MedBillsAssist

Health Insurance Newsletter

Volume 1, Issue June 2006

Informed Decisions

Choosing the right insurance policy is not a small task. Consider your personal situation, such as whether you are a family of six or a single person. Making an educated choice in picking the most beneficial coverage is critical.

Your past history is a good indication what type of coverage you will need.

Families are using more preventive services and immunization visits. Frequent appointments to the primary care physicians are costly. HMOs (Health Maintenance Organizations) generally allow lower co-pays while utilizing in-network providers. If you are concerned about having a limited network consider a POS (Point Of Service) type of coverage. This is an HMO product with an extension for out-of-network provider options.

PPOs (Preferred Provider Organizations) carry a higher per doctor visit co-pay and often add a percentage of charge liability, also referred to as co-insurance. However, PPOs have a much larger network of providers. Consider this a viable option if you are a more mature age and want to take advantage of a large network of providers. Families with a greater need for medical care may also consider this as a better suited option. Co-pays can be offset by an FSA (Flexible Spending Account). An FSA is a pre-determined amount of pre-tax income set aside for medical expenses. Choose the amount carefully because what you don't spend you lose at the end of the calendar year. In addition to co-pays, this money can be spent on any health related expense, such as band-aids, dental treatment and over-the-counter medications.

Take a walk with me in the world of insurance.

HSAs Are On The Rise

Health Savings Accounts are a new way of paying for healthcare. It is a special savings account attached to a Qualified High Deductible Health Plan for both taxpayers and employers to deposit money to pay for current and future medical expenses. Participants in the plan establish a tax-free special bank account. These accounts are designed with a unique tax code that is both income tax deductible on deposit and tax-free on withdrawal. If the available funds are not used, these will accumulate and can be used for future medical expenses. As with most medical plans this could be beneficial for some, but careful analysis of the financial implications is essential before choosing this type of coverage. This plan could be most advantageous for young individuals and couples who are healthy.

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Editor's note:

Welcome to the first issue of the Health Insurance Newsletter from MedBillsAssist.

Your comments and suggestions are welcome.

Understanding Medicare A, B, C and D

Medicare A is a federal insurance program created to provide medical insurance for those over the age of 65 and for the disabled. This is an entitlement earned by working and paying into the program for a minimum of ten years. Traditional Medicare only covers inpatient hospital stays. There is no monthly cost for those who earned Medicare A, but deductibles apply.

Outpatient hospital and physician services are provided under the **Medicare B** program which is available to eligible individuals for a monthly cost of $88.50 (rate varies by year).

Medicare C is a managed choice program offered to all Medicare eligible recipients. Each state has one or more insurance companies that offer HMO enrollment in place of traditional Medicare. This could be beneficial to those who are frequent users of preventive services. Keep in mind that all appropriate HMO rules apply.

The program created in 2006 is the confusing and complicated Medicare prescription benefits.

Medicare D is a prescription program which, for the first time, offers coverage for medications. There are 44 different products to choose from just in Connecticut alone. It could be a cost-saving opportunity for those who choose wisely and a waste of money for those who make an inappropriate choice. Those who missed the May 15, 2006 enrollment deadline will face a penalty. The penalty continues to accrue for each month you decline coverage. The next enrollment period starts in November, making coverage effective on January 1. For late enrollees penalties still apply.

The Often Confused Medicaid

Medicaid is a state assistance program for people with limited financial resources. There is no age limit to apply.

It provides much needed medical care options for low-income earners. Most full-time Wal-Mart employees are eligible for this program.

To qualify, one must meet Medicaid income and asset limits. Income limits vary, depending on the size of family and geography. If an individual is over the income limit, he or she may still qualify if they have high medical bills.

Most Wal-Mart employees are eligible for Medicaid.

The asset limit for an aged, blind or disabled person is $1,600. For families with children or persons under 21 years of age, the asset limit is slightly higher. There is no asset limit for pregnant women or infants whose incomes are less than 185% of the poverty level.

There are a special eligibility criteria for persons needing long-term care.

Senate Stops Junk Health Insurance Bill

Bill S.1955, sponsored by Senator Mike Enzi, was blocked by the Senate last month. This bill would allow the sale of junk health insurance. These “junk” policies use elaborate and confusing language to mask the fact that they cover few, if any, medical expenses. Seemingly insured patients would be left with hundreds to thousands in medical bills and no legal recourse for forcing insurers to pay them. The strong consumer insurance protections in states like Connecticut and New York would have been pre-empted by the proposed bill.

Many California residents have been victims of these junk policies.

The junk insurance policies offered in 10 states are low cost and appear to cover needed medical expenses. When it is time to collect during an illness, people discover that only partial payment will be issued because the policy limits hospital stays and pays only a small portion of most medical treatments.

45 million people in the US don’t have any medical insurance.

The Ills of Our Health Insurance System

United Health, the nation's second largest health insurer, announced a profit of 21 percent for the first quarter of 2006. In 2005, William W. McGuire, M.D., its CEO, earned $124 million.

In the past ten years there have been more than 400 mergers of managed care companies. Five large companies account for more than half the U.S. health insurance market.

The recent figures from the Centers for Medicare and Medicaid Services show that health insurance overhead costs (profit, advertising, and administration) are the fastest growing factors in health care spending. Medical insurance companies spend

20 percent on overhead. For the sake of comparison, public programs like Medicare spend just 2 percent.

Insurers could provide payment for services that are deemed medically necessary by doctors instead of creating a chain of paperwork for prior authorizations. These insurance requirements delay needed care and sometimes deny coverage. They create even more administrative costs and unnecessary headaches for both the provider and the patient.

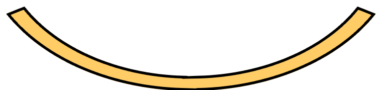
Most of us don't have a sudden urge to have a colonoscopy; we will only request the service if our doctor advises us to do so.

Are you thinking that here should be government-sponsored Universal Healthcare?

Consider the calamitous handling of the Medicare prescription benefits. Seniors who were used to the pay-as-you-go type of coverage were handed a maze of HMO rules while their choices were further complicated by prescription formularies. In my view, Universal Healthcare would look much like our tax code.

Please call 203-570-3904 for a

Free Consultation



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MedBillsAssist

Our mission is to represent our clients best interest and work on their behalf in an ethical manner in accordance with state and federal regulations.

While offering a wide range of solutions, we tailor our services to each client's specific need. Our services range from resolving claim problems from one specific illness to reviewing and tracking all health related solutions.

Your patient advocate to negotiate with both medical providers and insurance companies.

We are trained to provide Medicare-specific solutions.

We are licensed in both Connecticut and New York state.

In the next issue:

- How to choose your insurance
- Don't ask, don't tell coverage issues
- Getting ready for Medicare
- In the news
- Q and A