MedBillsAssist

Health Insurance Newsletter

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Q&K Consulting LLC

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is much more than a law that prevents us from having easy access to healthcare information for our children, spouses and parents. It was created to protect our privacy during the exchange of personal and medical information by medical institutions, doctors, insurance companies, and others.

Before HIPAA, it was up to medical providers and insurance companies' discretion to ensure that our information was kept private. Today, electronic networks make it easy to transfer data on thousands of patients to anyone, anywhere. HIPAA ensures the safety of that electronic interchange. Now, individuals must give access to their medical and personal information before it can be transmitted.

HIPAA also provides rights and protections for participants and beneficiaries in group health plans. The law includes protections for coverage under group plans that limit exclusions for preexisting conditions; prohibits discrimination against employees and dependents based on their health status; and allows individuals in some circumstances an opportunity to enroll in a new plan. HIPAA may also give people a right to purchase individual coverage if no group health plan is available and they have exhausted COBRA or other continuation coverage.

Among HIPAA's many features are new regulations on long term care and the standardized National Provider Identification (NPI). One group, however, does not benefit from HIPAA. Individual policies are excluded from the portability provisions. Thus, for example, sole proprietors are not protected for continuity and preexisting conditions.

Take a walk with me in the world of insurance.

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Editor's note:

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

Your comments and suggestions are welcome.

Using HSA Policies

HSAs have a simple principle: When the insured is sick while covered by an HSA/QHDHP, the insured will pay for services rendered from the health savings account. If the insured receives preventive services, the insurance company pays. In-network providers are paid a pre-negotiated rate.

Complications arise when the HSA account is depleted but the policy deductible is not met. The maximum family contribution to the plan is $5,650. However, the maximum out-of-pocket deductible is $11,000. If a member's expenses fall between these two amounts, he or she must pay out-of-pocket for the services. Once the full deductible is met, the insurance company will pay for all future services.

The HSA account is funded by the policyholder but employers may elect to contribute. The deductible and policy maximum are part of the policy design.

Medicare Prescription Benefits

It proved challenging, but last year, a majority of Medicare beneficiaries still managed to choose policies that provided savings. This year will be different. Policies are becoming costlier, while coverage levels are decreasing.

Staying with the same policy is probably not a good option, especially for those who carefully researched their alternatives last year. This year, the number of choices has increased to 51 plans in Connecticut. The most affordable plan now costs $13.40 per month and the annual deductible has risen to $265. The total cost for the least expensive plan will therefore be $160.80 before a member ever fills a prescription. However, one of these policies would still be a reasonable option for those who have minimal or no immediate need. For all purposes, the insurance policy provides protection for drug expenses, while allowing a member to avoid late enrollment penalties.

It is difficult to determine the correct plan for individuals with several prescription medications. The cost and type of drugs should be the deciding factors. More expensive policies have a greater level of coverage, and if carefully chosen, can cover the well-known gap in coverage for prescription drugs. There are 15 plans available that cover this “doughnut hole,” but their extensive coverage is limited to generics drugs only.

Before making a final decision, a prospective member should call the Prescription Drug Plan to evaluate customer service responses and to ask specific questions regarding benefit levels, formulary options, mail order options, quantity limits and pre-authorization limits.

Appeals

Patients are usually shocked whenever a payment for medical services is denied. When this happens, the best course of action is to find out what was denied and why. Start by contacting the insurance company, to understand the reason for the denial.

There are three types of denials: administrative, technical and medical.

Administrative denials are coverage issues. For example, there may be an error in the insurance company's database, or the doctor may have billed the wrong insurance company.

Once you commit to an appeal, be sure to follow up and be prepared to go to the second and third levels.

Technical denials are the most frequent. These include authorization errors, coding errors, misquoted benefits, etc.

Medical denials are the least common. They are often caused by diagnostic errors or unfamiliarity with new technology.

Most do-it-yourself appeals fail because they do not address the denial, but instead argue medical necessity.

Is it Legal?

Is it logical to buy a car that will only allow four short trips? In the same vein, is it logical to buy an insurance policy that only pays for four medical treatments?

Strategic Resources Company, an Aetna subsidiary, sells medical insurance that only covers a maximum of $1,000 annually. That will buy approximately four visits to a doctor’s office, or one day’s stay in a hospital. Lab work and Tylenol will push the plan over the limit. The sale of these policies was approved by the Connecticut State Insurance Commissioner, but is being challenged in court. Although Connecticut has mandated benefit requirements, these plans render them meaningless. They appear to incorporate the benefits required by statute, but such benefits are effectively unavailable as a result of the annual maximums. Aetna spokeswoman Jon Sandberg says, "Aetna has dedicated time and effort to develop products like this. It is a focus of ours to provide insurance to the uninsured, and this is clearly an option." Aetna described the lawsuit as "a political maneuver" that misses the point and misleads the public.

Strategic Resources Co., an Aetna subsidiary, sells medical insurance that only covers $1,000 annually.

You decide: who is misleading whom?

Q & A

Q: Which is the best insurance?

A: So many people have asked me this question that I would like to devote some time to explain in detail. My answer is that the best insurance coverage is whatever works best for the individual or family in question. It can be a Cigna HMO, a Blue Cross PPO or anything in between. The most important thing about a medical insurance policy is the understanding of its terms, limitations and restrictions. Reading the policy handbook will provide most of this information. Confirming with the insurance company's customer service people before signing up for expensive services provides an additional level of

understanding and prevents any unwanted surprises.

Answering questions about how much insurance you are comfortable with will help you decide which is the best insurance for you. For instance, a young family may want to choose an HMO where the cost is low and the co-pays are affordable, and the family commits to using in-network providers exclusively. A more expensive PPO policy is a good choice for a professional who travels often and may need to utilize services outside of the home state. POS policies are chosen by those who want an out-of-network option and are willing to take on more out-of-pocket expenses and administrative responsibilities while using out-of-network coverage. An HSA is a great choice for someone who does not get sick often and is interested in saving money on the cost of coverage as well as putting money aside for future medical expenses.

The name of the company isn't important; it is the coverage provided that makes it the best.

In the next issue:

- Policy
- Coverage issues
- Medicare
- In the news
- Q and A