**Healthcare Domain**

### Why You Need Health Insurance

Health insurance is necessary for Americans to pay for the [high cost of health care](https://www.thebalance.com/causes-of-rising-healthcare-costs-4064878). You need it unless you are very wealthy, over 65, or very poor. The very wealthy can afford the cost of even extraordinary emergency or chronic medical care. Those over 65 have paid into Medicare. The very poor can qualify for Medicaid.

Everyone else must either purchase health insurance or risk [medical bankruptcy](https://www.thebalance.com/medical-bankruptcy-statistics-4154729). Since it is so common, many people have lost sight of its underlying purpose. It's just like insurance for your car, home, or apartment. It's supposed to protect your life savings from the devastating costs of a major accident, medical emergency, or a chronic disease.

But, unlike other insurance, health insurance makes it possible for you to get that health care when you need it. If you don't have [car insurance](https://www.thebalance.com/best-car-insurance-4158710), you can take the bus until you can afford to get your car fixed. If you break your leg, you can’t splint it yourself until you save up enough to go to the doctor.

### How to Choose Health Insurance

[Health insurance companies](https://www.thebalance.com/picking-the-best-health-insurance-company-4157817) provide lots of choices. But before you select a plan, you've got to wade through various combinations of deductibles, copayments, coinsurance, and premiums.

1. Monthly premiums. Like auto or [homeowners insurance](https://www.thebalance.com/best-homeowners-insurance-4158706), you pay this even if you never make a claim. That provides the cash flow so insurance companies can pay their day-to-day expenses.
2. The [deductible](https://www.thebalance.com/understanding-your-health-insurance-deductible-2645645). That's what you pay before the insurance company contributes a dime. Deductibles can range anywhere from $500 a year to $10,000 a year or more. The lower deductibles are only available from company-sponsored plans. They are annual, which means you start over on January 1 of each year.
3. A copayment for each visit. A typical copay is $20 for a doctor visit, $50 for a hospital visit, and $10 to $40 for each prescription. You pay 100 percent for the visit until the deductible is met.
4. [Coinsurance](https://www.thebalance.com/understanding-health-insurance-policy-2645652). That’s a percent you pay for procedures, like surgeries, or hospital stays. If your doctor visits you in the hospital, you might pay a copayment for the visit and coinsurance for the hospitalization.

Why do insurance companies charge deductibles, copays, and coinsurance? They want to keep you from running to the doctor for every sniffle. They were worried that, if health care were 100 percent free, their costs would skyrocket. The [Affordable Care Act](https://www.thebalance.com/2010-patient-protection-affordable-care-act-3306063) said these out-of-pocket costs can't exceed a maximum of $6,600 for individuals, or $13,200 for a family. After that, the insurance company pays 100 percent.

All these choices make [picking health care insurance](https://www.thebalance.com/health-insurance-101-2645682) very complicated. You’ve got to be an odds-maker on your own health.

For example, you might be willing to pay a higher monthly premium for a lower coinsurance percent and/or deductible. That would make sense if you have a chronic disease, like diabetes, and know you’ll be in to see the doctor frequently.

On the other hand, people who are healthy might want the lowest premium possible and a [higher deductible](https://www.thebalance.com/what-is-high-deductible-health-insurance-2385898). They are willing to take the chance of paying more for health care because they believe that chance is small. The lower the deductible, the higher the premium, co-pay, or co-insurance. As health care costs have grown, more people have opted for higher-deductible plans just to keep their monthly premiums affordable. [Obamacare](https://www.thebalance.com/obamacare-explained-3306058) has not been able to correct this underlying flaw of the health insurance system.

### Why America Relies on Health Insurance to Pay for Medical Care

Before World War II, most Americans had no health insurance. The policies that existed only covered the cost of the hospital room and board. After the war, the federal government instituted a wage freeze to curb inflation. But that meant companies couldn’t give raises to get the best employees. Instead, they offered benefits including health insurance.

In 1954, the Internal Revenue Service made health insurance premiums non-taxable. That made an additional dollar of health insurance more valuable than a dollar of taxable salary. The [Tax Policy Center estimates](http://www.taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work) that this tax break alone increases the U.S. deficit by $250 billion a year. But politicians aren’t likely to get re-elected if they suggest removing it.

