MedBillsAssist

Medical Claims Solutions

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Health Insurance Premiums Soar

Some health care law proponents promise that the recent Patient Protection and Affordable Care Act will lower health insurance cost. Contrary to this promise, health insurance premiums are steadily rising. The only real cost control written into the law, minimum medical loss ratio, is given temporary override in several states.

The republican explanation for rising cost seems silly for those working in the industry. Their listed expensive features, such as coverage for young adults under their parents policy and elimination of children's life time limits, only adds one percent or less to actual health insurance cost. The real reasons remain the same, rising cost of medical care, increased demand for services, insurance company greed and administration cost.

The cost of medical care is definitely rising. I wonder why in some hospitals it costs $4,400 per day, when that room only covers the bed and food. Medications and actual medical care are extra. I also wonder why some doctors charge a week's pay for a half an hour consultation.
Then, my attention goes to the insider fight between hospitals and insurance companies. They need each other, but contract negotiations are often at a standstill.
A recent medical bill for a week's stay in a hospital was charged at $96,000, yet the insurance company settled the bill for $30,000. The questions linger: Does the insurance company underpay, or does the hospital overcharge?

The next logical question is how much will the insurance premium be for the person who received care? The answer simply depends on the source of his or her policy. Large groups will see minimal increases, small group rates will jump to possibly 40% more, and individual policies will no longer be affordable.
Insurance is still based on numbers; when the risk and expenses are shared in large numbers, higher expenses will be better distributed and shared.

The health care reform had one promise that may actually work. Starting in 2014 each state will have an exchange where small businesses and consumers can pool their purchasing power to buy insurance.

High Deductible Health Plans

High deductible health plans touted to be the way of the future. Insurance companies promote them as Consumer Directed Health Plans as a real deal in consumer control.
The basic principal in high deductible plans is the up-front cost for health care is shifted to members, in return of a lower premium.
These medical insurance products have a place in the market mix. They work well for a younger, healthy and above average income demographic.

Unfortunately, high deductible plans are not a good choice for median or lower income families, and people with chronic medical conditions.

Medical care is a commodity that is viewed differently by consumers. People in a higher income bracket view health care as a necessity, and will pay for the needed care. People with lesser resources will cut back on care simply due to limited means.

A recent study from the Rand Corporation found just that. High deductible plans reduced health care spending by an average of 14 percent, however families covered by these plans significantly cut back on preventive care, such as childhood immunizations, routine tests and screenings. We all know immunizations and early detection saves lives. Undetected illness and untreated conditions are costly and can be deadly.

Quote of the Quarter

""Drug prices have continued to rise, often bearing no relationship to actual costs of production or development. As soon as the federal Affordable Care Act was enacted, drug makers hiked the prices for many commonly prescribed prescription drugs. The ACA did little to rein in drug prices, while opening new markets and the opportunity for additional profits to the drug industry as more consumers will be insured."

— Rep. Sharon Treat (D), a Maine lawmaker who in 2000 cosponsored the Maine Rx program.

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Hospital Admissions from Nursing Homes

The Patient Protection and Affordable Care Act (ACA) promised cutbacks in Medicare. Part of these cutbacks are new rules for patients re-hospitalizations from nursing homes. The new law attempt to address this long-standing problem with reduced payments to hospitals. ACA also approved a pilot program that provides a single payment for both hospital and nursing home care.

True to our government, congress seems to think that nursing home problems can be solved by monetary policies.

Unfortunately the underlying reason, for these often-avoidable re-admissions, has not changed. A recent study, matching one from twenty years ago, still list inadequate staffing levels, and consequently poor care as a root cause for hospital admissions and re-admissions. The recent Kaiser Family Foundation study reports that 70% of nursing home residents could have been treated in the nursing home if the nursing staff had been able to administer IV therapy. Just by employing more qualified staff, such as geriatric nurse practitioners, physician assistants, and nurse practitioners, along with more nurses aides, residents in nursing homes would receive sufficient and adequate care.

Behind Medicare, nursing homes and hospitals financial maneuvering, is a frightened and mildly ill senior who needs quality care. Sending them to hospitals and back, increases discomfort, anxiety, along with possible complications due to hospital contracted illness.

Definitions:

Medical Loss Ratio is the amount the insurance company pays out for medical claims.

HSA Health Savings Account

FSA Flexible Spending Account

HRA Health Reimbursement Account

Donut Hole is a gap in the Medicare prescription plan that is pay entirely by the patient

Medical Bankruptcies are Still on the Rise

Health care reform didn't change the overall effect on medical bills based bankruptcies. While more people are insured, the quality of their insurance didn't improve. Increased premiums force families to choose higher deductibles and higher co-pays, along with restricted benefits.

A new study published this month in the American Journal of Medicine found that in Massachusetts, while bankruptcy filing percentages were down slightly, medical bills still contributed to 52.9% of all bankruptcies. Families still faced substantial medical debt because healthcare costs are continuing to rise. The paper cited the example of the least expensive coverage available to a 56-year-old Bostonian in 2009. Such a policy carried a premium of $5,256 and a deductible of $2,000, and covered only 80% of the next $15,000 in costs for covered services. The authors calculated that an insured couple with an income greater than $44,000 could pay $20,512 for covered annual medical expenses. Insurance in Massachusetts has become even more expensive in the last two years. Balancing cost and coverage is very difficult. Uncovered, out-of-network services for HMO participants, drives cost even higher.

Health care reform did very little, if anything, to address these expenses.

Legal Issues or Who is in Trouble this Time?

Connecticut's Attorney General announced a settlement with Liberty Mutual to settle allegations it conspired with brokers to rig insurance bids and paid kickbacks. Connecticut settled with Liberty Mutual for $2 million, which will go to the state's general fund.

While I understand that insurance companies need to be punished and pay settlements when they are caught in the act of wrongdoing, I must confess I am a bit frustrated with these deals.

Once the settlement has been reached, the State will receive funds that go into the Connecticut's General Budget, and the State is free to spend the funds as it sees fit.

On the consumer side I had to pay more for my insurance, since the insurance company and its brokers fraudulently increased the premium for my policy. After the settlement had been reached between the State and the insurance company, the latter decided to increase rates again to recover state settlement expenses.

Here's an idea: why not return the settlement to the customers, who were and are overpaying their insurance premiums?

MedBillsAssist

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