MedBillsAssist

Medical Claims Solutions

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Health Reform - Implementation 2010

Many health care reform provisions went into effect on September 23, but as with any new law some will start right away, and others will slowly be implemented over time.

Small business tax credits for companies with fewer than 25 employees are now in effect. Provisions to rescind policies are banned. People now are afforded federally protected appeals rights.
Some provisions are not welcome by the insurance industry and are being challenged in their own way. For example, insurers are now prohibited from denying coverage for children with pre-existing medical conditions. Insurance companies have responded by eliminating children's policies in several states.
The ugly duckling, known as the medical loss ratio, is being legislated at 80% for small groups and 85% for large groups with a mandated rebate if the insurer fails to meet these ratios. Insurance companies have responded by reclassifying certain expenses as medical services.

Although other provisions are already in effect, such as dependent coverage for adult children up to age 26 for all policies, and requiring qualified health plans to provide minimum coverage for certain preventive services without cost sharing, these will only start when policies are renewed. In many instances, this will be in January 2011.
Interstate insurance exchange programs should already be in place, but they are running far behind schedule. The federal government does not know how to run them and state programs are so different from each other that most states have decided not to run their own.

Most states estimate serious financial shortfalls in this program; therefore they are hesitant to get it started.

Medicare changes are taking effect as well, such as cuts in all hospital payment rates, payment reduction to Medicare Advantage plans and a significant start in eliminating the prescription coverage gap.

Quote of the Quarter

"As a provider of health services [as opposed to an employer], I can characterize the recent health reform legislation using three words: **needed, insufficient, unclear**" *John S. Prout* is president and CEO of TriHealth, the partnership of Bethesda and Good Samaritan.

Cheaper Health Insurance?

New, cheaper health insurance policies are being offered by large insurers. They are being promoted within a limited network and are associated with cost reductions.

Reading between the lines, however, I wonder: How limited is this network? Five primary care physicians and one specialist per zip code? How about hospitals? How many miles is it to the nearest participating facility?

I don't think this is a new invention, it sounds like a limited network HMO, just like in the old days. It looks like insurance companies are selling out the medical community to make a profit in yet another way.

Consider this, both doctors and hospitals have to agree to reduced payments for their services in return for higher volume. Can our health care providers handle this higher volume? Our primary care physicians are already overworked; our specialists have long waiting lists. So what types of doctors will be selling their services to insurance companies for less? I would have to guess that it would be inexperienced new doctors in small practices. This might be fine for a simple sore throat, but what about for complex medical conditions?
This is the time when hospitals are coming to a standoff with insurers during contract negotiations. I wonder which hospitals will be taking on new patients with reduced payment rates. Presently, large specialty hospitals only accept PPO policies and refuse to treat patients who only have an HMO. Where, then, will patients with limited network insurance receive hospital care? 50 miles from home, perhaps 100? Allowing the market to sell such policies doesn't measure up to the President's promise of equality and affordable care for all Americans.

Medicare - Advantage Plan Reductions

Health care reform legislated significant payment reductions to the Medicare Advantage Plans (see definitions).

Actually, these companies were overpaid from the start. As a result, many were able to offer policies at no cost.

The Center for Medicare and Medicaid Services (CMS) paid more to cover these policies than it had paid for traditional Medicare beneficiaries' care. Basically, CMS paid to improve the insurance companies' bottom line.

The cuts that are being made will prompt policies to be restructured or eliminated. Without a generous federal incentive and a large profit margin, insurance companies will pull out from the market or at the very least, increase rates while reducing benefits. To complicate things, the Patient Protection and Affordable Care Act mandated out-of-pocket costs for 2011 at $6,700. All Medicare covered services will have to be paid by the plan through the end of the year.

Matters will be even more complicated for plans with prescription drug benefits because another part of the health care law calls for reductions in prescription drug gap coverage. The money to pay for this will have to come from somewhere. Money from the drug companies will run out in no time and the shortfall must be supplemented somehow.

Definitions:

Medicare Advantage Plan is an insurance policy that replaces traditional Medicare part A , B and often D. Seniors have a choice to chose one of these insurance products in place of traditional Medicare. when their needs are better met locally. A significant number of these HMO or PPO policies are also offering prescription benefits, annual physicals and other preventive services that are not covered by traditional Medicare.

Health Insurance Report Cards

According to the recent survey by the AMA (American Medical Association) one in five medical claims are processed inaccurately by health insurance companies.

An estimated $777.6 million in unnecessary administrative costs could be saved if health insurers would improve claims processing accuracy by one percent. It is further estimated that 100 percent accuracy would save $15.5 billion annually. Our current health care system spends about $210 billion each year on in-network physician claims processing. If we add out-of-network services and hospital claim processing errors, this number would at least triple.

Processing mistakes vary by state and by insurance company. For example, United Healthcare's error rate in NY is 32%, but in FL and MO it is only about 10%.

MedBillsAssist

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Licensed in Connecticut, New York and Virginia.

Legal Issues or Who is in Trouble this Time?

AIG was fined $100,000 by Minnesota regulators for selling bogus health policies and was ordered to repay its customers.

Policies sold under the name Essential Health. These plans were marketed by National Union Fire Insurance Co., a Pittsburgh-based subsidiary of AIG. The plans included accident and sickness insurance but did not meet state regulatory requirements and had not been approved by the commerce department. Essential Health was not an actual insurance policy, but a combination of limited insurance and a medical discount plan. These policies were sold after the government take over, as part of the federal bailout.

People who purchased these policies were victims of deceptive selling practices. When these policy owners sought medical care, they discovered that the policies covered very little.

As of August, the Federal Trade Commission (FTC) and 24 states had filed 54 lawsuits and regulatory actions to stop companies from deceptive marketing. The FTC has instructed the National Union Fire Insurance Company to fully refund Minnesotans.

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