real value of Explanation of Benefits—not a pitstop in the journey

Doctors' offices, hospitals, and medical billing companies sometimes make accounting errors. Billing mistakes can be frustrating and have potentially serious, long-term financial consequences for patients.

The EOB is a window into the patient's medical billing history. Patients should carefully review the EOB to make sure they have received the service being billed and that the amount the doctor received from the insurance company is correct. EOB and related billing data should be analyzed for accuracy, including the patient amount, and the diagnosis and procedure are correctly listed and coded.



An example of an EOB:

Frank F. is a 67-year-old man with type 2 diabetes and high blood pressure. He is enrolled in a Medicare Advantage Plan and sees his doctor every three months for a follow-up of his diabetes. Six weeks after his last visit, Frank received an EOB with the following information:1

- **Patient:** Frank F.
- **Insured ID Number:** 82921-804042125-00 – Frank's Medicare Advantage Plan Identification Number
- **Claim Number:** 64611989 – the number assigned to this claim by Frank's Medicare Advantage Plan
- **Provider:** David T. MD – the name of Frank's primary care physician
- **Type of Service:** Follow-Up Office Visit
- **Date of Service:** 1/21/20 – the day that Frank had on an office visit with Dr. David T.
- **Charge:** $135.00 – the amount that Dr. David T. billed Frank's Medicare Advantage Plan
- **Not Covered Amount:** $70.00 – the amount of Dr. David T's bill that Frank's plan will not pay. The code next to this was 264, which was described on the back of Frank's EOB as "Over What Medicare Allows"
- **Total Patient Cost:** $15.00 – Frank's office visit copayment
- **Amount Paid to the Provider:** $50.00 – the amount of money that Frank's Medicare Advantage Plan sent to Dr. David T.
- **Some Math:** Dr. David T. is allowed $65 (his charge of $135 minus the amount not covered of $70.00 = $65.00). He gets $15.00 from Frank and $50.00 from Medicare.

Explanation of Benefits leads to the next step in the patient journey: billing and payments

In today's health care environment, health plans and providers understand that their members (patients) are responsible for owning their own healthcare experience. As a result, members have higher expectations across the entire patient journey and expect their health payer to provide detailed treatment information, billing specifics, and payment options.

This expectation, driven by consumers, requires changes throughout the healthcare system and a more patient-centric approach.

A growing number of payers and providers are implementing technical solutions that provide convenient, more detailed patient access to billing information. These solutions help reduce calls to their billing offices, decrease mailing costs, increase payments, and improve member satisfaction. Implementing new patiently-friendly tools and solutions provide transparency in billing, helps hospitals decrease collection costs while improving consumer satisfaction, and supports revamping customer service to consumer-directed health care.

Payspan is the nation's leading provider of electronic healthcare payment solutions, leveraging the nation's largest provider payment network to drive fee for service and value-based care reimbursement, enable members to pay insurance premiums, and allow consumers to pay providers. Payspan customers enjoy the highest electronic payment conversion rates, user satisfaction and cost savings in the industry.

We offer a range of payment solutions to power the future of healthcare.

Payspan understands the ever-evolving healthcare market and takes a progressive and proactive approach to create solutions that help retain and engage members and patients. Our innovative tools, technologies, and services support payer operations, improve communications, and facilitate access to medical care for positive health outcomes.

The Future of Healthcare

Healthcare payers face a changing healthcare marketplace that is driven by consumerism and technology advancements. Consequently, it demands business model transformation and the redesign of operational processes. In this new paradigm, information-centric strategies that support data driven decisions that traverse the patient journey to help payers and members communicate.

Health plans understand that their members, who are tasked with owning their own healthcare experience, demand payment options aligned with their health payer. This expectation takes health plans down a potentially rewarding path that creates numerous opportunities to improve communication processes and program integrity efforts. This often begins with the initial claim and the Explanation of Benefits.

As a result, healthcare plans analyze social factors related to health and healthcare data as primary drivers of consumer experience. Consequently, they must respond in a positive manner that meets members needs and expectations. Hospitals must provide a satisfactory digital patient experience and payers need to create valuable, member-friendly portals. These dynamic actions are quickly becoming the driving forces of healthcare that must capitulate to the demands of members.

