cognizant

Healthcare Basics

Learning Services

Agenda

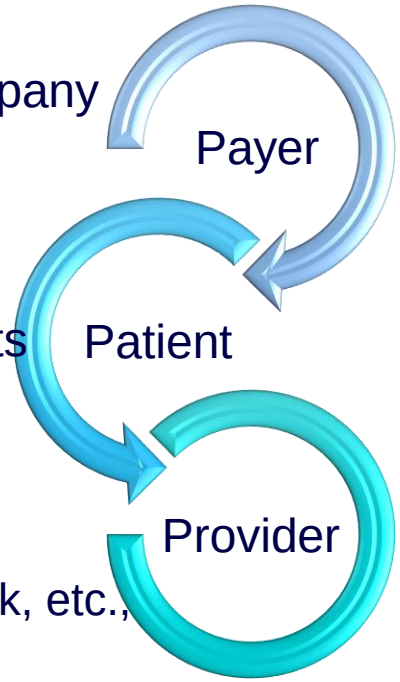
- Healthcare Introduction
- Historical Overview
- Current Trends
- Key Terminologies & Definitions
- Healthcare Entities
- Healthcare Ecosystem
- CDHP
- Provider Credentialing
- Utilization Review
- Claim Decision Process
- Laws & Programs

Introduction – Healthcare Terms

Payer – Insurance Company

Patient – Subscriber, Member, Dependents

Provider – Physicians, Hospital , X-Ray Centre, Blood Bank, etc.,



Introduction – Healthcare Terms – Contd..

Member

The beneficiary who is enrolled with a Payer and receives the healthcare service.

Payer

Typically the health plan who manage the health care service and pay for the services

Provider

The medical practitioner, Hospital, Labs, Tertiary care services etc. that provides Health care Service

Sponsor (Billing Entity)

The entity who pays premium to Payer. Can be Employer Group, Individual family member etc..

Introduction – Healthcare Terms – Contd..

Insurance	• Insurance whereby the insurer pays the medical costs of the insured if the insured requires medical services
Managed Healthcare	• A system that manages financing and delivery of healthcare services. Typically, managed care systems rely on a primary care physician who acts as a gatekeeper for other services, such as specialized medical care, surgery, and physical therapy
Health Insurance Policy	• a contract between an insurer and an individual or group, in which the insurer agrees to provide specified health coverage at an agreed-upon price (**the premium**) • Health insurance usually provides either direct payment to doctors and hospitals for services provided or reimbursement for expenses associated with illnesses and injuries

Key Terminologies & Definitions

Policy

- Contract between the payer and the subscriber

Cost shifting

- Practice of charging more for services provided to paying patients or third-party payers to compensate for lost revenue resulting from services provided free or at a significantly reduced cost to other patients

Premium

- Monthly/Quarterly/half yearly/yearly payments which the subscribers make to the Payers

Network

- Group of physicians, hospitals, and other medical care providers that a specific health plan has contracted with to deliver medical services to its members

Coordination of Benefits [COB]

- Non duplication of benefits provision.

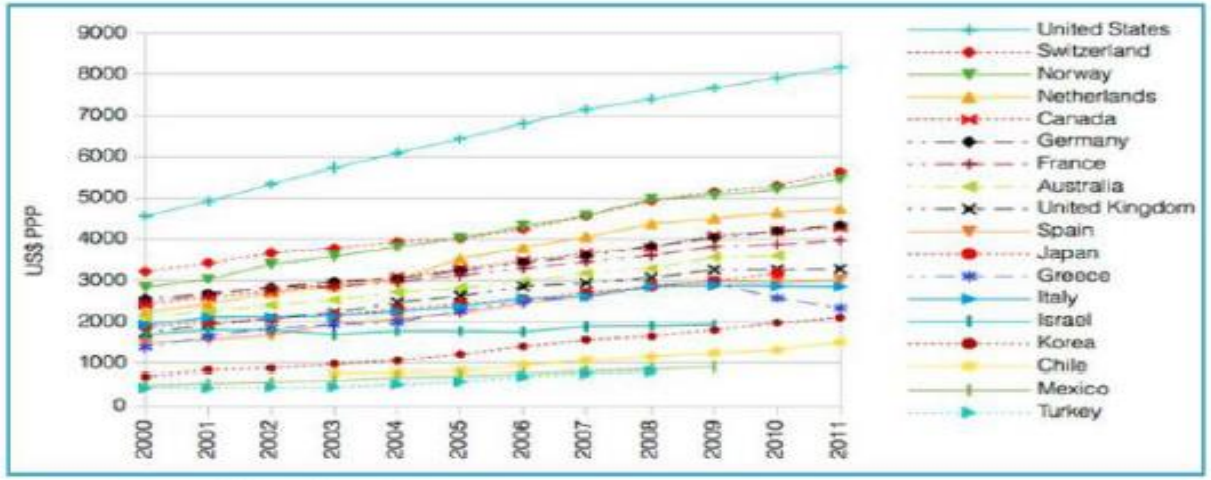
Benefits

- Coverage provided by the insurer as per the policy

Historical Overview

U.S. Healthcare – Expenditure and Quality of Care

US Healthcare is increasingly becoming unaffordable. The expenditure is expected to grow that in turn limits the stress of public resources.



Source: OECD Health Statistics, 2013

Health expenditure per capita by country, 2011

U.S. is the most expensive healthcare system in the world.
It spends $8,508 per person on healthcare, nearly $3,000 more per person than Norway, the second-highest spender.
But ranks 11th in overall quality of healthcare

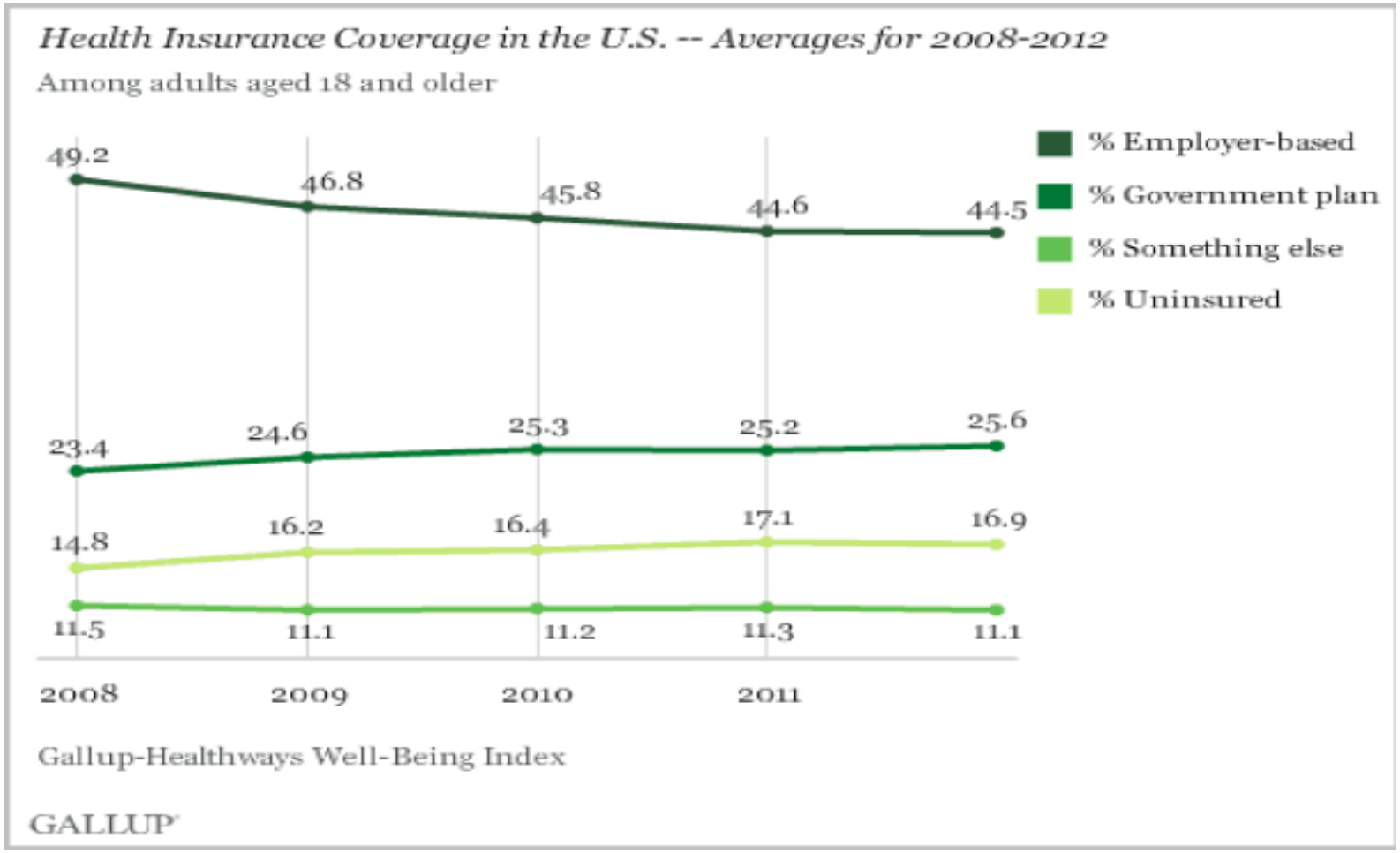
In 2018, the US$PPP was 10209

PPP – Purchasing Power Parity

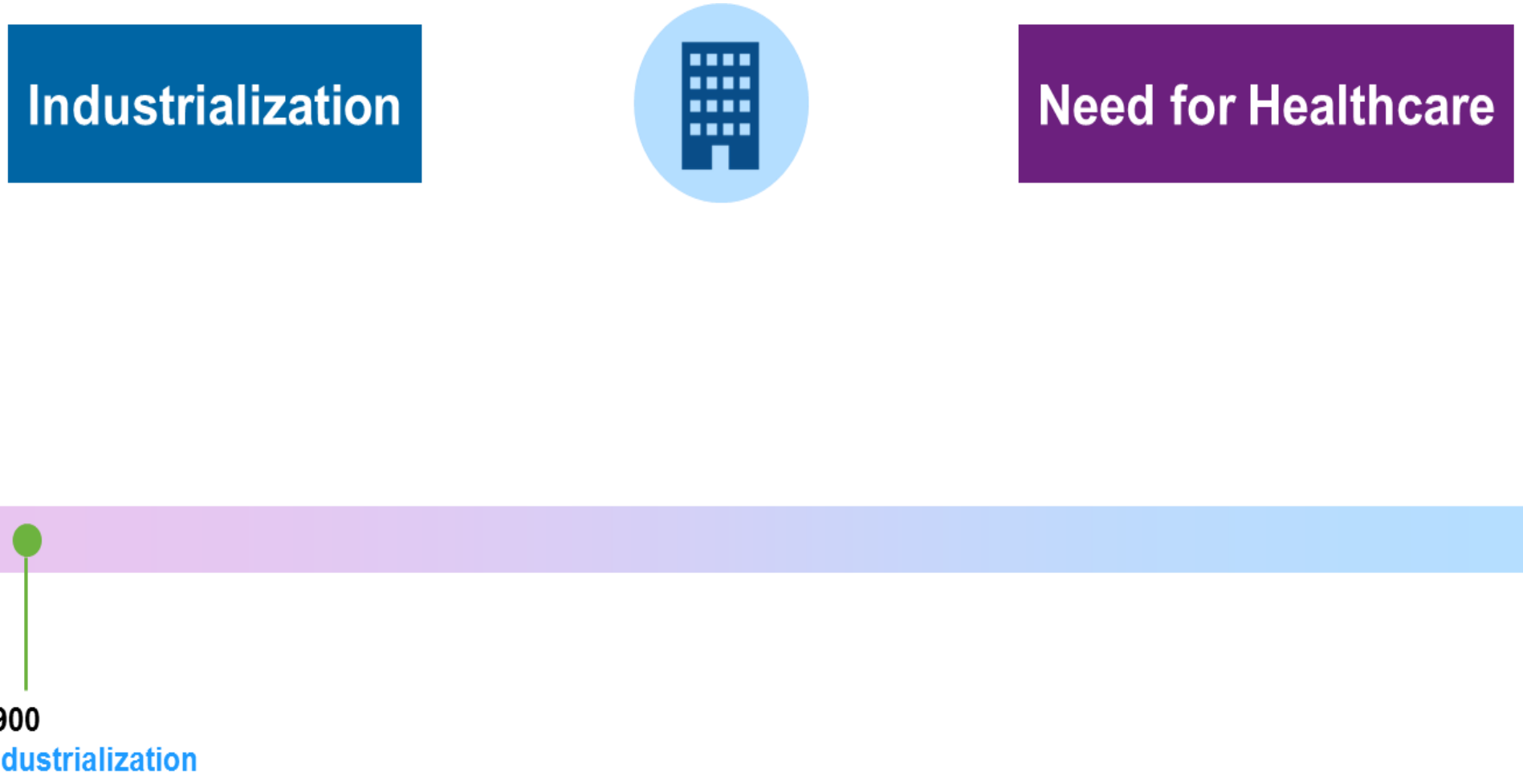
OECD – Organization for Economic Cooperation and Development

Historical Overview – Contd..

