

The Healthcare Bill, Rage, Concierge Practices, Cuts, Claims and Don Berwick (Yes!)

☒ HEALTHCARE BILL IMPACT ON INDIVIDUALS AND RAGE

A number of people asked me about the impact of health reform on them as individuals. Here is a **great story from the Atlanta Journal-Constitution** that takes specific examples of individuals and families and speculates on how the new bill(s) will impact them.

For 2010, the changes are minimal:

- Dependent children may be covered by their parents' health insurance policies until age 26.
- A high-risk insurance pool will open for people with pre-existing conditions who have been uninsured for six months.
- In 2011 Medicare will pay for an annual checkup, and deductibles and co-payments for many preventive services and screenings will be eliminated. The Medicare prescription drug doughnut hole will gradually narrow every year until it is eliminated in 2020. People in the "doughnut hole" could receive a \$250 rebate this year.

I have to say that I've been dumbfounded by the fury raised over the passage of the new healthcare legislation. I realize that the bills separate people into winners (uninsured, providers with uncompensated charity care, patients with pre-existing conditions, Medicare patients, providers who see Medicaid patients, families with adult children, etc.) and losers (companies who have to pony up more money for their retired employees, insurance companies, illegal immigrants, high wage earners, etc.), but **this story placed the fury into**

a different perspective for me. It's a good read.

CONCIERGE PRACTICES

What does healthcare reform mean for the physician practice? Many are predicting the rise of concierge practices (also called boutique medicine, retainer practices, VIP medicine and cash practices) as physicians find they cannot survive if their patient population is predominantly Medicare, Medicaid and uninsured patients. Concierge practices fall into two categories:

- The first operates on an insurance+ model, which means that the practice accepts and files the insurance for the patient, but also requires an additional out-of-pocket fee of anywhere from \$1500 to \$1800 per year to be a patient of the practice. The fee is to cover services that Medicare and commercial insurance do not, such as physicals, phone consultations, wellness counseling and patient education.
- The second operates on a strictly cash basis and the practice does not accept or file any insurance for the patient. The patient pays a flat fee per year for care (usually in the \$5,000 to \$15,000 range) and all primary care is provided for that amount. The patient still needs to carry insurance for prescriptions, hospital services and sub-specialist services. *Imagine being a manager in this type of practice – no pre-authorizations, no insurance department, no eligibility checking, no refunds...*

Concierge medicine has not been around that long, but it is growing in popularity by leaps and bounds. The first acknowledged concierge practice was formed in 1996 in the Pacific Northwest. In 2002, CMS (Centers for Medicare and Medicaid) published a memo stating that physicians may enter into retainer agreements with their patients as long as these agreements do not violate any Medicare requirements. In 2003,

the Department of Health and Human Services ruled that concierge medical practices are not illegal. Today, there are approximately 5,000 physicians using the concierge model in the United States today.

MEDICARE CUTS, MEDICARE CLAIMS AND DON BERWICK

Shortly after all the shouting and voting on healthcare reform was over, Congress recessed for two weeks leaving the controversy over the 21.5% cuts required by the SGR formula still unsettled. CMS has advised the MACs to again **hold claims for services provided from April 1 to April 10** to give Congress a chance to get back to work and back to voting for an additional delay (or not) for the cuts. If the cuts are allowed to stand, many physicians will start making their own cuts by minimizing the number of Medicare and Medicaid patients they will see.

Amidst this craziness, a voice of sanity is heard and it is Donald Berwick, MD, current President of the Institute for Healthcare Improvement (IHI) and **probable Obama pick for the head of CMS**. If you don't know Don Berwick or the IHI, click **here** to read an interview with him about the IHI's "100,000 Lives Campaign" or watch the video below of him speaking about the dimensions of quality. Good stuff!

