CHAPTER 2 Understanding Managed Care: Insurance Plans

Chapter Spotlight

The medical office specialist must understand the complexities of the various insurance plans. Other responsibilities of the medical office specialist include contacting insurance carriers for benefits information, estimating patient financial responsibility, and filing insurance claims. This chapter explains the intricacies of various types of health plans.

Resources

- Text
- Student Workbook
- MyHealthProfessionsLab
- TestGen
- Instructor's Manual
- Chapter 2 PowerPoint Lecture

Pretest

True/False Questions

1. The majority of payments received by a medical facility come from several sources. **(False)** *(The majority of payments received in a medical facility are from insurance companies.)*
2. The medical office specialist is responsible for estimating patient financial responsibility. **(True)**
3. The patient's benefits are known as the schedule of benefits. **(True)**
4. Medical costs escalated due to the baby boomers. **(False)** *(Medical costs escalated due to an aging population.)*
5. Prior to managed care, the American healthcare system financially rewarded healthcare providers for giving more care. **(True)**

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Learning Objectives

1. Understand the history and impact of managed care.
2. Be able to discuss the organization of managed care and how it affects the provider, employee, and policyholder.
3. Calculate the financial responsibility of the patient.
4. Identify the type of managed care plan in which a patient is enrolled.
5. Recognize various types of insurance coverage.

Learning Objective Lesson Plans

Lesson #1	
Objective	Lesson Plan
1. Understand the history and impact of managed care.	**PPT Slides 1-17** • Textbook: pages 26–27 • Table 2.1: pages 27–28 • IM ***Classroom Activities:*** 1a. Have students make flash cards for key terms to facilitate memorization. 1b. Break into groups and discuss the impact of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the creation of Medicare Part D, and the impact of baby boomers on current HMOs. **INSTRUCTOR NOTES:** **INDEPENDENT PRACTICE/HOMEWORK ASSIGNMENT:** Workbook pages: 12–22

Lesson #2	

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Objective	Lesson Plan
2. Be able to discuss the organization of managed care and how it affects the provider, employee, and policyholder.	**PPT Slides 18-21** • Textbook: pages 28–33 • IM ***Classroom Activities:*** 2a. List the managed care providers in your area. 2b. Discuss the ethical implications of "medical necessity" in patient care. 2c. Identify possible conflicts between the "gatekeeper" and the patient. 2d. Discuss *pay for performance* and how it can affect patient care. **INSTRUCTOR NOTES:** **INDEPENDENT PRACTICE/HOMEWORK ASSIGNMENT:** Workbook pages: 12-22

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Lesson #3	
Objective	Lesson Plan
3. Calculate the financial responsibility of the patient.	**PPT Slides 22–25** • Textbook: pages 30–31 • Practice Exercises: pages 31, 48 • IRM ***Classroom Activity:*** 3a. Using the practice exercises in the text on page 31 calculate the financial responsibility of both the carrier and the physician. **INSTRUCTOR NOTES:** **INDEPENDENT PRACTICE/HOMEWORK ASSIGNMENT:** Workbook pages: 12-22

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Lesson #4	
Objective	Lesson Plan
4. Identify the type of managed care plan in which a patient is enrolled.	**PPT Slides 26–37** • Textbook: pages, 34–39 • Table 2.2: page 38 - 39 • Figure 2.1, Figure 2.2: pages 35 and 36 • Professional Tip: page 33 • IM ***Classroom Activities:*** 4a. Discuss discharge planning and utilization review. 4b. After completing Practice Exercise 2.2, continue to role-play using different scenarios involving patients and insurance coverage issues. 4c. As a medical office specialist, create a policy covering collecting copayments, assignment of benefits, and promissory notes. **INSTRUCTOR NOTES:** **INDEPENDENT PRACTICE/HOMEWORK ASSIGNMENT:** Workbook pages: 12-22

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Lesson #5	
Objective	Lesson Plan
5. Recognize various types of insurance coverage.	**PPT Slides 38–59** • Textbook: pages 40–44 • Professional Tip: page 49 • Table 2.3: page 41 • IM ***Classroom Activities:*** 5a. Compare and discuss the differences between an HMO, PPO, and POS. 5b. Discuss the advantages and disadvantages of the different types of insurance plans. 5c. Research what types of alternative healthcare plans, if any, are available in your area. 5d. Have students make flash cards with the different types of group and individual insurance plans. **INSTRUCTOR NOTES:** **INDEPENDENT PRACTICE/HOMEWORK ASSIGNMENT:** Workbook pages: 12-22

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Learning Objective 1

Understand the history and impact of managed care.