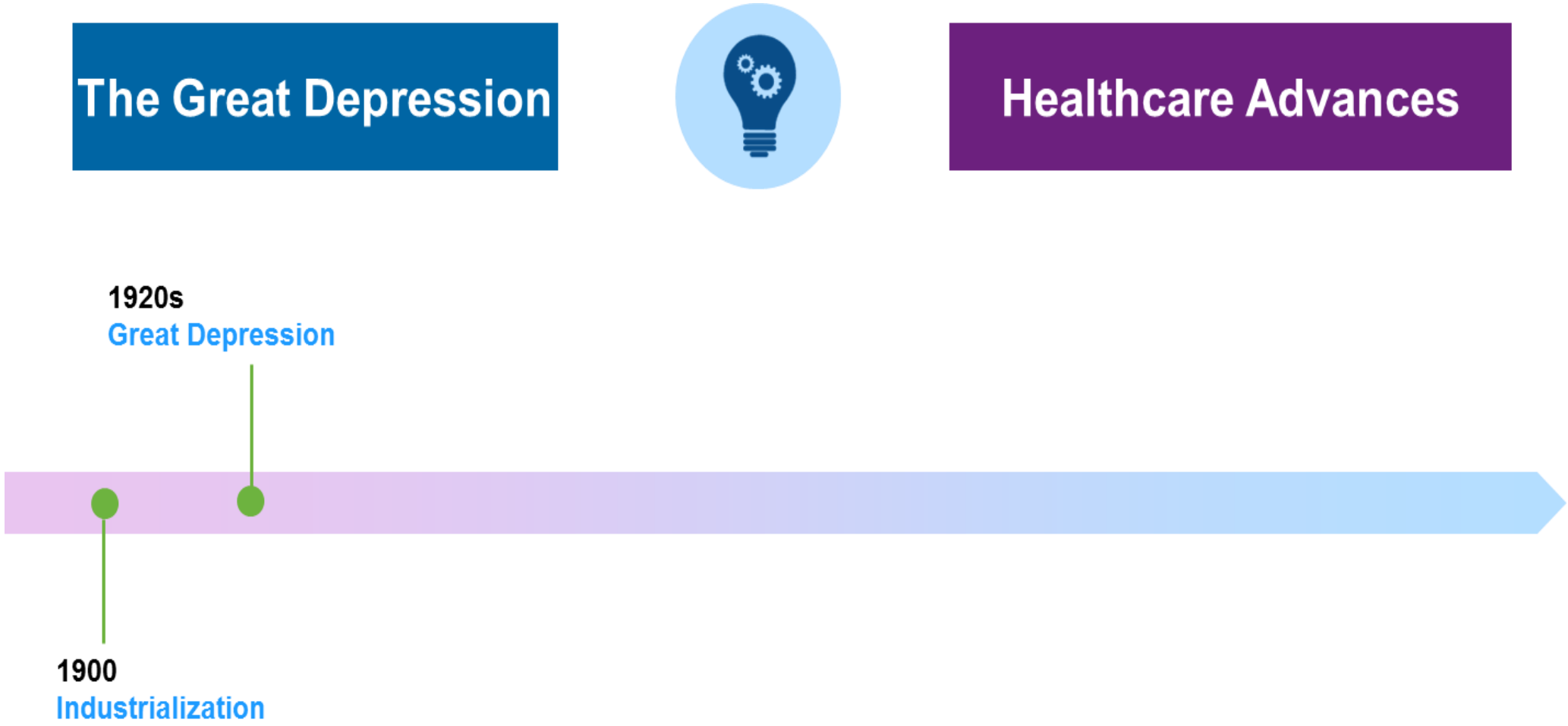
U.S. Healthcare – Expenditure and Quality of Care



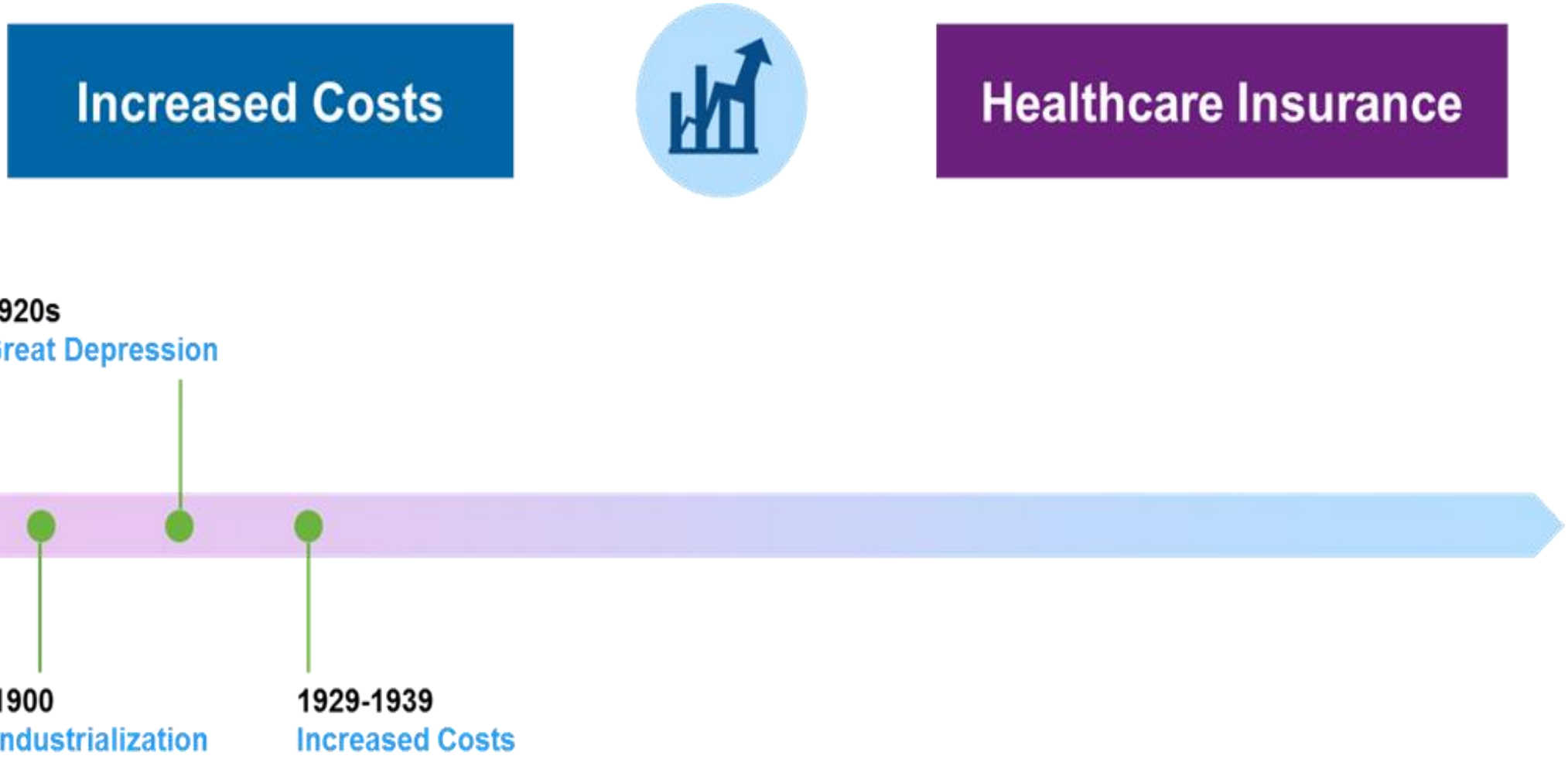
Evolution of US Healthcare



Evolution of US Healthcare – Contd..



Evolution of US Healthcare – Contd..



Evolution of US Healthcare – Contd..

Employment Benefits

Third-Party Payers

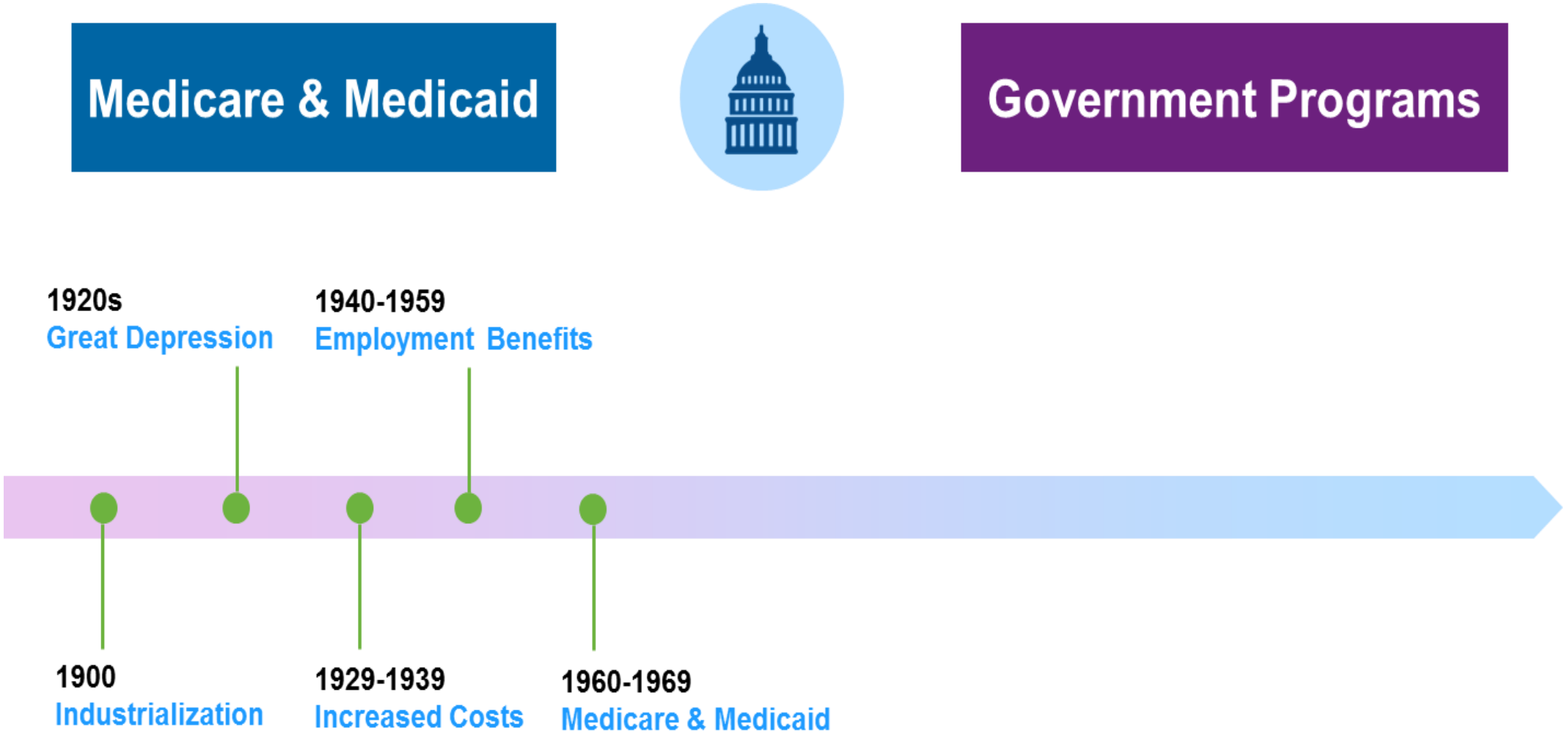
1920s
Great Depression

1940-1959
Employment Benefits

1900
Industrialization

1929-1939
Increased Costs

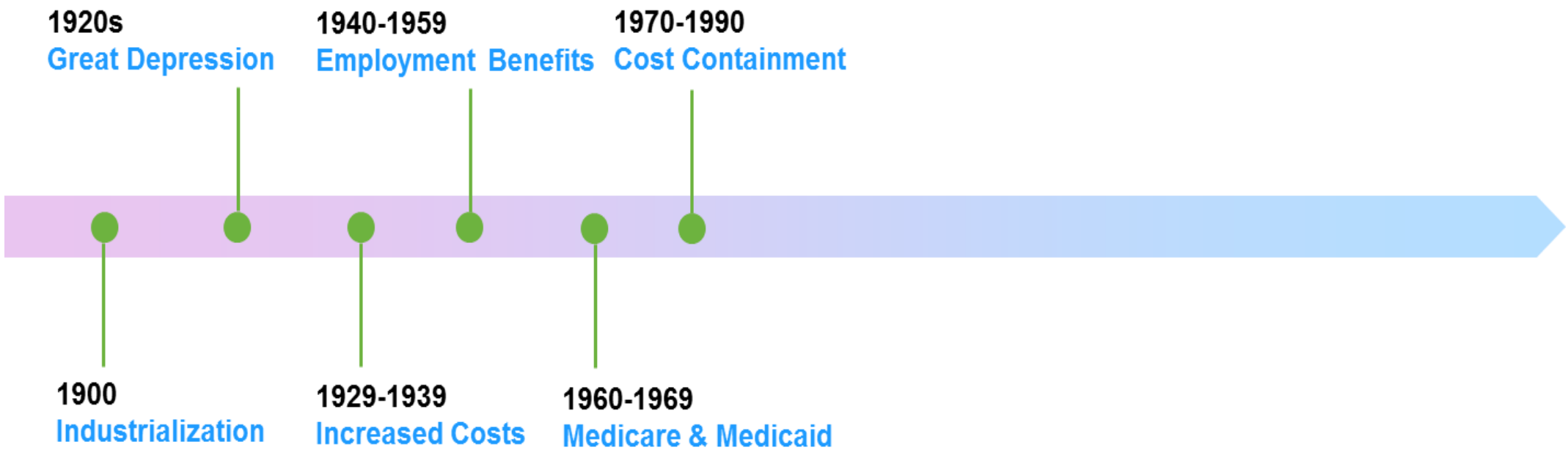
Evolution of US Healthcare – Contd..



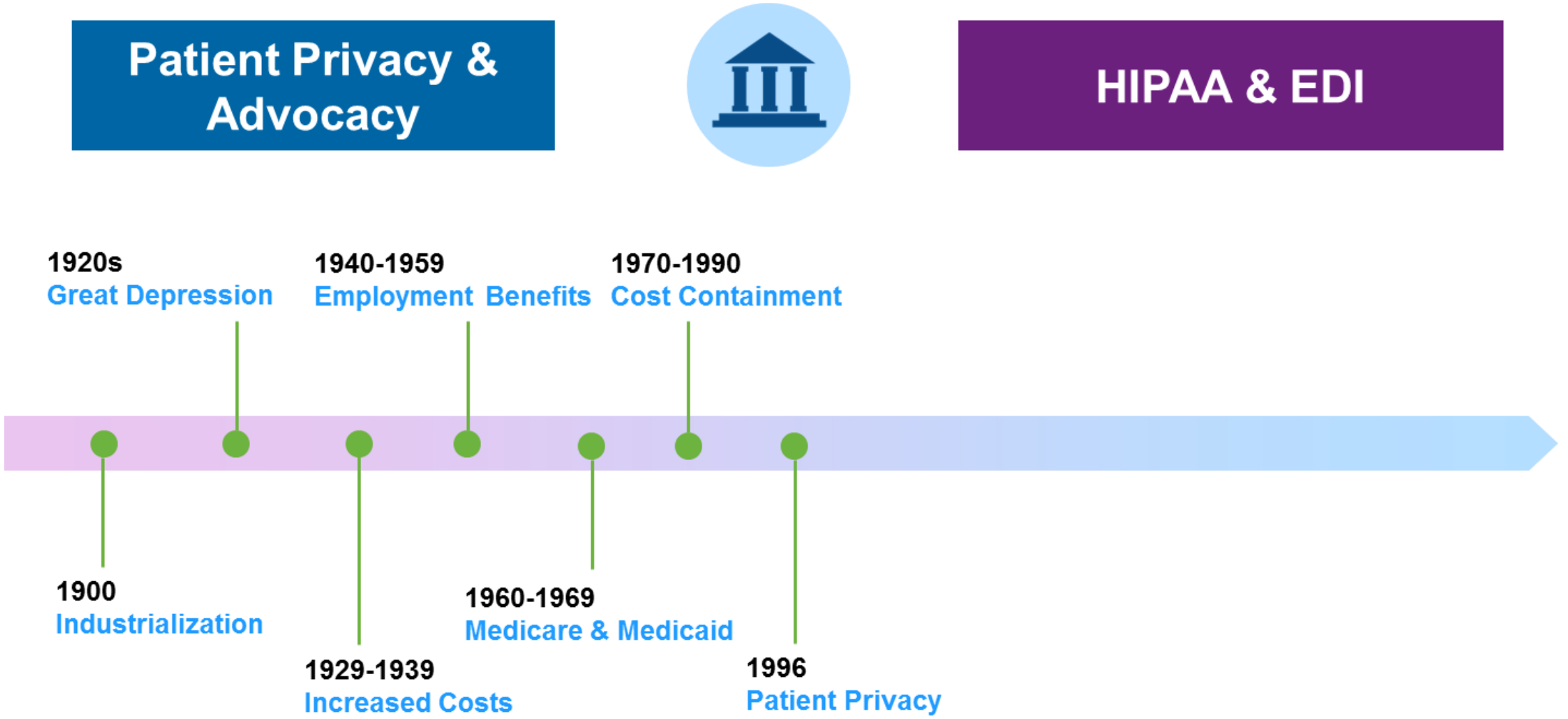
Evolution of US Healthcare – Contd..

Cost Containment

Health Maintenance Organizations (HMO)



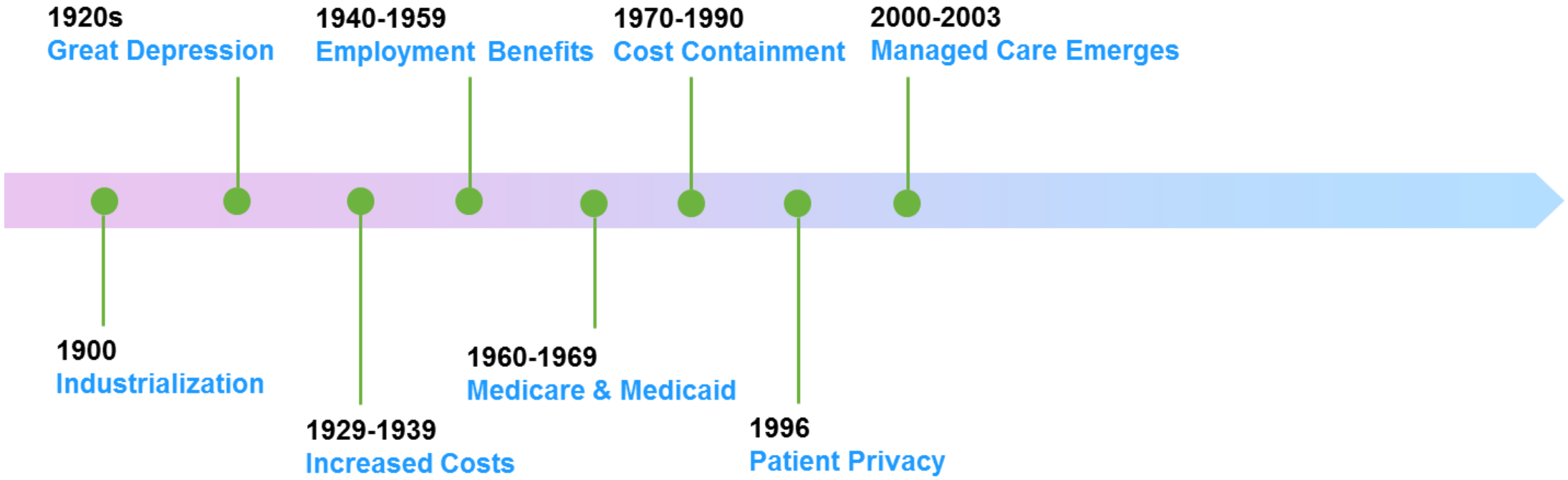
Evolution of US Healthcare – Contd..



Evolution of US Healthcare – Contd..

Managed Care Emerges

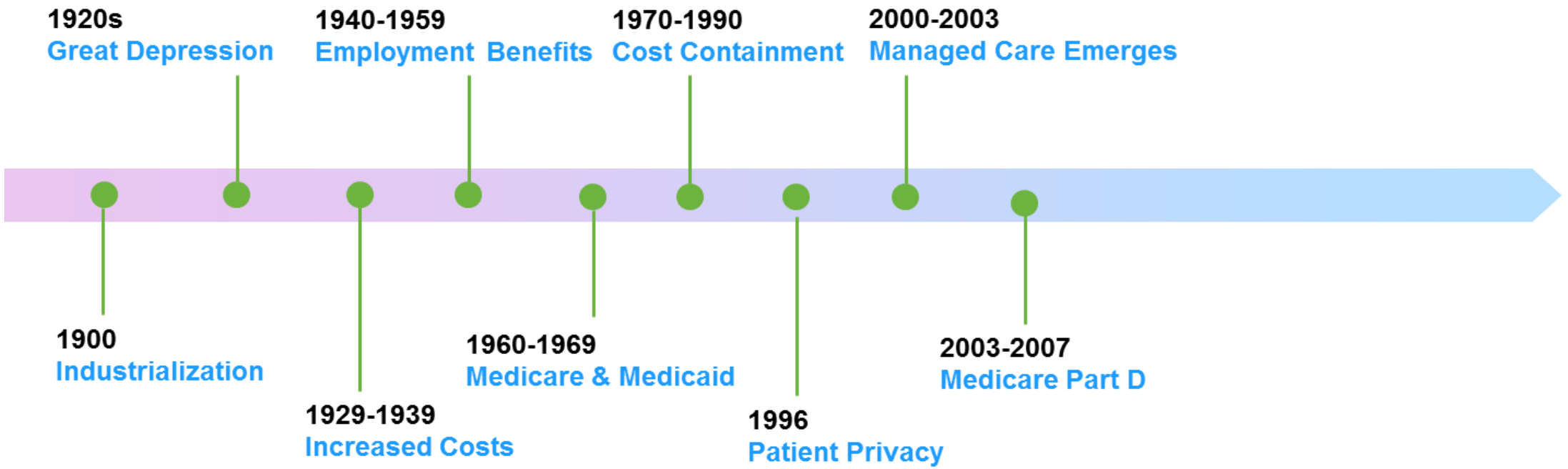
Shift to PPOs



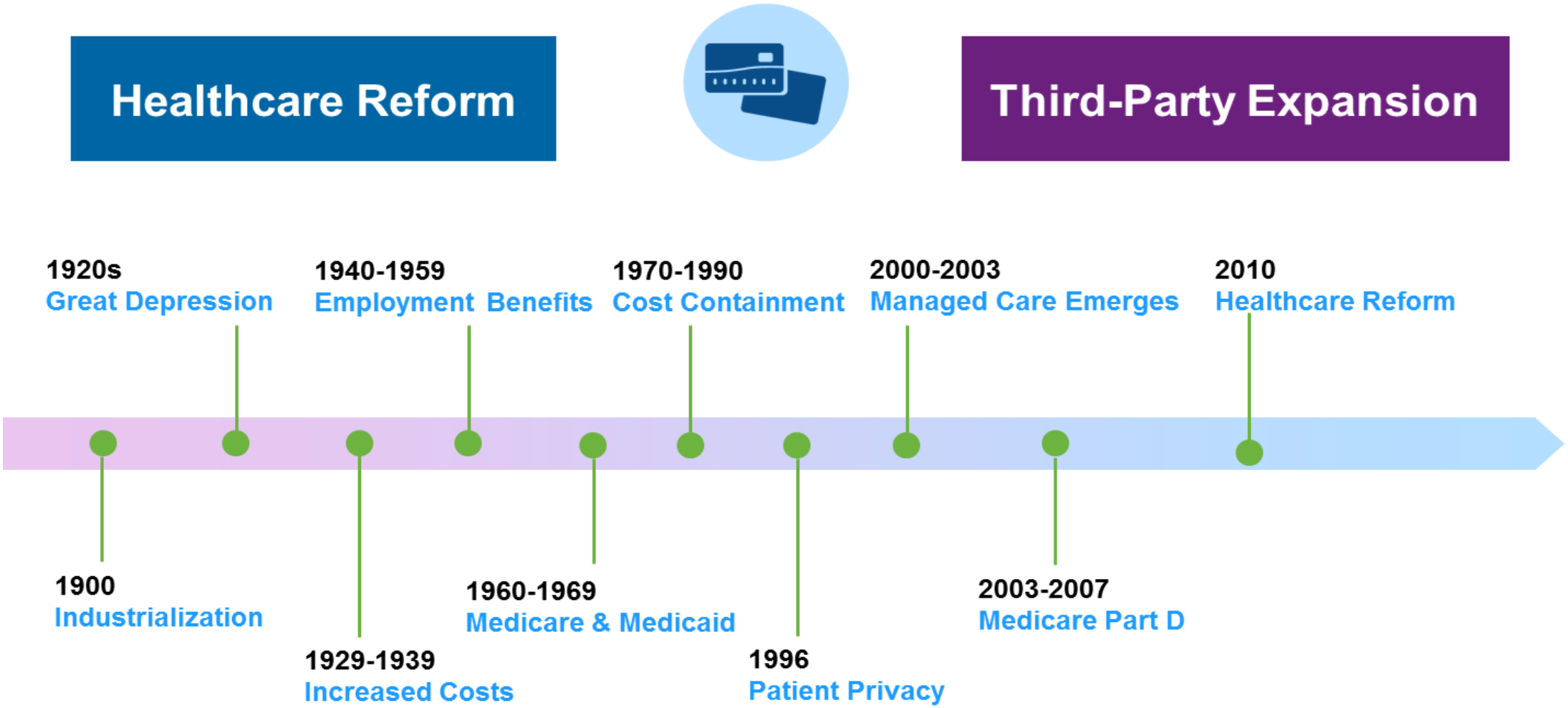
Evolution of US Healthcare – Contd..

Medicare Part D

Pharmacy Benefits



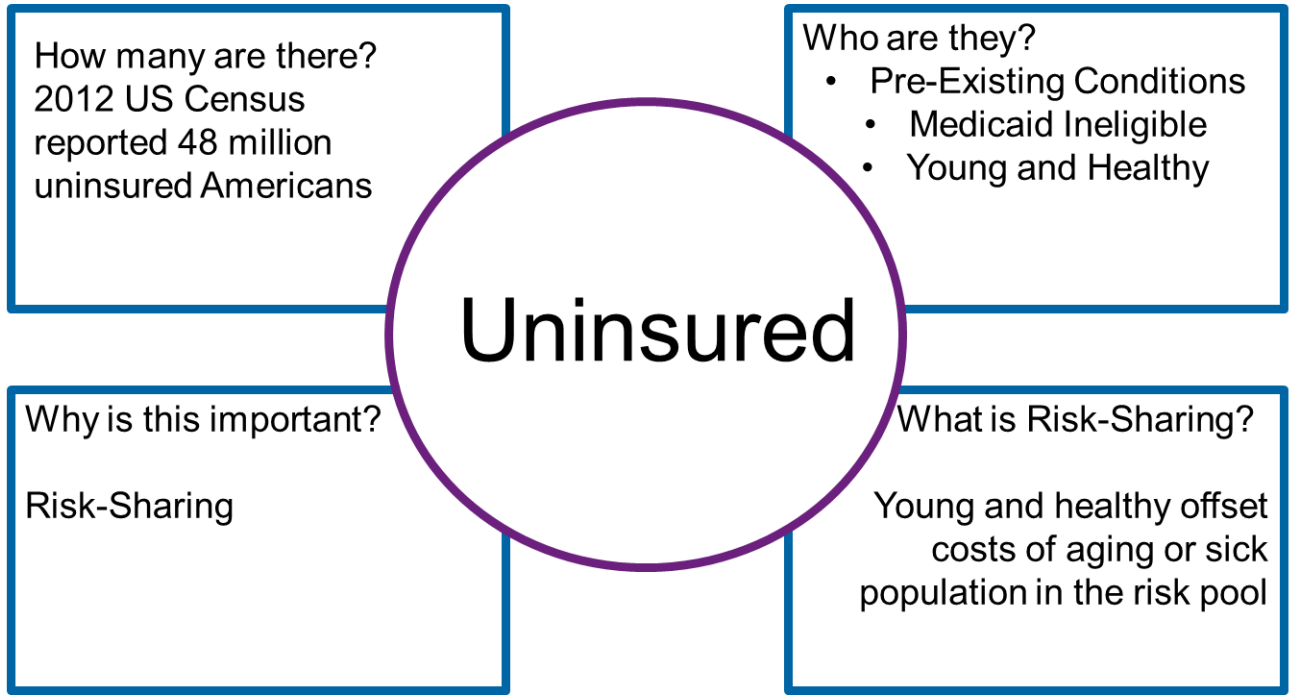
Evolution of US Healthcare – Contd..



