Component I: Core

Module H: Introduction to Health Insurance

Topic 1: Introduction to Health Insurance

Statement of Purpose
To prepare the learner with basic knowledge of medical insurance.

Student Learning Outcomes
Upon completion of this topic, the learner will be able to:

1. Spell and define the key terms.
2. Discuss the function of the multipurpose billing form, otherwise known as superbill (paper vs. electronic).
3. Discuss determination of primary coverage.
4. Describe group, individual and government sponsored health programs.
5. Explain the differences between health maintenance organizations (HMO) and preferred provider organizations (PPO) along with point of service (POS) plans.

Terminology

1. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
2. Claims
3. Consolidated Budget Reconciliation Act (COBRA)
4. Coordination of benefits (COB)
5. Copayment (Co-Pay)
6. Electronic Health Record (EHR)
7. Employment Development Department (EDD)
8. Group insurance
9. Health Maintenance Organization (HMO)
10. Individual insurance
11. Insurance Planning Associates (IPA)
12. Insured
13. Managed care
14. Medicare/Medicaid
15. Medi-Gap (Medicare + gap)
16. Network
17. Point of Service (POS)
18. Preferred Provider Organization (PPO)
19. Primary Care Physician (PCP)
20. Provider
21. Referrals
22. Skilled Nursing Facility (SNF)
23. State Disability Insurance (SDI)
24. Superbill
25. TRICARE®
26. Worker's Compensation

References

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4. Green, M., Rowell, J.C. (2012). *Understanding Health Insurance: A Guide to Billing and Reimbursement (11thEd.).* Albany, NY: Delmar an International Thomson Publishing Co.
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6. Sanderson, S., (2012). *Computers in the Medical Office* (8th Ed.), Chestnut Hill Enterprises, McGraw-Hill.
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Websites

1. http://www.edd.ca.gov

Content Outline/Theory Objectives	Suggested Learning Activities
Objective 1 **Spell and define key terms.** A. Review the terms listed in the terminology section. B. Spell the listed terms accurately. C. Pronounce the terms correctly. D. Use the terms in their proper context.	A. Games: word searches, crossword puzzles, Family Feud, Jeopardy, bingo, spelling bee, hangman and concentration. B. Administer vocabulary pre-test and post-test. C. Discuss learning gaps and plan for applying vocabulary.
Objective 2 **Discuss the function of the multipurpose billing form, otherwise known as superbill (paper vs. electronic).** A. Combination bill, insurance form and routing document which may be given to the patient at the time of the office visit. B. Superbills are also known as fee tickets, charge tickets, encounter form, patient service slip, routing form, transaction slip 1. Contains the patients name, date of service, insurance plan type, services rendered, procedure codes (list codes for basic office charges), diagnostic codes, the physician's identifying data and a section to indicate the patient's next appointment and whether they owe the practice balance due or Co-Pay. 2. In the paper office, clip the superbill to the front of the patient's chart. 3. Physician checks off procedures that are performed. 4. Physician applies diagnoses. 5. Return appointment time frame, if needed. 6. May be used as a receipt for the patient. 7. May be submitted to the billing department. 8. Should be updated to include new or revised procedures and diagnostic codes at the beginning of each year. C. Electronic Health Record (Encounter/Progress Note) 1. On the EHR side, within the progress note, procedures and diagnoses are selected for each patient note on any given day. 2. Using scheduling and demographics from the Practice Management software (such as Medisoft) and the Encounter/Progress Note from the Electronic Health Record, a claim is generated automatically, thus eliminating the need for a superbill. 3. Patients may receive a walkout receipt known as	A. Lecture/Discussion B. Assigned Readings C. Examples of Progress Notes within the Electronic Health Record.

the Clinical Visit Summary instead of a copy of the superbill.	
Objective 3 **Discuss determination of primary coverage** A. If the individual has only one policy, it is primary. B. If the person has coverage under two plans 1. Insurance for the longest period of time is primary person. 2. If active employee has a plan with a present employer and is still covered by a former employer's plan as a retiree or a laid-off employee, the current employer's plan is primary. C. If the individual is also covered as a dependent under another insurance policy, the patient's plan is primary. D. If an employed person has coverage under the employer's plan and additional coverage under a governmental sponsored plan, the employer's plan is primary 1. Person is enrolled in a PPO through employment who is also on Medicare. E. If a retired individual is covered by the plan of the spouse's employer and the spouse is still employed, the spouse's plan is primary even if he is a retired person and has Medicare. F. The birthday rule, if the person is a dependent child covered by both parents' plans and the parents are neither separated nor divorced (or have joint custody of the child), the primary plan is determined by which parent has the first birth date in the calendar year. G. If two or more plans cover the dependent children of separated or divorced parents who do not have joint custody of their children, the children's primary plan is determined in this order 1. The plan of the custodial parent. 2. The plan of the spouse of the custodial parent (if the parent has remarried). 3. The plan of the parent without custody. H. Coordination of benefits (COB) prevents duplication of benefits for the same medical expense (selecting which insurance company to bill first).	A. Lecture/Discussion B. Assigned Readings C. Primary vs. secondary insurance examples
Objective 4 **Describe group, individual, and government sponsored health programs.** A. Group insurance 1. Group health benefits are sponsored by an organization such as an employer, a union or an association. 2. A person covered by group health benefits is either an employee or a group member, who by virtue of employment or membership in an organization may participate in and receive benefits from a health	A. Lecture/Discussion B. Assigned Readings C. Sample insurance packets D. Discuss all types of insurance coverage and their impact on user's health care.

plan.
3. If an individual under group coverage leaves the employer or organization the insured may continue the same or lesser coverage under an individual policy.
4. COBRA is an extension of benefits offered to the employee who has left their place of employment and is only for a limited period of time.

