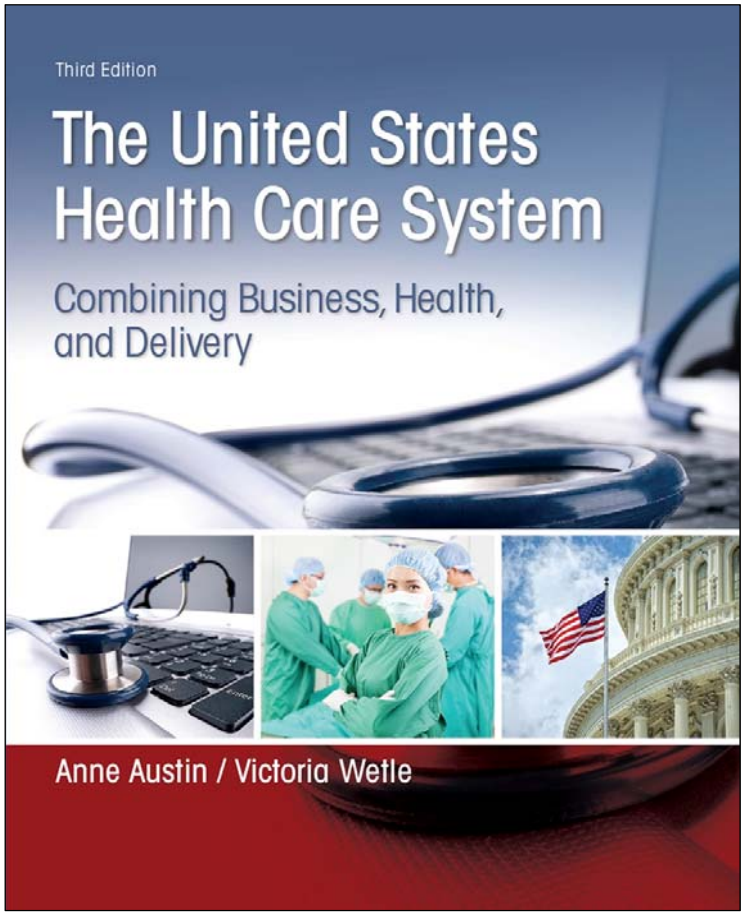
The United States Health Care System: Combining Business, Health, and Delivery

Third Edition



Chapter 3

The Payment Process: Insurance and Third-Party Payers

Learning Objectives (1 of 2)

3.1 Describe what arrangements are covered by the term health insurance.

3.2 Identify who is and who is not insured and how much is spent for coverage.

3.3 Describe the interaction between the patient, the third-party payer, the employer, and the health care provider.

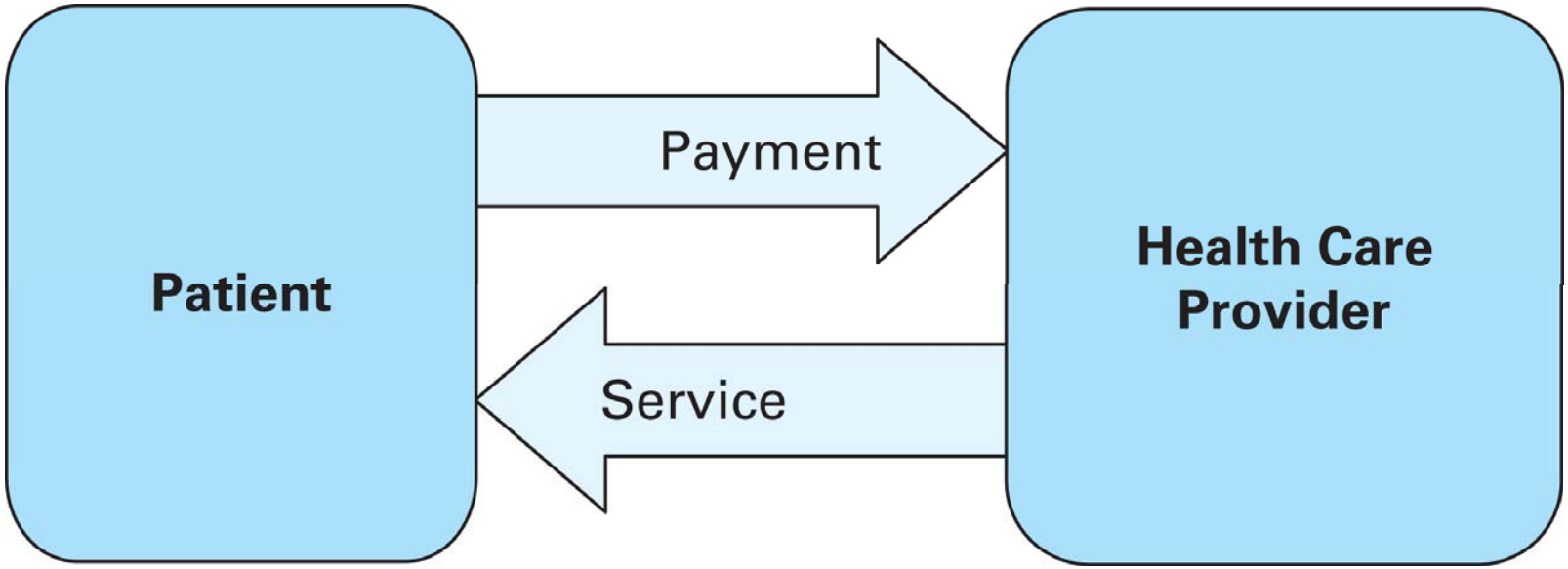
Learning Objectives (2 of 2)

