CHAPTER 12
HEALTH INSURANCE PROVIDERS

Although the health insurance industry started in the latter part of the 1800s, it did not boom until the 1940s. Today most people realize the need of health insurance due to the escalating cost of care. In the year 2008, the expenditures for health care were 16% of the gross national product. The United States spends more per capita than all other developed nations for medical care.

Health or disability insurance encompasses a broad spectrum of insurance plans that protect against the financial consequences of illness, accident, and disability. A health insurance provider is the source that provides the medical services such as a physician or hospital. Notwithstanding any other provision of law, and except as provided herein, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the Department of Insurance unless the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this or another state or the federal government. A person or entity may show that it is subject to the jurisdiction of another agency of this or another state or the federal government by providing to the commissioner the appropriate certificate or license issued by the other governmental agency which permits or qualifies it to provide those services for which it is licensed or certificated. (CIC 740) Service contractors (e.g. HMOs, PPOs) come under the authority of the Office of Managed Care.

Three categories of health insurance are medical expense coverage, disability income insurance, and accidental death and dismemberment insurance. Health insurance can be obtained through individual plans and group plans. Health insurance also is provided through state and federal government programs.

Individual plans may cover family members and are issued by commercial insurers and service organizations. These plans will require the applicant to file an application.

Group health insurance plans also are offered by commercial insurers and service organizations. Members of a specified group are covered under a master contract issued to the sponsor who may be an employer, trade or professional association, credit union, labor union, and other organization. The sponsor is the policyowner and responsible for paying the premiums. Group policies may be contributory or noncontributory, meaning the members may or may not be required to contribute to the premium payment. All members of the group will be covered under the policy and the group members are not required to provide

evidence of insurability. The provisions and coverages of group health insurance contracts usually are more liberal than individual health policies.

` Life insurance provides a sum of money upon the death of the insured and can protect those left behind from financial disaster. Likewise, health insurance provides protection just when needed—upon the illness of an insured or when an insured is disabled. Medical expense insurance provides the necessary funds to pay hospital and doctor bills when an insured is ill or suffers an accident. Disability income insurance provides a stream of income when the insured is disabled and unable to work and produce an income.

When deciding on the appropriate type of insurance coverage to purchase, all other possible sources of protection must be considered. Some of these include workers compensation benefits for a job-related disability, benefits provided through an employer-sponsored plan, health coverage under any statutory plan, Social Security disability benefits, Medicare (if eligible), and any individual plans the insured may have.

COMMERCIAL INSURANCE PROVIDERS

Commercial insurers are stock and mutual life insurers, casualty insurance companies, and monoline companies that specialize in one or more types of disability income or medical expense policies. These insurers issue both individual and group policies.

Traditionally, commercial insurers have provided coverage on an indemnity basis. In other words, claim forms are typically completed and submitted by the participant who is then reimbursed for incurred expenses by the insurer. Once the insured is reimbursed, it is the insured's responsibility to pay the providers of medical care. The benefits may be provided on a scheduled basis (fixed dollar amounts for services as stated in the contract) or on a usual, customary, and reasonable basis (payment based on the norm for the procedure in that geographical area). The right of assignment is included in most commercial health policies. This allows the policyowner to assign the benefit payments directly to the provider of medical care.

SERVICE PROVIDERS

Service contractors provide health care plans under which heath care benefits are provided to the covered individuals instead of monetary reimbursement for health care expenses. The policyholders are referred to as subscribers and they receive medical care services in return for paying a premium. The medical care provider enters into an agreement with the service organization agreeing to provide medical services to the subscribers. The service organization pays the medical care provider directly rather than reimbursing the subscriber. The primary examples of service contractors are

Blue Cross and Blue Shield, health maintenance organizations, and preferred provider organizations.

Blue Cross and Blue Shield

Blue Cross and Blue Shield have contractual relationships with hospitals and doctors. The providers (hospitals and physicians) have contractually agreed to accept certain fees to provide medical services to the subscribers. Due to this, there is no contractual relationship between Blue Cross/Blue Shield and the subscribers. Blue Cross and Blue Shield are prepaid plans in which the subscribers pay a premium, usually monthly.