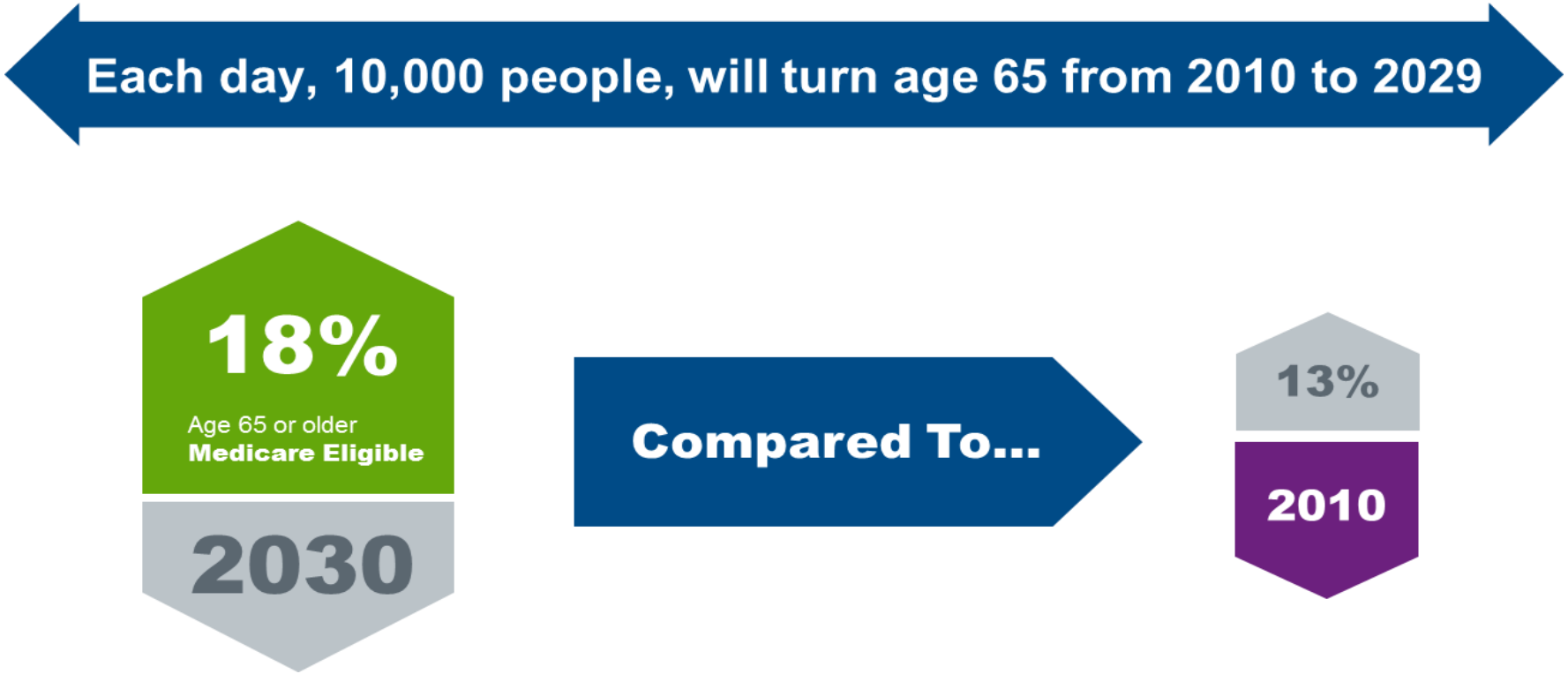
Issues Affecting HC Environment

- Continued rise in the cost of healthcare services and in turn, health insurance premiums
- United States spends more on healthcare than any other industrialized nation, yet the population is not healthy in comparison
- Shift to Consumer Directed Healthcare (high-deductible plans), Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs)
- 48 million Americans without healthcare coverage
- Continued rise in chronic conditions and obesity
- Baby boomer generation moving from employer-sponsored healthcare to Medicare

Issues Affecting HC Environment – Contd..

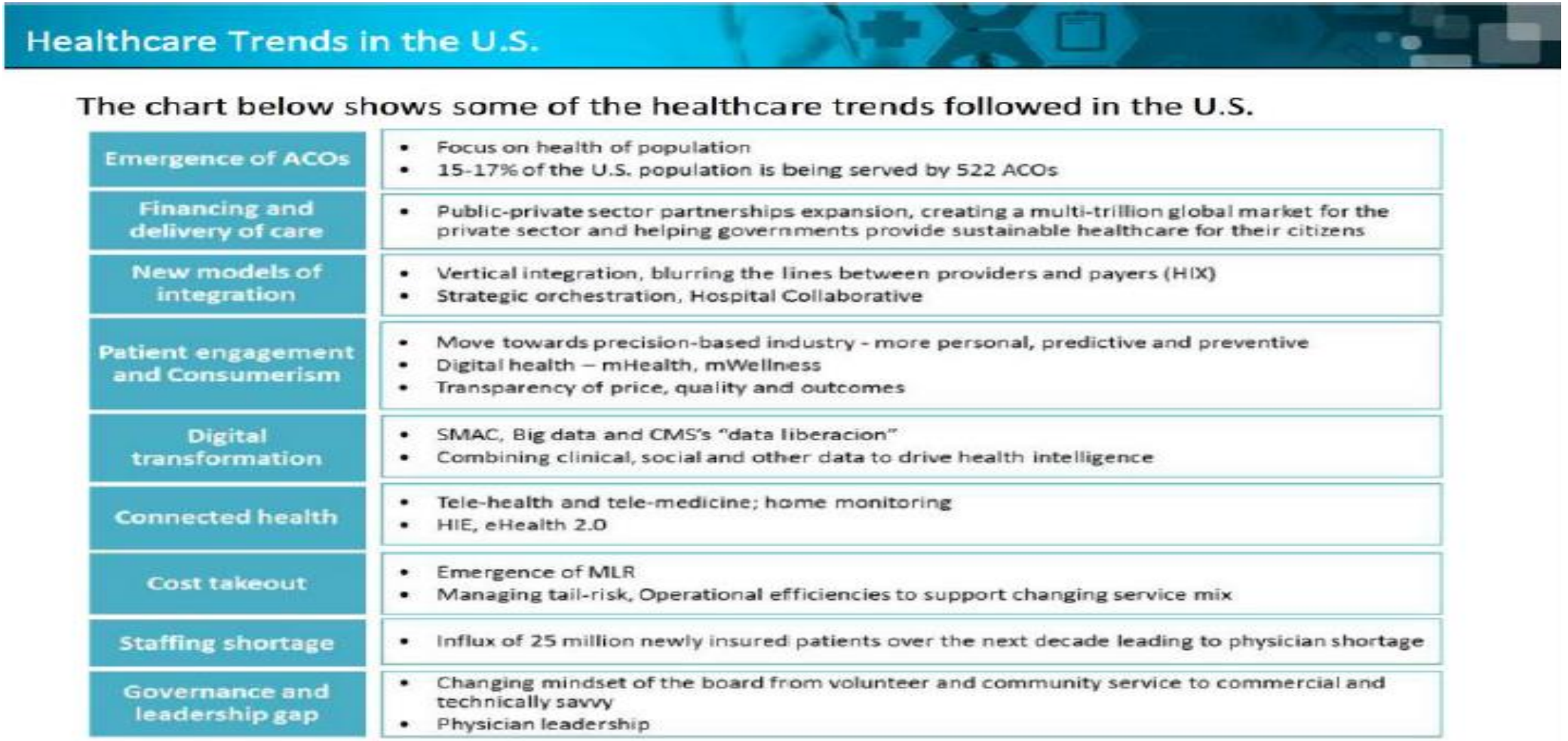


Issues Affecting HC Environment – Contd..

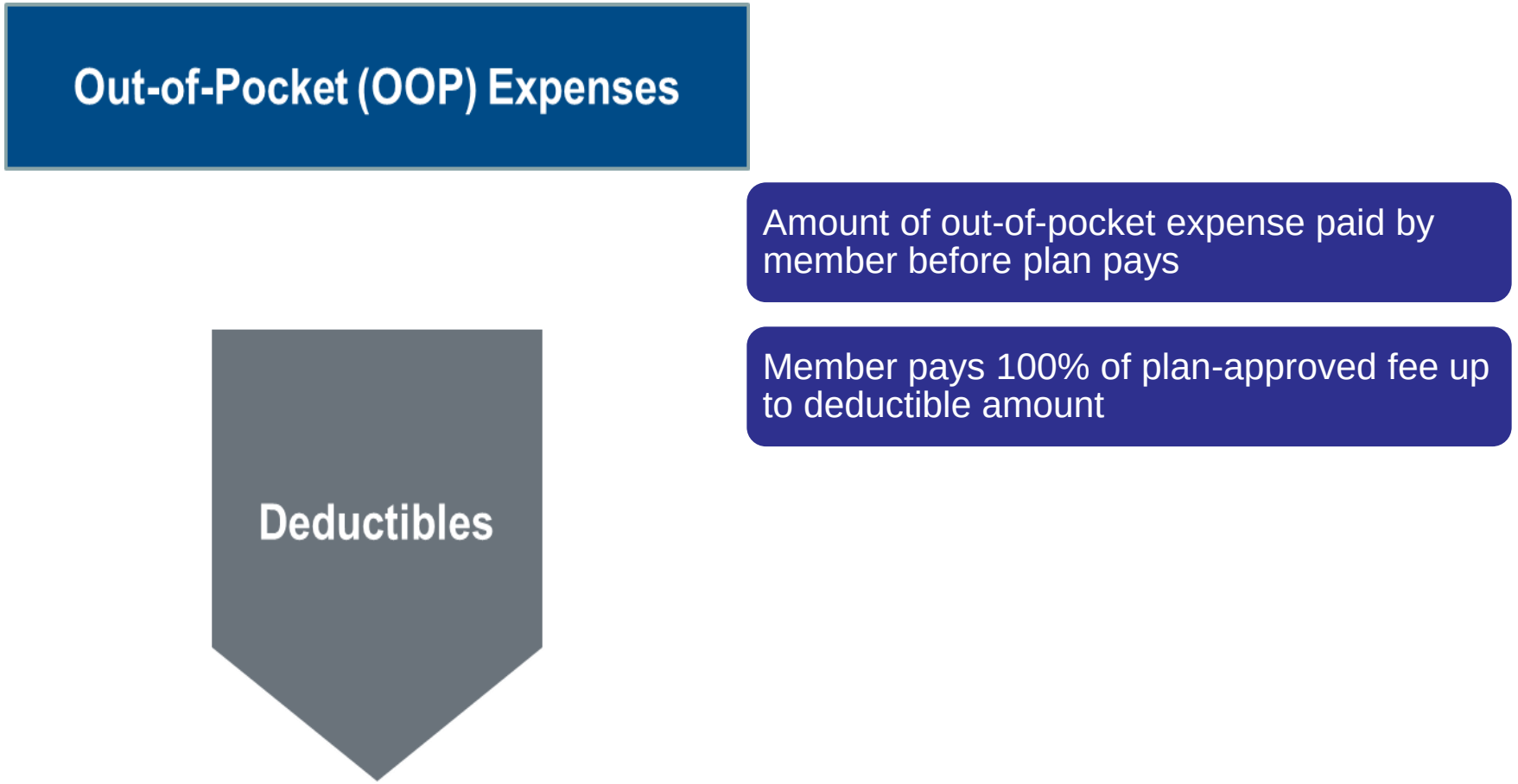


Baby Boomers

Current Trends



Deductibles



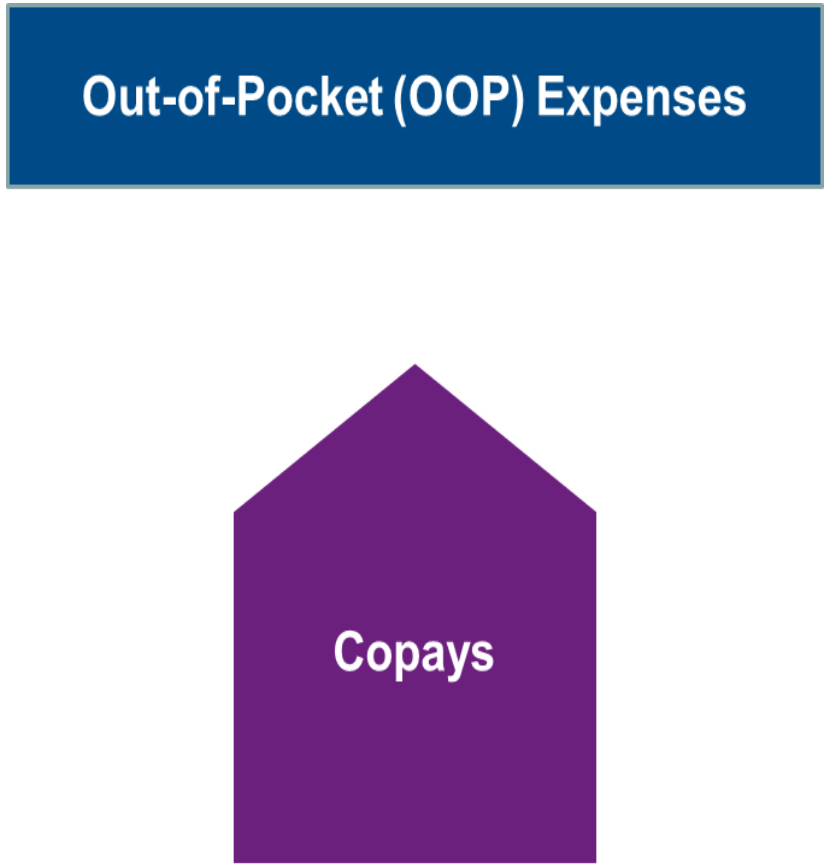
Coinsurance

Out-of-Pocket (OOP) Expenses

Amount member pays to healthcare provider for medical services:

- Based on health plan's approved fee
- Plan pays a percentage
- Member pays remainder

Copay

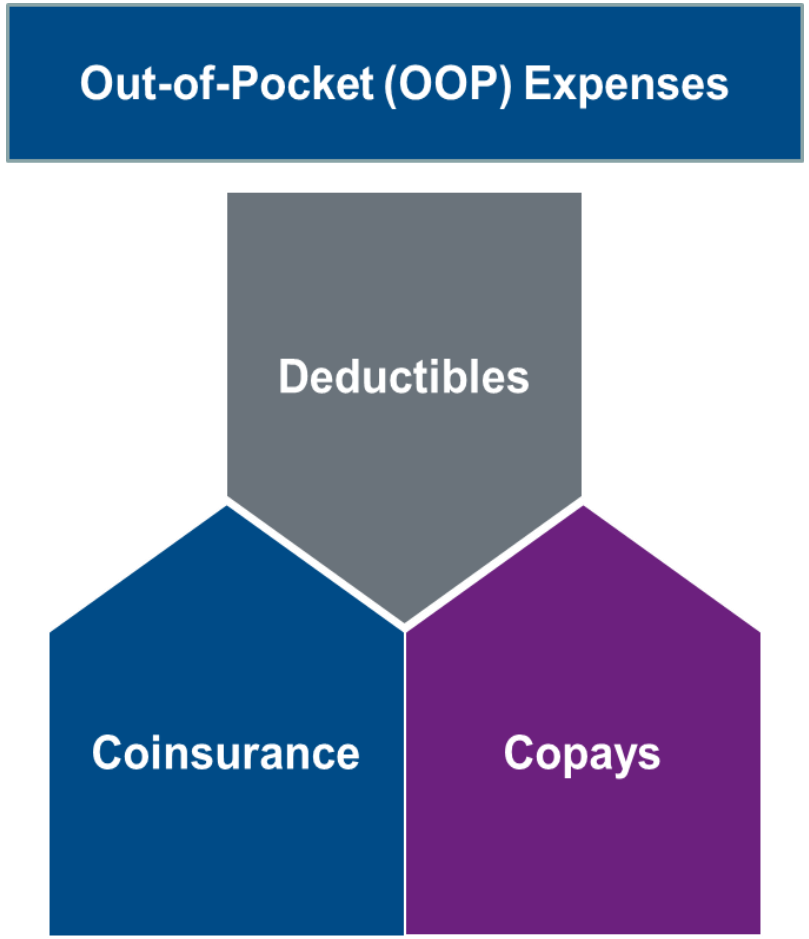


Fixed dollar amount paid by beneficiary

Due at time of service

Services such as office visits, chiropractic services, etc.

Out-of-Pocket Expenses

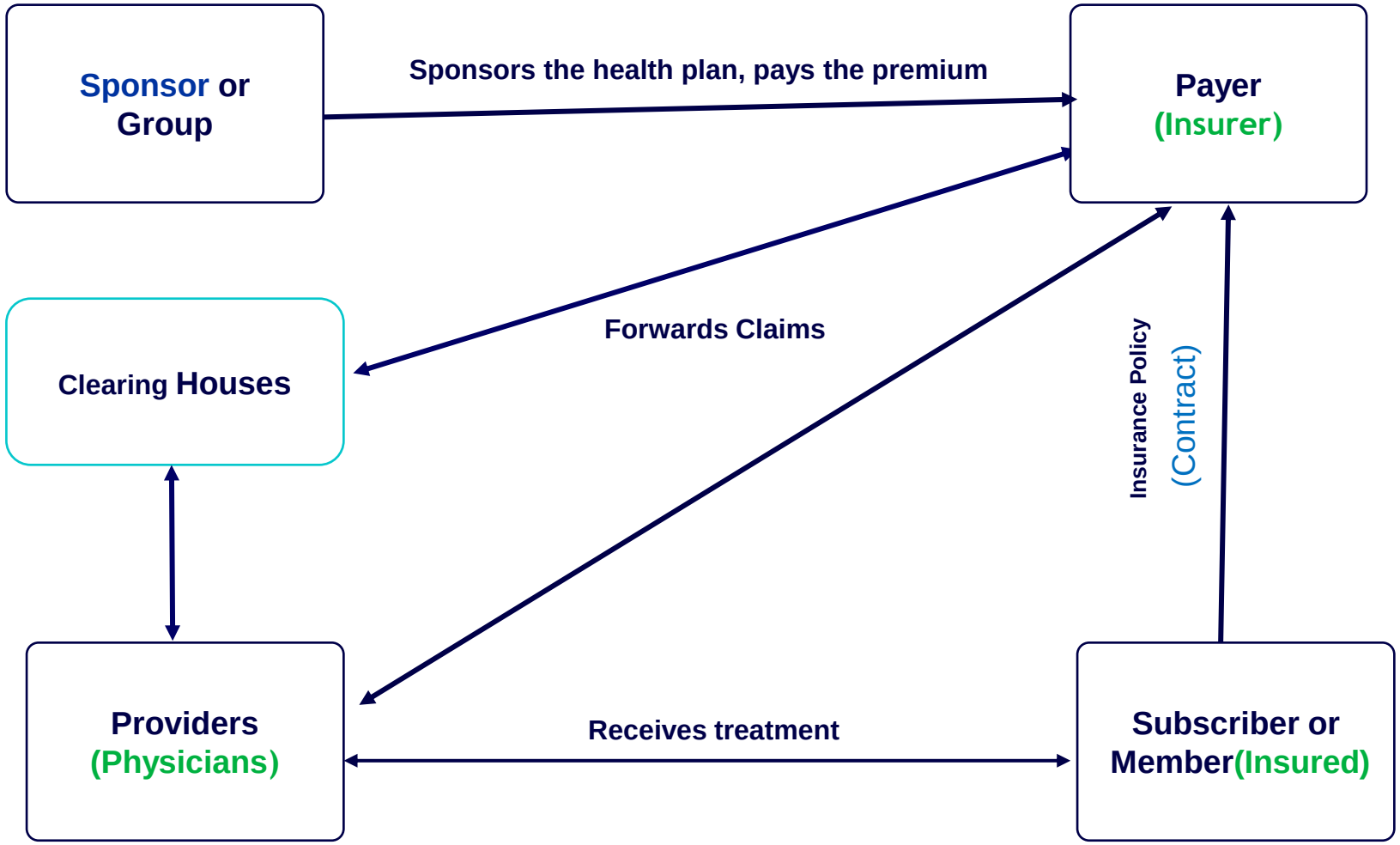


The total payment towards eligible expense that member funds. i.e., Deductible, Co-pay & Coins as defined by the plan benefit.

Key Terminologies & Definitions– Contd..

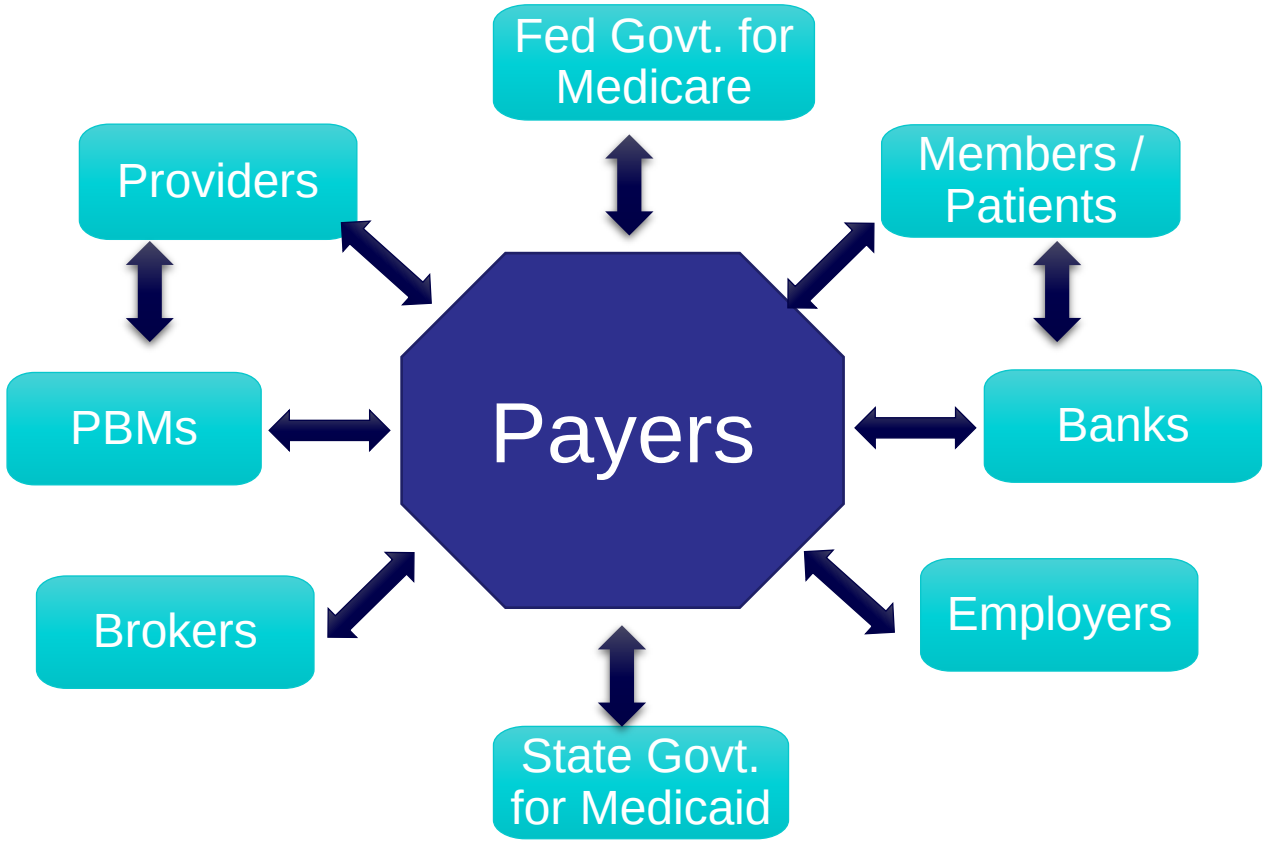
Claims	• The process of raising the expense incurred for rendering a service to the Health plan • Typically raised by Provider. Member can also raise claims
Eligibility	• The status of a member when the defined plan benefits is applicable to the member.
Accumulator	• The rolling up of total amount/units met for Deductible or Out of pocket during each service in given period (calendar year, plan year etc…)
Capitation	• A risk-sharing payment arrangement in which set amount is paid to Provider for each enrolled person assigned to them, per period of time, whether or not that person seeks care.
Pre-existing condition	• A condition for which the individual received medical care during the three months immediately prior to the effective date of coverage

How are the entities related ?

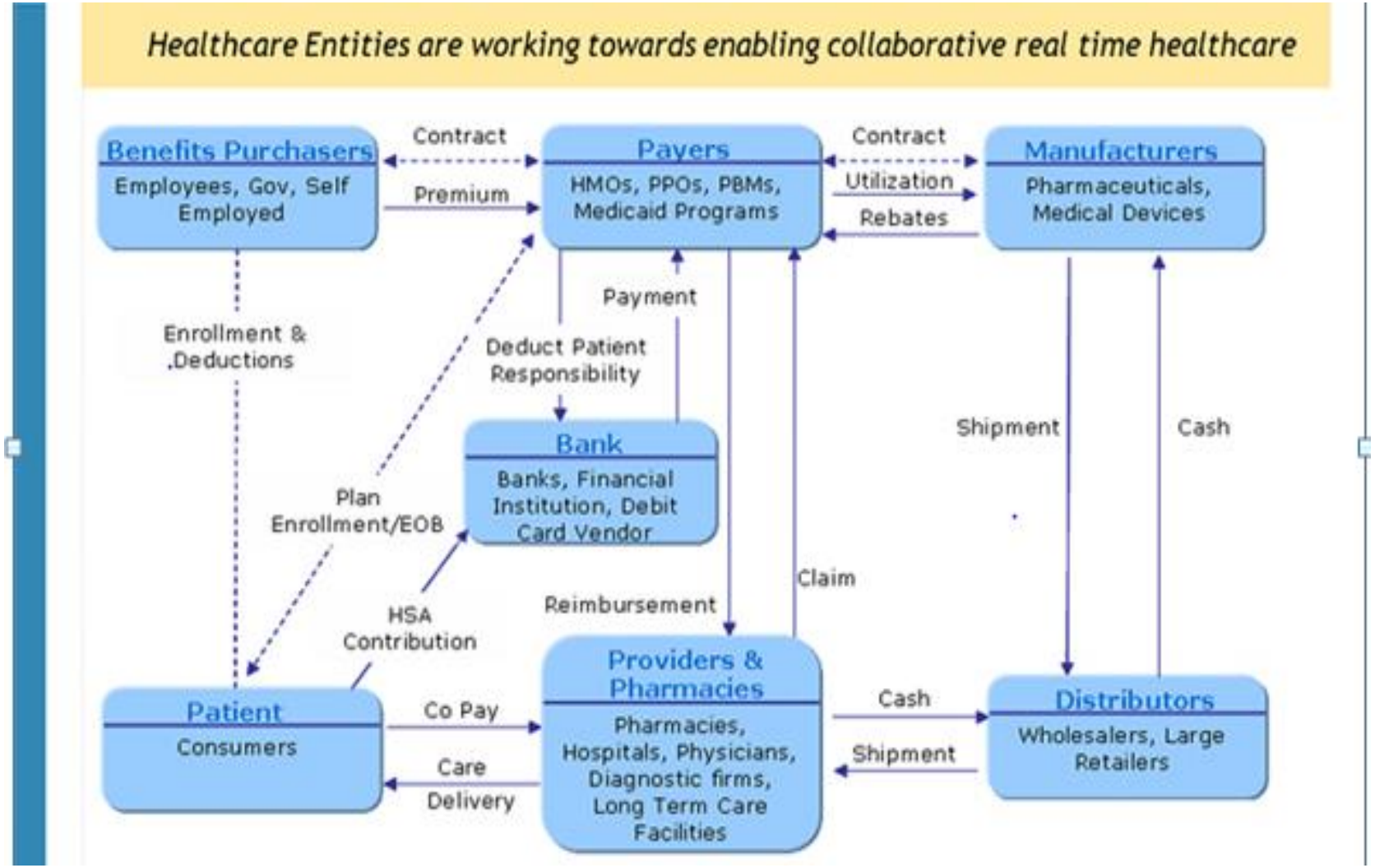


Healthcare Entities

Health Insurance – provides coverage for the financial expenses due to sickness, illness or accidents and they are issued either on individual or group basis.