That’s especially true because this tax break is like providing a government insurance subsidy for the upper-middle classes and the wealthy. The Tax Policy Center found that the average benefit of the health insurance tax break was about $281 for a household in the 15 percent tax bracket. But the benefit is $374 for those in the 25 percent tax bracket.

### Alternatives to Health Insurance

Many countries have adopted [universal health care](https://www.thebalance.com/universal-health-care-4156211). That's where the government pays for health care, just like it pays for education and defense. It's like expanding Medicare or Medicaid to everyone. When the [French or Germans](https://www.thebalance.com/universal-health-care-4156211) go to the doctor or the hospital, the government picks up most or all of the bill. The downside is that it takes a long time to see a specialist or receive a non-emergency operation. On the other hand, no one has to worry about dying from a disease because they can't afford treatment.

When [Hillarycare](https://www.thebalance.com/hillarycare-comparison-to-obamacare-4101814) tried to implement universal health care in America, the medical profession and health insurance companies defeated it. [Obamacare](https://www.thebalance.com/what-is-obamacare-the-aca-and-what-you-need-to-know-3306065) was initially presented as universal health care. But the insurance companies changed it to one that relied on their products.

An alternative to health insurance is self-pay. If people paid for their own health care, they'd bargain on price to get the best deal. That would lower the [cost of health care](https://www.thebalance.com/causes-of-rising-healthcare-costs-4064878) overall. They could take out loans for expensive procedures, like they do a car or a house. They would take better care of their health to avoid [preventable diseases](https://www.thebalance.com/preventive-care-how-it-lowers-aca-costs-3306074) like diabetes.

On the other hand, it might force low-income people to choose between food and medicine. Access to health care has become part of [today's American Dream](https://www.thebalance.com/what-is-the-american-dream-today-3306027). Research has found that [the higher your income, the better your health](https://www.urban.org/research/publication/how-are-income-and-wealth-linked-health-and-longevity). As a result, [income inequality](https://www.thebalance.com/income-inequality-in-america-3306190) has led to [health care inequality](https://www.thebalance.com/health-care-inequality-facts-types-effect-solution-4174842).

The Department of Health and Human Services has issued a final rule to modify the HIPAA privacy, security, breach notification and enforcement rules, as well as increasing privacy protections under the Genetic Information Nondiscrimination Act.

For the most part, the final rule is very similar to proposed rules and interim final rules issued in 2009 and 2010. But a major change in the final rule is made in the breach notification section replacing subjective measures of determining whether a breach has or could cause considerable harm to one or more individuals and must be reported with a more objective risk assessment process to determine if protected information has been compromised.

The final HIPAA rule becomes effective on March 26, 2013 with the compliance date for covered entities and business associates on September 23, 2013. Covered entities have one year from the compliance date to amend business associate agreements to match new requirements.

The final rule includes provisions:

* Setting four-tier financial penalty structure for breaches deemed serious enough to warrant a federal-imposed penalty. Based on fault, fines range from $100 to $50,000 per violation with a $1.5 million cap on violations of an identical provision within a calendar year.
* Making business associates and subcontractors comply with HIPAA rules in the same manner covered entities must; making BAs and subcontractors directly liable for HIPAA violations – even if a BA failed to enter into a formal contract with a subcontractor – and making covered entities and business associates legally liable for the acts of their business associates. The BA for a business associate would be a subcontractor. The BA – not the covered entity – is responsible for having a subcontractor appropriately safeguard information, but the covered entity is responsible for the BA’s actions.
* Expanding the definition of business associates to include patient safety organizations, health information organizations, e-prescribing gateways, providers of data transmission services for protected health information to a covered entity and requiring routine access to PHI, or personal health record vendors offering PHRs to individuals on behalf of a covered entity. PHRs offered directly only to individuals are not covered.
* Clarifying that PHI stored in photocopiers, faxes and other office equipment that retain data, whether intentionally or not, is subject to the privacy and security rules, and PHI should be wiped before a device is removed from the office.
* Applying to business associates the minimum necessary standard when using or disclosing PHI, or when requesting PHI from another covered entity or business associate.
* Enabling patients to ask for a copy of their electronic medical record in an electronic form, with fees charged not greater than labor costs.
* Enabling patients paying with cash to instruct providers to not make information about their treatment available to insurers. Separate or segregated records are not required, but some type of flag or other notification of restrictions in the record are necessary.
* Enabling patients to easily opt out of receiving fundraising and marketing solicitations.
* Prohibiting the sale of an individuals’ health information without their express consent, with exemptions when the information is used for public health activities or research purposes.

