Title
Payer Types, Job Aid

Question

What are the different types of Payers?

Summary
This document provides a detailed explanation of the different types of insurance plans (and sub-plans), such as Private Health Insurance and Public Health Insurance. This includes Workers' Compensation, Case Management Companies, COBRA, TriCare, the Veteran's Administration (VA), and more.

What I Need To Know

The following information applies to this document:

- Insurance is a contractual relationship in which one party pays another party to assume the risk of a defined set of future events. It may apply to a:
    - Limited or comprehensive range of medical services
    - Full or partial payment of the cost
- Health insurance can be placed into three different categories:
    - Private
    - Public
    - Other

Private Health Insurance

The following information applies to private health insurance:

- Private health care offers alternatives to government run public health care systems.
- Private health care operates:
    - Outside of government control
    - Only receives funds from:
        - Patients
        - Their insurance policies
- Private health insurance can be offered through:
    - An employer who pays the majority of the premiums
    - An individual health plan as an option

NOTE: Individual means the insurance is **NOT** connected to a business or the employer.

- Private health insurance can be broken down into the following two categories:
    - Traditional Indemnity Plans
    - Managed Care Plans

Traditional Indemnity Plans (Fee-For-Service Plans)

The following applies to Traditional Indemnity Plans:

- Traditional plans are plans covering health care under which payment is nearly automatic and oversight procedures are minimal.
- Normally require payment of medical expenses in the form of a deductible or out of pocket amount before the insurance company pays the majority of the bill.
- The advantage of this type of plan is that the insured has complete autonomy when it comes to choosing a provider of care.
- Authorization from a primary care physician (PCP) referral is NOT normally required.
- The disadvantage to this plan is that the insurance company pays a percentage of what it considers Usual, Customary, and Reasonable (UCR).

Managed Care Plans

The following applies to managed care plans:

- Managed Care Plans involve an arrangement between:
    - The insurer
    - A selected network of health care providers
- There are three types of Managed Care Plans

Health Maintenance Organization (HMO)

The following applies to HMO:

- HMO is the least:
    - Expensive
    - Flexible
- In exchange for lower insurance premiums, only in-network providers can be used for coverage.
- A Primary Care Physician (PCP):
    - Normally manages the care.
    - Referral and/or precertification from the insurance company are required for services.
    - **MUST** obtain the referral for AHG to service, if applicable.
- REDACTED Health Group (AHG) **MUST** verify:
    - The policy type during the benefit investigation.
    - the PCP referral is on file before dispensing.

- Policy types **MUST** be documented in the Insurance Profile screen of REDACTED.
- HMO referrals can **NOT** be backdated.
- Start and stop dates for HMO referrals **MUST** be documented.
- Approval time frame:
    - From the PCP can vary by payer.
- **MUST** be:
    - Validated.
    - Documented.
- HMO Policy type authorization for medication:
    - An HMO referral is an approval for the patient to see the specialist that AHG received the prescription from.
    - A PCP referral for an HMO policy type is **NOT** related to the health plan's authorization requirement for a specific medication, but AHG **MUST** follow the health plan's authorization requirements.
    - A PCP referral number and/or dates **MUST** be documented in the chart notes.
- Preventive care is almost always covered at 100% with a copayment for each appointment.
- In general, HMO plans have an unlimited lifetime maximum.
- The **ONLY** disadvantage is that the insured is financially responsible for any services rendered out of the HMO network.

Preferred Provider Organization (PPO)

The following applies to PPO:

- PPO plans allow for more flexibility at a slightly higher cost when compared to an HMO policy.
- PPO plans offer both in and out of network coverage giving the insured more options when choosing healthcare providers.
- In-network coverage offers a smaller coinsurance that gives the insured an incentive to choose providers within the PPO network.
- Specialist can be seen without PCP involvement or prior notification.
- PPO rules for coverage can be complex so it is best to verify what types of services are covered before picking this type of insurance plan.

Point of Service (POS)

- The POS plan has attributes of both the HMO and PPO plan.
- The POS plan is like an HMO plan because a PCP referral is usually required to see the specialist or provider.
- It is like a PPO plan because the insured has the option of coverage:
    - In network
    - Out of network

- There is a higher in network benefit level that encourages the use of in network providers but the insured can go outside of the network usually at a higher cost.
- POS plans normally cover:
    - More preventive care services
    - May offer improvement programs such as health club discounts.

Public Health Insurance

The following applies to public health insurance:

- Public health insurance can be separated into two major government programs:
    - Medicare
    - Medicaid
- The public health insurance option, also known as the public insurance option, or simply the public option, is a proposed government run health insurance.

Medicaid

The following applies to Medicaid:

- Straight Medicaid, the Medicaid Assistance Program, is a federal/state program providing medical/health-related services to:
- America's low-income families
    - Individuals
    - People with disabilities
- Some recipients may have financial responsibility known as spend down or cost share before the Medicaid benefits start.
- Within broad national guidelines that the Federal government allows each state to:
    - Establish its own eligibility standards
    - Determine the type, amount, duration, and scope of services
    - Set the rate of payment for services
    - Administer their own program
- The Medicaid program varies considerably from state to state, and within each state over time.

Medicare

The following applies to Medicare:

- Medicare is the federal health insurance program for:
- Individuals who are 65 or older
- Certain younger individuals with disabilities
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

- Medicare is not a comprehensive health care program or free of cost.
- Medicare does **NOT** cover:
    - Routine physical examinations
    - Hearing aids
    - Custodial care in nursing homes.
- Medicare coverage is divided into four parts:
    - Part A, Hospital Insurance
    - Part B, Medical Insurance
    - Part C, Managed Care
    - Part D, Prescription Drug Insurance

Other Insurance Plans

The following applies to other insurance plans:

- Insurance plans that do **NOT** fit into the Public and Private Health Insurance section will be categorized as Other insurance plans.
- Other Health Care plans include:
    - Commercial Insurance
    - Blue Cross / Blue Shield
    - Care Management Companies
    - Hospice
    - Worker's Compensation
    - Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
    - TriCare
    - Veterans Administration (VA)
    - Civilian Heath and Medical Program for the Veterans Administration (CHAMPVA).

Commercial Insurance

The following applies to commercial insurance:

- Commercial carriers such as John Hancock, Travelers, or Aetna offer contracts to individuals and groups.
- Payment for medical services is made to the beneficiary according to an indemnity table of allowable schedule.
- Reimbursement can range from 75% to 100%, but because each commercial carrier develops its own policies and guidelines, subscriber coverage can differ greater; therefore, it is important to explore coverage thoroughly for each patient.

Blue Cross/Blue Shield (BCBS)

The following applies to Blue Cross/Blue Shield (BC/BS):

- The BC/BS Association, created in 1982, is a result of a merger of the Blue Cross Association and National Association of Blue Shield Plans.
- Blue plans offer health insurance coverage in:
    - **ALL** 50 states
    - The District of Columbia
    - Puerto Rico
- The Blues cover **ALL** segments of the population, including:
    - Large employer groups
    - Small businesses
    - Individual customers
- Reimbursement is usually based off the Blue Cross or Blue Shield allowable, also referred to as a fee schedule.
- Payment for various components of the bill is dependent on the particular policy.

Case Management Companies

The following applies to case management companies:

- Case management is a comprehensive approach to health care given in a nonhospital setting that ensures the highest quality of care at the most economical cost.
- Case management is generally initiated when one of the following situations occurs:
    - The insurance company offers case management as an option.
    - Medical bills exceed a predetermined dollar amount.
    - The patient has a catastrophic chronic disease/disability.
    - The patient requires extended rehabilitation care or intensive care.
    - The patient is expending available claims dollars rapidly.

Hospice

The following applies to hospice:

- Hospice is a program that provides health care to terminally ill patients and their families.
- The focus is on the comfort and quality of life, rather than a cure.
- Services are available on a 24-hour basis.
- Most hospice policies require the attending physician to certify that the patient is terminal and has six months or less to live.
- Prior approval and individual review may be required for hospice services before reimbursement is granted.

Worker's Compensation

The following applies to worker's compensation (WC):

- Worker’s compensation is a type of insurance covering employment-related illnesses and injuries.
- Worker's compensation insurance:
    - Is a state agency
    - Processes claims
    - Provides benefits for health care costs and lost wages to qualified employees and their dependents if an employee suffers a work-related injury or disease.
    - Is paid for by employers (the company)
    - Does **NOT** require the employee to contribute to the cost of compensation.
    - Worker's Compensation is considered a payer source when the patient’s diagnosis and history indicate a job-related injury or an occupational illness.
    - Home care services are usually covered at 100% of the Worker’s Compensation fee schedule if they are directly related to the workplace accident or illness and are ordered by an MD. Case managers are usually involved with these cases.
    - Worker's Compensation requirements are clearly defined by each state.
    - The Worker's Compensation Board:
    - Worker's Compensation insurance packages are fairly standardized with little variation amount different companies’ basic policies.

    - **ALWAYS** use the proper worker's compensation claim center to run a dummy claim in REDACTED. Worker's compensation claim centers indicate WORKERS COMP as the **CC GROUP** on the **Patient Insurance** screen.
    - Refer to the REDACTED to reference field mapping to the REDACTED Workers Compensation tab of the NCPDP Response screen.

REMINDER: Refer to the following information for REDACTED Worker's Compensation:

    - Claim Center: 75518 - REDACTED CLAIM CENTER
    - Bank Identification Number (BIN): REDACTED
    - **IMPORTANT:** Do **NOT** use BIN REDACTED
    - Refer to the following guidelines to clear a Worker's Compensation referral:

IMPORTANT: Engage the REDACTED team at REDACTED for any challenges when processing a WC claim. The team is also available via email at REDACTED.

Follow the steps below to identify a workers compensation patient in Card Finder:

1. Review the Provider Control Number (PCN) field in Card Finder to confirm the PCN indicates Workers Compensation (WC).

2. Review **ALL** available documents to verify the WC authorization is on file:

IMPORTANT:

- If there is **NO** WC claim in the system, contact the prescriber to verify the prescription is **NOT** associated with Workers Compensation
- If the prescription is **NOT** associated with Workers Compensation, move the order to an available commercial insurance plan.
- If there authorization is on file, follow the standard process to clear to the pharmacy.
- If there is **NOT** an authorization on file:
    a. Contact REDACTED to verify there is an active claim.
        b. Determine if the adjuster's contact information is available:
            i. Yes: Contact the WC adjuster to get the approved authorization, then proceed with the standard process to clear to the pharmacy.
            ii. No: Contact the prescriber to obtain the adjuster's contact information, contact the adjuster to get the authorization, then proceed with the standard process to clear to the pharmacy.
        c. Do **NOT** bill the patient's personal insurance upon determining the prescribed medication related to a work-related injury or disease.
            a. **IMPORTANT:** This includes both the patient's personal primary and/or secondary insurance
        d. The patient will **NEVER** assume monetary responsibility:
            a. **IMPORTANT:** The patient's employer or the employer's worker's compensation carrier are legally obligated to cover **ALL** related medical expenses as related to the work-related injury or disease.

COBRA

The following applies to COBRA:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA): Health benefit provisions amend the Employee Retirement Income Security Actis a law that provides a vital bridge between health plans for:
    - Qualified workers
    - Spouse/partners
    - Dependent children

- COBRA provides group health insurance coverage for employees who lose their coverage due to a loss of job.
- The option allows the employee's coverage to continue for up to 18 months but the employee will have to pay the full premium; up to 102% of the employer's cost.
- A COBRA policy, like private insurance, will be canceled if a person does **NOT** pay their monthly premiums.

Veteran's Administration

The following applies to Veterans Administration (VA):

- VA provides a medical benefits package, a standard enhanced health benefits plan, available to **ALL** enrolled veterans.
- This plan emphasizes:
- VA maintains an annual enrollment system to manage the provision of quality hospital and outpatient medical care and treatment to **ALL** enrolled veterans.
- A priority system ensures that veterans with service-connected disabilities and those below the low income threshold are able to be enrolled in VA's health care system.

Civilian Health and Medical Program for Veterans Administration (CHAMPVA)

The following applies to Civilian Health and Medical Program for Veterans Administration (CHAMPVA):

- CHAMPVA is a health benefit program for:
    - Families of veterans with 100% service-connected disability,
    - The surviving spouse/partner or children of a veteran who dies from a service-connected disability.
- The Department of Veteran Affairs:
    - Determines eligibility
    - Processes CHAMPVA claims