A Health Insurance Primer for Physicians

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Presentation Objectives

- Understand the Fundamental Concepts of Health Insurance
- Understand the Design of the US Health Insurance System
- Recognize Payment and Reimbursement Models
- Recognize Administrative Concerns
- Discuss Future Trends

How Physicians Benefit from Understanding Health Insurance

- System Navigation
- Clinical Autonomy
- Patient Impact And Advocacy

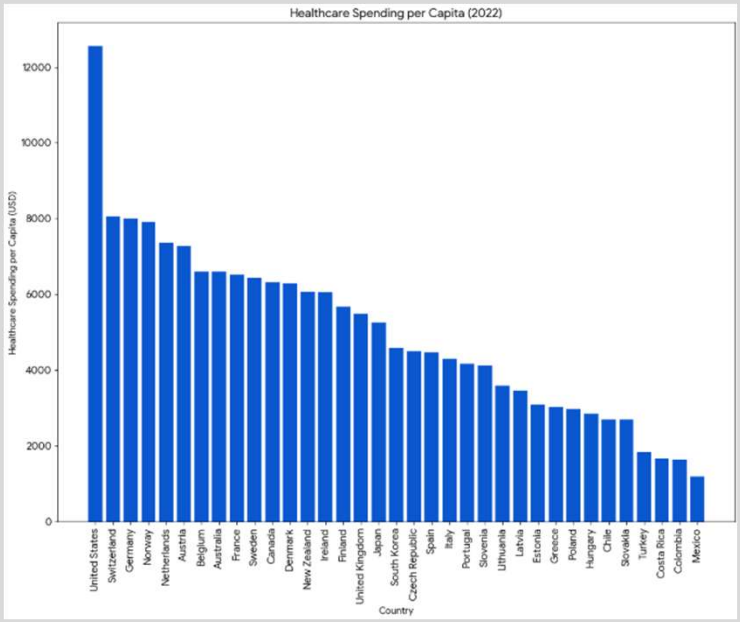
Nomenclature Review

- Patients, Providers, Payers, Employers, Government
- Premium, Deductible, Coinsurance, Copayment, Out-of-Pocket Maximum
- Network, Formulary
- Universal Healthcare, Single-Payer Healthcare, Socialized Medicine

Countries With and Without Universal Healthcare

- **With:** All of Europe, Australia, New Zealand, Canada, Japan, Russia, Brazil, India
- **Without:** The United States

US Healthcare Spending vs the World



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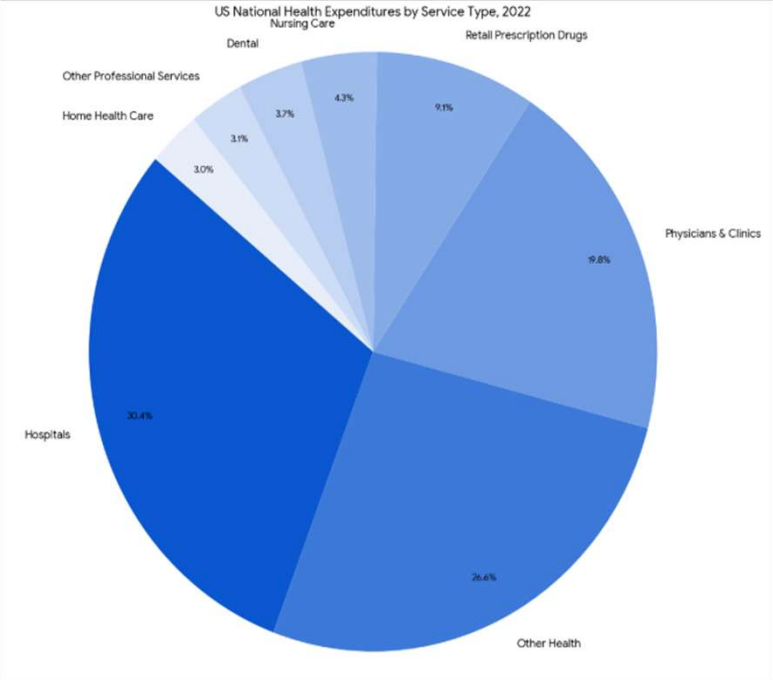
How the US Spends Health Expenditures



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Why Do People Use Health Insurance

- Does Health Insurance Improve Health?
- Does Health Insurance Provide Financial Protection?
- Why Does the US not have Universal Healthcare?
  - Political Perspectives
  - What have Experimental Studies on Cost and Health Outcomes Shown?

The RAND Health Insurance Experiment

- A major US study (1974-1982) on how health insurance cost-sharing affects healthcare use and outcomes.
- Randomly assigned nearly 7,000 people to different insurance plans.

Core Findings

- **Cost-Sharing Reduces Use:** People with higher out-of-pocket costs used fewer healthcare services.
- **Health Impact Minimal (Mostly):** For most, reduced use didn't harm health, except for some low-income individuals with chronic conditions.
- **Demand is Price Sensitive:** Healthcare demand responds to price.

