

NCDS *update*

A Billing Industry Newsletter for Clients

Keeping your office up-to-date on industry and insurance changes, late-breaking billing & reimbursement news, and general inter-office communication...

AETNA BUYS HUMANA FOR \$37 BILLION IN LARGEST-EVER INSURANCE MERGER

ANTHONY BRINO – HEALTHCAREFINANCENEWS.COM

Aetna will pay \$37 billion cash and stock to acquire Humana, the companies announced on July 3, in what will be the biggest health insurance merger to ever hit the industry.

"The acquisition of Humana aligns two great companies," said Aetna chairman and CEO Mark Bertolini. "The complementary combination brings together Humana's growing Medicare Advantage business with Aetna's diversified portfolio and commercial capabilities to create a company serving the most seniors in the Medicare Advantage program and the second-largest managed care company in the United States."

aetnaSM With Humana valued at \$37 billion, or \$230 per share, the deal is the fourth-largest consolidation in the American economy this year, ranking behind HJ Heinz's \$44 billion takeover of Kraft Foods and the pending \$79 billion Charter-Time Warner deal. The acquisition is the largest consolidation in the global insurance industry, exceeding Swiss property and casualty giant ACE's proposed \$28 billion takeover of the Chubb Group and the \$16.5 billion Anthem-WellPoint merger in 2004. Aetna said it will cover the costs through a combination of cash and stock, based on the company's closing stock price of \$125 on July 2.

The deal is part of an expected wave of consolidation in managed care and health insurance. Anthem may chase an acquisition of Cigna after its earlier \$50 billion bid was rejected. Meanwhile, Centene, a growing St. Louis-based Medicaid managed care company, is going ahead with a \$6.8 billion acquisition of Health Net. Aetna told investors that the deal should yield \$1.25 billion in 2018, along with higher operating earnings in 2017.

For health systems, the insurance industry consolidation brings cost containment and competitive pressures but it also creates opportunities for collaboration. A large part of Aetna's accountable care strategy has involved new health plan networks designed and co-branded with health systems like Banner Health and Catholic Health Initiatives. Aetna is also helping some hospital systems launch their own health plans for their workforce and for regional employees.

If the deal is approved as a whole by regulators, Humana will bring Aetna's membership to more than 33 million. Humana will add 3 million seniors on Medicare Advantage, as well as 4.3 million Medicare Part D drug plan customers, 1.1 million individual members (including some high-cost Affordable Care Act exchange populations in markets like Georgia), 1.8 million members in employer-sponsored plans, and more than 3 million military plan members.

The companies also said Humana will boost Aetna's pharmacy business. Humana owns or jointly owns 2,700 primary care providers, mostly in Florida, and employs 6,000 clinical management professionals. Humana has also contracted with thousands more primary care providers and started pilots with primary care startups like Iora Health.

"Through the use of technology and integrated services to simplify the consumer experience, the combined entity will be even more effective in meeting the health needs of many more people," said Bruce Broussard, the president and CEO of Humana. "The transaction is a testament to the accomplishments of Humana associates and an outstanding outcome for our shareholders, who will receive an immediate premium and the opportunity to participate in the growth potential of the combined organization."

To read this article in its entirety or for more information please visit: <http://www.healthcarefinancenews.com/news/aetna-buys-humana-largest-ever-insurance-merger>

NEW ICD-10 CLAIM SUBMISSION GUIDELINES FROM CMS

On July 6 Centers for Medicare and Medicaid Services (CMS) released more information to help physician coders and billing companies ready for the implementation of ICD-10. CMS, working jointly with the AMA, are optimistic the new recommendations provide flexibility in claims auditing and quality reporting as providers acclimate to utilizing ICD-10 codes. The new information released specifically states that during the first 12 months, claims will not deny due to lack of specificity as long as an appropriate ICD-10 code is submitted.



