MedBillsAssist

Medical Claims Solutions

Volume 3 Issue 4 Winter 2010

Health Reform - Implementation 2011

Below are some highlights in phase two of the Health Care Reform Bill. This is the year when our tax codes are going through significant changes driven by the health care law. Overall, health care is getting more regulated, therefore it is forcing businesses, health care providers and insurance companies to spend more money on administration. There are a lot of plans that are studying and "advising" on how to make health care better. Sadly, those groups and advisory bodies should have been created prior to the enactment of this law.

Minimum Medical Loss Ratio
Health plans, including grandfathered plans, must report on the share of premium dollars spent on medical care and provide consumer rebates for excessive medical loss ratios.

Consumer Protection
Prohibits individual and group health plans from placing lifetime limits on the dollar value of coverage as well as rescinding coverage except in cases of fraud. Annual limits are still in effect until 2014. The provision also prohibits plans from denying children coverage based on pre-existing medical conditions.

Standardizing the Definition of Qualified Medical Expense
Match the definition of qualified medical expenses for HSAs, FSAs and HRAs to the definition used by the IRS itemized deduction. Over-the-counter medicine will now only be considered as medical expense of accompanied by a doctor's prescription.

Reporting Health Coverage Costs on Form W-2
Requires employers to disclose the value of the benefit provided by the employer for each employee's health insurance coverage on the employee's annual Form W-2.

Creating Simple Cafeteria Plans
Creates a Simple Cafeteria Plan to provide a vehicle through which small businesses can provide tax-free benefits to their employees.

Appealing Health Plan Decisions
Appoints the right to appeal medical claim and/or policy decisions made by any health plan and the right to appeal decisions made by the health plan to an outside, independent decision-maker, no matter what state a person lives in or what type of health coverage a person may have. This includes, for the first time, new self-funded plans.

Changes in Medicare

Closing the Donut Hole
Requires pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap.

Medicare Advantage Payment Reductions
Freezes 2011 Medicare Advantage payment benchmarks at 2010 levels to begin transition. Continues to reduce Medicare Advantage benchmarks in subsequent years relative to current levels.

Preventive Health Coverage
Provides a free, annual wellness visit and personalized prevention plan services for Medicare beneficiaries and eliminates cost-sharing for some preventive services.

Center for Medicare and Medicaid Innovation
Creates the Center for Medicare and Medicaid Innovation to test new payment and delivery system models that reduce costs while maintaining or improving quality.

National Quality Strategy
Requires the Secretary of the Department of Health and Human Services to annually develop and update a national quality improvement strategy.

Medicare Independent Payment Advisory Board
Establishes an Independent Advisory Board, comprised of 15 members, to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds targeted growth rates.

Quote of the Quarter

"This bill has more moving parts than a Swiss watch," Henry E. Hudson Judge of Federal District Court in Richmond said about the challenged health care bill.

New Trends in Medicare Audits

Medicare auditors are finding new ways to cut payments to hospitals and physicians by questioning the diagnosis of doctors.

In the past, Medicare auditors merely reviewed notes and documentation to ensure all information was present. The new trend is to question and override physicians' conclusions about a patient's condition. In essence, someone sitting behind a desk, who has not seen the patient, is changing diagnosis decisions and downgrading conditions to reduce payments.

Hospitals often challenge and are able to reverse these decisions. Unfortunately this just creates more administration and takes away valuable resources from more critical and important functions.

This is incredibly frustrating, because physicians have extensive training in how to properly diagnose patients, based on the examination and direct contact with a patient. Adding more tests to justify an already known diagnosis is simply a waste of resources. This is especially true when a prescribed treatment cures the patient. More documentation and more tests simply increase the cost of our health care without any benefits.

The only person questioning the doctor and the hospital should be the patient. He or she is the only person who is present at the time and needs to be working with the doctor to ensure proper treatment and recovery.

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

Mental Health Parity Implementation

The Mental Health Parity and Addiction Equity Act was signed into law in 2008. It prohibits large health plans (any firm over 50 employees) to differentiate medical/surgical benefits from mental health benefit for plans that offers both. Federal regulation implementing the legislation went into effect this year and enforcement goes into effect in January 2011. With every legislation there is an associated cost. Full coverage for mental health increases benefits. Adding benefits increases premium. To balance this added cost, policies are revised to offset this new cost by changing other provisions, such as increasing co-pays. According to the Kaiser Family Foundation's 2010 Employer Health Benefits survey, about one-third of firms with more than 50 workers said they made changes in the benefits they offer in response to the law, and 5% of those said they dropped mental-health coverage.

MedBillsAssist

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

Medicare trained specialist.

Licensed in Connecticut, New York and Virginia.

Legal Issues or Who is in Trouble this Time?

Truth to be told, I don't think that Blue Cross of Connecticut is really in trouble.

The Department of Insurance denied their outrageous request for a 21.5% premium increase for small group and individual plans. The Department did an actuarial analysis with revised assumptions and concluded that a zero-percent increase would be both reasonable and actuarially sound.

The review discovered declining claims experience - per person per filed claim to be between 4% to 7% last year. Basically Blue Cross is paying out less in benefits, than prior years. Furthermore, the medical loss ratio calculated by the Department of Insurance, while considering zero increase, is 80.4% which is very close to the federally mandated ratio.

These grandfathered plans only needed tweaking to meet the new federal law. Connecticut already had similar mandates in the state, such as dependent coverage to age 26. The Patient Protection and Affordability Care Act only removed the requirement to the child be unmarried. The calculated financial impact is only 0.2% for this minor change.