MedBillsAssist

Health Insurance Newsletter

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Q&K Consulting LLC

Mental Health

Seeking to stop the erosion of insurance coverage for mental healthcare, the federal government in 1996 introduced a law requiring equal coverage for mental health and medical conditions. Called the Mental Health Parity Act, the law was designed to ensure quality care for people with mental illness. This parity mandate, however, failed to address all the issues. For example, the law only requires that the mental health dollar limits be equal to dollar limits on medical benefits only if mental health coverage is offered. Further, the law does not regulate deductibles, co-payments, hospitalization or office visits. It gives insurers and employers a wide range of options, including dropping mental health benefits altogether or tightening administration by requiring prior authorizations, higher co-pays and higher out-of-network cost shares. At the same time, it limits patient visits to 20-30 annually.

Many states tried to improve on the federal law by enacting their own mental health parity laws. But state laws, too, left many areas of concern unaddressed.

For example, Connecticut failed to mandate coverage for mental retardation and for learning, motor skills and communication disorders.

New York state recently created its own mental health parity law, named in memory of a young boy, Timothy. It states that coverage for mental illness must be equal to that for medical illness. However, the overall problem persists because these legislations only apply to group insurance plans that cover 50 or more people. Patients with individual plans still lack a parity law.

Take a walk with me in the world of insurance.

This Issue:

Editor's note:

Welcome to the fifth issue of the Health Insurance Newsletter from MedBillsAssist.

Your comments and suggestions are welcome.

Pharmacy Benefits

The process of having a new prescription filled can be a frustrating experience. The pharmacy benefit is commonly managed by a third-party prescription administrator, not the insurer. Plans are administered according to intricate rules that govern formularies and three tiers of benefits. Patients and doctors must navigate between insurance companies and their pharmacy benefit administrators. Doctors, for instance, have to adjust their treatment to meet the insurer's approval.
The way to obtain required medication is to learn the rules and produce the needed paperwork. Sign up at your insurance company's website, where quick solutions are often only a few clicks away. Many sites have forms available for printing. However, accomplishing all this takes time and coordination with your doctor. One option is to pay for a few pills to get the treatment started while approval is in progress.

Medicare: Back to the Basics

Enrolling in Medicare does not solve all your health insurance needs. Like HMOs and PPOs, Medicare has numerous rules—more rules, in fact, than any other insurance program.

Healthcare providers fall into one of four categories: Medicare participants, non-participants, those who have opted out of Medicare, and those who are not Medicare-approved. Medicare places the burden of ensuring that services are covered on the participating provider. However, there is a loophole. Advanced Beneficiary Notice (ABN) letters are often used to notify the Medicare recipient that services may not be covered. Non-participating doctors and hospitals typically charge patients their full fees. Since Medicare reimburses the providers only the approved amount, patients are liable for the balance.

Opted-out and non-approved providers do not bill Medicare, and Medicare supplemental policies do not pay for their services.

Medicare secondary and Medicare supplemental policies provide two distinctively different types of coverage. A secondary policy is a source of additional coverage, while a supplemental policy pays for 20 percent of the amount approved by Medicare. The supplemental policy pays only if the doctor, hospital and the particular service are approved. The type of supplemental policy (A-L) determines the additional benefits and the extent of coverage.

Medicare has more rules than private insurance programs.

Money Matters

A medical bill may be an unpleasant thing to deal with, but it should not be ignored. An unpaid bill will not go away; it will only invite past due notices. And if the notices remain unanswered, they will eventually be replaced by collection letters.

Medical issues and medical bills are both best treated in the early stages. Begin by calling the insurance company to find out why the claim wasn't paid. It is time-consuming, but you may be able to convince the insurance company to pay the bill. Often the denial is due to a minor issue and the customer service representative can resolve the problem right away. If it is more complicated, the insurer will mail a denial to your home address. Most companies will tell you how and where to send an appeal letter. Focus your discussions on their basis for denial.

Uninsured people can ask for a discount from the doctor or office manager at the time of the visit. Hospital claims can be negotiated before or after services are rendered. Once the bill is in collection all the rules change. Since the provider has already spent time and money trying to collect, getting a discount at this stage is less likely.

Legal Issues

Connecticut Governor Jody Rell is expected to sign a bill that prohibits insurance companies from sifting through patients' old medical records to find pre-existing conditions that can be used to deny medical claims. This bill, approved by state legislators, arose from an investigation into Assurant Health and its subsidiaries. The Connecticut Insurance Commission had reviewed over 500 claims processed by Assurant Health, Fortis Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company. It found that these companies failed to comply with the state's prompt-pay laws, delayed investigations into denials, and denied claims based on pre-existing conditions. (The denials were later overturned on appeals.) The CT insurance commissioner ordered that restitution be made to claimants and providers in the form of full payment with appropriate interest. The companies are further required to submit to an external compliance audit, corrective action plan and face other administrative actions.

Another part of this bill affects pharmacy benefit managers, who are now under mandate to register with the insurance department. This makes them compliant with CT insurance laws and regulations.

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Q & A

Q: Will universal health coverage solve our healthcare crisis?

A: Let's start with an assessment of health coverage in other nations. I have lived and worked in Hungary and have experienced universal healthcare as both patient and healthcare worker. Services are paid by the government, which decides the budget for each institution. High-cost technology is often unattainable, hence diagnosis mostly depends on the doctor's knowledge.

When I lived in Austria I experienced much the same type of care as in Hungary: crowded waiting rooms and a shortage of

expensive technology. Austria, too, has universal health coverage.

My research shows conditions in the United Kingdom are a bit better, but there is a long waiting list (six months to years) in accessing certain technologies. This is because of the high number of people who need each type of medical equipment. For example, hip resurfacing, the better and less-invasive alternative to hip replacement, is a U.K. brainchild and is frequently performed there. Still, patients using universal health coverage must wait as long as three years for the procedure.

Wait times in Canada are similar. If someone finds a lump in the breast in September they will have to wait until January to have it diagnosed.

Services and better technology can always be secured by "greasing the wheels" of healthcare. In Hungary the grease takes the form of a bribe. In the U.K. one can choose privately paid healthcare. And Canadians have the option to travel to the U.S. and receive services by paying full price.

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MedBillsAssist

Our mission is to represent our clients' best interests and work on their behalf in an ethical manner, in compliance with state and federal regulations.

While offering a wide range of solutions, we tailor our services to each client's specific needs. Our services range from resolving claim problems from one specific illness to reviewing and tracking all health-related solutions.

When you need a patient advocate to negotiate with medical providers and insurance companies, call us.

Medicare trained specialists.

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In the next issue: