

**BASIC
INSURANCE
CONCEPTS**

NOTE PAD

Basic Insurance Concepts

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Class Guidelines

- Please return from breaks and lunch on time
- Two 15 minute breaks
- 30 minute lunch

Class Guidelines

- Pagers/Cell phones turned off or set on vibrate
- Proficiency examination – 80% required to pass course

Class Guidelines

- Ask Questions



Class Objectives

- Define basic insurance terms and concepts
- Define commercial and publicly funded (government) insurance types

Class Objectives

- Interpret insurance cards
- Determine payer priority

Basic Terminology

➤ Health Insurance -

- ❖ Coverage that pays all or some portion of a patient's medical bill

Basic Terminology

➤ Health Insurance -

- ❖ Two major categories of health insurance:

1. Commercial
2. Publicly Funded

Basic Terminology

➤ Commercial Insurance -

- ❖ Purchased by individuals or employers
- ❖ Commonly obtained as an employee benefit

Basic Terminology

➤ Publicly Funded Health Insurance -

- ❖ Uses federal, state and/or local money to provide health care coverage
- ❖ Various guidelines for eligibility

Basic Terminology

➤ Publicly Funded Health Insurance -

- ❖ Can be used alone or in conjunction with commercial coverage

Insurance Terminology

➤ Subscriber -

- ❖ Person who obtains health insurance through employment, purchase or by qualifying for a publicly funded program

Insurance Terminology

➤ Subscriber -

- ❖ Often a subscriber will also obtain health insurance for a spouse or partner and any qualifying dependents

Insurance Terminology

➤ Member -

- ❖ Anyone covered by health insurance

Insurance Terminology

➤ Premium -

❖ Amount paid to an insurance company to obtain health insurance coverage

Insurance Coverage

➤ Non-Managed Care -

❖ Patient has freedom in choosing where and when to be seen without losing total coverage (although patient liability may change)

Insurance Coverage

➤ Non-Managed Care -

❖ Insurance payment is made directly to the provider per service

❖ Neither authorizations nor referrals are required for outpatient clinic care

Insurance Coverage

➤ Managed Care -

❖ Current trend in commercial health insurance and public programs

❖ Used to control costs

Insurance Coverage

➤ Managed Care -

❖ Several different managed care models

❖ Important limitations on where health care is received with many rules and restrictions

Patient Liability

➤ Deductible -

❖ A specific dollar amount a patient pays to a provider for medical expenses before the insurance will pay for covered services

Patient Liability

➤ Deductible -

- ❖ Most deductibles are paid annually

Patient Liability

➤ Co-insurance -

- ❖ The portion of a covered medical expense that a patient pays after the insurance has made payment

- ❖ Usually a percentage (%)

Patient Liability

➤ Co-payment (co-pay) -

- ❖ A specific dollar amount a patient pays for a certain type of visit or service

- ❖ Collected at the time of the visit or service

Provider Classification

➤ Network Providers -

- ❖ Medical providers who sign a contract with an insurance company on an individual basis

Provider Classification

➤ Network Providers -

- ❖ Providers agree to accept a reduced insurance payment in exchange for patient referrals

Provider Classification

➤ Two Types of Networks -

- ❖ Internal Network
- ❖ External Network

Provider Classification

➤ Internal Network -

- ❖ The insurance company creates an assortment of contracted providers (only the initial insurance company is involved)

Provider Classification

➤ External Network -

- ❖ The insurance company contracts with an outside (external) company to access a collection of contracted providers (two companies involved and both are indicated on the insurance card)

Provider Classification

➤ Examples of External Networks -

- ❖ First Health
- ❖ Community Care Network (CCN)
- ❖ Private Healthcare Services (PHCS)

Provider Classification

➤ Primary Medical Group (PMG) -

❖ A group of medical providers who have joined together and contracted with an insurance company to provide care for managed care patients



Provider Classification

A Primary Medical Group (PMG) may also be called an Independent Practice Association (IPA)

Example:

Brown and Toland

Provider Classification

➤ Primary Care Provider (PCP) -

❖ A managed care provider who coordinates all of a patient's medical care and regulates the patient's access to health care