Key Takeaways

- Influenced health policy and debates (e.g., ACA).
- Showed the trade-off between cost control and access to care.

The Oregon Study

- 2008 Oregon lottery study on Medicaid's impact for low-income adults.
- Randomly assigned participants to Medicaid or control.

Core Findings

- **Increased Healthcare Use:** More doctor visits, hospitalizations, prescriptions, and ED visits.
- **Reduced Financial Strain:** Less medical debt, fewer catastrophic expenditures.
- **Improved Mental Health:** Lower depression, better self-reported health.
- **No Physical Health or Job Impact (Short-Term):** No significant changes in physical health metrics or employment.

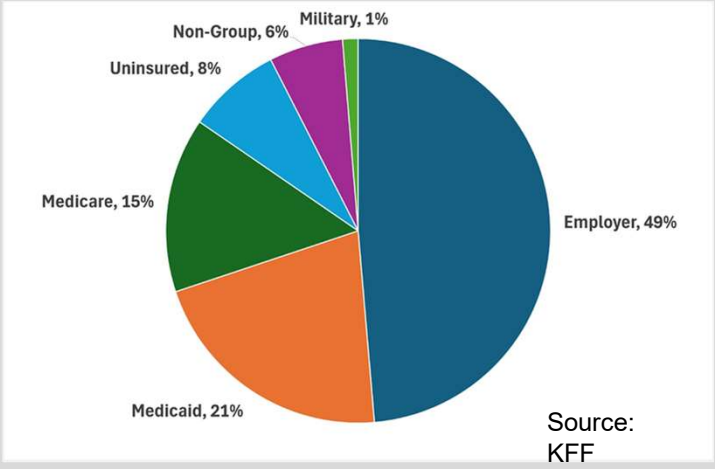
Key Takeaways

- Medicaid offers financial protection and mental well-being benefits.
- Increases healthcare use, including emergency care.
- Informed Medicaid expansion policies (e.g., ACA).

Evolution of Health Insurance in the US

- **Early 20th Century:** Emergence of "sickness insurance" and hospital plans
- **Post-WWII:** Employer-sponsored insurance grows due to wage freezes
- **1960s:** Creation of Medicare and Medicaid to cover elderly and low-income
- **1980s-90s:** Rise of Managed Care (HMOs, PPOs) to control costs
- **2010:** Affordable Care Act (ACA) aims to expand coverage and regulate markets
- **Present:** Ongoing shifts towards value-based care and digital health

How the U.S. Population Is Insured



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Types of Insurance Plans

Types of Private Health Insurance: Employer-Sponsored

- Coverage provided by an employer to its employees and their dependents
- Covers the largest segment of the U.S. population
- Often jointly funded by employer and employee contributions
- Can include PPOs, HMOs, HDHPs (High-Deductible Health Plans)
- Understanding employer plan specifics (networks, formularies) is key for patient guidance

Types of Private Health Insurance: Individual Market (ACA Marketplaces)

- Plans purchased directly by individuals, often through state or federal exchanges established by the ACA.
- Many individuals qualify for premium tax credits and cost-sharing reductions based on income.
- ACA-compliant plans must cover 10 categories of services.
- Growing patient segment, often with high deductibles; understanding subsidy eligibility can help patients.

Managed Care Organizations (MCOs)

- **Goal:** Controlling costs and improving quality by managing access to care.

Health Maintenance Organizations (HMOs):

- Require selection of a Primary Care Physician (PCP).
- PCP acts as a "gatekeeper" for referrals to specialists.
- Generally lower premiums, stricter networks.

Preferred Provider Organizations (PPOs):

- No PCP required, no referrals needed for specialists.
- Can go out-of-network, but at a higher cost.
- Higher premiums, more flexibility.

Managed Care Organizations (MCOs) - Continued

Point of Service (POS) Plans:

- Hybrid of HMO and PPO.
- Require a PCP and referrals for in-network care (like HMO).
- Can go out-of-network for higher cost (like PPO).

Exclusive Provider Organizations (EPOs):

- Similar to HMOs but without the PCP gatekeeper requirement.
- Strict network; no coverage for out-of-network care (except emergencies).

Government Programs: Medicare

Federal health insurance program for:

- People aged 65 or older.
- Certain younger people with disabilities.
- People with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).

Government Programs: Medicare

Parts of Medicare:

- **Part A (Hospital Insurance):** Covers inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.
- **Part B (Medical Insurance):** Covers certain doctor's services, outpatient care, medical supplies, and preventive services.
- **Part C (Medicare Advantage):** Private insurance plans that contract with Medicare to provide Part A and Part B benefits (and often Part D).
- **Part D (Prescription Drug Coverage):** Helps cover the cost of prescription drugs.

