MedBillsAssist
Health Insurance Newsletter
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O&K Consulting LLC

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides temporary continuation of health insurance coverage at group insurance rates for employees and their families following terminations of employment and/or qualifying events for family members. The act was signed in 1986 and applies to companies with 20 or more employees.

The individual or family must elect COBRA coverage within 60 days and make the first payment within another 45 days. A COBRA plan premium is usually higher than an active employee's cost because the employer is no longer subsidizing the premium. The length of coverage is 18 months, but additional qualifying events can extend this period up to a maximum of 36 months. If a qualifying event occurs, the employer must notify the beneficiary about the policy changes in writing within 14 days.

A common qualifying event is a college student reaching age 24. Coverage through a parent's employer is usually terminated and the adult child becomes eligible for COBRA. Once coverage is elected and payment is made, the plan will continue to provide protection seamlessly.

While COBRA is a good option for those with chronic medical problems, healthy people can choose more cost-effective solutions. Most colleges offer enrollment in their medical insurance plans at group prices. Low-cost single coverage can be obtained from an agent or directly from the insurance company. A third option is a temporary policy for those between jobs or about to start a new position.

A health insurance agent can help you select the best option.

Take a walk with me in the world of insurance.

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Editor's note:

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

Your comments and suggestions are welcome.

Flexible Spending Account (FSA)

An FSA is a way to supplement any gaps in your insurance coverage while trimming your taxable income. It can be used for co-pays, deductibles, over-the-counter medications, child care, dental services, vision services, etc.

FSAs are pre-funded. The entire elected amount is available on January 1st, and can be used immediately to pay for charges not covered by medical insurance, such as dental work.

It is important to be as accurate as possible in estimating the amount you will spend on uncovered medical costs during a year. Unlike an HSA (Health Savings Account), any leftover FSA money will stay in the employer's bank account if not claimed within the year.

With this tax break comes the responsibility of filing claims, keeping track of co-payments and justifying your expenses. Be sure to keep track of all eligible expenses and file within the time limit the IRS sets each year.

Medicare Therapy Limits

Good news!

Medicare has relaxed the physical, occupational and speech-language therapy limitation rules for 2007. The Medicare and You booklet contains a short paragraph at the end of page 103 that says, "In 2007, there may be limits on physical therapy, occupational therapy, and speech-language pathology services. If so, there may be exceptions to these limits."

But let's not celebrate just yet.

In order to qualify, a person has to meet Medicare's criteria for medical necessity. Reduced pain and increased range of motion following physical therapy don't always mean the treatment was medically necessary. If your treatment doesn't qualify for the therapy limit exception, you will receive a bill from the provider for full payment of services rendered.

As always with Medicare, there are complex rules the therapist must follow. A number of questions have to be answered. Is the provider participating in Medicare? A "yes" answer leads to another question: Is the provider a hospital or nursing home? If yes, the rule doesn't apply. If no, start counting the physical therapy dollars. Medicare's limit for allowable charges is $1,780. When a person is close to the limit, the provider will ask for a signed ABN (Advanced Beneficiary Notice) letter. Signing this letter makes the beneficiary responsible for any amount that isn't paid by Medicare.

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Money Matters

Aetna released the results of a four-year study of CDHPs (Consumer Directed Health Plans). The study found that CDHPs consistently result in lower medical costs while maintaining or improving levels of chronic and preventive care. Compared to PPO plans, use of generic drugs rose 4.5 percent. Doctor visits for preventive care also increased.

Overall, HSA members saved money, and 52 percent rolled their entire funds over in 2005. Employers also enjoyed cost savings when purchasing these plans.

However, one cannot draw general conclusions from these figures, because out of 15.544 million Aetna members, just 152,000 were insured by a CDHP. Further, Aetna did not provide information on the financial liabilities of the 48 percent who did not roll their funds over.

In contrast, the National Coalition on Health Care reports that total health spending rose 7.9 percent in 2004, over three times the rate of inflation.

Since 2000, employment-based health insurance premiums have risen 87 percent, compared to cumulative inflation growth of 18 percent and cumulative wage increase of 20 percent.

Is it Legal?

Attorney General Richard Blumenthal has requested the Connecticut Insurance Department for a highly focused audit of Assurant Health's procedures, following numerous complaints of unfairly denied claims. The department will soon issue its findings, after which Connecticut may take legal action against Assurant for improper or potentially illegal denials of health benefits.

The company has also come up on legal charges in South Carolina and Oregon. A South Carolina court approved $15 million in punitive damages because Assurant's Fortis subsidiary refused to pay for the care of a policyholder with HIV. According to court documents, Fortis's computer system was programmed to recognize and deny billing codes for expensive medical conditions. This triggered an investigation for fraud.

Oregon fined Assurant Health $70,000 for violating the state's consumer protection laws. The state listed 6,452 violations, from improperly applied deductibles to denials based on past medical history.

The Connecticut Insurance Department will issue findings on its investigation following complaints of unfairly denied claims by Assurant Health.

Connecticut is reviewing claims from 2000 through 2005, and is focusing on claim denials for pre-existing conditions.

Q & A

Q: What happens when someone has two (primary and secondary) insurance policies?

A: In ideal circumstances, all the bills are paid in full. In practice, however, complications can arise.

Bills will be paid if the provider is in-network for both insurance companies. Bills may not be paid, or may be only partially paid, if the provider is out-of-network. If the doctor is out-of-network for both insurance companies, and those companies are HMOs, the insured may end up paying the entire bill.

Q: How much does an MRI cost?

A: It depends on the part of the body being imaged, the type of service provided, and the geographic region. An MRI has a two-part charge: facility and reading (in other words, hospital and doctor).

An MRI of the pelvis only, without the use of contrast material, costs about $1,680 in a Manhattan hospital. The charge for the doctor's reading is an additional $420.

The same MRI of the pelvis using contrast material costs about $2,420, plus $485 for the reading by the doctor.

Finally, the same MRI performed without contrast material in the first stage and with contrast material in the second stage, costs $2,322 plus a doctor reading charge of $580.

MedBillsAssist

Our mission is to represent our clients' best interests and work on their behalf in an ethical manner, in compliance with state and federal regulations.

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