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I. Medical Plans

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A. Medical Plan Concepts

a) **Fee-for-service** means the doctor receives payment when he or she performs a service such as an office visit. 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.

b) **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.

c) **Specified coverage** only covers what is named, eg. 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.

d) **First Dollar Coverage** the insurance company pays first, there is no deductible or out of pocket for the insured. Wellness checks and flu shots would be an example of this today.

e) **Comprehensive Coverage** complete and total coverage in one plan. An HMO is an example covering all of a person's medical needs, from immunizations and well- baby care to sport physicals to hospital care. Comprehensive 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 required to be offed by all plans.

f) **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 exclude a pre-existing condition from coverage. 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. 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). The insured pays the bill and is reimbursed for the amount specified in the contract, after any deductible and coinsurance amounts, up to the policy limits.*

- ***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) Major Medical Expense Insurance…

The **purpose** of major medical insurance is to provide complete coverage for all your covered medical needs. ***Major medical has a deductible, high limits, 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. 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?

2) 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.

- **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).
- **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 pcp 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***.
- Some HMOs pay the doctor a ***Capitation Fee,*** a fixed monthly amount per subscriber, **regardless of whether services are used or not.**
- **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.
- All HMOs are required to have a complaint system, often called a grievance procedure, to resolve written complaints by members.

3) Preferred Provider Organizations (PPOs) are groups of health care providers who agree to provide services for less money than they might charge otherwise. For pre-set fees, all of the enrollees in a medical plan are given a list of names of the PPO's doctors and hospitals which must be used by the insured for their care. A Primary care physician is not required.

- ***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.

4) 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	yes	no, but 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
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

a) **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.

b) 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.

c) Outpatient Benefits 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.

d) 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.

e) Utilization management for insurers is a cost containment tool for both the carrier and the insured.

There are 3 types involved:

i. 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?*

ii. **Concurren**t reviews will assess the situation right now, is everything being done that is necessary, coordinate care for today (meds, pt, etc), discharge planning if this is a hospital stay. Finally, there may be a

iii. **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.

f) 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.

g) Gatekeeper : An HMO and a POS 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).*** 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

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?

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" 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.