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I. Medical Plans

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A. Medical Plan Concepts

1) Fee-for-service means the doctor receives payment when he or she performs a service such as an office visit. You are billed according to the serves rendered. There are health plans known as fee for service or indemnity plans. The original major medical plan was and still is a fee for service plan and can be called by that name.

2) Capitation Fee-Doctors are paid a set fee per patient per unit of time, paid in advance of the visit.

3) Prepaid – HMO's have a pre-paid concept where the doctor is paid a fixed monthly regardless of whether or not the services were used.

4) Specified coverage – only covers what is named. e.g. dental care or vision care. A Cancer policy only pays on the diagnosis of cancer. This coverage pays in addition to another policy, it does not coordinate benefits. It is designed to cover the copay or coinsurance owed after the insureds major medical policy pays. It is paid directly to the insured.

5) First Dollar Coverage – the insurance company pays first, there is no deductible or out of pocket for the insured. Wellness checks or flu shots would be an example of this today. Basic medical was a first dollar coverage plan.

6) Comprehensive Coverage – plans are plans that cover a wide range of health services. Not limited plans such as an AD&D policy or a Cancer plan. Since the ACA was implemented there are 10 essential health benefits with no annual or lifetime cap.

7) Dependent coverage – spouse, children, perhaps a dependent parent covered under an insureds medical coverage.

B. Provisions and Clauses

1) Deductible…

A provision in an insurance policy that requires the insured to pay the first specified dollars of expense which will not be reimbursed by the insurer. Expenses above the deductible then will be paid by the insurer as indicated in the policy.

- ***The purpose of the deductible for the insurer is to eliminate coverage for small losses*** and minimize the abuse of insurance. The purpose of the deductible for the consumer is to lower premiums.
- **Per Injury or Sickness (Per Cause) vs. Cumulative Deductible (All Cause)…** Under the per sickness or ***per cause***, a new deductible is charged for each sickness or injury.
- Under the cumulative or ***all cause***, a deductible is charged for that benefit period. The ***Benefit Period*** usually begins and ends each calendar year (January 1st - December 31st). The insured pays all medical expenses until the deductible has been met. After that has happened, the insurer pays their percentage of the co-insurance until the insured has paid out to the stop loss limit.

    - The **Common Accident/Sickness** provision provides that only one deductible has to be met if two or more family members are injured in the same accident or have the same illness.
    - The **Family Maximum** provision waives any further deductibles once any two or three of the family members have reached their deductibles in the same year. For example, a policy may read " *A $5,500 deductible per person or $11,000 per family*." This total may be reached through any combination of deductibles paid by all family members,

2) Stop Loss… a.k.a. Out of Pocket Maximum A provision found in Major Medical policies which states that once the total costs of eligible health care expenses received exceeds a specific amount, such as $5,000, the insurance company will pay 100% of the eligible expenses above that amount. This covers only costs that are approved and 'in network'. Premium is still due.

3) Impairment Rider-Due to the Affordable Health Care Act, the application for a medical policy is no longer allowed to ask any medical questions. Any other type of coverage (disability income, medigap, etc) will still have a questionnaire to ferret out any pre-existing conditions. A pre-existing condition is something you had, were treated for or advised to have treatment for. This rider limits or eliminates coverage for that condition for a period of time or completely.

C. Types of medical plans

Medical Expense Insurance provides benefits for medical care. The ACA has required all plans sold in the Marketplace offer at least 10 essential health benefits. They are outpatient care, emergency services, hospitalization, maternity, mental health and substance abuse treatment, Rx, rehabilitative, laboratory services, preventative and wellness services, and pediatric which includes dental and vision required up through age 18.

The preventative and wellness services are at no expense to the consumer, all other services are paid by the carrier according to the type of plan, after the consumer pays the deductible, copay and/ or coinsurance.

Traditional Medical Expense contracts may provide for payment of medical expenses incurred on a/an:

- ***Reimbursement basis*** *; paying benefits to the insured, such as a Major Medical Plan. After you pay the doctor; and send in notification of claim; and the carrier sends you a claim form, and you fill it out and file proof of loss, and get reimbursed by the carrier. You could use the right of assignment (you sign your name) and let the doctor bill the insurer directly and bill you for your portion after.*

- ***Indemnity basis*** *paying a set amount* [a.k.a. Stated Value] ***regardless*** *of the actual charge for the medical expenses, e.g. Hospital indemnity plan. You are indemnified to what the contract states.*

1) Basic Medical Expense Insurance provides protection against the financial losses incurred for hospital, medical and surgical expenses. These three basic coverages may be sold separately or together and usually pay on an ***indemnity*** basis. Features include ***low limits and no deductibles*** (first dollar coverage), so they were inexpensive. Basic medical plans may be difficult to find today. Insurance companies can no longer have annual or lifetime limits on their plans for the essential services as listed by the ACA.

a) Basic Hospital (Indemnity) Expense Policy will cover:

1) Room and Board pays on a dollar amount basis, that is, a pre-established amount (stated value) per day for a maximum number of days, ***regardless of the amount of actual hospital expenses***. For example, if an insured has a $200 a day room and board limit and spends 10 days in the hospital, the policy would pay $2,000 total, regardless of actual charges.

