MedBillsAssist

Medical Claims Solutions

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Health Care Reform = More Laws, No Solutions

According to the latest news health care reform moved to the Senate. The much debated "democratic bill" won't pass both houses and the fresh "republican bill" is being marked up in the senate. While the rest of the country was arguing, I spent my time reading the congressional bill and learned a great deal.

Public Option
The Public Option is the breaking point of the debate. Ultimately, it is the most important and necessary component of the bill. As it is currently written, however, it will eliminate most employer based policies. The bill states that if companies do not offer health care coverage they must pay the government 8% of each employees annual salary. Doing the math, 8% of the average employee wage amounts to approximately 300 per month. This number is significantly less than an employer pays for medical insurance. Therefore it would be cost effective for corporations to eliminate insurance benefits and pay the government this sum instead. Also, the actual payment calculation for medical care is faulty. The failed proposal bases costs on Medicare's low payment rates. The public option must do better paying our physicians and healthcare providers.

Good parts
Added the elimination of pre-existing conditions, mental health parity, gradual elimination of the Medicare prescription gap, and repealing the Balanced Budget Act of 1997 section 4505 (d). The pre-existing provisions in health insurance policies are punishing the very people who need them most. This specification will open the door for everyone to get health insurance without bias while eliminating costly administration. The provision in the Balanced Budget Act dictates the way payment is calculated and reduced every year for physician services. Improving this provision will increase or at least keep doctor participation at even level.

Missing, but badly needed
Elimination of lifetime maximums. It is not difficult to incur over a million dollars worth of medical bills while suffering from a serious illness in as little as a year. Addressing out of network provider payments along with reasonable and customary rates. Something must be done to control cost in this level. Patients nationwide often end up paying more than half just by utilizing an out of network provider.

Financing
The original reform had several financing sources, but mostly referred to "fund not otherwise appropriated from the Treasury." I must wonder how much we have in that obscure fund we don't know much about.

Wasteful spending
Analysis of medical outcomes does not belong to government operations. Let our nation's physicians decide what is best for each of their patients. For added support we can turn to medical schools and other organizations that are best suited to perform such tasks.

The simply silly
There is no death panel or clause in the proposed bill. The controversial code argued instead allows older patients to visit their doctors for a consultation on end of life planning.

Equality
I personally would love to see the federal employee health plan, yes the health plan congress utilizes, to be eliminated and replaced by the public option plan. Let our legislators use the actual health care policy they created!

Employer sponsored plans
These are the backbone of our health care. We must preserve them.

Food for thought
Although Medicare is a federal program it is administered by insurance companies. Claims processing takes place based on the type of claim and geographic region. Eliminating health insurance companies would bring Medicare to its knees.

Quote of the Quarter

"They've decided to write a very partisan one-sided bill without any input from the experts in health care in this country other than their chosen experts. It's certainly not a great attempt at bipartisanship and they're doing it under the auspices and guidance of the White House...."It's about as anti-bipartisan as any bill I've seen in the whole time I've been here. And it's a massive, massive bill that's going to result in...trillions of dollars [in unnecessary spending]."

— Sen. Orrin Hatch (R-Utah), speaking with reporters about the health reform bill drafted by Sen. Edward Kennedy (D-Mass.) and others on the Senate Health, Education, Labor, and Pensions committee.

Medicare Secondary Payer– MSP

There are a number of situations when Medicare will not pay for medical services as usual. It is called Medicare Secondary Payer or MSP. This rule was created 29 years ago to preserve Medicare funds when other insurance should reasonably making a payment.

Medicare will pay second under these situations:

- No fault insurance (including auto)
- Liability insurance
- Black lung benefits (paid by the Department of Labor)
- Workers Compensation
- Medicare beneficiary, or spouse is still working for a company that has more than 20 employees
- Medicare beneficiary still working, disabled and employer has more than 100 employees
- ESPD, this related to severe kidney disease and 30 month coordination of benefits apply

It is important to know and understand this Medicare rule. Claims submitted to Medicare that should have been paid by other insurances will be denied.

Definitions:

MSP: Medicare Secondary Payer—rules governing when Medicare pay as a first or second insurance

FDA: US Food and Drug Administration

ESRD: End Stage Renal Disease

Trouble in California

We have all seen the news about uncontrollable fires and government budget crisis. What we didn't hear about is the crisis in California health care.
The largest California insurers rejected more than one out of every five claims for insured patients, even when services were recommended by the physician.
The California Nurses Association/ National Nurses Organizing Committee analyzed data that was reported by the insurers to the California Department of Managed Care.

The tally of denials for the first six month of this year:

- PacifiCare with 39.6%
- Cigna at 32.7%
- HealthNet 30%
- Blue Cross 27.9%
- Aetna 6.4%

There is nothing in the national health care bill that offers solution to these type of denials.

Legal Issues or Who is in Trouble this Time?

Pfizer agreed to pay the state of Connecticut 5 million, the state of New York 66 million, as part of a nationwide settlement of 2.3 billion, as a penalty for illegal marketing practices. The company was accused of paying kickbacks to doctors in exchange for prescribing Pfizer drugs such as Lipitor, Viagra, Zyvox, Lyrica and Zoloft.

Also included in the suit was illegal marketing for off-label use of the drug Geodon and Bextra. Off-label use is use of a drug for a condition it is not certified by the FDA to treat. Physicians are allowed to do this at their discretion, but drug companies are only allowed to market drugs for treatments approved by the FDA.

Almost every major drug maker has been accused of illegal marketing practices in the past few years. It is advisable to check your drugs on Consumer Reports Best Buy Drugs. If your drug is not approved ask your doctor to explain.

MedBillsAssist

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