The Medical Group Management Association (MGMA) has voiced its concern with the new final rule:

“We are strongly supportive of comprehensive privacy and security standards aimed at avoiding unauthorized use or disclosure of patient health information. However, it is critical that the safeguards mandated by the government be practical, flexible and affordable for the broad spectrum of medical practices”.

“We are concerned about the ability of practices to implement the changes associated with this final rule, including the requirement to modify and reissue notices of privacy practices and modify business associate agreements–within the short time frames allotted. We will continue to monitor our member practices to ensure that administrative burdens imposed by the government do not hinder the necessary flow of health information for patient treatment, payment and healthcare operations purposes”.

The final rule is available [here](https://www.federalregister.gov/articles/2013/01/25/2013-01073/modifications-to-the-hipaa-privacy-security-enforcement-and-breach-notification-rules-under-the) for further review.

## Meaningful Use Stage 2

The Centers for Medicare and Medicaid services (CMS) recently published a final rule that specifies the criteria for Stage 2 of Meaningful Use. The earliest Stage 2 will be effective is in 2014. CMS is permitting a one-time three-month reporting period in 2014 to allow providers to upgrade to 2014 Certified EHR Technology.

The new objectives and measures under Stage 2 will require eligible professionals and hospitals to communicate to patients relevant to their health information. This will require healthcare professionals to provide patients with an electronic patient health record which they can view online, download, and transmit their health information. The ultimate goal for Stage 2 is to require patients to use health information technology in order for providers to achieve meaningful use.

### Core and Menu Objectives

To demonstrate meaningful use under Stage 2 criteria below is a list of core and menu objectives. Eligible professionals must meet 17 core objectives:

1. Use computerized provider order entry (CPOE) for medication, laboratory and radiology orders
2. Generate and transmit permissible prescriptions electronically (eRx)
3. Record demographic information
4. Record and chart changes in vital signs
5. Record smoking status for patient 13+ years
6. Use clinical decision support to improve performance on high-priority health conditions
7. Provide patients the ability to view online, download, and transmit their health information
8. Provide clinical summaries for patients for each office visit
9. Protect electronic health information related or maintained by the Certified EHR Technology
10. Incorporate clinical lab-test results into Certified EHR Technology
11. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach
12. Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care
13. Use Certified EHR Technology to identify patient-specific education resources
14. Perform medication reconciliation
15. Provide summary of care record for each transition of care or referral
16. Submit electronic data to immunization registries
17. Use secure electronic messaging to communicate with patients on relevant health information

Eligible professionals must meet 3 menu objectives:

* Submit electronic synfromic surveillance data to public health agencies
* Record electronic notes in patient records
* Imaging results accessible through CEHRT
* Record patient family health history
* Identify and report cancer cases to a State cancer registry
* Identify and report specific cases to a specialized registry (other than a cancer registry)

## Understanding the Key Players in the Medical Claims Process

The relationship between policyholders, healthcare providers, and insurance companies is essential to understand before tackling the details of the medical billing and coding process.

### Healthcare providers

A healthcare provider is any facility or practice where you receive and are billed for a product or service related to your personal health. Healthcare providers include hospitals, private clinics, and pharmacies as well as specialized care providers like nursing homes, in-home caretakers, and chiropractors.

### Insurance companies

Health insurance companies subsidize medical care for qualifying patients, called policyholders. Health insurance is not mandatory in the U.S., but many Americans have insurance coverage, whether they purchased it privately or obtained it from their employer or the government. Insurance policies vary, but they all operate under the same business model: policyholders pay a certain amount of money each month or year to the insurance company, which is called a premium. If policyholders need procedures for which they qualify, the insurance company pays for that procedure, either in full or in part.