CMS has formulated responses to the most frequently asked questions (FAQ) regarding ICD-10. Please visit the following link for more information:

<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf>

ICD-10 is set to implement on October 1, 2015. Though the debate continues as to if providers can make the transition or if insurance companies are ready and ultimately, if ICD-10 will actually happen or be postponed again, NCDS is ready. Over the past two years NCDS has increased training for all of our Certified Professional Coders (CPCs), completed IT conversions and live testing with every major carrier ready to test claim submissions, and our ICD-10 Committee has undertaken the task of additional research and packet preparation for each of our valued clients.



Questions?: If you are concerned about your practice's readiness for ICD-10 please contact NCDS. Whether you need clarification or have practice specific questions regarding ICD-10 we are always happy to help. Contact us today to set up a meeting or to evaluate what changes should be implemented to bring your practice up to speed.

ANTHEM TO BUY CIGNA –AND THEN THERE WERE THREE: 7 KEY POINTS

AYLA ELLISON AND MOLLY GAMBLE – BECKER'S HOSPITAL REVIEW

Anthem announced that it has reached terms to buy Cigna. Earlier this month, Aetna inked a deal to acquire Humana. These two mergers involve four of the five largest payers in the nation and will greatly shift the healthcare landscape.



This consolidation at the very core of the healthcare industry may have a very negative impact on employer healthcare costs and the costs of insurance coverage. It greatly strengthens the hands of the payers vis a vis employers and vis a vis providers. It is likely to provide payers with greater leverage and market power with each audience.

Here are seven key points about the payer consolidation:

1. In the U.S., the big five payers have traditionally been Aetna, Blue Cross Blue Shield — which includes 36 companies, the largest being Anthem — Cigna, Humana and UnitedHealthcare. Whether looking at revenue, market share or presence in a specific area such as Medicare Advantage, each of these insurers is a major to dominant force in the industry.
2. With Aetna acquiring Humana and a deal in the works for Anthem to takeover Cigna, the landscape drastically changes, and there will be three key payers instead of five.
3. While not yet a single-payer system, consolidation is causing the system to look more like a small oligarchy. It may actually lead some parties who hated the idea of Medicare as a single payer to desire this. It may also over time lead to the proliferation of new payers.
4. The consolidation is quite frightening for smaller providers of all sorts as it leaves them with fewer access points for patients. The leverage of providers with payers will take a significant hit.
5. The consolidation is unlikely to reduce employer costs or really bend the cost curve as such payers will also mean less options for employers and more leverage with employers. A recent AON Hewitt survey noted that 46 percent of large and midsize employers expect a negative impact from health insurer consolidation and only 21 percent saw it as good thing for costs. As the number of insurers shrinks from five to three, those payers will likely have more leverage on both sides of the equation — with employers and providers. Employers who are large enough may resort to trying to work around the payers.
6. Anthem is reportedly offering more than \$48 billion for Cigna. Cigna rejected Anthem's offer of \$47.5 billion — \$184 a share — in June, calling it "inadequate and not in the best interests of Cigna's shareholders." Cigna shares closed Wednesday at \$151.13, a market value of about \$39 billion, although shares rose about 8 percent in after-hours trading following reports of the impending deal. In the other deal, Aetna agreed to buy Humana for \$34 billion, \$230.11 a share.
7. The CEOs of what would be the remaining big three — Mark Bertolini (Aetna), Joseph Swedish (Anthem) and Stephen Hemsley (UnitedHealth) — are highly regarded. Decisions about leadership can make or break a potential agreement. For instance, talks between Anthem and Cigna started last summer but broke down over issues about who would run the combined company, the *Wall Street Journal* reported.



For the complete article or more information please visit:
<http://www.beckershospitalreview.com/payer-issues/anthem-to-buy-cigna-and-then-there-were-3-7-key-points.html>

HOUSE GOP LOOKS AHEAD TO HUGE MEDICARE OVERHAUL IN 2016

DYLAN SCOTT – NATIONALJOURNAL.COM

For years, Republicans have openly pined for pushing Medicare further into the private sector. But they have been restrained by the practical realities of divided government and the political risks of a plan that Democrats have said would turn the popular insurance program into a voucher system.