Required Documentation

➤ Referral -

- ❖ A document or verbal statement (*communication*) between one medical provider to another medical provider regarding the medical service or treatment a managed care patient is to receive

Required Documentation

➤ Authorization -

- ❖ Usually a written document requested by the patient's Primary Care Provider from the Primary Medical Group
- ❖ *Permission* for a treatment or procedure

Required Documentation

➤ Authorization -

- ❖ Usually includes a unique identifying *Authorization Number*
- ❖ *Necessary* for the insurance to pay for the service

Required Documentation

➤ Authorization -

❖ An Authorization is not a guarantee of payment

COMMERCIAL INSURANCE PLANS

Indemnity

➤ Traditional Medical Plan

➤ Fee-For-Service Plan

➤ Non-Managed Care

Indemnity

- No specific contract between the provider and the insurance
- Very few restrictions

Indemnity

Patient Liability

Yearly deductible

Coinsurance for most services

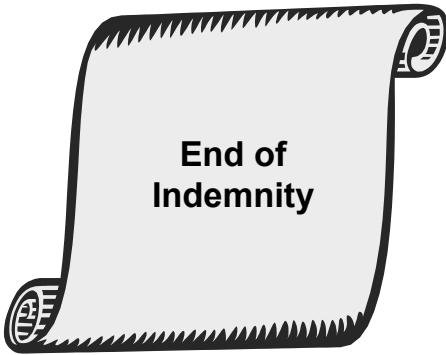
Indemnity

Providers

Any licensed provider

Documentation

Authorizations may be required for high dollar outpatient services and/or inpatient services



Preferred Provider Organization (PPO)

- Non-Managed Care
- Few restrictions
- Preferred Providers agree to discount charges for PPO patients

PPO

- UCSF is a Preferred Provider (contracted) with many insurance companies

PPO

Patient Liability

Yearly deductible

Coinsurance for most services (both will be lower if using a Preferred provider)

May have a co-payment

PPO

Providers

Preferred Provider
Non-Preferred Provider
(any licensed provider)

Documentation

Authorizations may be required for high dollar outpatient services and/or inpatient services

PPO



ALWAYS CHECK FOR AN EXTERNAL NETWORK WITH ANY PPO INSURANCE PLAN

End of Preferred Provider Organization (PPO)

Health Maintenance Organization (HMO)

- Managed Care
- Most restrictive insurance plan



HMO – Medical Group Model

- Patient MUST have a:
 - ❖ Primary Care Provider (PCP)
 - ❖ Primary Medical Group (PMG)

HMO – Medical Group Model

- Patient must receive all medical services within the PMG if possible
- Determining the PMG is ESSENTIAL

HMO – Medical Group Model

<u>Patient Liability</u>	Co-payment and uncovered services
<u>Providers</u>	Primary Care Provider (PCP) or PMG specialist

HMO – Medical Group Model

Documentation
The patient's PCP refers the patient for ancillary and specialty services within the PMG

Authorizations are needed for any service outside the PMG and for high dollar procedures within the PMG

HMO – Medical Group Model

Documentation

Authorizations are *requested* by the patient's Primary Care Provider (PCP)

Authorizations are *issued* by the Primary Medical Group (PMG)

HMO – Medical Group Model



**IT IS ESSENTIAL THAT YOU
DETERMINE THE PATIENT'S
PRIMARY MEDICAL GROUP (PMG)**

HMO – Staff Model

- All services are provided by staff hired directly by the insurance company
- Patient **MUST** choose a Primary Care Provider (PCP)

HMO – Staff Model

Example: Kaiser



HMO – Staff Model

Patient Liability

Co-payment and any uncovered services

Providers

Primary Care Provider (PCP) or staff specialist

HMO – Staff Model

Documentation

Authorization is needed for any service provided by non-staff physicians



**End of
Health
Maintenance
Organization
(HMO)**

Point of Service (POS)

- **Most versatile type of insurance**
- **These plans have Tiers, Levels, or Options (choices)**

POS

- **Patient decides which level to use every time they seek service**
- **It is essential to determine which level the patient is using**