2) Intensive Care pays a multiple of the semi-private room rate of the hospital. The number of days of coverage also is limited to a stated number of days.

3) Miscellaneous Charges, a.k.a. *Ancillary Coverage*, covers such expenses as convalescent care, nurses, medical expenses, charges to cover non-surgical hospital expenses, X-rays, lab fees and miscellaneous supplies.

b) Basic Surgical Expense Policy

coverage provides benefits for the surgical services of a physician performed in or out the hospital. Basic **Surgical Expense Benefits** may be listed in one of two different ways:

1) Absolute Value gives a stated amount in the contract. For example, spleen surgery $5,000 or gall bladder surgery $3,500.

2) Relative (Unit) Value uses a ***unit value*** which is assigned to each procedure when it is not listed as an *absolute value*. These unit values are multiplied times the conversion factor to establish the benefit amount to be paid for a surgical procedure.

The **Unit Value** is used to reflect regional differences in medical costs.

For example, spleen surgery = 300 units or gall bladder surgery = 175 units. The unit value is multiplied by a dollar amount paid for each unit. The dollar amount can differ depending on the location of where the services are used.

c) Basic Medical Expense Policy… This basic policy covers charges for ***non-surgical services*** provided by a physician. Some policies cover visits by a physician while in a hospital, and others limit the benefits per visit and/or the number of visits. Other medical expenses which may be covered with this policy include maternity benefits, home or outpatient care.

2) Major Medical Insurance… The **purpose** of major medical insurance is to provide complete coverage for all your covered medical needs. ***Major medical has a deductible, co-insurance and stop loss provisions.*** These plans offer coverage on a reimbursement basis. *Remember the claim provisions?* Rather than paying the doctor, filling out a claim form, sending it to the carrier and waiting for reimbursement, an insured can choose to assign those claim provisions to the doctor and the carrier pays the doctor directly. The insured is then billed for the difference. This is especially important to use with PPO plans where there is a negotiated rate. Major medical plans can also be called an indemnity plan or a fee for service plan. There is no Primary Care Doctor required, there are no referral requirements, this is not managed care by a physician or carrier.

Many of these plans offer a higher deductible than traditionally was offered. If that is the case, they are known as High Deductible Health Plans and are eligible for an HSA or Health Savings Account. Originally the high deductible meant a lower premium. If you did not need to use the plan very often you could open up a tax-free account to invest the difference between a high premium low deductible plan and a high deductible lower premium plan. The premium savings would go in to this savings account to pay the high deductible when needed. There are tax benefits to the HSA as well. (more on that in the taxes section of this book)

Major Medical Coverage extends to Hospital, Medical and Surgical expenses incurred by the insured, however, there may be ***internal limits*** within the policy, i.e., ambulance service, speech therapy, or x-rays.

Coinsurance… A provision found in Major Medical policies whereby the insurance company and the policy owner share covered losses in agreed proportions. The insured pays for a percentage of the expenses in excess of the deductible. ***The purpose of the coinsurance feature is to prevent over use of the contract benefits by making the claimant pay part of the claim.*** The insurance company is responsible for the higher of the two percentages.

Federal Law categorizes the co-insurance by values of metals, like the Olympics. The plans vary in premium, co-insurance amounts, and internal limits. (A bronze plan may limit all radiology to no more than $300 paid by the company for a full year.)

The metallic plans and their co insurance limits are as follows

Platinum	90/10
Gold	80/20
Silver	70/30
Bronze	60/40

Usual, Customary and Reasonable (aka UCR) benefits depend on what is considered usual and customary in a certain geographical area. When l benefits are not listed by a specific dollar amount in a schedule, a policy will pay on the basis of what is considered usual, customary and reasonable.

Common Exclusions for Basic and Major Medical Plans

- ∅ Self-inflicted injuries
- ∅ Injuries or illness from acts of war, or while on active military duty
- ∅ Dental and vision care –pediatric dental is covered
- ∅ Benefits payable under workers' compensation
- ∅ Injury while committing a crime
- ∅ ***Injury or illness while under the influence of intoxicants or narcotics***
- ∅ Cosmetic surgery
- ∅ **Custodial care** (help with the Activities of Daily Living)

When there is a bill, the first dollar amount applies to the deductible. **After** the deductible has been met, i.e. paid by the insured, the co-insurance applies and the insurance company pays their portion until the insured reaches the stop loss amount. At that time, the insurer pays all incoming approved bills.