3.4 Define the basic terms in an insurance agreement.

3.5 Identify the major types of third-party payers.

3.6 Describe how third-party payers are regulated.

Figure 3.1 The Simple Payment Process



What Is Health Insurance?

- Insurance is the business of shifting the risk of loss from the individual to a third party.
- The insurance company is predicting they will make a profit by taking in more money than they will have to pay out.
- The process is known as risk pooling.

Who Is Insured? (1 of 6)

- 5% of Americans under age 65 purchase private individual health care insurance.
- How do the other 95 percent pay for health care services?
- Americans under the age of 65 are:
  - covered by insurance as part of an employer-sponsored plan.
  - covered by Medicaid, Medicare, and other government programs.
  - do not have health insurance.

Who Is Insured? (2 of 6)

- Americans over age 65 are covered by Medicare.
- Large employers almost all offer health care benefits.
- In smaller companies, the number drops to about 44%.

Who Is Insured? (3 of 6)

- Under the Affordable Care Act:
  - Companies must offer insurance that will pay for up to 60 percent of expenses.
  - The premium cannot exceed 9.5 percent of family income.
  - Employees can opt not to participate in their employer's plan.

Who Is Insured? (4 of 6)

- Health care is an expensive benefit for an employer to offer to its employees.
  - In 2014, the average premium for single coverage was $6,025
  - For family coverage it was $16,834.
  - Employers have passed the increases on to their employees.

Who Is Insured? (5 of 6)

- Average contribution for single coverage was $1,081.
- Average contribution for family coverage the average was $4,823.
- Most plans cover common areas of preventive care.
- There is a strong correlation between having insurance and being able to access the health care system.

Who Is Insured? (6 of 6)

- Uninsured are twice as likely to postpone or go without care due to cost.
  - More likely to do without prescription drugs
- Most of the uninsured are from low-income families.

How Does "Insurance" Work? (1 of 7)

- The Patient/Employer–Third-Party Payer Relationship
  - Insurance company, government agency, or managed care organization (MCO) is known as the third-party payer.
    - Third part of the transaction between the patient and the service provider.
  - The third-party payer will set a price for the benefit package.
  - The price is determined by the number of people being insured and the general state of their health.
  - Once the employer has negotiated an agreement with the insurer, the employer can offer health care benefits to its employees.

How Does "Insurance" Work? (2 of 7)

- The insurance plan is a legally binding contract known as a policy.
- The purchaser is the insured.
- The enrollment period is when employees decide to take advantage of the benefit being offered by the employers.
- If they take the benefit, they are known as enrollees.