**Medicare for 2010:
Deductibles and Premiums**

Update



Medicare is a federal health insurance program created in 1965 for:

- people age 65 or older,
- people under age 65 with certain disabilities, and
- people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant)

Medicare Part A – 99% of patients don't pay a premium for Part A (hospital insurance) because they or a spouse already paid for it through their payroll taxes while working. The \$1,100 deductible for 2010, paid by the beneficiary when admitted as a hospital inpatient, is an increase from 2009. Part A helps cover:

- inpatient care in hospitals (excluding the physician fees), including critical access hospitals
- skilled nursing facilities (not custodial or long-term care)
- some hospice care
- some home health care

Medicare Part B – Part B (outpatient/doctor insurance) base premium for 2010: \$96.40/month (no change from 2009.) Premiums are higher for single people over 65 making more than \$85K per year and for couples making over \$170K. Part B premiums cover approximately one-fourth of the average cost of Part B services incurred by beneficiaries aged 65 and over. The remaining Part B costs are financed by Federal general

revenues. In 2010, the Part B deductible is \$155. Part B helps cover:

- physician fees in the hospital
- physician fees in their offices and other outpatient locations
- other outpatient services (x-rays, lab services)
- some services of physical and occupational therapists
- some home health care

Medicare Part C – Medicare now offers beneficiaries the option to have care paid for through private insurance plans. These private insurance options are part of Medicare Part C, which was previously known as Medicare+Choice, and is now called Medicare Advantage. Medicare Advantage expands options for receiving Medicare coverage through a variety of private insurance plans, including private fee-for-service (PFFS) plans, local health maintenance organizations (HMOs) and regional preferred provider organizations (PPOs), and through new mechanisms such as medical savings accounts (MSAs), as well as adding payment for additional services not covered under Part A or B.

Medicare Part D – Starting January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. The so-called “doughnut hole” is the amount the patient pays between the initial coverage limit of \$2,830 and the out-of-pocket threshold of \$4,550 – a total of \$1720 that the patient is responsible for.

- **Initial Deductible:** \$310
- **Initial Coverage Limit:** \$2,830
- **Out-of-Pocket Threshold:** \$4,550



COMPARISON OF MEDICARE PLANS

Original Medicare Plan

WHAT? The traditional pay-per-visit (also called fee-for-service) arrangement available nationwide.

HOW? Providers can choose to participate (“par”) or not participate (“non-par”.) Participating providers accept the Medicare allowable and collect co-insurance (20% of the allowable.) Reimbursement comes to the providers. Non-participating providers may charge 15% more (called the “limiting” charge) than the Medicare allowable schedule, but the patient will receive the check, which is why some non-par practices require payment at time of service for Medicare patients. To be able to charge patients for non-covered services, patients must sign an ABN before the service is provided.

Original Medicare Plan With Supplemental Medigap Policy

WHAT? The Original Medicare Plan plus one of up to ten standardized Medicare supplemental insurance policies (also called Medigap insurance) available through private companies.

HOW? Medigap plans may cover Medicare deductibles and co-insurance, but typically will not cover anything Medicare will not. Medicare primary claims will “cross-over” to many Medigap secondary claims so the practice does not have to file the secondary Medigap claim. Patients may still have a small balance that is cost-prohibitive to bill for.

Medicare Coordinated Care Plan

WHAT? A Medicare approved network of doctors, hospitals, and

other health care providers that agrees to give care in return for a set monthly payment from Medicare. A coordinated care plan may be any of the following: a Health Maintenance Organization (HMO), Provider Sponsored Organization (PSO), local or regional Preferred Provider Organization (PPO), or a Health Maintenance Organization (HMO) with a Point of Service Option (POS).

HOW? You have to have signed a contract or be grandfathered in (called an “all-products” clause) under an existing contract to see patients and get paid. Primary care providers may have to provide referrals and/or authorization for specialty services and providers. A PPO or a POS plan usually provides out of network benefits for patients for an extra out-of-pocket cost.

Private Fee-For-Service Plan (PFFS)

WHAT? A Medicare-approved private insurance plan. Medicare pays the plan a premium for Medicare-covered services. A PFFS Plan provides all Medicare benefits. Note: This is not the same as Medigap.

HOW? Most PFFS plans allow patients to be seen by any provider who will see them. PFFS plans do not have to pay providers according to the prevailing Medicare fee schedule or pay in 15 days for clean claims. Providers may bill patients more than the plan pays, up to a limit. It would be a good thing to notify patients if your practice intends to bill above the plan payment.

Need more? Click on **CMS** (provider-oriented) or **Medicare** (patient-oriented.)