If you have a math question, the process is as follows:

A policy has a $5000 deductible and 80/20 co insurance.
A doctors' visit results in charges for the month of $8000

Subtract the deductible	$8000-5000 =$3000
Multiply the balance by the co-insurance %	$3000*20% = $600
Add the 2 numbers ($5000+$600)	A total of ……..$5600 was paid by the insured

The difference (8000-3600) of $2400 was paid by the insurer

Things to be aware of are:
is the question how much did the insured pay?
How much did the insurer pay?
Did you reach the stop loss limit?

3) Health Maintenance Organizations (HMOs) provide for **comprehensive health care** in return for a pre-negotiated sum (a.k.a. **pre-paid premium**) or periodic payment. An HMO is a corporation that is financed by premiums and has physicians on staff (salaried) who focus on preventative care while still providing curative care to those who are subscribers. An HMO has their own **network** of doctors, hospitals and other healthcare providers who have agreed to accept payment at a certain level, a negotiated rate, for any services they provide. This allows the **HMO** to keep costs in check for its members. As a result, the premiums may be lower than another plan. The drawback is it can be very restrictive to the consumer.

Key characteristics of the HMO include:

- **The HMO Pays 100%** of expenses minus any co-payments for covered care
- A co-payment is the dollar amount which an insured must pay each time he goes to visit a doctor (usually around $20).
- Some HMO's have a deductible
- **Pays $0** if you see a doctor 'out of network' or without a referral from your Primary Care Doctor
- An HMO has a **gatekeeper system** in which a member must select a **Primary Care Doctor** (a.k.a. Provider) who oversees the insured's care and must approve any treatment by other providers before it is given (a.k.a. ***Managed Health Care***).
- You must get a referral from your primary care physician in order for the visit to the specialist to be covered.
- You also must utilize only the specialists contracted through the HMO in order for the HMO to pay.
- HMO's operate within a specified geographical area known as the ***service area***.
- **HMOs are required to provide basic benefits**: physician services, diagnostic lab services, out-of-area coverage, preventive care, emergency care, hospital in-patient care and out-patient care.

4) Preferred Provider Organizations (PPOs) are groups of health care providers who agree to provide services for less money than they might charge otherwise. This is similar to an HMO with the negotiated rate. It is also very similar to a major medical plan, except there is a network you should stay within. Out of network care is covered but at a higher out of pocket expense to the insured. A primary care doctor is not required nor are referrals.

- ***A PPO is a form of managed care but pays on a fee-for-service or reimbursement basis***. PPOs are usually combined with a major medical plan.
- ***If the insured does not use the prescribed doctors or hospitals, the insured will be required to pay a larger portion of the approved medical bills.*** For example, instead of 80-20 co-insurance, the insurer may pay on a 50-50 basis, or may double the deductible.
- **PPOs** were developed as a compromise between the benefits of the HMO and the traditional reimbursement plan offered by commercial insurers. Commercial insurers implemented PPOs as an answer to some of the perceived negative aspects of HMOs, such as a limited choice of physicians.

5) Point of Service (POS) Plans are a form of managed health care that look like an **HMO and PPO combination**. Like an HMO, an insured must choose a primary care physician. ***This designated physician is the referral source for all other medical professionals,*** i.e. referrals. The covered person selects a ***primary care physician*** from the list of practitioners that are acceptable to the plan administrators. 'In Network' care is paid for at the plans higher rates, perhaps a co-pay is all the insured is required to pay.

'Out of Network 'care is covered, but the insured will have more out of pocket expenses, a deductible and co-insurance instead of a copay.

The problem with this approach is that of HMO's, if you are in a small geographic area, the choice of primary physicians may be very restricted or nonexistent. Comparable to a PPO, ***if an insured doesn't like that physician, he or she can choose to go to a doctor outside of the POS plan, but would need to pay a deductible and coinsurance percentage.*** *The POS plan will still make a payment 'out of network'. Note: if going out of network on an HMO $0 is paid by the insurance company.*

Comparison Chart between the plans

	Major Medical	HMO	PPO	POS
Managed Care	no	yes	yes	yes
Primary Care Doctor	no	yes	no	yes
Must use listed doctors or clinics	no	yes	no, but carrier will pay more if use listed	no, but carrier will pay more if use listed
Deductible	yes	no	yes	out of network
Co-insurance or co pay	co ins	co pay	co ins	in network, co pay, out of network = deductible and co-ins
Insurer will pay for care anywhere	yes	no	Yes, but will pay more if you use an in network provider	Yes, but will pay more if you use an in network provider
referral needed for payment by insurer	no	yes	no, but will pay more if a referral is given	no, but will pay more if a referral is given
Insurer will pay without a referral	yes	no	yes, but there may be a larger deductible and co insurance	in network, co pay, out of network = deductible and co-ins

D. Cost Containment in Health Care Delivery

1) Managed Care imposes controls on the use of health care services and the providers of health care services, usually through health maintenance organizations or preferred provider arrangements.