Blue Cross and Blue Shield offer individual, family, and group plans. They offer a number of different health care plans, including health maintenance organizations and preferred provider organizations.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Due to escalating health care costs, health maintenance organizations evolved. HMOs' objectives are to contain medical costs by:

- Stressing preventive care through physical exams, well-child examinations, and diagnostic screening
- Reducing unnecessary hospital admissions
- Reducing the average number of days per hospital visit
- Reducing duplication of benefits

Besides trying to contain costs, the growth of HMOs also is attributable to the HMO Act of 1973 known as the **dual choice rule** which later was repealed in 1995. It was a federal ruling stating that if an employer (1) had 25 or more employees, (2) provided health insurance, and (3) there was a federally qualified HMO servicing the area, the employer had to offer the HMO coverage as an alternative choice to traditional health care coverage. Now the federal law requires that employers "not financially discriminate" in the amount contributed by employees toward HMOs and indemnity plans.

HMOs may either be for profit or nonprofit organizations. Organizers of HMOs include commercial insurers, governments, hospitals, unions, employers, and local communities. HMOs operate within a service area that needs to be approved by the Department of Insurance. The service area may be a city, a county, or a state. Members of the HMO must live within the service area. It should be noted that although the service area of an HMO is controlled by the Department of Insurance, HMOs come under the regulation of the Department of Managed Health Care in the state of California.

Under traditional insurance arrangements, the health care is received from the medical profession and the financial coverage comes from the insurance company. An HMO handles both the financial arrangements for the coverage and makes the health care services available. The HMO members, known as subscribers, prepay a specified amount for the coverage. Nominal co-payments are made at the time of a doctor's visit. Copayments for supplemental services are frequently more than for basic health care services.

A feature common to HMOs is that the primary care physician functions as the **gatekeeper**. The primary care physician (PCP) monitors the subscriber's health care needs. The PCP renders the necessary care to the subscriber and when needed refers the subscriber to a specialist for treatment. The PCP determines what care is needed and not needed. To contain health care costs, the PCP should not make unnecessary referrals.

HMOs are structured in different ways. The different models of operation are group model, staff model, network model, and independent practice association model.

Group Practice Model (Medical Group Model)

Under the group model arrangement, the HMO contracts with an independent medical group composed of physicians of various specializations practicing in one facility or location. The HMO pays the medical group entity. The medical group will determine how to pay the individual physicians. Frequently, the HMO pays the medical group a **capitation fee**, a fixed monthly fee for every member (per capita) of the HMO. The group receives this fee even if a subscriber has received no services. However, the group could stand to lose money on a subscriber who makes frequent visits.

Group practice models can be either **open panels** or **closed panels.** When the medical group provides services to HMO members only, it is called a closed panel. In a closed panel, the doctors are normally salaried employees of the HMO and work at a clinic owned by the HMO. When the medical group provides services to members of the HMO as well as non-member patients, it is called an open panel. In this latter case, the doctors are not salaried employees of the HMO and treat patients in their own facilities.

The group model HMO refers members internally within the group. If an HMO member needs the services of a specialist who is not part of the group, special arrangements will be made. The HMO also contracts with area hospitals to provide necessary hospital care.

Staff Model

In the staff model, the contracting physicians are paid employees who work in a facility owned by the HMO. The HMO may own and operate its own hospital. In any case, the HMO's own employees and facilities are being used to deliver health care to its subscribers. In this type of model, there is no financial risk to the physician as he/she is a salaried employee. It is the HMO that is assuming the financial risk.

Network Model

An HMO will contract with several medical groups in the network model instead of just one as in the group model. The HMO also may contract with independent doctors to offer services to members out of their individual offices. In this type of organization, the medical group normally will be paid a capitation fee and the independent doctors may receive either a capitation fee or a discounted fee for services rendered.

