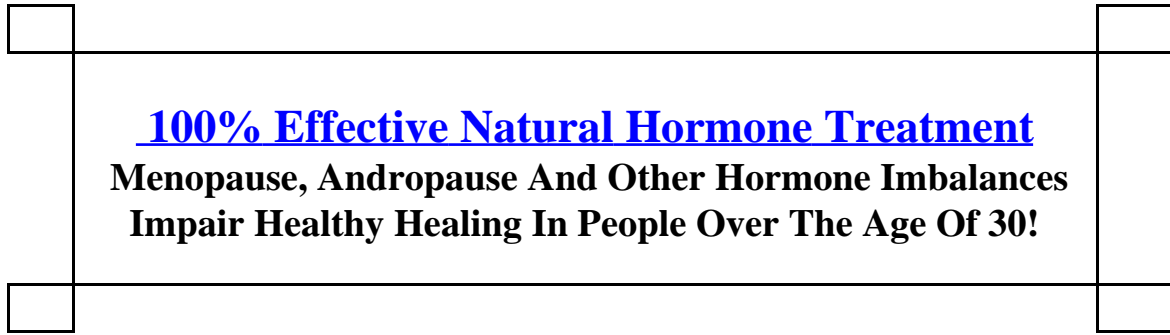


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Health Insurance: The-More-The-Better, Or No-More-HMO?

By Irina

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In the movie "John Q," Academy award winner Denzel Washington fights the HMO restrictions to provide the necessary cure for his dying son. When such a lackluster topic like health insurance generates enough drama for a Hollywood movie, you know that something must be seriously wrong...

The problem indeed is severe. Almost 45 million Americans are uninsured and the number continues to rise. Those

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still insured are frustrated by the double–digit premium increases outpacing all other sectors of the economy. High costs and HMO limitations discourage seeking an immediate medical help. As a result, "little aches" often develop into the life–threatening illnesses and financial disasters for some unfortunate individuals and further escalate already intolerably high health care costs for the rest of us.

To endure the existing health care crisis, we all must recognize one simple fact. There are **TWO DIFFERENT LEVELS** of health care needs that must be covered with two

separate tiers of payment. One level is catastrophic illness – and for that, insurance may still be the answer. Policies that carry a high deductible (say \$5,000 a year) are relatively inexpensive, even when the coverage is very high (\$1 million or more) or unlimited. That is because most people do not get catastrophic illnesses or injuries.

In fact, most of us only need health maintenance and routine medical procedures that comprise a totally different level of health care needs. For these, the present **INSURANCE**–based model is not the answer because it is financially incompatible with any efficient **HEALTH CARE** system.

Everyone knows that the **INSURANCE** works best when the fewest number of participants actually use it (i.e. make claims). Then the system generates profit, which lowers the premium that, in turn, brings more paying participants. The participants are happy **NOT TO USE** the insurance, especially if it does not cost them too much. On the contrary, the **HEALTH CARE** system works best when the most people use it (i.e. get teeth cleaning, checkups and vaccinations).

Fortunately, back in the 1980s, the idea of so–called patient advocacy via health care savings programs was introduced to the U.S. These programs negotiate prices with health care providers on behalf of their members. Since they represent large groups, the resulting discounts are usually the same that the hospitals and physicians give to big insurance companies.

This innovative approach benefits medical providers because they get paid "on the spot" without enormous paperwork and disputes with insurance companies. It also benefits you and me by providing an access to the discounted "insurance rates" without high premiums.

Many of such programs also allow their members to contribute money to medical savings accounts that are tax deductible or not taxable. Monthly membership fee is affordable and no one can be turned down because of a pre-existing condition.

It does not look like the current health care crisis is going to have a Hollywood–style "happy ending". It's up to us to analyze the situation and find the solution... otherwise, the next blockbuster about healthcare may well be a horror movie.

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About the Author:

Irina helps people save money on healthcare and create steady stream of residual income working from home
<http://www.megaone.com/hbb/savemoney/>

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Health Insurance Hmo Ppo Plan -- What's The Difference?

By Elizabeth Newberry

Health Maintenance Organizations, also known as HMOs, and Preferred Provider Organizations, also known as PPOs, are just two types of health insurance plans that belong to a larger spectrum of health insurance plans called Managed Care Insurance.

The characteristic that all health insurance plans categorized as managed care insurance have in common is that they provide policy holders with a list of doctors and other health care providers that they would prefer the policy holders to visit when in need of medical attention. The doctors and other health care providers are contracted to work with the health care plan's network, which means the policy holder will be able to pay less money to visit them than he or she would pay to visit a doctor not on the list, or "out-of-network."

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So, what's the difference between HMOs and PPOs?

Health Maintenance Organizations, or HMOs, require their policy holders to pay a monthly insurance bill in order to see a doctor or health care provider, regardless of whether or not the policy holder actually seeks medical attention during that month. This may not sound like a very good deal, but HMOs do tend to provide a vast array of medical services for their policy holders under the HMO health insurance plan.

Preferred Provider Organizations, or PPOs, include a network of doctors and other health care providers that cover only a specific group of policy holders, such as the employees of a company. Policy holders pay a co–payment at the time of service, and the rest of the bill is either sent to the insurance company, or paid by the policy holder who is then reimbursed by the insurance company.

Being a policy holder of an HMO or PPO doesn't always mean you have to see a doctor or other health care provider included in the network. Sometimes HMOs and PPOs allow you to seek out–of–network medical attention at an increased price.



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