MedBillsAssist

Medical Claims Solutions

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Health Care Reform

The Patient Protection and Affordable Care Act was signed into law last week by the President. According to estimates it will afford coverage for an additional 31 million legal US residents; an estimated 24 million remains uninsured.

The most significant changes to the current health care system are:

- Elimination of pre-existing conditions limitations.
- Elimination of calendar-year and lifetime maximums.
- Establishment of community rating with variation for age and geography.
- Permitting young adults to remain on their parent insurance plan until age 26

The Congressional Budget Office (COB) estimates that the coverage provisions in the bill will cost 848 billion over ten years. Most of the major provisions will not take effect until January 1, 2014. Therefore, the current COB estimate uses 10 years of revenue to cover 6 years of coverage. In contrast, Republican staff on the Senate Budget Committee estimates that the total spending in the bill for 10 years will exceed 2.5 trillion.

The bill creates an estimated 150 new government entities to the teeming bureaucracy and countless new additions to the already overly complex tax codes.

More regulations will force everyone involved to spend more money on administration, driving the ultimate cost of health care even higher.

Large business entities and insurance companies will pay higher taxes, and those not providing insurance will be penalized. Small businesses, with less than 25 employees, will receive subsidies.

Extended coverage will be achieved by extending Medicaid for lower income individuals and families, providing tax credits for people above the Medicaid income threshold and by interstate insurance exchanges for the presently uninsured.

The law is promising protection from exorbitant out of pocket costs in the form of yearly caps on co-payments and co-insurance charges. However, it does not address the small print, such as usual and customary rates and non-covered (medically needed, but excluded from policy coverage) charges. It appear that the burden is entirely left on the insurance companies, but in reality the public will remain unprotected from overcharges and non-covered expenses. We are still at the mercy of deals made by insurance companies and large hospitals.

Physicians, the backbone of health care, are still affected in several ways. They are still forced to take contract of adhesions, limiting their ability to negotiate fees with insurance companies. They are still waiting for the permanent fix to the faulty Medicare formula, that was removed from the bill and replaced with a temporary fix. Tort reform, a major player in health care cost, hasn't been addressed.

This legislation missed the mark of real reform. It only added several layers to an already fragmented system. It missed the opportunity to address real cost control, both by insurers and medical providers.

Regulatory authority between the federal and state governments is still divided and will be clarified via regulations in the coming years.

Regardless of what we think about this bill, it has been passed. Now it is time to move forward and make it work, hopefully, for all Americans.

Quote of the Quarter

"A lot of [health insurance] companies are focusing on the 55 to 65 market. [Pre-retirees] are not looking for anything fancy, they just want something easy to understand and that's priced appropriately to get them through to Medicare. [In fact, some insurers are offering two- to three-year rate guarantees] with the idea they can lock people up and when they turn 65 sell them Medicare products."

Todd Catlin, an independent broker with Liberty Insurance Group in Brookfield, Wis.

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Client Spotlight

Judy a former New York City teacher planned for the worst case scenario. She purchased a catastrophic insurance policy to cover medical expenses that are not routinely covered by regular health insurance.

When her wonderful husband of many years became ill she concentrated on taking care of him, providing the best possible care during his declining health. After he passed, she took time to grieve, then set her new life in motion. With her policy handy and lots of bills at hand she called me to help her collect previous expenses. On our first meeting we devised a plan. Then I took

over, and assembled claims information in an insurance friendly format. Once I started submitting claims her insurance responded with processing and applying the first large batch to deductible. Once we reached the deductible limit checks started to come in. It was a lot of fun getting emails from Judy letting me know that she got her first check, then the second. For the next several month she had a steady flow of checks coming to her mailbox.

Her smart mind and capable oversight, with a little assistance from me, allowed her to recover most of the medical expenses which her regular insurance did not cover.

Medicare-Implication of Observation

Medicare part A covers inpatient care; Medicare part B covers physician services , outpatient hospital care, along with observation. Normally observation is defined by less than 24 hours time in a hospital setting. It has been a growing trend to keep patients in observation status for several days. This actual hospitalization seem like an inpatient stay; nurses and doctors serving the patient in a regular hospital bed, the patient receives medications, food and tests.

The difference is in the billing and consequently the split between Medicare payment and patient liability. Medicare reimburse hospital inpatient care based on Diagnosis Related Group (DRG). That is one inclusive payment for all services.

Outpatient, including observation services, are reimbursed on each line of service, at 80% of Medicare allowable rates. Some services, such as prescription drugs, are not covered under part B benefits. This line item charge system can get very expensive quickly.

The other significant implication is nursing home coverage. Medicare covers nursing home services following, at least three days of acute hospital admission. Observation services are not admissions, therefore if nursing home care needed it will be denied by Medicare.

Legal Issues or Who is in Trouble this Time?

Connecticut Attorney General Richard Blumenthal is suing the former executive director of a medical supply charity for allegedly diverting approximately $100,000 of charitable funds for trips, concerts, spa services, pet supplies and other non-business personal expenses.

Blumenthal's lawsuit names Tammy Young, the former executive director of Remedy, Inc., an 18-year-old nonprofit in New Haven that promotes recovering unused medical supplies for distribution to other nonprofit agencies. Remedy Inc. also aids hospitals, industry, and individuals in distributing unwanted medical devices to nonprofit groups.
Blumenthal's office began an investigation after receiving a complaint and information from Remedy's founder, Dr. William Rosenblatt, who discovered the inappropriate expenses.

MedBillsAssist

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