How Does "Insurance" Work? (3 of 7)

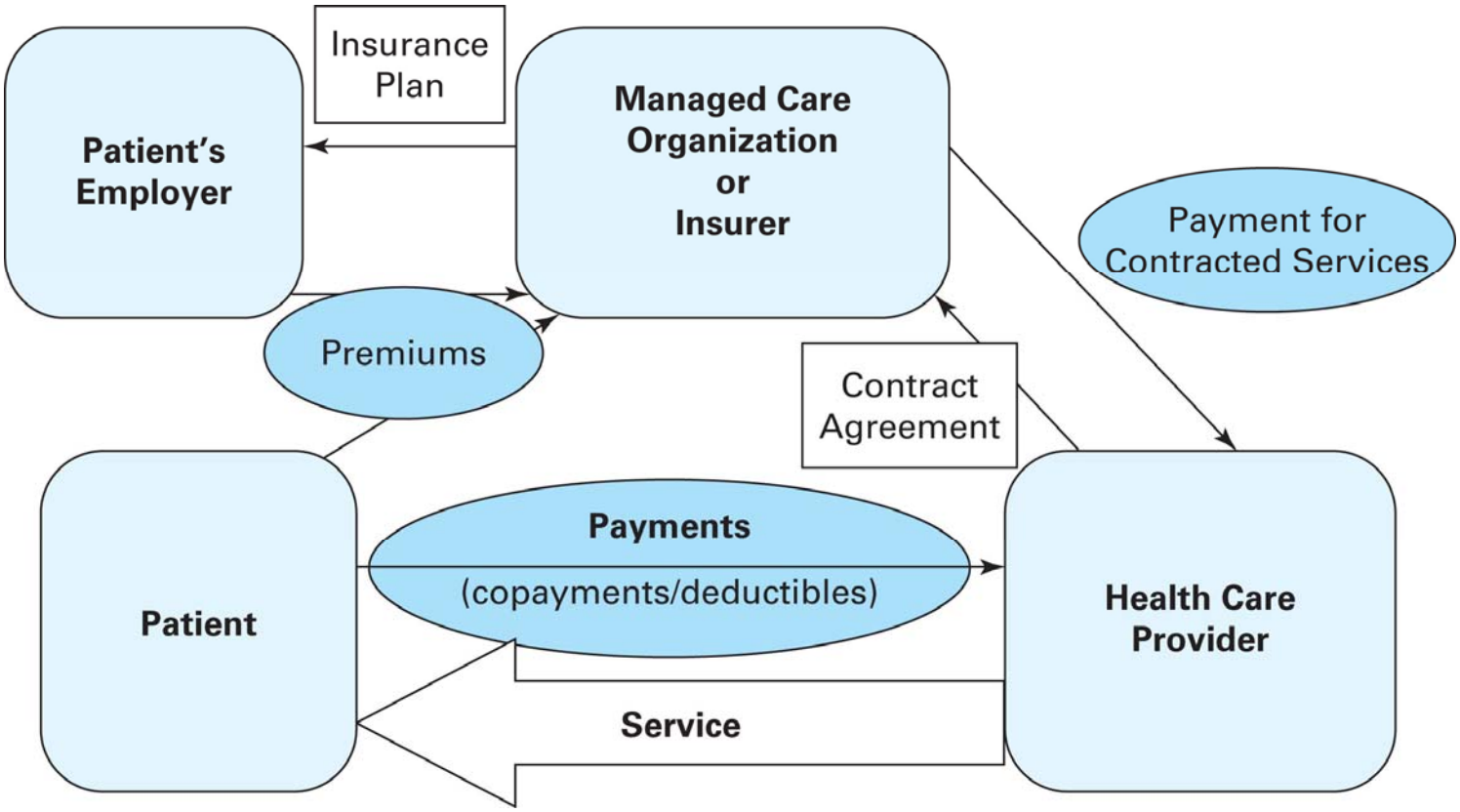


Figure 3.2 The Third-Party Payer Process

How Does "Insurance" Work? (4 of 7)

- The Patient–Provider Relationship
  - A deductible is a dollar amount of services that must be paid by the patient.
  - A copayment (coinsurance) is typically paid at the time that services are rendered.
  - A patient may be insured under more than one policy.
  - A coordination of benefits clause will determine which third party pays for services.

How Does "Insurance" Work? (5 of 7)

- The Provider–Third-Party Payer Relationship
  - A health insurance claim is a request for reimbursement for the services that have been provided.
  - Coding is the process of correctly coding what diagnoses, procedures, and services were provided to the patient.

How Does "Insurance" Work? (6 of 7)

- The Provider–Third-Party Payer Relationship
  - ICD-10-CM
    - International Classification of Diseases, 10th Revision, Clinical Modification
    - Used in physician's offices
  - HCPCS
    - Healthcare Common Procedure Coding System
    - Consists of two levels:
      - Current Procedural Terminology (CPT)
      - National codes (HCPCS level II codes)
    - Used in hospitals/outpatient facilities and clinics

How Does "Insurance" Work? (7 of 7)

- The Provider–Third-Party Payer Relationship
  - Billing
    - Process of charging the patient/employer for services
    - Claims are transmitted to the third-party payer.
    - The third-party payer sends the insured an explanation of benefits (EOB).
      - Tells insured how much they are going to pay and if any part of the claim has been denied
    - Payment is sent to provider.