Conservatives on Capitol Hill, however, have not surrendered the dream and now are planning to undertake the dirty work to make it a legislative reality. House Republicans will start working next year on drafting a Medicare "premium-support" bill, according to Ways and Means Health Subcommittee Chairman Kevin Brady.



It is the most ambitious item on the upcoming legislative agenda that the Texas Republican laid out in an interview with *National Journal*.

Brady said his panel wants to start the laborious work of creating actual legislative text, likely in preparation for 2017 under a new Congress and president at the earliest. This year's House budget endorsed the policy, as it has for several years under Republican control.

It would follow the first two of Brady's self-described steps to saving Medicare. The first was the "doc fix" deal reforming physician payments, passed this spring. He also hopes to advance in the fall a package of reforms that would, among other things, simplify Medicare hospital payments and introduce pay-for-performance to post-acute care.

For the complete article please visit:

<http://www.nationaljournal.com/health-care/house-gop-looks-ahead-to-huge-medicare-overhaul-in-2016-20150810>

KING V. BURWELL – FOLLOW UP

JESSICA MEYERS – NCDS MEDICAL BILLING

Last month's newsletter brought you the background on this important case challenging the legality of the Affordable Care Act and whether the Federal government could provide subsidies for the program due to the language used in the final written version of the law. Now that the Supreme Court has ruled in favor of Obamacare what does that mean for providers?



The greatest impact to national healthcare hinged on if the Supreme Court ruled in favor of the plaintiff. That ruling could have essentially crippled the Affordable Care Act and collapsed the law as a whole. Instead, the Supreme Court ruled in favor of the ACA. For providers this means business as usual, whether you choose to accept Obamacare plans at your practice or not. It is unlikely we will see another challenge to the ACA law, at least while President Obama is in office, but many argue we will see more arguments come to the forefront if a Republican candidate is elected in 2016.

August 28th marks NCDS' 30th Anniversary! We know it would not have been possible without all of our dedicated, loyal providers that work hard day in and day out to provide exceptional care for their patients. Thank you to all of our clients that have been with us through this journey. The best is yet to come!



MEDICARE AT 50 – ORIGINS AND EVOLUTION

DAVID BLUMENTHAL M.D. – NEW ENGLAND
JOURNAL OF MEDICINE



Many Americans have never known a world without Medicare. For 50 years, it has been a reliable guarantor of the health and welfare of older and disabled Americans by paying their medical bills, ensuring their access to needed health

care services, and protecting them from potentially crushing health expenses. However, as popular as Medicare has become, Congress created the program only after a long and deeply ideological struggle that still reverberates in continuing debates about its future. Nor was the Medicare program that was signed into law by President Lyndon B. Johnson on July 30, 1965, identical to the program we know today. Medicare was born out of frustration, desperate need, and political opportunity. The intellectual and political architects of the program did not set out to create a health care system for the elderly (defined here as persons 65 years of age or older). Starting in the early 1930s, during President Franklin D. Roosevelt's New Deal, they sought a much grander prize: the enactment of universal national health insurance for all Americans.

However, opposition from Republicans, conservative Democrats, and organized medicine frustrated those ambitions.

Even after Harry Truman became the first president to unreservedly advocate national health insurance in 1948, his proposal stalled on Capitol Hill. Supporters reluctantly concluded they would have to pursue more modest goals, so they targeted health insurance for elderly Americans.

Medicare was originally a program exclusively for persons who were 65 years of age or older. That changed in 1972, when Congress extended Medicare eligibility to persons under the age of 65 years who qualified for Social Security disability payments (with a 2-year waiting period) or who had end-stage renal disease. These additions covered two groups of persons who had difficulty finding private insurance and faced very high health care costs. In 2013, a total of 8.8 million of the 52.3 million Medicare beneficiaries were under the age of 65 years and disabled.