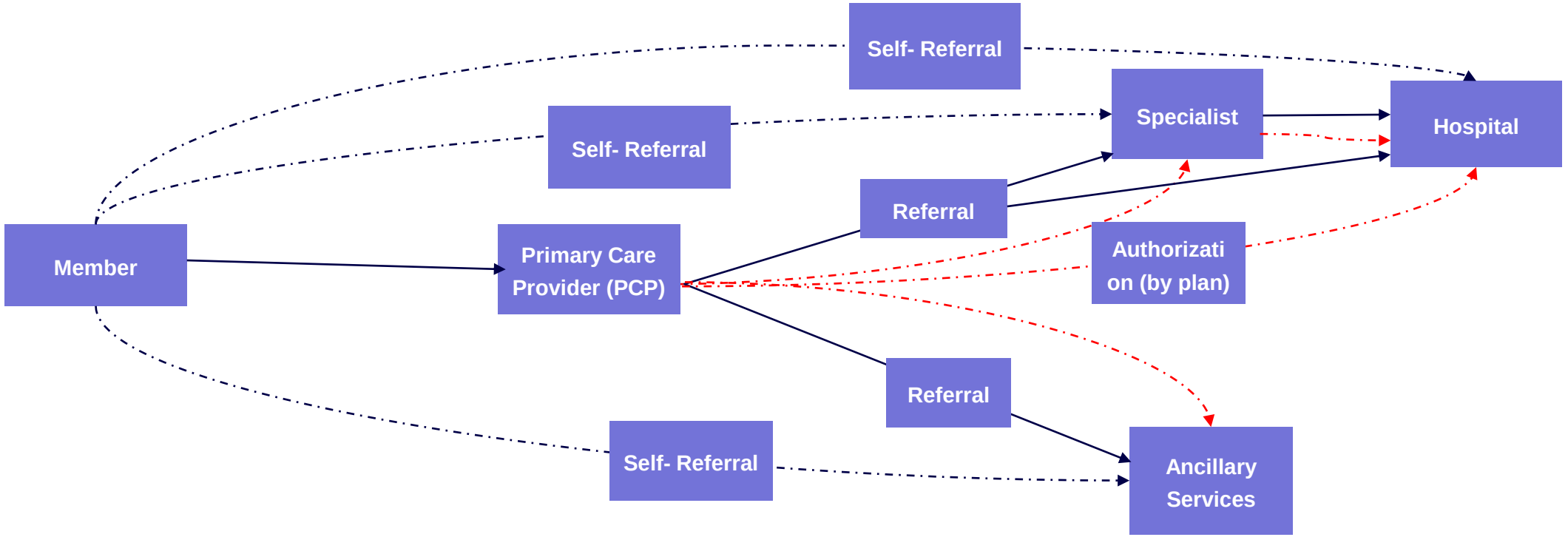
Healthcare Ecosystem



Comparison of Managed Care Entities

Constraint	Indemnity	HMO	PPO	POS
PCP	Not Required	Required	Not Required	Required
Deductible	Required	Not Required	In-network : Not Required Out-of-network: Required	Same as PPO
Out of Network Coverage	Available	Not Available	Available	Available
Referral for Specialist Visit	Not Required	Required	Not Required	Required
Cost (1-5) 5 is max	5	1	4	3
Freedom (1-5) 5 is max	5	1	4	3

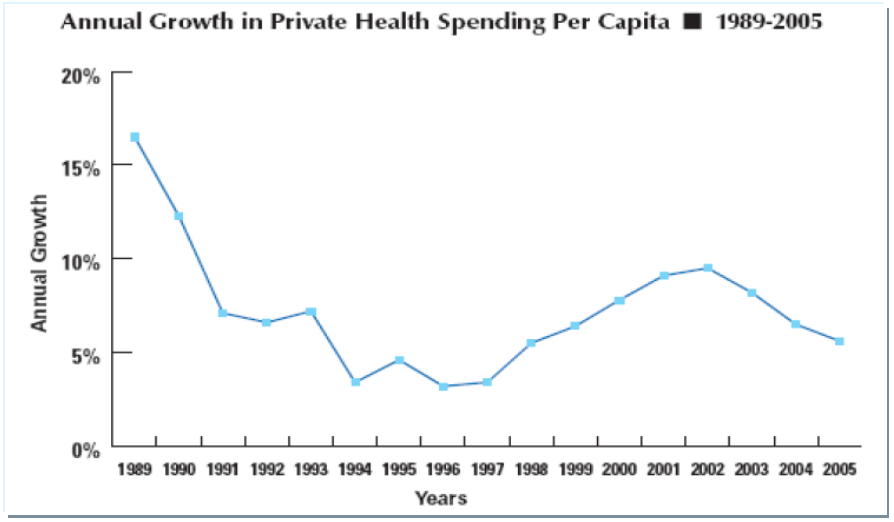
Typical Managed Care Scenario

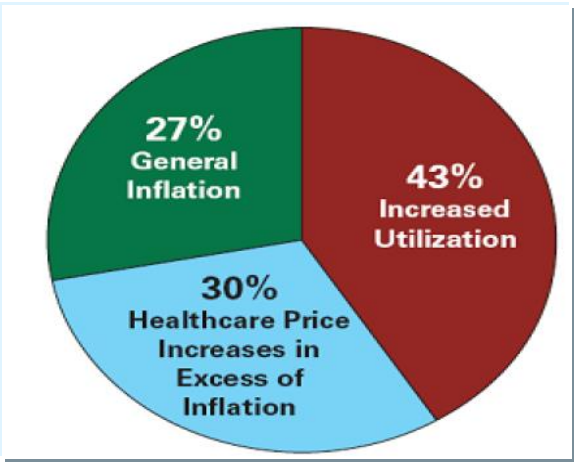


CDHP

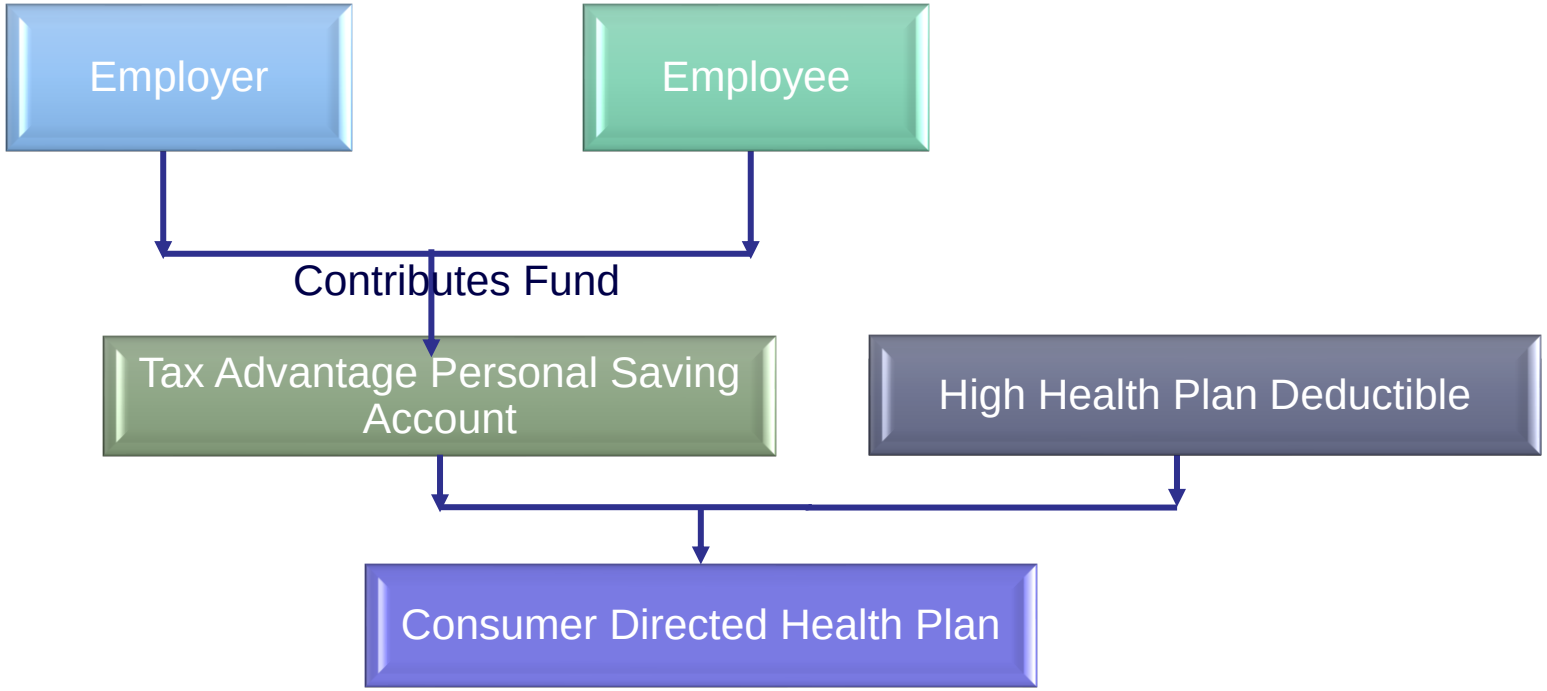
Reason Behind growth of CDHP

- Rise in per capita healthcare spending.
- Premium increases by 13%
- Employers began to offer less restrictive types of plans
- Advancement in internet technology – static to dynamic websites.
- Consumers seeking increased decision making and financial responsibility.

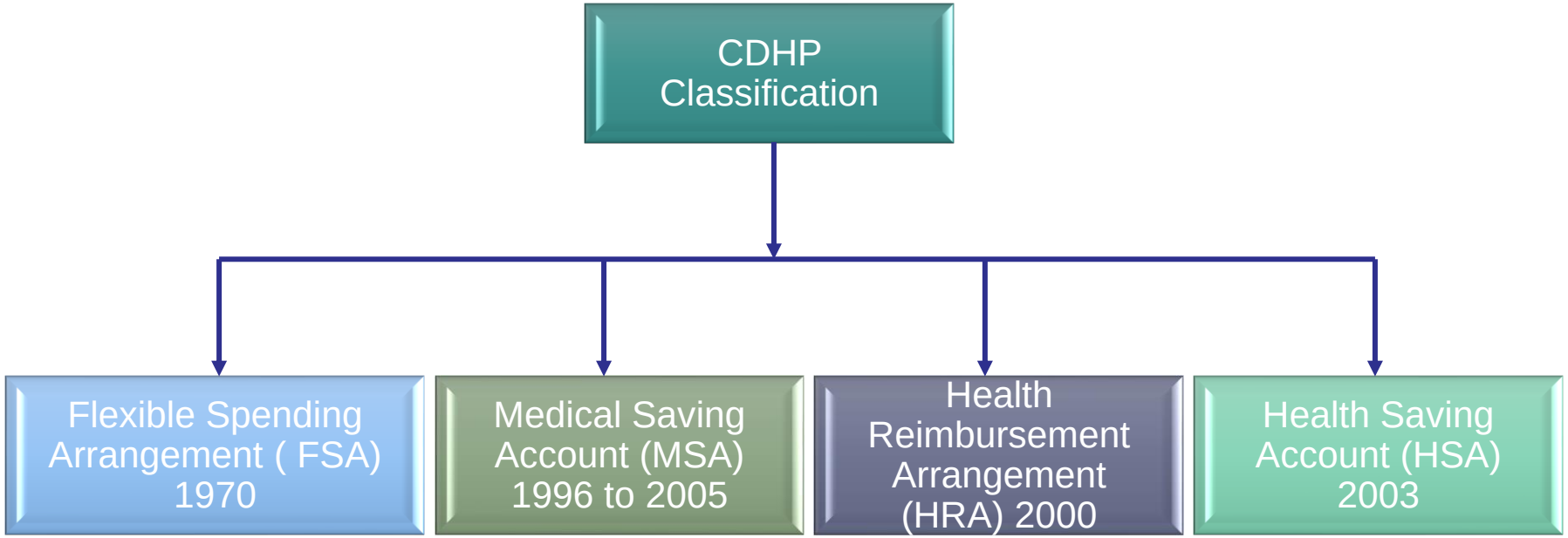




Formation of CDHP



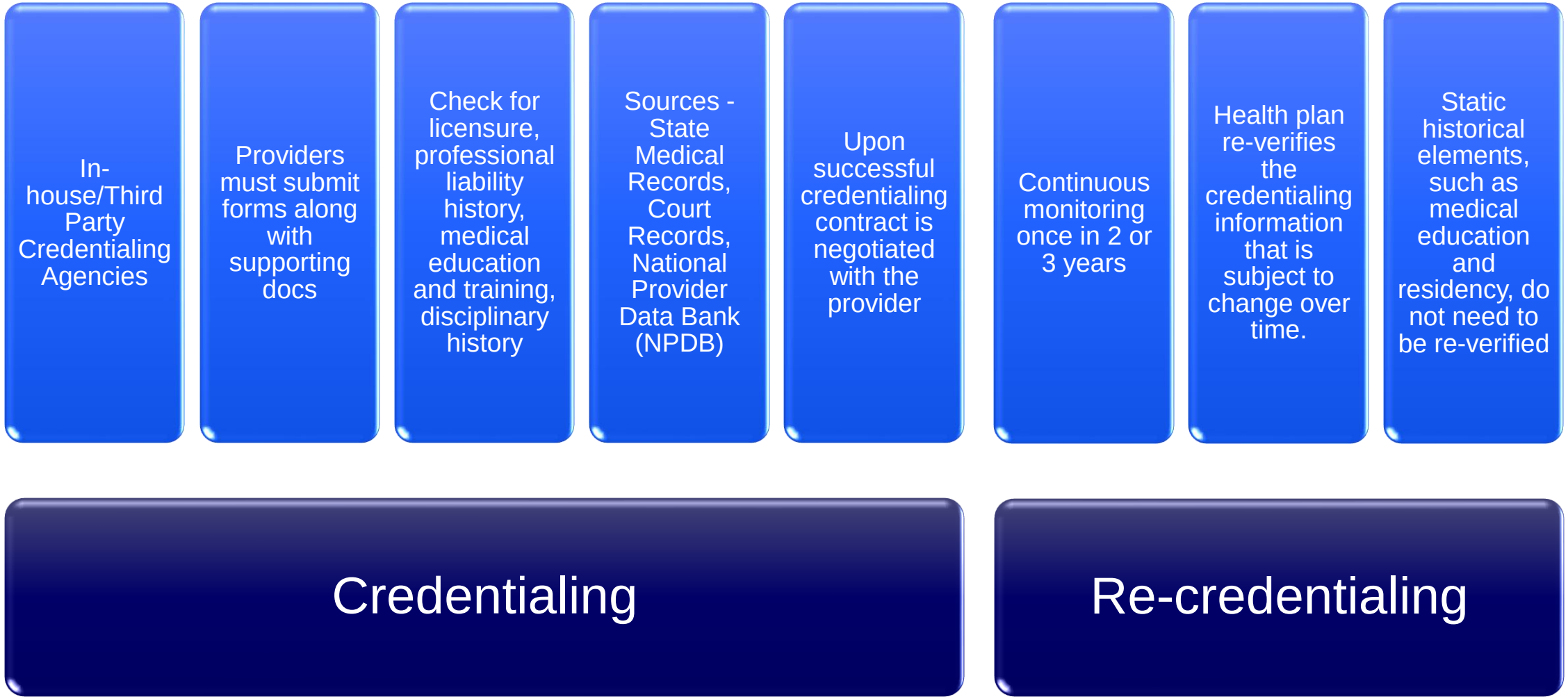
Formation of CDHP – Contd..



Comparison among various CDHP Products

Comparison of Various type of CDHP Products				
	FSA	MSA	HRA	HSA
Time of Introduction	Introduced in late 70s	Introduced in 1996 under HIPAA	Introduced in 2000	Introduced in 2003 under Medicare Modernization Act
Established by	Employer	Employer as well as Self Employed Individuals	Employer	Employer as well as Self Employed Individuals
Applicable to	Employer Sponsored People	Small Business or Self Employed People	Employer Sponsored People	Employer Sponsored People & Self Employed
Not Applicable to	Self Employed people	Large or Mid Size Business	Self Employed people	N/A
Fund Contributed by	Employee	Either Employer or Employee Contributes	Employer	Both Employer as well as Employee
Fund use with HDHP	May or may not be used in conjunction with HDHP	Must be used in Conjunction with HDHP	May or may not be used in conjunction with HDHP	Must be used in Conjunction with HDHP
Portability Allowed	No	Yes	No	Yes
Year End Transfer Allowed	No	Yes	Yes	Yes

Provider Credentialing



Utilization Review & Authorization

Utilization review (UR)

Evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

Authorization

Health plan's system of approving payment of benefits for services that satisfy the plan's requirements for coverage.