B. Individual health benefits
1. Individual health benefits policies are purchased by an individual from an insurance company.
2. Premiums are submitted by the individual directly to the insurance company.
3. Company then reimburses the covered individual eligible medical expenses.
4. Medi-Gap plans.

C. Government sponsored health benefits
1. Government sponsored benefits programs are funded and regulated by the federal or state government.
2. Government programs have been developed over the years to assist persons who might otherwise have health benefits such as the elderly, the indigent and others unable to obtain benefits.
3. Government programs include Medicare, Medicaid (MediCal is the Medicaid program in California), CHAMPVA/TRICARE, Worker's Compensation (State program) and SDI (State program)
    a. Medicare
        1) Medicare was designed to provide medical care and benefits for the elderly population.
        2) Medicare has since been expanded to provide benefits for blind individuals, disabled individuals who are eligible for social security benefits and meet certain criteria, children and adults with end-stage renal disease and kidney donors.
    b. Medicare advantage plans
        1) Part A hospital insurance
            - Provides inpatient up to 90 days for each benefit period (begins the day a patient goes into the hospital and ends the day patient has not been hospitalized for 60 days).
            - Patient who has been an inpatient in a skilled nursing facility (SNF) for no more then100 days in each benefit period (one calendar year).

• A patient who is receiving medical care at home. • A patient who has been diagnosed as terminally ill and needs hospice care (6 months to live). • Patient who requires psychiatric treatment, covering 190 days of psychiatric hospitalization in a patient's lifetimes. • Patient who requires respite care (short break for caregivers), those who care for the terminally ill. 2) Part B – pays for procedures (physician's services) and supplies. 3) Part C – Medicare Advantage Plans including HMO's that contract with Medicare. 4) Part D – voluntary prescription coverage with three levels • Payment per prescription up to $2930.00. • Payment per prescription after and up to $4700.00. • Payment per prescription after yearly out-of-pocket drug costs reach $4700.00. c. Medicaid or (for California) MediCal 1) Government sponsored programs provide health benefits to low income or indigent persons. 2) Eligibility for Medicaid is based on a patient's eligibility for other state programs such as welfare assistance. 3) Medicaid eligibility and benefits vary from state to state. 4) Federal government contributes partial funding to each state for Medicaid costs. 5) Medicaid provides coverage for the following • Inpatient hospital care. • Outpatient treatment and services. • Diagnostic services. • Family planning services. • Skilled nursing facilities • Diagnostic screening for children. d. CHAMPVA/TRICARE® 1) CHAMPVA: the civilian health and	

medical program of veteran's administration covers dependents of veterans who have total and permanent service connected disabilities. The CHAMPVA program is administered by the area veterans' administration program. 2) TRICARE Manager Care Programs are offered to control escalating medical costs and to standardize benefits for active-duty families, military retirees and their dependents. Eligible individuals have options from which to choose • TRICARE Prime (HMO). • TRICARE Extra (PPO). • TRICARE Standard. • Tricare for Life supplementary payer to Medicare. 4. Workers' Compensation a. Employers in every state are covered by a Workers' Compensation program administered by the state or private insurers. b. Worker's Compensation benefits were developed to cover the expenses resulting from a work related illness or injury http://www.edd.ca.gov. 5. State Disability Insurance (SDI) a. Insurance coverage for off-the-job injury or sickness that is paid for by deductions from the working individual's paycheck. b. Benefits begin 7th consecutive day of disability. c. Total disability vs. partial disability.	
Objective 5 **Explain the differences between health maintenance organizations (HMO) and preferred provider organizations (PPO) along with point of service (POS) plans.** A. HMO 1. Unlike the traditional insurance system, HMOs promise to provide covered services rather than pay for them. 2. HMOs act both as an insurer and a provider of service; medical services are rendered by participating providers. 3. HMO policy lists the medical services the member is entitled to receive and the physicians and hospitals that provide these services. 4. HMO has a contract with both the patient and the provider. 5. HMO, rather than the patient, is responsible for the	A. Lecture/Discussion B. Assigned Readings C. Obtain and study brochures and application for a HMO, PPO and POS plan. D. Assign students to research the various medical plans available in your community: 1. Have them report to class the benefits of their chosen plan. 2. What are the advantages of your

cost of medical services. Providers bill the HMO rather than the patient if a reimbursable service has been rendered to an HMO member. 6. Physician typically paid by capitation if the medical group is an IPA, otherwise by contracted rate. 7. Patient's pay a co-payment for services rendered 8. Three types of HMO plans a. Group practice model (independent physicians). b. Staff model (Kaiser). c. Network model (group practices). 9. Patient selects a primary care physician (PCP) whose name and phone number appear on the insurance card. 10. Patient's PCP refers to specialists if needed. B. PPO 1. While an HMO promises to provide services and have a financial risk in their relationships with subscribers, a PPO is an organization whose purpose is simply to contract with providers and then lease this network of contracted providers to health care plans. a. Participating Physicians accept assignment. b. Nonparticipating physicians do not. 2. PPO network is not risk bearing and does not have any financial involvement in the health plan. 3. A PPO is typically developed by hospitals and physicians as vehicle to attract patients. Some are developed and managed by insurance companies. 4. A PPO contracts with participating providers including hospital and physicians. These contracts allow the PPO to contract with insurers and other purchasers of health care services on behalf of the participating providers who accept less than normal charges and agree to follow the utilization management and other administrative protocols. 5. Subscriber has more freedom of choice than an HMO patient. C. Point of Service (POS) plan 1. A managed care organization that combines elements of an HMO and a PPO. 2. It is like an HMO with the flexibility to go out of network and receive benefits at a greater level of flexibility.	plan? 3. What are the possible disadvantages of this plan?