

Health Insurance

- A quick easy breakdown for MA students

Third party reimbursement means payment by someone other than the pt. The most common third party payers are federal and state agencies, insurance companies, and workers comp

Carrier is a term used to refer to insurance companies that reimburse for health care services

Third party liability (TPL) refers to the legal obligation of third parties to pay part or all of the expenditures

Some people choose higher premiums so they have the flexibility to seek medical care from health care professionals of their choice, known as fee-for-service care, they don't have to worry about whether they are in network or not

It's imperative that a pts insurance coverage is verified every time they are seen in office

If, after providing services to the PT and submitting a claim, the service is denied for lack of coverage, the office can then supply proof that it provided the service in good faith because it checked eligibility and it was active at the time the service was rendered. Many payers reimburse providers under these circumstances upon appeal

Managed care is a system of health care that integrates the delivery and payment of health care for covered persons (pts or subscribers) by contracting w/ selected providers for comprehensive health care services at a reduced cost. The subscriber is the person who has been insured, an insurance policy holder

Commercial health insurance plans are typically provided by employees as part of a benefit package and often have an annual deductible and coinsurance. A deductible is a predetermined amount the insured must pay each year before the insurance company will pay for an accident or illness. Coinsurance is the percentage owed by the pt for services rendered after a deductible has been met and a co-payment has been paid. Copayment is a specified amount the insured must pay toward the charge for professional services rendered at the time of service

Indemnity type insurance has the least amount of structural guidelines for pts to follow. Pts are able to see the provider of their choice w/o having to deal w/ listings of participating providers and other managed care guidelines, and are able to see specialists w/o needing referrals from another provider. It's sometimes referred to as the 80/20 plan, which means the carrier will pay 80% of the expenses and the insured will pay the other 20% after the deductible has been satisfied. "Go anywhere, pay first, get reimbursed"

<u>HMO</u>	<u>PPO</u>	<u>EPO</u>
● A more restricted and manager care	● Less managed care	● Broader, less managed care
● It may be more difficult to get authorizations for tests and procedures	● May be ideal for those needing more provider options and want more control of available health care	● May be ideal for those wanting lower premiums and no primary care physician

Health maintenance organizations (HMOs) require their members to choose a primary care physician (PCP) to oversee their medical care. The PCP is responsible for the pt, and is called a “gatekeeper”

- Staff model HMOs are plans in which the providers are employed by the HMO and all services are provided by the practice. If the pt is traveling outside the HMO geographic service area, they must call and obtain preauthorization of any nonemergency case
- Group models are multispecialty practices contracted to provide health care services to members. Capitation means that providers are paid a set fee per pt each month, whether if the pt is seen multiple times or not at all

Preferred provider organization (PPO)

Exclusive providers organization (EPO)

Point of service (POS) plans allow members greater freedom in their choice of care. They do not have to have a PCP and can self-refer to specialists. If they choose to use a non panel provider, the benefit is more like an indemnity plan w/ a deductible and coinsurance. If they choose a panel provider, they receive the HMO benefit of only paying a co-payment w/ no deductible or coinsurance

Independent practice association (IPA) consist of providers who practice in their own individual offices and retain their own office staff and operations

A health savings account (HSA) is a tax-sheltered savings account that can be used to pay for medical expenses. Any amount not used in a given year remains in the account and continues to gain interest. An HSA has a high deductible and must be paired w/ a qualified health plan. Preventable care is not subject to the deductible. Small medical expenses can be paid for through the HSA, up to the deductible amt, as long as they are considered a qualified medical expense

Health reimbursement arrangement (HRA). Like an HSA, a HRA pays for medical expenses

A flexible spending arrangement (FSA) is sometimes referred to as a cafeteria plan. Qualified medical expenses are those specified in the plan that would generally qualify for the medical and dental expenses deduction. The plan is usually funded by the employee w/ pretax dollars. In some instances, an employer might contribute small amounts. A “use it or lose it” type deal. The money belongs to the employee; however, any unused amounts at the end of the year are returned to the employer

Medicare is a program of health insurance administered under the social security administration for people over the age of 65 who meet the eligibility requirements and have filed for coverage. People who are disabled, receiving social security benefits, or in end-stage renal disease, regardless of age, are also eligible. It's important for pts to understand that most supplemental plans only cover the deductible and coinsurance after medicare has paid for services. These plans do not cover the cost of services that medicare does not cover at all