Medically necessary services

- Consistent with symptoms & diagnosis
- Accordance with standard of good medical practice
- Not solely for the convenience of the member
- Furnished in the least intensive type of medical care setting

Medically appropriate services are diagnostic or treatment measures for which the expected health benefits exceed the expected risks by a margin wide enough to justify the measures.

Framework for Utilization review

- Access requirementsf
- Frequency of utilization
- Cost and risk of a service
- Total cost
- Level of inappropriate utilization
- Cost of review.

Claims Decision Process

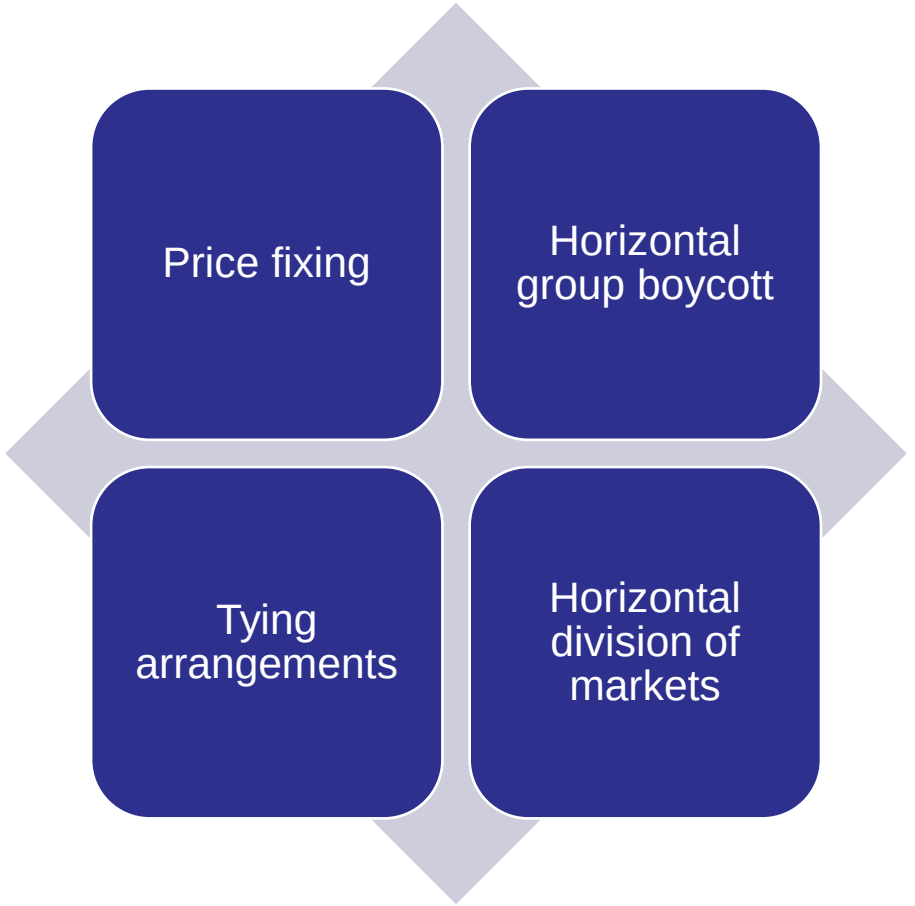
- Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim.
- Verifying Member Status - Was the member eligible to receive benefits under the plan at the time services were provided?
- Verifying Provider Status - Was the provider a participant in the plan's network?
- Determining Appropriateness of Treatment Provided - Was the treatment provided medically appropriate and/or medically necessary?
- Verifying Authorization –
    - Was a preauthorization or referral required for the service or treatment?
    - Was a preauthorization or referral given for the service or treatment?
- Verifying That the Service Is Covered by the Plan - Is the service covered under the plan?
- Verifying That the Service Was Actually Provided - Determining the Amount of Benefits to Pay
- What benefits are payable? - Does the member have other health insurance coverage?

- Claims Forms - UB-04(Institutional) and CMS-1500 (Professional)
- Edits- criteria that, if unmet, will prompt further investigation of a claim
- Claim investigation

Federal Laws that affect Healthcare

Legislative Act	Who must Comply	Protected Class	Effect of Legislation on Healthcare
Age Discrimination in Employment Act (ADEA)	Employers with > 20 employees	Employees aged over 40	All active employees irrespective of age must be eligible for the same healthcare coverage and discrimination based on age is prohibited
Title VII of the Civil Rights Act	Employers > 15 employees engaged in interstate commerce	All employees	Prohibits discrimination based on race, color, religion, sex or national origin Pregnancy Discrimination Act (an *amendment to this act*) requires health plans to provide coverage during childbirth and related medical conditions on the same basis as they provide coverage for other medical conditions
Family and Medical Leave Act FMLA	Employers that have > 50 Employees	Birth/adoption or provide care to seriously ill family members / themselves	Can take up to 12 weeks of unpaid leave in a 12 month period. Employers need to maintain the coverage of group health insurance during this period

Anti- Trust Violation



Federal Anti-Trust legislation

Sherman Antitrust Act (1890)

- Established Competitive Market Mechanisms by prohibiting
  - Monopolizing any part of trade or commerce
  - Engage in contracts, combinations and conspiracies in restraint of trade
  - Applies to all companies engaged in interstate commerce and foreign commerce

Clayton Act (1914)

- Differential Pricing without justification
- Bundling of services

Federal Trade Commission Act (1914)

- Established Federal Trade Commission to enforce Sherman and Clayton Act

McCarran Ferguson Act 1945

- Placed the primary task of regulating health insurance companies on the state

Federal Laws that affect Healthcare

Stark's Law – Ethics in Patient Referral Act (1989)

- Guards against anti trust activities in the healthcare space
- Prohibits physicians from referring patients to another agency in which he has a financial interest
- Some exceptions for rural providers

Healthcare quality improvement Act

- Exempts Hospitals, group practices and HMOS from antitrust provisions

ERISA (Employee Retirement Income Security Act)

- Regulates entities involved in employee retirement income
- Applies to employer sponsored pension plans and to all benefit plans that provide healthcare benefits
- ERISA generally take precedence over any state laws that regulate employee welfare benefit plans
- Under ERISA, self-funded plans are exempt from paying premium taxes at the state level.
- ERISA limits damage awards in lawsuits to the cost of non-authorized treatment. i.e. no compensatory or punitive damages

Federal Laws that affect Healthcare – Contd..

COBRA (Consolidated Omnibus Budget Reconciliation Act,1986)

- Applies to firms with greater than 20 employees
- Deals with continuation of insurance coverage in the case of a qualifying event
  - Reduced working hours
  - Divorce or death of a covered employee
  - Termination of employment
- Continuation of coverage up to 18 months
- Spouse and Dependents are covered UPTO 36 Months following an employees death or divorce
- Dependent child who ceases to be eligible can continue for UPTO 36 months
- Employees have a right to convert to individual health plan
- The Plan administrator may add the admin fee of 2% to the cost of plan

Gramm-Leach-Bliley (GLB) Act,1999

- Financial Services Legislation
- Convergence among the traditionally separate components of the financial services industry—banks, securities firms, and insurance companies

Federal Laws that affect Healthcare – Contd..

Gramm-Leach-Bliley (GLB) Act,1999 contd..

- How the financial services industry will be structured in the future and (2) how the financial services industry will be regulated and supervised.
- Describes the rights of customers to protect the privacy of personal financial information
- Notify customers of any sharing of non-public personal financial information with non-affiliated third parties
- Provide the consumers the opportunity to “opt out” of sharing non public personal information

Healthcare Legislations

Federal HMO Act 1973

- Instrumental in defining the structure and operations of HMOs
- Authorized for profit HMOs to contract with Independent Practice Associations (IPA)
- Contracts started with individual physicians for services and compensation
- Paved the way for the growth of HMOs
- Requirements for Federal Qualification
  - Benefits – need to offer a comprehensive benefits package which includes inpatient and outpatient services, unlimited home healthcare benefits, outpatient behavioral healthcare
  - Enrollment – Need to enroll individuals eligible for group coverage without regard to health status
  - Financing – Need to be financially sound and protect against insolvency
  - Quality Assurance – Establish ongoing quality assurance program in line with HCFA
  - Dual choice provision (removed in 1995)
  - Federal funds (removed in 1995)

Health Insurance Portability and Accountability Act

Title I – Insurance Portability

- Individual Coverage Provisions
  - Compulsory provision for individuals who in the last 18 months had group coverage but is now ineligible for either group coverage or Medicare/ Medicaid
  - Issued automatically without a medical examination and without regard to preexisting conditions
- Group Coverage Provisions
  - Preexisting condition treatment/diagnosis should have been received within 6 months prior to enrollment date
  - Preexisting condition exclusion not to exceed 12 months after enrollment date (18 months for late enrollees)
  - Need to reduce the length of preexisting condition based on the creditable coverage
  - Creditable coverage only if the period was not followed by a break in coverage of 63 days or more
  - Waiting period under employee sponsored plan does not constitute a break in coverage
  - Pregnancy cannot be treated as a preexisting condition
  - Guaranteed availability of coverage for small groups – Employees or employee dependents of employee groups with 2 to 50 employees cannot be excluded based on health status
  - Guaranteed Renewability of coverage for all groups

Health Insurance Portability and Accountability Act – Contd..

Title II – Administrative Simplification

- EDI Standards, Privacy and Security Regulations
- Need an individual's written consent to use e-PHI for activities other than treatment, payment or health operations
- Allow patients to access their medical records and request amendment of incorrect or incomplete medical information.
- Allow patients to request that restrictions be placed on the accessibility and use of protected health information.
- Ensure the confidentiality, integrity, and availability of all electronic protected health information (EPHI) the covered entity creates, receives, maintains, or transmits;
- Ensure compliance by its workforce.

Amendment of Title I of HIPAA

Mental Health Parity Act of 1996

- Prohibits group health plans from applying more restrictive annual and lifetime coverage for mental illness than for physical illness.
- Does not require health plans to offer mental health coverage. Instead, it imposes requirements on those plans that do offer mental health benefits

New born’s and Mothers Health Protection Act of 1996

- Cannot mandate hospital stays be shorter than 48 hrs for normal deliveries or 96 hrs for cesarean birth
- Does not require health plans to offer maternity benefits. Instead, it imposes requirements on those plans that do offer such benefits

Women's Health and Cancer Rights Act

- Require Health plans that offer medical and surgical benefits for to provide coverage for reconstructive surgery following the same
- Does not require health plans to offer mastectomy benefits. Instead, it imposes requirements on those plans that do offer such benefits

Affordable Care Act (ACA)-2010

Individual Mandate

- Coverage for all, else pay tax penalty
- effective 2014

Employer Sponsored Coverage

- Tax exemptions for employer
- Effective 2014

American Health Benefit Exchanges –

- Information of various health plans to consumers and help in enrollment-
- Effective 2014-
- Run by state or federal government
- Qualified Plans & Grandfathered Plans (March 23, 2010)
- Categories
  - Bronze plan (actuarial value = 60%)
  - Silver plan (actuarial value =70%)
  - Gold plan (actuarial value =80%)
  - Platinum plan (actuarial value =90%)

Subsidies for Individuals

Affordable Care Act (ACA)-– Contd..

Requirements for Health plans

- No Life time limits – effective 2010
- No annual limits – effective 2014
- Medical Loss ratio (MLR) and rebates - 85%- effective 2011
- Guaranteed issue – effective 2014 – without considering individuals current and past medical history
- No Pre-existing condition – effective 2010 for children and 2014 for adults
- Premium rating – effective 2014- based only on age, geographic area, family size and tobacco use
- Guaranteed renewable – effective 2014
- Dependent coverage – effective 2010- children upto age 26
- Deductibles – effective 2014 – for small group market cannot exceed $2000 for individuals and $4000 for family
- Rescission – effective 2010 – Insurer cannot rescind coverage except for fraud

Taxation

- Tax on High value (Cadillac) health plan – effective 2018- premium greater than $10,200(individual) or $27,500(family)
- Medicare taxes on high-income taxpayers –effective 2013
- Tax on health insurers - 2014 to 2018
- Tax on drug (branded) and medical device manufacturers

State Laws

NAIC Health Maintenance Organization Model Act (HMO Model Act)

- Regulates HMO operations in two critical areas: financial responsibility and healthcare delivery.
- Financial Responsibility Requirements
  - COA
  - If the state insurance commissioner finds that an HMO is or is likely to become insolvent, the commissioner can intervene by
    - Monitoring a corrective plan developed by the HMO
    - Reducing the volume of new business the HMO can accept
    - Taking steps to reduce the HMO's expenses
    - Prohibiting the HMO from writing new business for a specified period of time
  - *Administrative supervision*
  - *Receivership*