### Policyholders

A policyholder is any individual who has purchased health insurance. For example, a young adult looking for a basic insurance plan may purchase a policy where the insurance provider will pay for all medical bills that cost more than the deductible, which is a pre-arranged amount that the policyholder must pay out-of-pocket before insurance coverage kicks in.

## How Medical Claims Work

The medical claims process is initiated when a policyholder goes to a healthcare provider for a medical service, which can be anything from obtaining a monthly prescription to major surgery. After the policyholder receives the service, they are usually financially responsible for a deductible, which is the amount of money that the policyholder agrees to pay before their insurance starts. The policyholder gives their insurance information to their healthcare provider, and the transaction between the policyholder and healthcare provider is complete.

Behind the scenes, the transaction between healthcare provider and insurance company begins. The healthcare provider records all the medical services and their costs offered to the policyholder. This record is known the medical claim, or bill. While working for healthcare providers, medical billers and coders are responsible for creating this record and sending the claims out to the policyholder’s insurance company, which has three options. It can:

* Accept all expenditures and pay the bill in full
* Deny the claim on account of a billing error (like incorrect patient information). The bill is then returned to the healthcare provider to be corrected.
* Reject the claim outright, usually on account of the services not being covered within the health plan. The policyholder then pays for the service out of pocket.

## Working with Insurance Providers

The two major types of insurance providers are managed care plans and public insurance. Learn how to handle both types of coverage below.

### Managed care

A large portion of insured Americans receive coverage through their employer, usually through managed care plans. These insurance plans work with a specific group of doctors, hospitals, pharmacies, labs, equipment vendors, and other care providers. Individuals insured under managed care plans seek medical services within this managed care network. The three main components of managed care are preferred provider organizations, health maintenance organizations, and point of service plans.

* **HMOs** require their policyholders to receive most or all of their medical care under the insurance provider’s managed care network. They also require policyholders to select a primary care physician. If HMO policyholders see a specialist without a referral from their primary care physician, or seek treatment outside of the managed care network, they will most likely have to pay medical bills out of pocket.
* **PPOs** also have a network of preferred healthcare providers they request their policyholders to seek treatment from. However, unlike HMOs, individuals do not need to select a primary care provider. Also unlike HMOs, if an individual seeks treatment outside of the managed care network, they can pay the out-of-network healthcare provider directly and possibly get reimbursed for their medical expenses.
* **Point-of-service Plans:** Point-of-service plans form a hybrid between PPOs and HMOs. As with HMOs, point-of-service plans allow you to select physicians and services from within a dedicated network of providers. Unlike HMOs, patients can receive care from out-of-network providers, but they will likely have to pay a deductible.

HMOs and PPOs differ in the insurance claim process. All healthcare providers within a managed care network must file a claim with the HMO. So long as services are rendered in-network, policyholders are not required to file anything themselves, and healthcare providers may not bill the policyholder directly. In the case of PPOs, policyholders may have to file a claim to their insurance provider if seeking treatment outside of the managed care network. Filing claims to insurance providers isn’t necessary for POS plans.

### Public insurance coverage

The government is also a major provider of insurance coverage in America, through public programs called Medicaid and Medicare.

* **Medicaid** is a health service program designed for low-income individuals and families. Medicaid recipients receive health coverage decided by the state in which they reside, though some coverage is federally mandated, such as inpatient and outpatient hospital care. Within this system, states make payments on a fee-for-service system or through arrangements with HMOs.
* **Medicare** is another government-funded insurance program for the elderly. Like Medicaid, certain medical services must be covered for Medicare recipients, such as hospital stays and nursing care. This basic coverage is called Medicare Part A. Recipients may also receive coverage in Medicare Part B, also called Supplementary Medicare, for services such as medical equipment, x-rays and labs, and outpatient hospital visits. Recipients of Medicare Part B must pay a monthly premium and pay an annual deductible. There are also Medicare Advantage plans where users can create custom plans that meet their specific needs.