Healthcare forecasts indicate the growing implementation of digital technologies in payer operations, increasing demand for consumerism, and the upsurge in the number of mergers and acquisitions are anticipated to boost the market in the coming years. These changing factors involve operations – claims management services, member management services and billing and account management services – and other services to drive the effectiveness and efficiency across the medical spectrum to drive payer to member communications.

The future of health will be driven by digital transformation enabled by radically interoperable data and open, secure platforms

Always-on sensors that capture data and platforms that aggregate, store, and derive insights from individual, institutional, population, and environmental data will catalyze the transformation.

The **catalyst for change:** Radically interoperable data will empower hyper-engaged consumers to sustain well-being and receive care only in the instances where well-being fails.

Two **jobs to be done** for consumers to holistically address their health (overall state of well-being encompassing mental, social, emotional, physical, and spiritual health).

Five **enablers** for consumers to accomplish their jobs to be done.

Five **tasks** that ecosystem players will perform on behalf of consumers.

Three categories of **business archetypes** in the future of health environment.

Source: Deloitte analysis.

Deloitte Insights | deloitte.com/insights

Journey to member engagement and empowerment

Experts recognize a shift in consumer attitudes and behaviors toward greater engagement in a patient's (and dependents) healthcare. With full visibility into and control over their health information, consumers expect to perform many tasks. Healthcare tools designed to meet consumers' health goals, life stages, and lifestyles will enable members to look after themselves and their families.

In today's app-driven environment, consumers are accustomed to seamless customer experiences in other sectors. From an app on their phones, consumers can order groceries or a ride to a particular destination, and they have come to expect that packages containing their orders because just about anything will arrive on their doorstep in just two days or sooner thanks to Amazon.

When it comes to healthcare, members have similar expectations: medical treatment, speed, efficiency, and convenience and payers are expected to respond with strategies to improve patient satisfaction and ensure provider performance is superior.

Payspan: solutions for members, payers, and consumers

The fundamentals of healthcare have changed. Trends once viewed as potential disruptors – such as virtual health and retail medicine – have become the new standard in healthcare delivery. As a result, digital transformation is no longer optional, but required if healthcare providers want to achieve the level of performance necessary to compete in today's market.

Payspan can accelerate your organization's transformation and put in place the tools, insights, workflows, and the flexible technology infrastructure necessary to succeed in the digital-infused health system.

Whether you are a health plan seeking to increase payment collections from members who want more digital interactions or a provider seeking payments from patients now responsible for a third of the costs. We are in the business of providing positive payment experiences for your consumer clients.

The Payspan approach leverages the payments function as a foundation from which to build lasting, positive relationships that lead to member satisfaction and engagement, and drive revenue for health plans and providers.

Our member/patient engagement solutions deliver:

- An easy-to-use, online interface with flexible payment options
- Payment plans, autopay, and future settlement arrangements
- A multilingual online payment feature supporting 26 different languages
- Integrated voice response (IVR) capabilities with multilingual options
- A clear understanding of payment responsibility
- A branded, white-label solution that stands alone or integrates with your existing portal
- Engagement of patients in care gap closures and quality care

"Payspan's mission, "We Simplify Healthcare Payments" is more than a slogan. It drives everything we do; and we are proud to offer providers excellent solutions for collecting patient payments. With credit card, debit card and ACH payment options, one-time and recurring payments, and simple reconciliation of patient accounts, we make it simple for healthcare service providers to increase cash flow and patient satisfaction while enabling efficient reconciliation and posting of payments," said Rob Pinataro, CEO of Payspan.

About Payspan

Payspan is the nation's leading provider of healthcare reimbursement and payment automation services, leveraging the largest healthcare network in the United States to drive value-based care reimbursement, improve the patient experience and reduce costs for payers and providers. Payspan connects more than 750 health plans, 1.3 million provider payees and 1 million consumers to facilitate alternative payment and reimbursement solutions and the exchange of meaningful healthcare information.

www.payspan.com