

HEALTH CARE – PROFIT IMPROVEMENT

Improving Health Care Reimbursement

A diverse array of payer guidelines has created challenges to streamlining processes.

U.S. Health Insurance Impacts on Commercial Providers

There currently is no standard health insurance provided in the United States, nor mandates that require individuals to purchase health insurance (individually or through an employer). Although low income earners are automatically qualified for Medicaid through the government, most uncovered individuals are not eligible for this option and do not chose to obtain coverage privately due to the high associated costs. The U.S. has struggled for many years to arrive at approaches to a health care reform that would provide access to a cost effective healthcare system and basic medical necessities with little progress. This has created opportunities for the private sector to create tailored coverage plans to fill this gap and take advantage of consumer demand. Insurers are coming up with many different variations in structure, coverage, and pricing of such plans which have continuously grown over time such that the numbers of possibilities are seemingly infinite.

Insurance Coverage Variations

Cost sharing is a popular plan design which results in expenses for the patient who will be 'balance billed' for amounts that are incurred above the coverage levels while reducing monthly insurance premiums. The main types of cost shares are:

- Deductibles – this is a fixed amount that the patient must pay per claim and any amount over this will be covered under the plan
- Out of Pocket Limits – this is similar to a plan level deductible where once the limit has been met any additional amounts above will be covered under the plan
- Maximums – this is a fixed amount that the plan is designed to cover with any amount above this being patient responsibility (can be on a claim or plan level)
- Coverage Percentages – this is a set percentage that the plan is designed to cover regardless of the cost and the remaining percentage is covered by the patient

To make matters more complex, these can be combined to further limit the coverage that is available to the patient adding confusion to what the final costs will be.

Speculative or Non-Medically Necessary treatments are also generally not covered by most plans, however the definition of these terms will vary depending on which insurer is involved.

Reimbursement Issues

Patients often don't know the costs associated with their medical bills or the coverage under their plan because this information is generally not publicly available or there are too many details and exceptions to remember. Medicare is the only insurer with a published fee schedule of the percentage of coverage while all other payers do not have such a system. This lack of information initiates many questions and contest when a bill arrives at the patient's home which then impacts collections of the product provider who now has no way of salvaging the product.

Common techniques to maximize collections are:

1. Get patient involved with any insurer disputes
2. Prepare patient with any cost information that is known as early as possible
3. Request information regarding the patient's knowledge of their plan coverage (primary and secondary)
4. Target patients who have coverage with Insurance Plans that provide better coverage
5. Design payment programs for patients to help cushion impact of balances

Challenge of streamlining processes for a diverse mix of payers

The variability of payers and coverage plans also leads to differing claims submission requirements which have been complicating reimbursement processes. Although this may seem like basic principles, gathering all plan data and then break down characteristics into two groups: similar and different will assist in illustrating how to streamline the processes. Generally most payers actually require the same basic requirements which becomes apparent after all the data is gathered.

Conclusions

The health insurance industry in the U.S. has evolved to satisfy varying consumer needs resulting in the existence of many hurdles for the reimbursement areas of medical service and product providers. This external factor has created challenges to streamlining processes; however various techniques pre and post sale with the consumer are within the control of the business. Obtaining detailed and current information on coverage plans will show that the variables are generally repeatedly in the same aspects of the plans. ✨