Controls are the use of a visit to the Primary Care Physician's for a referral. The PCP may decide IF you need to see a specialist and WHICH specialist you should see. This can keep the overall costs down since a specialist is generally more expensive and may not need to be seen.

2) Preventative Care focuses on keeping people healthy through regular care. Numerous screenings are available at differing ages at no cost to the patient due to the Affordable Health Care Act. There is a list of required care, available without co-insurance or a copay or applying towards a deductible. There is NO COST to the consumer. Preventive care includes health services such as screenings, wellness check-ups, and patient counseling that are used to prevent illnesses, disease, and other health problems. It is also used to detect illness at a potentially early stage when treatment is likely to work best. Getting recommended preventive services and making healthy lifestyle choices are key steps to good health and well-being.

3) Outpatient Benefits is treating people on an outpatient basis rather than admit them to the hospital for an overnight stay reduces costs for both the insured and the insurer. Not being admitted to a hospital for a day surgery or using a surgical center instead of a hospital are examples of outpatient care. This is also known as ambulatory care. Other examples include getting your flu shot at the pharmacy.

4) Utilization Management for an individual, is the process of a caseworker (an RN with UM training) coordinating care for an insured, evaluating and advising treatment on a case by case basis. This could include new clinical activities, inpatient admissions, discharge planning, etc. Utilization management for insurers is a cost containment tool for both the carrier and the insured.

There are 3 types involved: A **Prospective** Review is to review the service before authorizing it to be paid. *E.g., is an MRI needed? Was an x-ray taken and physical therapy done?* **Concurren**t reviews will assess the situation right now, is everything being done that is necessary, coordinate care for today (Meds, Physical Therapy, etc.), discharge planning if this is a hospital stay. Finally, there may be a **Retrospective** review to assess the appropriateness of the care given, verify the billing codes are the correct ones used. The ultimate goal is to reduce excess spending while at the same time managing and improving care and effectiveness.

5) Pre-certification (usually for the patient) and pre-authorization (usually for the procedure performed by the doctor or hospital): This process allows an insurance company to review and approve treatment for the insured, and to review and approve the expected hospital and surgical costs before the patient enters the hospital. Simply put, it is a cost cutting method on the part of the carrier when they deem a service is not necessary or that the client has not done all they could do prior. For example, if someone has a sore shoulder, operating immediately may not be the best solution. Medication and physical therapy may solve the issue and is safer. Do that program first.

6) Gatekeeper The one who controls the gate is your PCP**.** An HMO and a POS have a **gatekeeper system** in which a member must select a Primary Care Doctor (a.k.a. Provider) who oversees the

insured's care and must approve of and refer any treatment by other providers before it is given (a.k.a. ***Managed Health Care***). They refer you to the specialist who can help the most (and who is in your network).

E. HIPAA… The Health Insurance Portability and Accountability Act

1) Eligibility Requirements To be eligible for HIPAA you must have insurance in some form and are at risk of losing it. HIPAA law forbids the new insurance company from holding an insured to a pre-existing condition exclusion if they :

- previously had coverage with another plan for 18 months and
- were covered for that condition and
- they applied for the new coverage within **63** days of losing the old coverage and
- no other coverage was available, including COBRA and
- the old coverage was not lost due to fraud or non-payment of premium

2) Privacy : Accountability means to hold accountable for sharing a person's health information. This cannot be done without their express permission. The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

3) Who is covered? The consumer is protected in many forms here. Health plans covered include all health, dental, vision RX, etc. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity.

4) What is protected?"Individually identifiable health information" which is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

- and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual

The main reason for HIPAA is to help keep personal information ***confidential***. Proper disclosure is required under the HIPAA Privacy Rule.

> **Disclosure: The HIPAA Privacy Rule's** purpose is to define and limit the circumstances in which an individual's protected health information may be used or disclosed to other parties. ***No entity*** may use or disclose health information unless ***the individual authorizes it in writing***.

(Visit HHS.gov for more information)

5) Portability means to take it with you. *Due to the Affordable Health Care Act an exclusion for a pre-existing condition is not allowed in health insurance so a person can always qualify.*

The Affordable Health Care Act (ACA) took care of that issue with health care, no pre-existing conditions may be excluded period, from health insurance. Any other type of disability insurance is subject to the pre-existing condition exclusion. HIPAA allows and individual to sign up for coverage at a new employer within 63 days of losing coverage and not have to do a medical questionnaire.

An example of violating HIPAA law would be discussing or reviewing a client's application with a co-worker while not behind the closed office doors.