- Part A of medicare is for hospital coverage, and any person who is receiving monthly social security benefits is automatically enrolled. Along w/ health care costs in general, the annual deductible increases each year
- Part B is for payment of other medical expenses, including office visits, X-ray and lab services, and service of a provider in or out of the hospital. The premiums are automatically deducted for those who wish the coverage and are on social security, railroad retirement, or civil service annually. Other eligible individuals pay premiums directly to the social security administration. Pts insured w/ part B have an annual deductible to satisfy any portion of their medical expenses paid by medicare. Medicare pays 80% of the approved amount after the deductible is satisfied. The remaining 20% is paid by either the pts supplemental insurance, or by the pt
- Part C is also known as medicare advantage and is the segment that enables beneficiaries to select a managed care plan as their primary coverage. It is provided by private insurance companies approved by medicare
- Part D was created to provide coverage for both generic and brand name drugs

Providers and medical assistants must keep current w/ the regulations governing health care and processing of claims. After May 1, 1992, regulations were established requiring that all claims submitted to medicare had to be on an original CMS-1500 claim form. The CMS-1500 is a uniform health insurance claim form designed to standardize requested info and the method it was submitted. To be HIPAA compliant, providers must submit all medicare claims electronically. If they wanna use a paper form, they must receive medicare approval. Medicare claims must be filled within a year of the time of service is received by a pt. Providers who sign a contract w/ medicare to be a participating provider receive payment directly from medicare. Providers who choose not to participate can only charge 15% above the medicare participating provider fee schedule. Non participating providers are paid 95% of the fee schedule amount

Medicare will only pay for services or supplies considered medically reasonable and necessary for the diagnosis given. Medicare will not pay for cosmetic surgery or experimental, unproved, or investigational services. If the provider does provide a service that is not covered, the pt needs to be informed and has to sign an advance beneficiary notice (ABN)

- Exs of an ABN
- Medicare usually does not pay for this service
- Medicare usually does not pay for this injection
- Medicare does not pay for this service because it is considered experimental

This form needs to be completed before or else it is considered invalid and the pt cannot be held responsible for payment associated w/ the service. Any money collected must be refunded

Medicaid is a government program that is funded by both federal and state governments, and is for people w/ limited or low income. Pts covered by medicaid must seek care from a participating provider; not all providers are medicaid providers

Every state has workers comp laws. The employer pays the premium for workers comp insurance, w/ the premium based on the risk involved in performance of the job as well as on the company's loss history. There are 4 principal types of state benefits:

1. Medical benefits: the pt may have medical treatment in or out of a hospital
2. Income benefits: if a temporary disability is present, the pt may receive weekly cash benefits in addition to medical care, and when a percentage of permanent disability is found, the pt is given weekly or monthly benefits, and in some cases a lump sum settlement; or
3. Death and
4. Burial benefits: payments are made to dependents of employees who are fatally injured. Benefits also include comprehensive vocational rehabilitation for employees w/ severe disabilities
 - A few states have their own state fund for workers comp. Time requirements for filing a claim may vary
 - A pt who has an industrial injury should set up a separate medical record for it. The pt is never billed in these cases unless treatment was given w/o authorization or was considered excessive

Tricare was established to aid active service personnel and their dependents, retired service personnel and their dependents, and dependents of service personnel who died in active duty, w/ a supplement for medical care in military or public health service facilities

Civilian health and medical program of the Department of Veterans Affairs (CHAMPVA) was established for the spouses and dependent children of veterans who have total, permanent, service-connected disabilities. It is also available for the surviving spouses and dependent children. The local VA hospital will determine eligibility, then the members can choose their own providers

Pts can have more than one insurance plan. Often, families have coverage from each spouse's place of work. The coordination of benefits (COB) is a procedure insurers use to avoid duplication of payment on claims when the pt has more than one policy. One insurer becomes the primary payer, and no more than 100% of the costs are covered

The birthday rule is a variable that can determine a child's coverage. It is:

- The plan of the parent whose birthday occurs first in the calendar year is primary, and the other parents is secondary
- If both parents have the same birthday, the plan in effect longest is the primary
- If the parents divorce and retain their plans, the parent w/ custody is the primary
- If a court order exists, it overrules the birthday rule

Medigap is health insurance offered by private companies to people eligible for medicare benefits and is specifically designed to supplement medicare benefits. Medicare generally forwards the claim info directly to the medigap carrier (aka crossover). Medigap policies generally do not cover long-term care, vision, or dental care, hearing aids, eyeglasses, or private duty nursing

Summary

- Commercial health insurance consists of indemnity plans and managed care plans: HMO, PPO, EPO, POS, and IPA
- Health maintenance organizations (HMOs) are plans that require pts to have a primary care provider who manages their care

- Preferred provider organizations (PPOs) consist of a network of providers and hospitals that contract to provide an insurance company or an employer w/ services for their members or employees at a discount rate
- Exclusive Provider Organizations (EPOs) are like HMOs in that pts must use their EPOs provider network when receiving care
- Point of Service plans allow for members to seek care w/ any provider but at a higher cost to them