POS

- Each level has different rules

POS – Three Tier Model

- Tier 1 –

- ❖ Works like a HMO

- ❖ Patient has a PCP and a PMG

POS – Three Tier Model

- Tier 2 –

- ❖ Works like a PPO

- ❖ Patient may self-refer to any Preferred Provider

POS – Three Tier Model

➤ Tier 3 –

- ❖ Works like a PPO Out-of- Network
- ❖ The patient may self-refer to any Non-Preferred Provider

POS – Three Tier Model

Patient Liability

Tier 1

Co-payment and any uncovered services

Tier 2

Yearly deductible
Coinsurance for most services

POS – Three Tier Model

Patient Liability

Tier 3

Yearly deductible
Coinsurance for most services
(higher than at Tier 2)

POS – Three Tier Model

Providers

Tier 1

Primary Care Provider
(PCP)

Primary Medical Group
(PMG)

POS – Three Tier Model

Providers

Tier 2

Preferred Provider

Tier 3

Non-Preferred Provider
(any licensed provider)

POS – Three Tier Model

Documentation

The patient's PCP refers the patient for ancillary and specialty services within the PMG

Authorizations are needed for any service outside the PMG and for high dollar procedures within the PMG

POS – Two Tier Model

➤ Tier 1 –

❖ Works like a HMO

❖ Patient has a PCP and a PMG

POS – Two Tier Model

➤ Tier 2 –

❖ Works like an Indemnity plan

❖ Patient may self-refer to any licensed Provider

POS – Two Tier Model

Patient Liability

Tier 1

Co-payment only

Tier 2

Yearly deductible

Coinsurance for most services

POS – Two Tier Model

Providers

Tier 1

Primary Care Provider
(PCP)

Primary Medical Group
(PMG)

POS – Two Tier Model

Providers

Tier 2

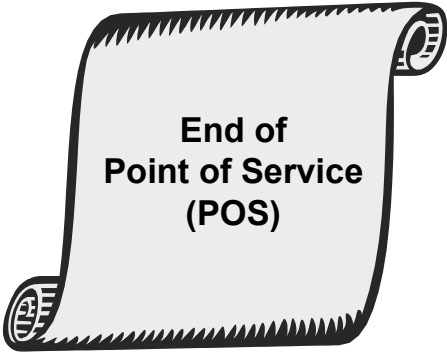
Any licensed provider

POS – Two Tier Model

Documentation

The patient's PCP refers the patient for ancillary and specialty services within the PMG

Authorizations are needed for any service outside the PMG and for high dollar procedures within the PMG



**End of
Point of Service
(POS)**

**Exclusive Provider Organization
(EPO)**

- **Least standardized type of insurance**
- **Insurance contracts with providers *not with medical groups*. These providers are called "Exclusive"**

EPO

- **Each EPO has different rules**
- **You must call to verify the rules for each EPO patient**

EPO

Patient Liability

PCP or Authorization = co-payment

Self-refer to Network provider = Deductible and Co-insurance

Self-refer Out-of-Network = No Coverage

EPO

Providers

Primary Care Provider (PCP)

Preferred Providers

EPO

Documentation

Authorizations are needed to receive highest benefit level

EPO



**ALWAYS CHECK FOR AN
EXTERNAL NETWORK WITH
ANY EPO INSURANCE PLAN**

**End of
Exclusive
Provider
Organization
(EPO)**

Workers' Compensation

- Insurance purchase employers
- Covers medical expenses for a job-related injury or illness

Workers' Compensation

- A Doctor's First Report, the date and type of injury, and the claim or file number are required when filing a claim



**End of
Workers'
Compensation**

**PUBLICLY
FUNDED
INSURANCE
PLANS**

Standard Medicare

- Federal insurance
- Few restrictions
- Provides health benefits to people age 65 and over and people with certain disabilities

Standard Medicare

- Medicare consists of two parts:
 - ❖ Part A – Hospital (Inpatient/Tech-Fee)
 - ❖ Eligible persons automatically receive Part A if they qualify

Standard Medicare

- Medicare consists of two parts:
 - ❖ Part B – Medical (Outpatient/Prof-Fee)
 - ❖ Enrollment in Part B is voluntary and must be purchased