The gaps in the original benefits of Medicare generated efforts to enrich its benefit package. In 1988, President Ronald Reagan successfully sponsored the Medicare Catastrophic Coverage Act, which added prescription-drug coverage and limits on out-of-pocket expenses. In a dramatic reversal, Congress repealed the law in 1989 because of opposition to the increases in Medicare premiums required to finance these new benefits.

In 2003, President George W. Bush strongly advocated Medicare prescription-drug coverage, which passed Congress as part of the Medicare Modernization Act of 2003 (MMA). This new drug coverage (under a new Medicare Part D) reflected the preference of conservatives that private plans have a larger role in providing Medicare benefits. The MMA made a prescription-drug benefit available, on a voluntary basis, only from private plans, with a premium paid directly to the plan. In 2013, a total of 39.1 million Medicare beneficiaries were enrolled in a Medicare prescription-drug plan.¹³ Other beneficiaries have similar prescription-drug coverage from other sources, including Medicaid and retiree health plans, but an estimated 12% continue to lack such coverage.¹⁵

For the complete article please visit the following link:
<http://www.nejm.org/doi/full/10.1056/NEJMp1411701>

Medicare

CONFETTI USED FOR US WOMEN'S SOCCER VICTORY PARADE FOUND TO BE SHREDDED MEDICAL RECORDS

AKANKSHA JAYANTHI – BECKER'S HOSPITAL REVIEW

After clinching the World Cup championship with a 5 to 2 win over Japan, the U.S. Women's soccer team returned home with a lineup of celebrations across the country. At the victory parade in New York, confetti fell around the newly minted champions. This is an expected scene for any celebration, but less expected was that the confetti was made of shredded medical records, according to a WFMY2 report.



According to the report, the strips of confetti displayed protected health information, including prescriptions, patient names and addresses of physician offices.

However, this doesn't appear to be a unique incident, according to the report. In 2012, New York's CBS station reported confetti dropped for the New York Giants Super Bowl parade contained Social Security numbers and medical treatment histories.

<http://www.beckershospitalreview.com/healthcare-information-technology/confetti-used-for-us-women-s-soccer-victory-parade-found-to-be-shredded-medical-records.html>

ADVOCATES SAY MENTAL HEALTH 'PARITY' LAW IS NOT FULFILLING ITS PROMISE

AKANKSHA JAYANTHI – BECKER'S HOSPITAL REVIEW

When Michael Kamins opened the letter from his insurer, he was enraged. His 20-year old son recently had been hospitalized twice with bipolar disorder and rescued from the brink of suicide, he said. Now, the insurer said he had improved and it was no longer medically necessary for the young man to see his psychiatrist two times a week. The company would pay for two visits per month.

"There was steam coming out of my ears," Kamins recalled, his face reddening at the memory of that day in June 2012. "This is my kid's life!" His son again became suicidal and violent, causing him to be rehospitalized eight months later, said Kamins, a marketing professor at the State University of New York, Stony Brook. Kamins is suing the insurer, OptumHealth Behavioral Solutions, which disputes his version of events and denies that it left the young man without sufficient care.

Seven years after Congress passed a landmark law banning discrimination in the treatment of mentally ill people, many families and their advocates complain it stubbornly persists, largely because insurers are subverting the law in subtle ways and the government is not aggressively enforcing it.

The so-called parity law, which was intended to equalize coverage of mental and other medical conditions, has gone a long way toward eliminating obvious discrepancies in insurance coverage. Most insurers have dropped annual limits on covered therapy visits. Higher copayments and separate mental health deductibles have become less of a problem.

To read the article in its entirety please visit:
<http://khn.org/news/advocates-say-mental-health-parity-law-is-not-fulfilling-its-promise/>

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