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| US Health Care Domain |
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# Insurance

Insurance is the equitable transfer of risk of a potential loss, from one entity to another, in exchange for a reasonable fee.

Insurance is a way to share risk with others.

# Types of Insurance Companies

1. Life Insurance
2. General Insurance
3. Reinsurance

# Healthcare

Healthcare is the prevention, treatment, and management of illness and the prevention of mental and physical well-being through the services offered by the medical and allied health professions.

A healthcare system is the organization by which healthcare is provided.

# Entities Involved in Healthcare System

1. Patient
2. Provider
3. Insurance Companies
4. Facilities
5. Pharmacies
6. Laboratories
7. Employer
8. Third Party

## Providers

A Provider can be anyone who provides services to a patient. It can be a physician, hospitals, pharmacist, entities, etc.

There can be two types of healthcare providers: Contracted or Non-Contracted.

* Professional
* Institutional /Facility

### Practitioners/Physicians

1. Medical Doctors [MD]
2. Doctors of Osteopathic Medicine [DO]
3. Podiatrists [DPM]
4. Optometrists [OD]
5. Chiropractors [DC]

Note: All are addressed “Doctor”

### Ancillary Providers

1. Physician Assistants [Pas]
2. Nurse Practitioners [ARNPs]
3. Certified Registered Nurse Anesthetists [CRNAs]
4. Therapists:
   1. Physical [PT]
   2. Occupational [OT]
   3. Speech [ST]

### Others:

1. Home Infusion Therapy
2. Orthotics and Prosthetics
3. Home Medical Equipment Suppliers
4. Medical Suppliers
5. Freestanding MRI
6. Freestanding Radiology
7. Independent Laboratory
8. Ambulance

## Patients

A Patient can be any individual who makes a visit to a physician for illness treatment. He/she can be a **subscriber** or **dependent** on policy.

## Insurance Companies [Payors]

Payors are the companies providing different health plans to their subscribers.

Claims are accepted by most of the insurance companies electronically through EDI format but many of them also accept the claims on paper through HCFA-1500 or UB-92.

Health Insurance is a type of insurance whereby the insurer pays the medical costs of the insured if the insured becomes sick due to covered causes, or due to accidents.

Private health insurance – Commercial Payers

Publicly funded insurance – Federal funded plans like Medicare, Medicaid, etc..

## Facilities

* Hospitals
* Ambulatory surgery centers
* Skilled nursing facilities
* Home health agencies
* Freestanding substance abuse facilities
* Hospice
* End-stage renal disease centers

## Laboratory

Laboratories is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of information for the diagnosis, prevention, treatment of disease or impairment, or assessment of health.

* CLIA (Clinical Laboratory Improvement Amendments) – Regulatory authority

## Pharmacy

They are the medicines providing pharmaceuticals companies which also play an important role in healthcare system. Medicines are the most common used form of Healthcare treatment. Pharmacies use to bill their prescription drugs to the Insurance companies.

## Employer

They are the organizations providing medical insurances to their employees including their spouses and dependents.

## Third Party Administrators

A TPA is essentially an outsourcer that works with companies and organizations on many aspects of their medical benefit plans.

## Clearing House

They act as an intermediary between the provider and payer.

Provider 🡨🡪Clearing Houses 🡨🡪Payer

### Administrative Functionality

* Distributing Claims to payers (EDI & Mail)
* Converting paper claims to Electronic Format

## Banks

* Patient amount credit and collection
* Financial Management
* Accounts Reconciliation

Providers receive payment either as:

* Cheque
* EFT (Electronic Funds Transfer) – Direct deposit

Healthcare Experience

A screenshot of a computer screen

Description automatically generated

# Healthcare Insurance Plans

Healthcare Insurance plans are usually described as either:

1. Traditional Indemnity plan
2. Managed Care Plan

## Traditional (Group) Indemnity Plan

Features of traditional indemnity plan:

1. Freedom of choice
2. No referrals
3. No PCP [Primary Care Providers]

# Deductible and Coinsurance

In addition to your monthly premium payments, most health policies require you to pay some share of the bills for covered expenses.

## Deductible

* A set amount that a group member must pay before the insurer will make any benefit payments
* Most policies contain a calendar year deductible

## Coinsurance

* After the group member has paid the deductible amount, most policies require group member to pay a stated % of all the remaining medical expenses

## Deductible and Coinsurance in indemnity plan

Plan specifies $ 500 deductible and includes 20% coinsurance provision. Hospital Bill: $ 1500. Assuming that these are the first and only expenses in the calendar year.

Total covered expense $ 1500

Less deductible -$ 500

Total $ 1000

Less coinsurance (20%) -$ 200

Insurer will pay $ 800

# Coordination of Benefits (COB)

* Primary plan pays full benefit
* Secondary plan pays difference of the amount of expenses and amount paid by primary plan
* Birthday Rule:
  + The plan of the parent whose birthday occurs first in the calendar year is designated as primary. The date of birth is the determining factor – not the year – so it doesn’t matter which spouse is older.
* Gender Rule
  + The father’s plan is primary for the dependent child. If one contract uses Birth rule and one more Gender rule. Then Gender rule is applied.