Government Programs: Medicaid

- **Joint federal and state program** that helps with medical costs for some people with limited income and resources.
- **Eligibility:** Varies by state, but generally includes low-income adults, children, pregnant women, elderly adults, and people with disabilities.
- **Medicaid Expansion:** States that expanded Medicaid under the ACA cover more low-income adults.
- Large patient population, often with complex social determinants of health; understanding state-specific eligibility and managed care carve-outs is critical.

Government Programs: CHIP, VA, TRICARE

- **Children's Health Insurance Program (CHIP):** Provides low-cost health coverage for children in families who earn too much to qualify for Medicaid but cannot afford private insurance.
- **Veterans Health Administration (VA):** Healthcare system for eligible military veterans.
- **TRICARE:** Healthcare program for active duty and retired uniformed service members, their families, and survivors.

Payment Models

Payment Models: Fee-for-Service (FFS)

- **Definition:** Traditional payment model where providers are paid for each service they provide (e.g., office visit, procedure, test)
- **Pros:** Simplicity in billing for individual services, Incentivizes volume of services.
- **Cons:** No direct incentive for efficiency or coordination of care, Can lead to overutilization of services.

Payment Models: Capitation

- Providers receive a fixed payment per patient per period (e.g., monthly) regardless of how many services the patient uses.
- **Pros:** Incentivizes preventive care and managing population health, Encourages efficiency and reduces unnecessary services
- **Cons:** Potential for under-provision of care if not properly managed, Requires robust risk stratification and care management
- Common in some HMOs and increasingly in value-based care arrangements.

Payment Models: Bundled Payments

- A single payment is made for all services related to a specific condition or episode of care (e.g., hip replacement, heart attack).
- **Goal:** To incentivize coordination and efficiency across different providers involved in an episode.
- **Pros:** Promotes collaboration among providers, Encourages cost-effective pathways
- **Cons:** Complex to implement and attribute costs,Requires strong care coordination capabilities.

Payment Models: Value-Based Care (VBC) Overview

Shift from Volume to Value: Moving away from FFS to models that reward quality, efficiency, and patient outcomes.

Core Principles:

- Better health for individuals.
- Better care for populations.
- Lower costs.

Key Components: Risk-sharing, performance incentives, care coordination.

Physician Relevance: Requires a fundamental shift in practice operations, data analytics, and team-based care.

Value-Based Care: Accountable Care Organizations (ACOs)

- Groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high-quality care to their Medicare patients.
- **Goal:** To ensure patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- **Shared Savings:** If an ACO meets quality targets and spends less than a benchmark, it shares in the savings.
- Participation in ACOs requires significant investment in infrastructure, data sharing, and population health management.

More Insurance Related Concepts

Examining Hospitalization Bills

- Hospital Charges - MS-DRGS
- Professional Charges - CPT Codes

SAMPLE HOSPITAL BILL

HOSPITAL CHARGES	
Room and Board	$2,800.00
Pharmacy	450.00
Laboratory	275.00
Supplies	350.00
TOTAL HOSPITAL CHARGES	$3,875,00
PROFESSIONAL CHARGES	
Physician	$1,000.00
Radiology	300.00
Anesthesia	850.00
TOTAL PROFESSIONAL CHARGES	$2.15,00
AMOUNT DUE	$6,025,00

What's Grouped in Each Category

- Hospital Charges - MS-DRGS
  - Room, Food, Medical Supplies, Medications, Lab Test, Procedures, Imaging
- Professional Charges - CPT Codes
  - Admissions, Follow Ups, Consultants, Procedures

What's Important to Your Job

- Placing and Choosing an ALOC
  - Choosing Inpatient, uses MS-DRGs
  - Choosing Observation, uses a more "pay by the day" model
- Professional Charges, Your Billing
  - Essentially should not change depending on Observation vs Inpatient

Revenue Cycle Management (RCM)

- The entire process of managing claims, payments, and revenue generation from the moment a patient schedules an appointment until the final payment is collected
- Patient registration and insurance verification
- Coding (CPT, ICD-10) for services rendered
- Claim submission
- Payment posting and denial management
- Patient billing and collections

Utilization Management/Review and CDI

- Inpatient/Observation Status Determination
  - Evolving Definition of what is Observation
  - Two Midnight Rule
  - Outpatient Status
  - Medicare Advantage Plans
- Peer to Peer Management
- Documentation Improvement for DRG Upcoding
- Payer Relationships

Emerging Trends & The Future of Health Insurance

- **Telehealth Expansion:** Increased coverage and reimbursement for virtual visits.
- **Artificial Intelligence (AI) & Data Analytics:** Used for risk stratification, fraud detection, and personalized care.
- **Price Transparency:** Regulations pushing for greater transparency in healthcare costs.
- **Consumer-Directed Health Plans (CDHPs):** High deductibles paired with Health Savings Accounts (HSAs).
- **Medicaid and Health Insurance Reform**

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