Independent Practice Association Model (IPA)

The HMO contracts with individually practicing physicians to provide services to its members. As these doctors are practicing out of their own offices and independently of one another, it gives the subscribers an ability to find a doctor in a convenient location. The subscriber chooses a primary care physician who is responsible for the subscriber's care. If the subscriber is in need of a specialist's care, the primary care physician will refer to a doctor in the IPA network. The physicians of the IPA can use hospitals contracted by the HMO for needed subscriber inpatient care just as in the group model. IPAs can be structured as either open panels or closed panels.

HMOs--Basic and Supplemental Services

Services that HMOs are required to provide are referred to as basic services. Any services an HMO provides that are in excess of the basic services are referred to as supplemental services.

Basic Services are inpatient hospital and physician services, outpatient medical services, preventative health services and emergency services.

- Inpatient hospital and physician services include: At least 90 days per calendar year for inpatient treatment of illness and injury; 30 days per calendar year inpatient treatment for mental, emotional and nervous disorders (including alcohol and drug rehabilitation); hospital services including room and board, maternity care, operating rooms, intensive care, medications, anesthesia, physical therapy, x-rays, laboratory and diagnostic tests.

- Outpatient medical services include care given by a physician outside the hospital, laboratory and x-ray services, outpatient surgery, diagnostic services, and short-term physical therapy.
- Preventative health services include periodic health examinations, well child care, and immunizations.
- Emergency services must be available on an inpatient and outpatient basis 7 days a week around the clock. This also includes necessary ambulance services.

Supplemental services that may be offered by an HMO are prescription drugs, vision care, dental care, home health care, long-term care, substance abuse services, and mental health care. Subscribers who desire these services may purchase them from the HMO as an addition to their basic services.

Evidence of Coverage

An evidence of coverage must be provided to members of the HMO. The evidence of coverage will include coverages and benefits as well as exclusions, the effective date and term of coverage, a list of providers, description of service area, conditions of termination, and complaint system. This document will also contain information regarding the 30-day grace period, the coordination of benefits provision, incontestability clause, and a provision regarding the eligibility requirements for membership in the HMO.

All HMOs are required to have a complaint system to deal with coverage complaints and care complaints. Coverage complaints include grievances regarding coverage offered and denial of health claims. These complaints are reviewed internally and, if not resolved, may be referred to the Department of Insurance. Care complaints involve the quality of medical care. Medical personnel review this form of complaint.

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

Preferred provider organizations were developed as a compromise between traditional insurance coverage and coverage provided by an HMO. Organizers of PPOs include traditional insurance companies, Blue Cross/Blue Shield, trade unions, local groups of physicians or hospitals, and large employers. PPOs, like HMOs, are prepaid plans and both are referred to as managed care.

A PPO is made up of private physicians and hospitals in an area that have agreed to provide health services to the PPO subscribers. PPOs can operate as either open panels or closed panels. The health care providers are paid on a fee-for-service basis. The providers are willing to accept discounted fees in exchange for a guarantee of payment and the potential increase in patient load.

A PPO gives subscribers more flexibility in choice of physicians than does an HMO. When a subscriber sees a preferred provider, the cost of care will be completely covered minus a nominal copayment. If the subscriber decides to seek care from a nonpreferred provider, the benefits paid by the PPO will be somewhat reduced. Perhaps the PPO will only pay 80% of the normal fee. However, PPOs normally will pay in full for emergency services regardless of where or by whom rendered. This system gives the subscriber freedom of choice in the selection of a health care provider.

EXCLUSIVE PROVIDER ORGANIZATIONS (EPOs)

Exclusive provider organizations are a type of PPO. However, members must use particular preferred providers who are paid on a fee-for-service basis. The members do not have the great flexibility of choice of care providers as under a PPO. EPOs use the gatekeeper system in which the member selects a primary care physician who monitors the member's care and makes referrals to specialist within the network.

POINT OF SERVICE (POS) PLAN

The point of service plan (POS) is a type of managed health care system. It combines the characteristics of both the HMO and the PPO. When a subscriber enrolls, he/she needs to choose a primary care physician to monitor his/her health care. The primary care physician must be chosen from within the health care network and becomes the subscriber's "point of service". The primary care physician may make referrals outside the network with the POS paying a portion of the costs.