Government Programs

Medicare

- Federal Program
- Age 65 & Older
- Disabled
- ESRD

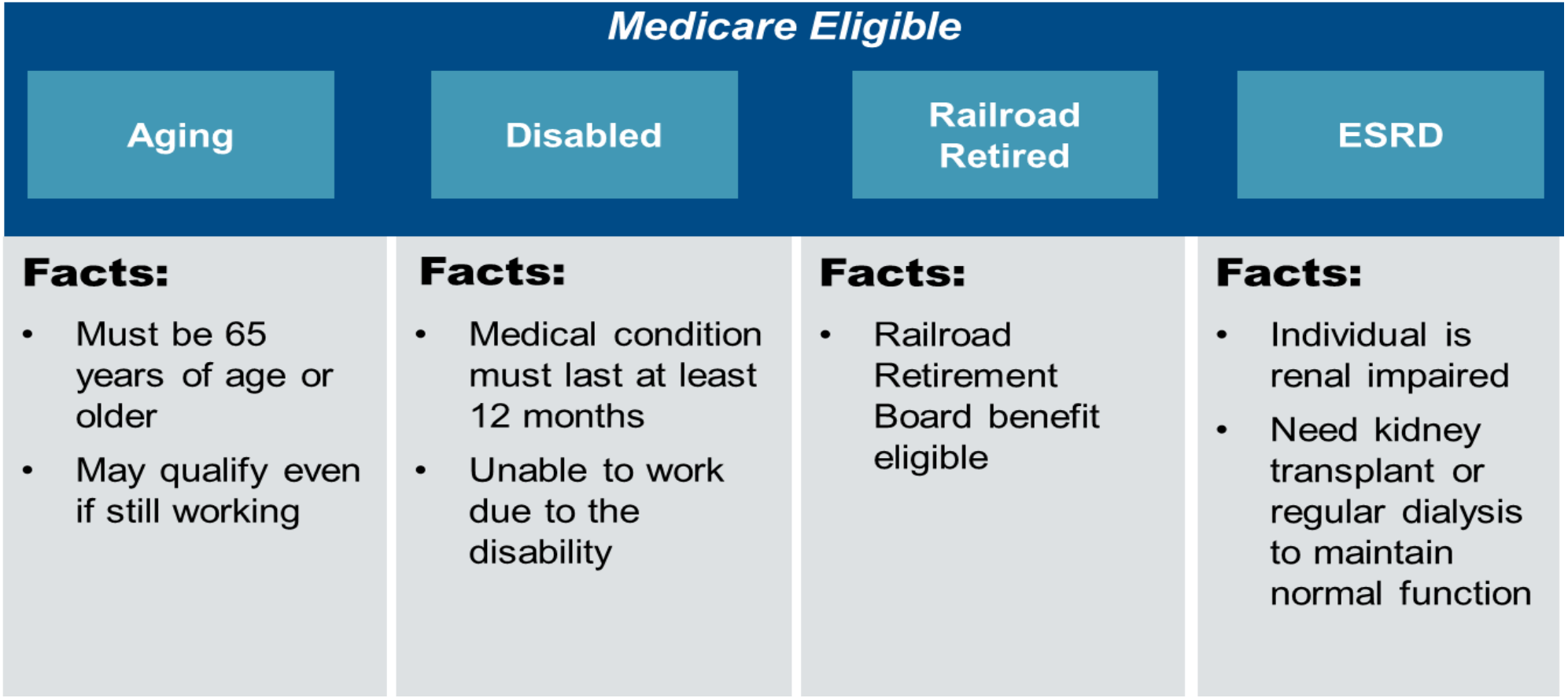
Medicaid

- State Program
- Income Based

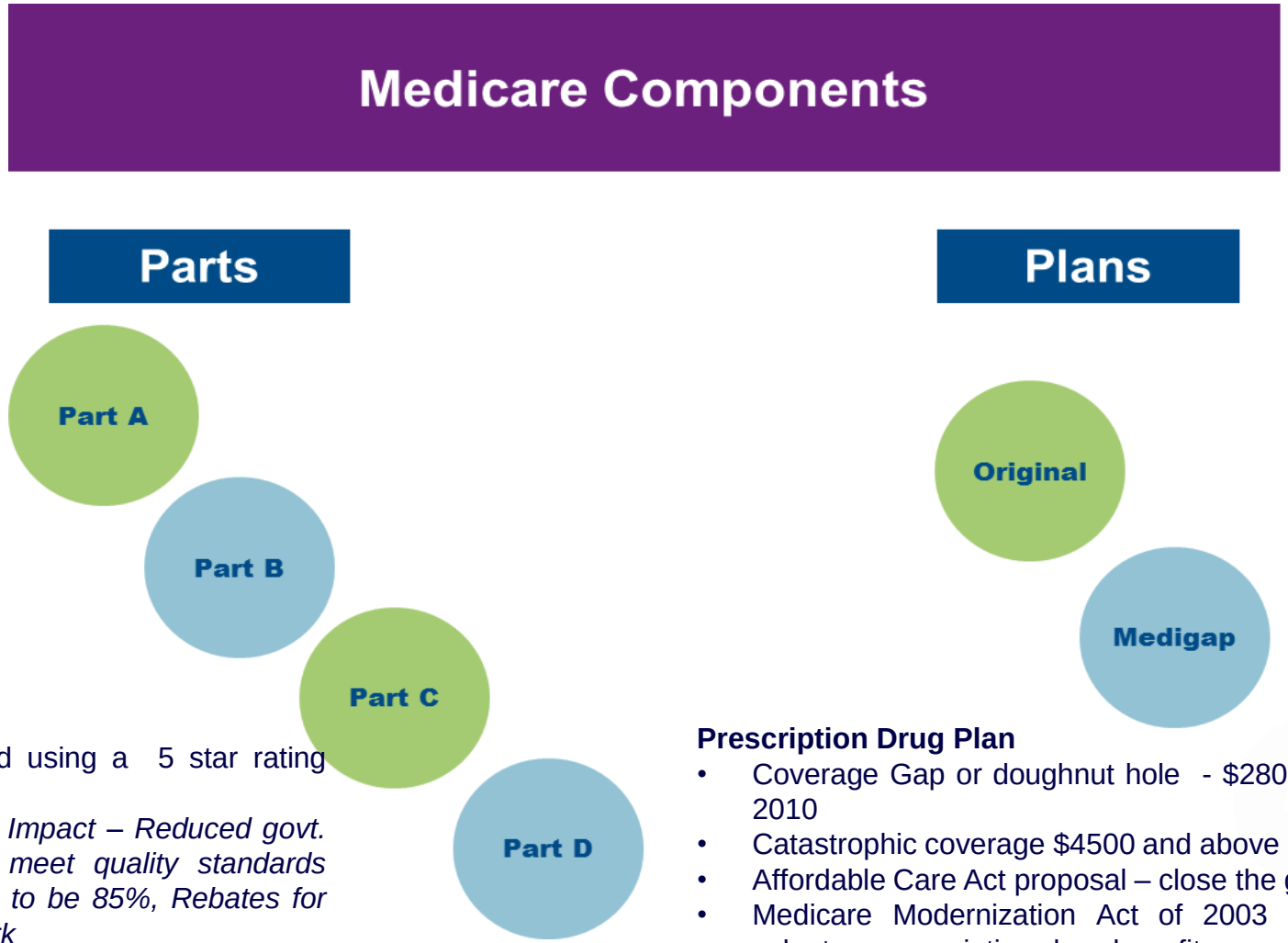
Medicare & Medicaid:

- Federally Funded
- Similar Benefits

Medicare



Medicare – Contd..



Medicare Advantage

- MA plans are ranked using a 5 star rating system
- Affordable Care Act *Impact – Reduced govt. funding from 2012, meet quality standards and get bonus, MLR to be 85%, Rebates for bids below benchmark*

Prescription Drug Plan

- Coverage Gap or doughnut hole - $2800 to $4500 as of 2010
- Catastrophic coverage $4500 and above
- Affordable Care Act proposal – close the gap by 2020
- Medicare Modernization Act of 2003 - Creation of a voluntary prescription drug benefit coverage for Medicare Part D recipients

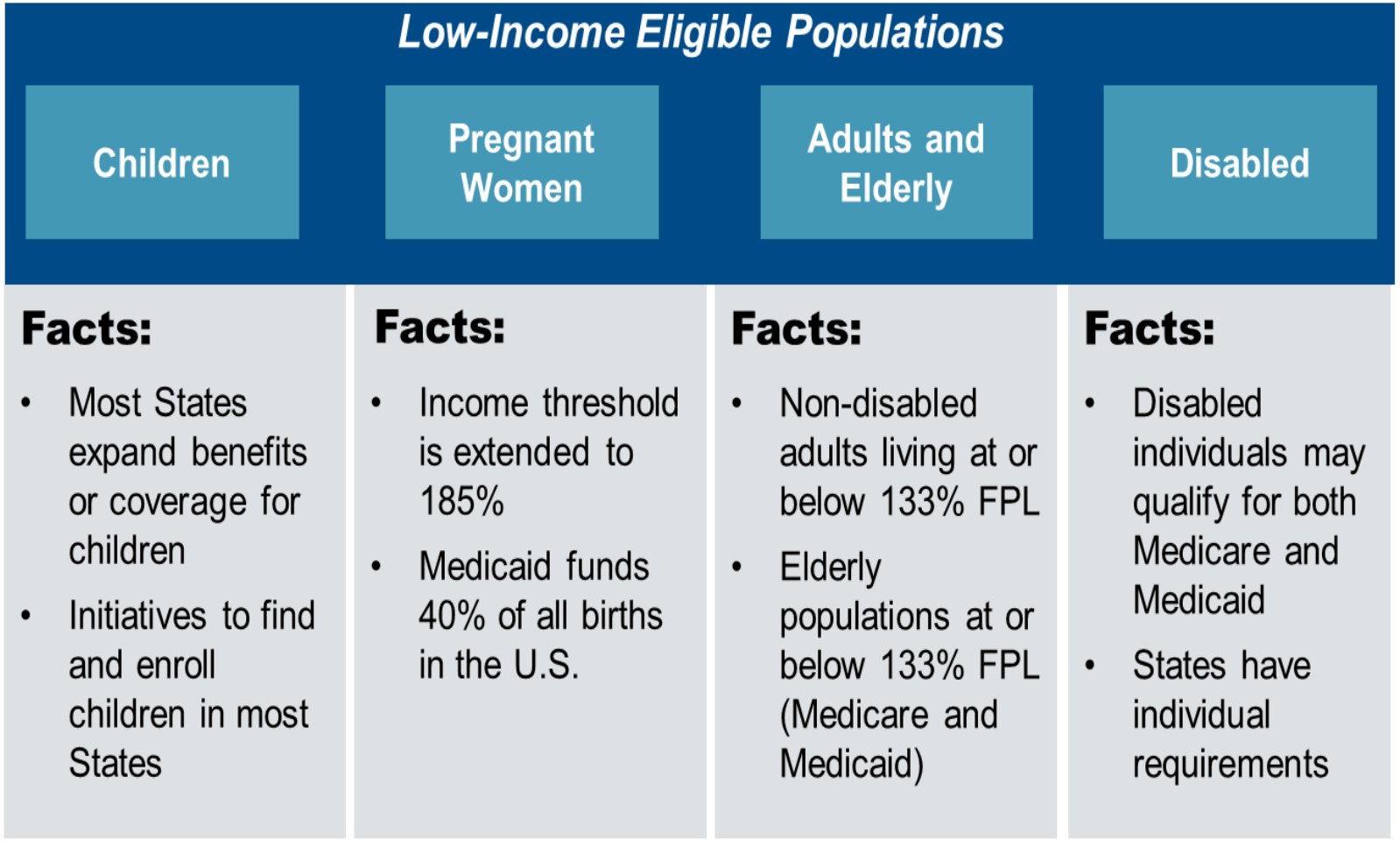
Medicare – Contd..

Medicare supplement – reimbursement for deductibles, coinsurance and some other benefit not covered by Medicare

- Medigap policies- sold by State licensed private insurance companies
- Medicare Advantage enrollees do not need (and are not permitted to purchase) Medigap policies
- Medicare SELECT is a Medicare supplement that uses a preferred provider organization (PPO) to supplement Medicare Part B coverage. Medicare SELECT does not apply to Part A benefits.

	Medigap Plans Effective June 1, 2010									
Medigap Benefits	**A**	**B**	**C**	**D**	**F***	**G**	**K**	**L**	**M**	**N**
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓
Medicare Part B Deductible			✓		✓					
Medicare Part B Excess Charges					✓	✓				
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓
Medicare Preventive Care Part B Coinsurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Medicaid



Medicaid – Contd..

Low-income population and certain aged and disabled individuals – medically needy and categorically needy

Dual Eligible

Spend down – to be eligible for Medicaid

Medicaid recipients could voluntarily enroll in managed care plans

Funding – both state and federal government

Medicaid Health plans

- HMOs and health insuring organizations
- Prepaid inpatient Health Plan (PIHP)
- Prepaid ambulatory health plan (PAHP)
- Health Insuring Organization (HIO)
  - a fiscal intermediary that contracts with a state Medicaid agency
  - The HIO does not provide medical services, but contracts with medical providers on behalf of the Medicaid
- Primary care case manager (PCCM)
  - PCP who contracts directly with the state to provide case management services, such as coordination and delivery of services, to Medicaid patients
  - Most PCCMs receive a case management fee in addition to reimbursement for medical services on a FFS basis

Medicaid – Contd..

States could also make managed care enrollment mandatory for Medicaid recipients through waivers provided under Section 1915(b) and Section 1115 of the Social Security Act. *Section 1915(b) waivers*, called “freedom of choice” waivers

- Assigning a PCCM
- Emphasize preventive measures
- Benefits - Early and periodic screening, diagnostic, and treatment (EPSDT) services for children under 21
- Access to care
- Enrollment in non rural areas a choice of two managed care plans

Reimbursement for providers- accept the payment provided as payment in full

Expansion populations

- Include individuals who do not meet categorically needy or medically needy criteria and therefore fall outside the traditional Medicaid population

Premium Assistance- State pays for premium and cost sharing with private insurance

Medicaid is always the payor of last resort

Other Government Sponsored Programs

SCHIP assistance is available to any child who meets the following eligibility requirements:

- Is under age 18
- Is not currently eligible for Medicaid or covered under other health insurance
- Resides in a family with income below the greater of 200% of the federal poverty level or 50 percentage points above the state's established eligibility limits

The Federal Employee Health Benefits Program (FEHBP)

- Voluntary health insurance program for federal employees, retirees, and their dependents and survivors
- Operated by the federal Office of Personnel Management (OPM)

Programs of All-inclusive Care for the Elderly (PACE)

- 55yrs of age and above
- Long term and acute care services at a nursing facility level care
- No limits on amount, duration, or scope of service, and requires no deductibles, copayments, or other cost-sharing features

TRICARE

The TRICARE program offers following options to military personnel, retirees(honorably discharged after 20 or more years) and their dependents:

- TRICARE Standard –FFS plan – out of pocket expense highest
- TRICARE Extra – similar to network portion of PPO- reduced FFS
- TRICARE Prime –PCP, no co pay, deductibles, co insurance
  - Retires and their dependents enrolled in Tricare prime are subject to co pay and other cost sharing requirements
  - Active-duty personnel are automatically considered enrolled in TRICARE Prime
- US Family Health Plan – a version of TRICARE Prime
  - Beneficiaries do not receive care from military facilities, TRICARE network providers, or Medicare providers, but rather one of the six former Public Health Service healthcare providers.
- TRICARE Reserve Select
  - a premium-based health plan for certain members of the Reserves and their families who are not eligible for FEHB
- TRICARE for Life
  - Medicare wrap-around coverage for individuals enrolled in Medicare Parts A and B
- TRICARE Dental Program
  - a voluntary traditional, premium-based dental insurance plan. It is free-of-charge for active duty service members and activated reservists.
- TRICARE Pharmacy Program

Treatment thru *Military treatment facilities (MTFs)*

TRICARE is always the payor of last resort

Workers Compensation

State mandated program that provides healthcare benefits for healthcare costs and lost wages due to work related injuries

No deductible & co-insurance

Both for full time & part time employees

Employers cant deny benefits even if they are not at fault

Exclusive Remedy Doctrine – Employees cant sue employers for losses

24 hour coverage

- Worker's compensation+ Group health plan + disability plan

Questions?

Thank you