Concepts for Lecture

Knowledge of the history of health care in the United States will assist the medical office specialist when communicating with patients. Prior to managed care, patients were responsible to pay directly for their care. There were few controls in place to manage costs. Patients visited a provider for illness and preventive care was rare. Healthcare costs and insurance premiums began to escalate due to technological advances, pharmacological research and development, and an aging population. Providers began ordering more costly tests and medications, practicing "defensive medicine" in response to the increased number of malpractice suits being filed. This cost increase was directly reflected in the insurance premiums, which increased rapidly. The employers could no longer afford to pay the full premiums for their employees, and employees could no longer afford the increasing insurance rates or cost of care.

The cost of healthcare had grown so rapidly that many Americans could no longer afford health insurance. Employers blamed insurance companies for higher premiums; insurance companies pressured providers to control costs. All attempts to resolve the issues were unsuccessful. The government intervened and managed care was created. Managed care is a method of controlling healthcare costs and ensuring that medical care is available to everyone. The idea of managed care is not new. Refer to the timeline in Table 2.1.

Learning Objective 2

Be able to discuss the organization of managed care and how it affects the provider, employee, and policyholder.

Concepts for Lecture

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Managed care controls costs of delivery of healthcare services to members enrolled in that specific plan. Goals of the plan include the following:

1. Providers deliver high-quality care in a facility that manages or controls costs.
2. Medical care or procedures are medically necessary and appropriate for the condition or diagnosis.
3. Medical care is rendered by the appropriate provider.
4. Medical care is rendered in the most appropriate, least restrictive setting.

The managed care organization (MCO) contracts with the physician or medical facility and determines the reimbursement fee for every procedure. This fee is viewed as the usual, customary, and reasonable fee; or the reasonable and customary fee. If the provider's fee is higher than the contractual fee, the provider must write off the balance. The medical office specialist's responsibility includes estimating the amount owed by the patient prior to services being rendered by the provider.

Utilization is a guideline that deems whether a procedure, treatment, or medication is medically necessary under the MCO guidelines. Utilization review is used as a cost-containment measure. A goal of managed care is for patient care to be provided by the most appropriate provider. The plan of care is usually determined by a "gatekeeper," which is usually the primary care physician.

Learning Objective 3

Calculate the financial responsibility of the patient.

Concepts for Lecture

It is important for the medical office specialist to calculate the amount of the fee the patient is responsible for paying, and the amount of reimbursement the provider can expect for services rendered. The usual fee is the individual provider's average charge for a procedure. The customary fee is determined by what a physician with similar training in a similar geographic location would charge. To determine the amount paid by the carrier, any adjustment or write-off, and the amount due from the patient (or paid at the time of service by the patient), use the following steps:

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1. *Contractual adjustment or write-off amount.* Subtract allowed amount from billed amount.
2. *Carrier's responsibility*. Subtract any unpaid deductible or copay (if no deductible or copay, go to Step 3).
3. *Patient responsibility*.

Learning Objective 4

Identify the type of managed care plan in which a patient is enrolled.

Concepts for Lecture

The major types of managed care plans are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service plans (POS). HMOs are the most restrictive plan. The subscriber is restricted in selecting a provider; however, the plan has a greater range of benefits for members with the lowest out-of-pocket expenses. For the services to be covered, the subscriber may only use facilities and providers within the network. The subscriber must obtain a referral from the primary care provider (PCP) prior to seeing a specialist, or the plan will not cover the care provided. The different types of HMOs include group model, individual practice association, network model, and staff model. The preferred provider organization (PPO) is similar to the HMO, except the subscriber does not have a gatekeeper, nor do they have to use an in-network provider. If the subscriber goes outside of the network they will have reduced benefits and higher out-of-pocket expense. Point of service (POS) is an option offered by some PPO and HMO plans. In a POS option, there is more out-of-pocket expense, but more flexibility.

Managed care has been criticized for mismanagement of patient care, especially in emergency situations. MCOs have also been criticized for denying patients the care and treatments needed, with the patient having no recourse. Many procedures require preauthorization which adds another layer of cost and possibly a delay in treatment. If the preauthorization is not obtained, the payer will not pay for the service(s).

