

## The Diagnosis and Treatment of Medicare...

Medicare is in critical condition. Spending has risen dramatically since the program's inception, growing from about \$200 billion to \$450 billion over the last decade. Expenditures have consistently grown at twice the rate of inflation, and at times much faster, outstripping economic growth and absorbing a growing share of federal revenue. The situation will only worsen in the coming decades. As the Baby Boom generation reaches 65, Medicare's demands on federal revenues will climb even more sharply. Left unchecked, Medicare spending threatens to crowd out federal funding for education, energy, the environment, defense, and other important policy priorities.

### The Current Medicare Program:

- Medicare's financial burden is not simply the product of an aging population. It also reflects the growing use of health services by the average Medicare beneficiary.
- Medicare has created perverse financial incentives: Doctors are paid for virtually any service they provide, while patients have almost no direct financial responsibilities and, therefore, no incentive to control costs.
- Raising taxes or increasing beneficiary premiums will not be enough to support the current program's explosive growth in costs over the long term.
- Medicare's very structure pits the interests of its patients against the younger workers who are paying the bills. Medicare's payment structure is built on transfers from taxpayers to retirees, with future generations shouldering larger costs as health spending spirals upward year after year.

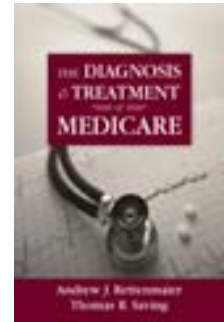
In *The Diagnosis and Treatment of Medicare*, Rettenmaier and Saving use an innovative model to assess the long-term impact of popular reform proposals on Medicare's future finances. Increasing the eligibility age to match the Social Security retirement age or means-testing benefits to

increase the share of the financing burden borne by the higher-income elderly would provide some fiscal relief but would not solve the long-term problem. Even extreme policies, such as eliminating first-dollar coverage, would not substantially lower the burden of the program's unfunded obligations in the long term. The authors conclude that stronger medicine is needed for Medicare.

### Real Reforms to Ensure Long-Term Medicare Solvency:

Rettenmaier and Saving propose a fundamental change in the way the program is financed: prepayment for retirement health care spending. Under this plan, members of each birth cohort (i.e., individuals born during the same time period or year) would pay an annual premium throughout their pre-retirement years to secure coverage during retirement. Instead of relying on younger taxpayers to pay for retiree health benefits, as we do now, the quantity of retirement health care consumed by each birth cohort would be directly tied to the contributions made by that group during their working years. Prepaying Medicare benefits would ultimately improve generational equity by making each age group responsible for financing the cost of its own care. Rettenmaier and Saving also support greater cost-sharing to increase cost-consciousness among consumers. That would create a health care market that is guided more by consumer choice, producing more economically efficient decisions about how much to spend on health care

-By Andrew J. Rettenmaier & Thomas R. Saving, AEI, '07



▪ *“Medicare’s financial burden is not simply the product of an aging population...”*

▪ *“...propose a fundamental change in the way the program is financed...”*

### Individual Highlights:

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# Massachusetts: Health Insurance connector board votes to require prescription drug coverage...



- *“The board in June will consider a less-expensive requirement for drug coverage that might include higher deductibles...”*

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*“...Massachusetts the first state in the US to establish standards for it's residents and insurers.”*

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The requirements, which are subject to final approval in June, would make Massachusetts the first state in the U.S. to establish standards for its residents and insurers. Under the state's health insurance law, all residents must obtain health care coverage or face tax penalties. The board on Tuesday agreed to phase in some of its requirements to allow residents and employers an additional 18 months to buy health plans that meet the new criteria. Residents will need to have some level of coverage by July 1 but will not have to meet the required level of coverage until January 2009 (Belluck, New York Times, 3/21).

The board also agreed to place a maximum deductible of \$2,000 on individual plans and a \$5,000 annual limit on out-of-pocket spending if beneficiaries use health care providers within an insurer's network. The minimum standards would require all plans to include prescription drug coverage and allow plans to charge beneficiaries an additional deductible for drugs of up to \$250 for individuals. The board in June will consider a less-expensive requirement for drug coverage that might include higher deductibles but that would require coverage of drugs for chronic conditions before the deductible applies.

The board hopes the higher-deductible drug plan will add no more than 5% to the premiums of health plans. In addition, board members agreed to allow insurance plans to continue placing caps on lifetime coverage.

## **Exemptions**

Jon Kingsdale, the connector's executive director, said the board would consider exempting penalties for individuals whose employers do not offer coverage that meets the new requirements.

The board already has agreed to continue accepting certain plans that do not meet the new standards, even after the January 2009 deadline.