HMOs, PPOs, and POSs are referred to as **managed care**. Managed care refers to a system that imposes control of the use of health care services, the amount charged for services, and the access to health care providers.

SELF-INSURANCE

Instead of having an insurance policy with an insurance company, some businesses choose to self-insure health plans for their employees. This means the business will provide the money to cover the costs of their employees' medical bills. Other groups that may elect to self-insure are labor unions, fraternal associations, and co-ops. In these cases, dues and contributions from members cover the costs of medical care.

Self-insurers frequently will use an outside organization to handle the paperwork and process claims. Such an outside organization is called an administrative-services-only (ASO) or third-party administrator (TPA).

MEDICAL SAVINGS ACCOUNT (MSA)

A medical savings account is available to self-employed persons or employers who have 50 or fewer employees. The plan calls for a high deductible health plan (HDHP) to help pay for major medical expenses and the making of regular deposits into a medical savings account to cover minor expenses such as office visits. Deposits made toward the MSA are 100% tax deductible and can be used toward any out-of-pocket medical expense (e.g. premium, policy deductible, prescriptions, doctor's visits, vision or dental care, long term care). Once the yearly plan deductible has been met, the HDHP will pay any remaining covered medical expense in that year. If there are funds remaining in the MSA at the end of the year, the funds can either roll over for the following year or can be withdrawn as taxable income.

The HDHPs that qualify are those with a minimum individual deductible of $1,200 and a minimum family deductible of $2,400. The maximum out-of-pocket limits are $5,950 for an individual and $11,900 for a family. These are 2011 figures.

FLEXIBLE SPENDING ACCOUNT (FSA)

A flexible savings account can be set up through a cafeteria plan of an employer. An FSA allows an employee to set aside a potion of his/her earnings to pay for qualified expenses as established in the cafeteria plan—most commonly for medical expenses. Money deducted from an employee's pay is not subject to payroll taxes. Funds not spent during the year do not roll over to the next year. FSA are normally offered in conjunction with a traditional health plan.

HEALTH SAVINGS ACCOUNT (HSA)

A HSA based plan involves contributions to a savings account on a pre-tax basis by an employer and/or employee and is portable as the participant changes employers/plans. It is linked with a HDHP. Funds that are not withdrawn in a year can be rolled over and used in future years. Once the HSA is exhausted, there are no further tax advantages to help defray additional out-of-pocket expenses.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A health reimbursement account is established by an employer and serviced by a third-party administrator or plan service provider. Employers fund individual reimbursement accounts for their employees. These plans must be funded solely by employers. There are no limits on the employers' contributions and employers are not required to prepay into a fund for reimbursements. Instead, employers may reimburse employees' claims as they occur. Employees

are reimbursed tax free for qualified medical expenses up to a maximum dollar amount for a coverage period. This plan will require a standard insurance plan—any health plan, not only HDHP.

CONSUMER DRIVEN HEALTH PLANS (CDHPs)

Consumer driven health plans refer to health insurance plans that allow members to use personal health savings accounts (HSA), health reimbursement accounts (HRA), or similar medical payment products to pay routine health care expenses directly. The associated high-deductible health insurance policy protects them from catastrophic medical expenses. It is referred to as consumer driven as the insured person becomes an active participant in controlling health costs rather than being passive and relying on the managed benefit plans. CDHPs are all about transferring the reins of health-care costs to the participating individual. By encouraging individuals to use CDHPs, it is assumed that consumers will eventually become more cost conscious which will enable them to make more cost-effective decisions about their health and health care.

OTHER HEALTH CARE PROVIDERS

Urgent care centers see patients without appointments during the day, evening, and weekend hours.

Surgicenters are sites for surgery requiring anesthesia but not requiring the patient stay overnight.

Home health care is provided by nurses and others for a patient who is able to return home but who is not yet able to fully care for his/her own needs.

Skilled nursing facilities provide transitional medical care for patients who no longer need to be hospitalized but who cannot care for themselves at home.