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Alternative healthcare plans have emerged in recent years, giving patients a broader range of choices for healthcare coverage. One of the biggest changes is the Affordable Care Act. Discuss the pros and cons of this act.

Learning Objective 5

Recognize various types of insurance coverage.

Concepts for Lecture

The medical office specialist needs to be familiar with the various types of health insurance available today. Some plans are private, such as Blue Cross Blue Shield, and some are government sponsored, such as Medicare, Medicaid, CHAMPVA, and TRICARE. Commercial plans are offered by for-profit companies such as Aetna, Prudential, and United Healthcare. These policies are regulated by the individual state insurance regulatory boards.

Healthcare insurance may be either group or individual plans. The major plans include hospital, medical, and surgical insurance. A comprehensive plan includes several categories of coverage, including major medical, catastrophic, and special risk–expanded services for hospital, medical, and surgical services. Specialized policies cover long-term care, COBRA, and various supplemental coverages.

The administrative office staff and the medical office specialist must be diligent in verifying insurance. This facilitates the patient care and receipt of payment for services provided.

Answers to Chapter Review Questions

True/False

1. False
2. False
3. True
4. False
5. False

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6. False
7. True
8. True
9. True
10. False
11. False
12. True
13. True
14. True
15. False
16. False
17. False
18. True
19. False
20. False
21. False
22. False
23. True
24. False
25. True

Multiple Choice

1. d
2. c
3. b
4. a
5. b
6. a
7. c
8. c

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9. d
10. d
11. b
12. b
13. d

Completion

1. preventive healthcare services
2. dependents
3. self-insured
4. coinsurance
5. copayment
6. referral
7. POS
8. benefits
9. PCP/primary care physician

Answers to Student Workbook Questions

Critical Thinking Questions

1. a. The insurance information is necessary for billing the patient's insurance company. Also, insurance information should be gathered up front to verify coverage. On subsequent visits, all information should be verified to ensure nothing has changed.

   b. Each time the patient comes in the medical office staff should ask if insurance information has changed and let the patient know what insurance information is on file. If coverage has changed, obtain a copy of the patient's new insurance card and verify coverage.

   c. 1) Is there a deductible, and has it been met?

   2) Is there coinsurance or a copay requirement?

   3) What is the lifetime maximum?

   4) Are there any exclusions?

   5) Are there any limitations or riders?

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6) Are referrals needed?

7) Are there any preexisting conditions?

8) What is the coverage date?

d. All the information received, including the representative's name, the phone number of the insurance carrier/representative, the date, the time, and the medical office specialist's name.

2. a. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

b. At least 18 months

c. 1) If coverage was under the spouse and the person is recently widowed or divorced

2) If coverage is under a parent's group plan while the person is attending school

3. a. Make note of this in the system, check "no" in the accept assignment box, and bill the patient for the amount of the visit as they will receive payment.

b. Yes, Linda will have to pay for the visit up front and then either bill her insurance, or the office will bill as a courtesy.

4. a. Prior authorization

b. A lawsuit and/or loss of income could be the result.

5. Most Americans paid physicians directly for services. Employers typically paid for the total cost of their employees' healthcare policies. Insurance companies cannot deny anyone coverage because of preexisting conditions. Coverage includes: preventative care, maternity and pediatric and emergency care, to name a few. There are different types of government plans that are different based on the cost of the premium. This coverage is ideally to allow all individuals to have health insurance. The fewer uninsured people in the United States, the lower the costs of healthcare and insurance will be for everyone.

Practice Exercises

1. a. Discount: $90, Carrier: $90

b. Patient owes 10%: $462.60 × 10% = $46.26

Discount amount: $462.60

Carrier pays: $462.60 × 90% = $416.34

c. Discount amount: $52.00

Carrier pays: $52.00–$10.00 (copay) = $42.00

d. Patient owes 40%: $1,745.32 × 40% = $698.13

Discount amount: $1,745.32

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Carrier pays: $1,745.32 × 60% = $1,047.19

Write-off: $2,995.70 –$1,745.32 = $1,250.38

2. a. Phyllis Gould will be responsible for her own bill.

   1) The physician doesn't contract with her HMO; thus, the HMO is not responsible for paying.

   b. Rodger McMurray will be responsible for his own bill.

