MedBillsAssist

Medical Claims Solutions

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Affordable Care Act - Moving Forward

2014 had been the start of medical insurance for all Americans. The Affordable Care Act (ACA) requires insurance companies to allow all US legal residents to obtain medical insurance. It has a been a big improvement for those with pre-existing medical conditions. Insurance companies can no longer deny coverage or charge a higher premium for their medical insurance based on past or chronic illness.

The regulation mandated that all residents must obtain health insurance to avoid paying a penalty. People with lower income can ask for federal subsidy or enroll in Medicaid.

Along the way there has been challenges, confusions, delays, computer problems and other issues. In spite of all that, most people were able to enroll.

What changed from last year?

Just as with any new initiative, or in this case compliance to the new regulation, implementation of ACA had been improving. Existing insurance companies increased their supporting staff and adjusted computer systems to accommodate the influx of new customers. New insurance companies had been established and many are doing well in their second year. There are rate increase requests by most insurance companies, and declining premiums by a few others.

My complaints stays the same. Policies are confusing for most people and their overall cost isn't easy to interpret. As a general rule, low premiums are directly connected with high deductibles and high cost shares. The so called Bronze level ACA policies actually carry an overall cost that is higher than the Gold level policy. The law did almost nothing to address the affordable part of the ACA for the people who need it most. Government subsidy for low income residents is helpful, but mainstream routine medical care often does not add up to the high deductible attached to these cheaper policies.

As a financial observation over many years in the US, ACA lines up with all things pecuniary. If you can afford to get a better product, in our case health insurance, you are spending more money on the surface. However, the better policy gives a much better protection and cost you less in the long run.

Insurance policies under the ACA can be purchased on or off the Insurance Exchange. If you are shopping on the Exchange the policies are more expensive when compared to policies purchased through an insurance agent, or directly from the insurance company. My best guess is that insurance companies are counting on the federal subsidies to absorb the higher rates. Furthermore, provider networks are smaller in the Exchange and larger with open market policies.

Having medical insurance is simply a smart financial decision. Relying on one's savings account to cover medical expenses will prove to be the wrong decision. The monetary implication of a sudden medical emergency, or management of a chronic condition can be devastating financially. The average one day hospital bed charge is around $3,000. This charge does not include any other services, such as laboratory, drugs, surgery, operating room.

Quote of the Quarter

"Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them" "If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."

chief justice John G. Roberts Jr. on June 2015

www.medbillsasist.com Tel: 203-569-7610 Fax: 203-883-6013 katalin@medbillsassist.com

Medicare Appeals

Medicare for most people is a simple and easy access to medical care. Have part A & B, have suitable supplemental policy, add part D and life should be simple.

Complications will arrive when a patient is using an opted out provider, or receive services that statutorily non-covered by Medicare. In addition, there are situations when a doctor does not list all the necessary codes and other times, when a Medicare Administrative Contractor wrongfully denies a claim.

Unlike regular insurance, Medicare health insurance is based on rules, named coverage determination for services. The National Coverage Determination, or NCD, managed and maintained by CMS. Adding Local Coverage Determination, or LCD, is managed and maintained by CMS contractor or fiscal intermediary that obligated to implement the services described by NCD within their coverage area. For example, MRI does not need prior authorization by Medicare, but the codes listed on the claim must meet the LCD to be considered covered. The same MRI usually have different payment amount from one state to the next. Rates are based on geographic location that is adjusted to consider cost of running a regional medical practice or hospital.

When a Medicare claim is denied a person or the provider can file an appeal.
Medicare has three levels of appeals. The first one called Redetermination, the second is Reconsideration, and a third is a hearing before an Administrative Law Judge (ALJ). Unfortunately, the chances of getting a denial overturned takes a very, very long time.

About ten years ago Medicare hired contractors to audit claims that has already had been paid. The audits resulted in post service denials; taking back money from the providers. Almost all of these denials were incorrect and as a result, entities and patients filed appeals.
98 percent of these appeals were denied in the first and second levels.

This resulted in filing to the ALJ, which in turn ended up backlogged. The AJL appeals process should be completed in 90 days, but due to the backlog it takes about three years.
The Senate Finance Committee held a hearing about this in April. The Committee has concentrated on the ALJ hearing delay, not the root cause for the delay. Medicare contractors routinely deny first/ second level of appeals, forcing providers and beneficiaries to request an ALJ hearing.

Definitions:

Medicare Administrative Contractor: an entity that contracts with CMS to process claims.

CMS: Center for Medicare and Medicaid Services.

ALJ: Administrative Law Judge ; the third level of appeal for Medicare

Legal Issues or Who is in Trouble this Time?

A biopharmaceutical company Amgen Inc unlawfully promoted Aranesp for the treatment of anemia caused by cancer. This drugs did not receive approval from the FDA for the treatment of cancer caused anemia. Furthermore the company failed to disclose that in drug trials there was an increased risk of death and tumor stimulation.
The second drug named Enbrel was off label marketed for treatment of mild plaque psoriasis. Although the drug was approved for arthritis and choric moderate to severe plaque psoriasis for adults it lacked competent evidence to support the use in the treatment of mild psoriasis. The FDA sent a warning letter to stop advertising for use in mild psoriasis. The FDA black box warning stated invasive infections were observed in children and adolescent patients.

47 states received a combined 71 million in settlement. The company also agreed to reform its marketing practices.

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Our Mission is to represent our clients' best interests. We work on your behalf in an ethical manner in compliance with state and federal regulations.

We tailor our service to your specific needs.

We work with claims in collection or track and resolve claim problems for the entire family.

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

Medicare trained specialist.

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