GOVERNMENT INSURANCE

Medicare

Hospital and medical expense insurance is provided for seniors by the federal government through the Social Security program. This is Medicare and is available to persons age 65 who are fully insured under the Social Security system, to persons who have been receiving Social Security disability payments for 24 consecutive months, and to persons suffering from chronic kidney disease.

Social Security Disability Income

Social Security has a very stringent definition for disability. The individual cannot perform any substantial gainful work due to physical or mental disability and the impairment must be expected to last at least 12 months or end in death. The individual also must have earned a certain minimum number of quarters of coverage. There is a six-month waiting period before benefits begin.

Medi-Cal (Medicaid)

The Medi-Cal program is administered by the state of California under broad guidelines established by the federal government. Most other states call their programs Medicaid. The program is to provide medical care for persons of all ages who do not have the financial ability to meet the costs of necessary medical care.

The following are eligible for Medi-Cal: people 65 or older, blind, or disabled and who receive Supplemental Security Income/State Supplementary Program (SSI/SSP); people receiving Aid to Families with Dependent Children or other public assistance programs; people who are medically needy and meet the state limits for income and property; and those who are medically indigent (those who are pregnant, refugees in the country 18 months of less, those who are in a skilled or intermediate nursing facility, those who are under 21 whose needs are met by public funds).

A person can qualify for both Medicare and Medi-Cal. If so, Medi-Cal will pay the monthly premium for Medicare Part B and the person will not be billed for the Medicare coinsurance.

State Workers' Compensation Programs

All states have worker compensation laws. California law requires all employers to provide liability for workers compensation. An employer can purchase workers compensation insurance through a state run program, a private insurer, or can self-insure. The employer is responsible for work-related injuries or illnesses without regard to fault or negligence of any party. If a worker is killed in work-related accident, a burial allowance will be paid and the surviving spouse and children will receive compensation. Medical bills and costs of rehabilitation for the worker will be paid. Benefits for loss of income will be paid to the worker subject to minimum and maximum amounts.

REVIEW QUESTIONS

1. Organizers of HMOs include commercial insurers, hospitals, employers, unions, and local communities.

    A. True
    B. False

2. If primary care physicians receive a flat monthly payment from the HMO for every member without regard to actual services provided by the physician, this agreement is known as:

    A. Over-insurance
    B. Co-insurance
    C. Coordination of benefits
    D. Capitation

3. If an HMO owns its own hospitals and clinics and doctors are considered employees, it is referred to as what type of organization?

    A. Independent practice association
    B. Network model
    C. Staff model
    D. Group model

4. When an HMO chooses a limited number of health care providers to provide services to its subscribers, it is called:

    A. An EPO
    B. An closed panel
    C. An open panel
    D. Medi-cal

5. HMO physicians who practice individually in their own offices are known as a/an:

    A. Network model
    B. Closed panel
    C. Independent practice association model
    D. Open panel

6. Which are examples of service contractors?

    A. HMOs
    B. PPOs
    C. Blue Cross/Blue Shield
    D. All the above

7. Persons insured by service contractors are referred to as:

    A. Insureds
    B. Subscribers
    C. Enrollees
    D. Assignees

8. The gatekeeper system is a common feature of HMOs.
    A. True
    B. False

9. The basic services provided by an HMO include:

    A. Hospital care, physician services, emergency services, and prescriptions.
    B. Physician services, emergency services, preventative care, and prescriptions.
    C. Physician services, hospital care, emergency services, and preventative care.
    D. Hospital care, emergency care, preventative care, and prescriptions.

10. Which of the following is/are true about a PPO?

    1. PPOs provide health care to subscribers.
    2. PPOs can be either open panels or closed panels.
    3. PPO doctors are paid on a fee-for-service basis.
    4. PPOs allow for more flexibility of choice of physicians than HMOs.
        A. 1, 3, & 4
        B. 2, 3, & 4
        C. 1, 2, & 4
        D. All the above

11. The California state program which provides medical services to those who are financially unable to pay the costs of needed care is:

    A. State Workers Compensation Fund
    B. Supplemental Security Income
    C. Medicare
    D. Medi-cal