Standard Medicare

➤ Medicare consists of two parts:

❖ Standard Medicare Part B acts like a PPO plan

Standard Medicare

Providers

Any licensed provider enrolled with Medicare

Documentation

None required for most services

Standard Medicare

➤ Medi-Gap -

❖ Supplemental PPO or Indemnity insurance in addition to Medicare coverage

Standard Medicare

➤ Medi-Gap –

- ❖ Purchased from a commercial insurance company to cover some or all of the expenses not covered by Medicare
- ❖ Always billed secondary to Medicare

Medicare

➤ HMO Medicare Risk Plan –

- ❖ HMO takes responsibility for the recipient's health care. Recipient no longer has Standard Medicare
- ❖ Recipient must follow HMO rules

Medicare

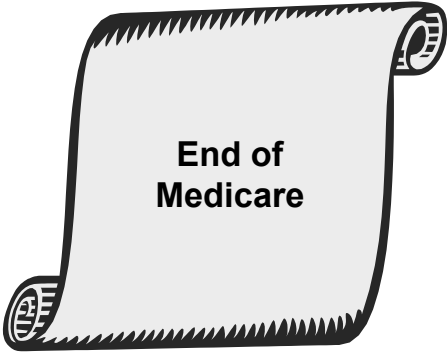
➤ HMO Medicare Risk Plan –

- ❖ Assignment of benefits is voluntary and reversible
- ❖ *We only bill the Medicare HMO Risk Plan*

Medicare

Examples:

**Kaiser Senior Advantage
HealthNet Seniority Plus
PacifiCare Secure Horizons**



**End of
Medicare**

Medicaid

- **Health coverage for certain low income/asset people**
- **Funded jointly by state and federal governments**

Medicaid

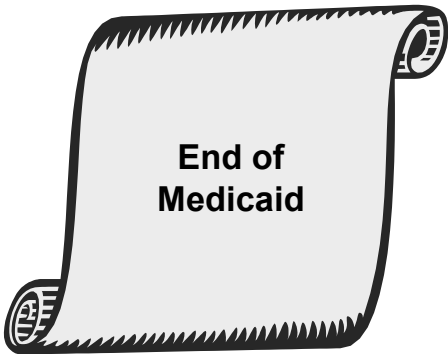
- **Must check eligibility monthly**
- **Must call to verify state authorization requirements**

Medicaid

- **Basic Medicaid Eligibility Guidelines:**
 - ❖ **People under 18 and over 65 years of age**
 - ❖ **Families with minor children**
 - ❖ **Women who are pregnant**

Medicaid

- **Basic Medicaid Eligibility Guidelines:**
 - ❖ **People with certain disabilities**



Medi-Cal

- California's version of Medicaid
- Administered by each county
- Prospective applicants apply in their county of residence

Medi-Cal

- Checking eligibility helps determine:
 - ❖ If the patient is eligible for Medi-Cal benefits in the current month
 - ❖ If the patient has a Share-of-Cost (SOC) in the current month

Medi-Cal

➤ **Checking eligibility helps determine:**

- ❖ **If the patient has another insurance in addition to Medi-Cal in the current month**
- ❖ **If the patient is covered under a Medi-Cal Managed Care plan**

Medi-Cal

➤ **Checking eligibility helps determine:**

- ❖ **If the Medi-Cal coverage is limited to certain services (Emergency Room)**
- ❖ **Checking eligibility also produces a unique Eligibility Verification Confirmation Number (EVC#)**

Medi-Cal

➤ **Two types of Medi-Cal –**

- ❖ **Standard Medi-Cal**
- ❖ **Medi-Cal Managed Care**

Medi-Cal

➤ Standard Medi-Cal –

❖ Traditional Medi-Cal. Non-Managed Care

❖ Few restrictions

Medi-Cal

Patient Liability

None or Share-of-Cost

Providers

Any licensed provider who will bill Medi-Cal

Medi-Cal

Documentation

Treatment Authorization Request (TAR) may be required for high dollar outpatient procedures