   1) He did not obtain a referral from his PCP to prove that the visit was medically necessary.

3. The usual fee is the amount that the individual provider usually charges. The customary fee is the amount that providers in the same geographical area are charging. Reasonable fees are set by the insurance company that include the time it takes to complete the procedure, the procedure itself, and supplies used, to render to physicians a "fair" payment for performing this procedure. Insurance carriers will insert into their contracts that they will pay UCR fees, which is usual, reasonable, and customary.

4. Managed care systems provide high-quality care while controlling costs by using networks and discounted fees for services.

5. Bronze, Silver, Gold, Platinum, and Catastrophic. All plans provide the same amount of coverage, the cost of the premiums is the only difference.

6. a. 1) Restraining growth of healthcare costs by discounting prices of service to deliver the most possible high-quality, cost-efficient care

   2) MCOs have a large enrollment, which physicians want a part of.

   3) Collecting and analyzing data on an MCO's delivery of care

   4) Shows outcome data of procedures to assess whether they are necessary for treatment.

   5) Creation of disease management programs and care pathways are used for increased quality, low-cost care that can be rendered by decreasing healthcare expenses.

   6) Assessment of new technology and treatments for the most effective care and safe delivery

   b. 1) Must use in-network during emergency

   2) Utilization protocol can restrict the care delivered by the physician and increase the chances of a lawsuit.

   3) Physicians have a risk of diverse enrollee selection under managed care, and managed care may require a large amount of a physician's time.

   4) Increased administrative burden

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5) Additional malpractice insurance, thus higher premiums

6) Too low an MCO payment, which may cause a physician to increase the number of patients seen per day, causing less time with patients and resulting in overall patient dissatisfaction

c. HMO

1) State licensed

2) Most strict and narrow choice of providers

3) Members must have a PCP

4) Limited network providers to choose from

5) Members must use in-network providers or pay a penalty

6) Financial reward to providers for managing the cost of care

PPO

1) Limited network of providers to choose from, but as strict as an HMO

2) May require a PCP

3) Financial penalty for using out-of-network providers

4) Usually, no financial reward to providers for controlling costs

EPO

1) Not licensed

2) Must use network providers

3) Financial penalties for out-of-network

4) Lower cost than PPO, but higher cost than HMO

POS

1) Hybrid of an HMO and a PPO

2) Choice of primary and secondary network

3) Primary is like an HMO

4) Secondary is like a PPO

5) Out-of-pocket expenses with either, but higher with the secondary

6) Members have more choices, and plan is less expensive than a PPO.

IPA Model HMO

1) Formed by physicians in sole or small-group practices that contract with other healthcare facilities, and only these facilities may be used

2) Physicians can see both HMO and nonmember patients because physicians remain self-employed.

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12) Policy that picks up any out-of-pocket expenses not covered by the primary insurance policy

f. 1) Incompatible claim systems

2) Authorization and quality assurance reporting

3) Physician usually has to carry additional malpractice insurance.

Review Questions

Matching Questions

1. e
2. b
3. c
4. d
5. a

Multiple Choice

1. d
2. b
3. d
4. b
5. c
6. b

Short Answer

1. Coinsurance is a percentage of the office charges or hospital fees that are payable by the patient. Copay is a fixed dollar amount that the patient has to pay for each hospital encounter or office visit. One is a percentage, and one is a fixed dollar amount.
2. 1) Policyholder

   2) Member

   3) Insured
3. 1) (Answers will vary.)

   2) (Answers will vary.)

   3) (Answers will vary.)

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4. 1) (Answers will vary.)

   2) (Answers will vary.)

   3) (Answers will vary.)

5. 1) One master policy issued to an organization or employer that covers any eligible members or employees. Contains better benefits with lower premiums.

   2) Self-owned policy with high premiums

   3) Employer-established fund used to pay a contracted third-party administrator for benefits covered. This type of plan is regulated by ERISA, which does not follow state insurance rules and regulations. Claims will be handled differently.

6. The goal of the Affordable Care Act is to make health insurance affordable to all Americans. Requirements: all individuals have health insurance beginning in 2014. Low income people who do not have access to affordable coverage through their jobs will be able to purchase a health plan with federal subsidies. Health plans cannot deny coverage for any reason.

True/False

1. False
2. False
3. False
4. True
5. True
6. False

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