MedBillsAssist

Medical Claims Solutions

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New Benefit Year Headaches

My recent visit to the pharmacy got me by surprise. I am told there is something wrong with my insurance, but the good news is that I got a coupon from the doctor, so I can get a discount.
Being in this business the first statement jolted me to action. I told the pharmacist that I have no plans to pick up my medicine today and I will check with my insurance to find out what is wrong with it. Just as suspected there was nothing wrong with my insurance. The medication in question is covered under my policy with a modest co-pay. Adding the drug company coupon to the mix, my actual liability is $20, instead of a discount my pharmacist wanted to give me for $57. Now all I had to do is print my benefit information and fax it to the pharmacist. Just like magic there is no longer a problem with my insurance and I am able to pick up the medication at the cost I was expecting to pay.

Most of us renew or change our insurance policies at the beginning of every year. Behind this process there are people making updates and changes. These changes are being completed at HR departments and at the insurance companies. It may seem that the process should be simple and seamless, but that is not the case. Mistakes can be made. A person or just a family member can be left out from benefits or entire families can be deleted from coverage. Then there are moving pieces, such as prescription plans, mental health benefits, vision plans, etc. Most insurance companies outsource some of their specialty processing and therefore they need to work with outside contractors to coordinate files to ensure all members are added with correct benefit packages.

Don't assume that whatever the doctor's office, or pharmacist, tells you is correct. Due to a mass amount of electronic file updates their information could be wrong as well. As my favorite IT person always say "garbage in garbage out". Basically if the information added in the computer is incorrect the information produced by this computer program is incorrect as well.

Then there is pharmacy benefit. A slightly higher copay may not seem so bad, but if it doesn't seem right, you should check. There are online tools available to price medications to match up with benefits.

In my case it took me ten minutes to log in and get the information, which saved me $37.

Quote of the Quarter

"A low-cost, all-inclusive benefit package is just "happy talk. You can't have it both ways. The idea of a low-cost essential-benefits package is like a unicorn. It doesn't exist….Everybody's complaining about the cost, so the goal was to develop an essential plan: only the things that people need. [But] it's impossible to do that, because everybody thinks their claim is the most important."

John Sheils, senior vice president of the research firm The Lewin Group, a unit of UnitedHealth Group

I Still Don't Know

A seemingly simple question: I am working, have two jobs, and have two insurance policies. Which policy is my primary insurance? To decipher the primary coverage is simple in most cases. This is what called a coordination of benefits. Married couples often covered under their spouses employer insurance which makes the primary policy holder's insurance primary for that person. In case of children with two policies, the answer is often based on which parent have the earlier birth date. Medicare provides a complete list of situations and guidance to decipher when and which insurance is primary. Medicaid has it in it's secondary name: insurance of last resort. Unfortunately my original question remains a mystery. This is one of those extremely rare situations when we have to go back and force each insurance company to disclose the small print, which is how they coordinate benefits in this specific situation.

Medicare - Sustainable Growth Rate

In case you are wondering why your doctor is leaving Medicare...
In 1997, the Congress has passed the Balanced Budget Act that had included a formula called the Sustainable Growth Rate (SGR) to control Medicare spending. The formula is based on the growth of GDP and the yearly Medicare Payment Advisory Commission (MedPAC) report. The MedPAC report includes a conversion factor that changes payment to the doctors that works like this. If the expenditures for the previous year exceeded Medicare budget, the conversion factor will decrease payment to the doctors; conversely, if the expenditures are less than Medicare budget, the payment is increased to the doctors. Starting in year 2003, the MedPAC report's conversion factor had been decreasing payment to doctors that had accumulated to a total of 27% by year 2012.
Congress had two options since year 2003: cut doctors' pay or appropriate additional funds. Legislators don't want to cut payments to doctors, because they are afraid that the doctors will leave the Medicare program. As such, Congress has passed short-term "doc-fixes" to keep physician payments stable and in some cases to provide a minor increase in payment. This year the Congress has passed yet another "doc -fix" that will not decrease payment to the doctors until year 2013.
The doctors' business growth is not sustainable under these condition and that is the reason why they are leaving Medicare...

Definitions:

SGR: Sustainable Growth Rate; a complex formula created by Congress in 1997 to control Medicare spending for physicians services.
COB: Coordination of Benefits; a collective set of rules created by insurance companies and Medicare to decide which insurance is the primary payer on medical claims.
MedPAC: Medicare Payment Advisory Commission is an independent US federal body that advises Congress of Medicare issues, including payment schedule for physicians

What is a Mini Med Health Plan?

In short, these are the policies which aren't worth the paper they were printed on. The Mini-Med Health Plan offers medical insurance what looks like one, but does not act like one. The most telling sign is the annual maximum. These plans offer coverage often up to $10,000 that will buy 2-4 days in a hospital bed. All other hospital based charges are above the policy limit, therefore not payable. But that is not all! These policies often have high deductibles, many limitations and of course worst of all they exhausted once reached the $10,000 limit.

These insurance products likely offered through food, retail and temporary staffing companies, or simply on the open market. When the healthcare law comes into full effect in 2014, these plans are supposed to be eliminated from the marketplace. However, every year there are thousands of waivers handed out by the federal government that are keeping these policies in place.

Legal Issues or Who is in Trouble this Time?

Ethex Pharmaceutical was selling Nitroglycerin Extended Release and Hyoscyamine Extended Release capsules to Medicaid and state programs nationwide as approved drugs, while knowing that these drugs were classified by the FDA as less-than-effective. Nitroglycerin is used to treat chest pain due to lack of oxygen supply and Hyoscyamide is for treating various stomach, intestinal and urinary track disorders.

Ultimately, neither of the drugs has received full regulatory approval for safety and effectiveness, nor are these product currently on the market. The 17 million dollar settlement will be distributed to various federal insurance programs and New York will receive $1,189,577.

As a standard practice, settlement will go back to the effected programs and/ or the general state funds. The patients, who took these less than effective medications, were not mentioned in the settlement.

MedBillsAssist

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www.medbillsasist.com Tel: 203-569-7610 Fax: 203-973-0367 katalin@medbillsassist.com