Types of Third-Party Payers (1 of 8)

- Indemnity Insurers
  - The insurance carrier agrees to pay (indemnify) the insured loss.
    - With health insurance, the loss is the need to obtain health care services.
    - Once the patient has paid the provider for services, the insurance company reimburses the patient.
    - The insurance company may also reimburse the provider directly.
    - Payment is not made to the provider of services until covered services are used.

Types of Third-Party Payers (2 of 8)

- Self-Insurers
  - The employer assumes the risk of loss for medical costs.
  - Often a third-party administrator (TPA) is hired by the employer to administer the health care benefits and process claims.
  - Self-insured plans are exempt from state insurance regulation.
  - They are regulated by Employee Retirement Income Security Act of 1974 (ERISA).

Types of Third-Party Payers (3 of 8)

- Blue Cross/Blue Shield
  - Teachers started Blue Cross in the 1920s.
    - Paid monthly sum in return for 21 days in yearly hospitalization.
  - In 2015, more than 106 million Americans were enrolled.
  - Was originally not for profit; some plans converted to for-profit in the 1990s.
  - Individuals subscribe to a plan.
  - A prepaid service; the subscriber is still responsible for deductibles, copayments, and any noncovered services.

Types of Third-Party Payers (4 of 8)

- Managed Care Models
  - Pay for services and deliver services.
  - Gatekeeping
    - Patient can only access certain services from the primary care provider.
    - Can only obtain specialist and rehabilitative services if referred by the primary provider.
  - Almost all workers covered by an employer plan are enrolled in managed care.

Types of Third-Party Payers (5 of 8)

- Managed Care Structures
  - Health Maintenance Organizations (HMOs)
  - Preferred provider organizations (PPOs)
  - Exclusive provider organizations (EPOs)
  - In 2009, the majority of employees were enrolled in one of these variations.
  - Health Maintenance Act of 1973 was a strong incentive for the growth of HMOs.

Types of Third-Party Payers (6 of 8)

- Managed Care Structures
  - Health Maintenance Organizations (HMOs)
    - Prepaid health plans (PHPs)
    - Traditionally hire physicians and staff to work for them
    - Pay for services by capitation
      - Each patient or group has a fixed dollar amount of services provided for a time period.
    - Prepaid health plans are attractive to employers because they know in advance what the cost of providing health care will be.

Types of Third-Party Payers (7 of 8)

- Managed Care Structures
  - Health Maintenance Organizations (HMOs)
    - Staff model HMO
    - Prepaid group practice model
    - Network HMO
    - Independent practice association (IPA) model

Types of Third-Party Payers (8 of 8)

- Managed Care Structures
  - Preferred provider organizations (PPOs)
    - A delivery network.
    - Patient may choose his or her physician or hospital.
    - If insured goes to a PPO, the cost of care is lower
  - Exclusive provider organizations (EPOs)
    - Patient must select his or her care providers from those in the network.
    - If the patient chooses to go outside the network, then those services are not covered.

Table 3.1 Largest Publicly Traded National Managed Care Firms, by Premium Revenue, 2014

Company	Revenue	Total Enrollment
United Health Group	$130.5 billion	29 million
Aetna	$58.0 billion	23.5 million
Anthem	$73.9 billion	37.5 million
Humana	$48.5 billion	13.8 million
CIGNA	$34.9 billion	14.5 million

Source: 2014 company reports.

Regulation of Third-Party Payers (1 of 2)

- Insurance companies are regulated by state and federal rules.
- Insurance companies must be licensed.
- HMOs and other managed care organizations are regulated differently.
- HIPAA regulates portability, access, and mandated benefits.

Regulation of Third-Party Payers (2 of 2)

- Consolidated Omnibus Budget Reconciliation Act
  - COBRA
  - Employees may continue health benefits after leaving employer for a time period and self pay
- The 2010 Patient Protection and Affordable Care Act has numerous provisions that regulate the actions of insurers.
- The law requires that states establish American Health Benefit Exchanges and Small Business Health Options Program Exchanges so that the uninsured and small businesses can obtain coverage.

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