Those plans include policies for young adults ages 19 to 25 whose employers do not provide insurance; federally sanctioned high-deductible plans with health savings accounts; Medicare; and plans provided by religious groups. The board next month will consider standards for providing waivers to individuals who cannot afford low-cost plans (December, Boston Globe [http://www.boston.com/news/local/articles/2007/03/21/basic\\_drug\\_coverage\\_okd\\_in\\_universal\\_health\\_plan/](http://www.boston.com/news/local/articles/2007/03/21/basic_drug_coverage_okd_in_universal_health_plan/) , 3/21).

Stuart Altman, a professor of health economics at Brandeis University said, the new requirements are "setting the definition of what is acceptable health care coverage, which is really unique in America" (New York Times, 3/21). Kingsdale said, "All the (minimum) requirements are significant steps in setting precedents for what other states are going to be looking at." Jon Hurst, president of the Retailers Association of Massachusetts and William Vernon of the National Federation of Independent Business in a statement said, "We remain concerned that the proposed standard will in the future eliminate affordable products currently available in today's marketplace".

For additional information, please visit the web at;

[http://www.news-medical.net/print\\_article.asp](http://www.news-medical.net/print_article.asp)

- Pharmaceutical News  
Published: Thursday, 22-  
Mar-2007

# WANTED: more information on healthcare...

More than one-quarter of Massachusetts adults said they or a family member had experienced a medical error while hospitalized, according to a survey being released today. Yet most of these same adults said they spent less than two hours doing research the last time they chose a doctor or hospital. The survey of 1,000 adults, conducted last month for Blue Cross and Blue Shield of Massachusetts, reveals good reason for this seeming dichotomy, said Andrew Dreyfus, the insurer's executive vice president for healthcare services. The type of information people want about their healthcare providers is generally unavailable. As a growing number of employers and elected officials push for greater transparency about the quality and cost of medical care, the Blue Cross survey (posted at <http://bluecrossma.com/healthcareexcellence>) provides a window into what consumers want. top of the problem. Massachusetts officials are counting on the release of cost and quality information to help reduce healthcare costs. The theory -- as yet unproven -- is that consumers provided with detailed information will choose high-quality, low-cost providers for non-emergency care, which in the long run will put pressure on high-cost providers to become more efficient.

mistakes to occur in the billing process are many. Massachusetts residents surveyed said they want information that is unavailable because it's difficult to collect or standardize comparisons between providers or has not yet been developed. Publicizing information has also met with objections from doctors and hospitals., which in some cases have has slowed the process. In choosing a doctor, people surveyed said the most important information is the doctor's experience treating a specific medical condition, the average amount of time the doctor spends with each patient, and patient satisfaction ratings. Most of the people who participated in the survey said they now choose a medical provider based on recommendations of other doctors, a friend, or a relative. In picking a hospital, consumers listed infection rates as most important. Massachusetts public health officials are working with hospital executives and doctors to develop standardized reporting for infection rates, which they expect to make public for individual hospitals later this year or next year. Consumers also want to know the results experienced by a hospital's patients, the accreditations the hospital has received, and the number of nurses per patient.



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*"...consumers provided with detailed information will choose high-quality."*

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Employee turnover, opportunities for

-The Boston Globe, 4-2007

## BCBS of MA wants to know...

Do you submit your Patient Medical Claims electronically? According to an "F.Y.I. Letter" recently published and issued to providers, it "is encouraged".

Use of Electronic Technologies is highly recommended (and soon to be mandated) for claim status, most eligibility, and benefit questions.

Over the past few years, Blue Cross Blue Shield of Massachusetts has invested significantly in the development of provider service technologies to serve providers BETTER and to help simplify your billing administrative efforts!

Check with your third-party billing resource to ensure that they have the most effective electronic processing tool. BCBS of MA has remained committed to providing providers with the most comprehensive service available 24 hours per day.

In order for BCBS to devote more time to helping providers with COMPLEX issues, you are encouraged to use provider technologies available to you to address routine, day-to-day problems or concerns. For more information on the technologies available, please visit <http://www.bluecrossma.com/provider>



# We are...

The **ONLY** medical billing company capable of:

- ✓ **Continuous expansion of services *beyond* electronic claims processing**
- ✓ **Implementing a strategy for continuous personal attention**

Through this approach, we provide a unique, total solution that's customized over time to fit your exact needs. And although medical billing is typically our initial solution, we consider it merely the beginning of the process.

## We proudly offer:

Electronic medical claims filing:

Option one: Billing and coding service

Option two: Open software for client use:

- Scheduler, Demographics, Encounter Maintenance, Reporting Tool

### Practice Management Consulting

- Phone/Data systems analysis, other bills, etc.
- Nortel and Cisco Certified

### Well-care Programs

### EMR (Electronic Medical Records)

### Patient Payment Plans

### Personal Health Records

- Via partner company, Direct Health Access, LLC (I.C.E.)

### Checks By Phone

### LIS (Lab Information Systems)

### Collection Services

### Special Projects / (Other)



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## Members of...



## INSIDE...

**BCBS: wants to know...**

**Diagnosis of Medicare...**

**...and much more!**



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