Other Rules

Must check eligibility monthly

Medi-Cal



**YOU MUST CHECK
ELIGIBILITY MONTHLY**

Medi-Cal

➤ Medi-Cal Managed Care –

Two Types of Managed Medi-Cal plans

1. County Organized Health Systems (COHS)
2. Two-Plan Model

Medi-Cal

➤ County Organized Health Systems (COHS) counties:

✓ Napa	✓ Solano
✓ San Mateo	✓ Sonoma
✓ Santa Barbara	✓ Yolo
✓ Santa Cruz	

Medi-Cal

➤ County Organized Health Systems (COHS):

- ❖ Recipients all have the same HMO plan
- ❖ Each recipient must choose a PCP
- ❖ The county acts as the recipient's PMG

Medi-Cal

➤ County Organized Health Systems (COHS):

- ❖ All recipients ***MUST*** have an authorization to be seen at UCSF

Example:

Health Plan of San Mateo

Medi-Cal

➤ Two Plan Model:

✓ Alameda	✓ Los Angeles	✓ San Joaquin
✓ Contra Costa	✓ Riverside	✓ Santa Clara
✓ Fresno	✓ San Bernadino	✓ Stanislaus
✓ Kern	✓ San Francisco	✓ Tulare

Medi-Cal

➤ Two Plan Model –

- ❖ Recipients have a choice between two HMO plans

Medi-Cal

Examples:

- Blue Cross Managed Medi-Cal
- San Francisco Health Plan

SAN FRANCISCO HEALTH PLAN

Need Health Coverage?



Medi-Cal

➤ Share of Cost (S.O.C):

- ❖ Amount paid by the Medi-Cal recipient that exceeds Medi-Cal's financial guidelines to qualify for coverage

- ❖ Works like a monthly deductible

Medi-Cal

➤ Share of Cost (S.O.C):

❖ Recipient only pay a Share of Cost for months they use their Medi-Cal coverage

❖ Medi-Cal cannot be billed until the Share of Cost has been "cleared"



End of
Medi-cal

California Children's Services (CCS)

➤ Provides specialty care to physically disabled children through the age of twenty one

➤ Only certain specific diagnoses qualify

CCS

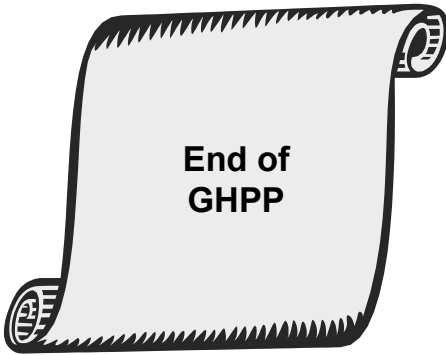
- Administered at the county level
- Authorizations may be valid for a year at a time



End of
CCS

Genetically Handicapped Persons Program (GHPP)

- Provides specialty care to physically disabled adults age twenty one and over with certain specific diagnoses
- Administered by the State of California

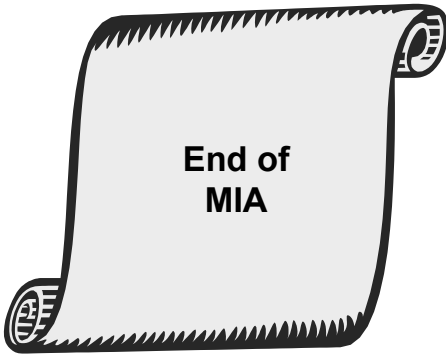


Medically Indigent Adult Program (MIA)

- Covers adults with little or no resources who do not qualify for other government programs
- Participants must seek services at a designated facility in their county of residence

MIA

- Program acts like a sliding scale
- Recipient ***MUST*** have an authorization to be seen at UCSF



County Medical Services Program (CMSP)

- MIA program in counties with populations fewer than 300,000
- CMSP functions like the standard Medi-Cal program

CMSP

- Must check eligibility monthly
- Recipients receive a Benefits Identification Card (BIC), but the program is not Medi-Cal

**End of
CMSP**

TRICARE

- **Health insurance for individuals affiliated with the Department of Defense, including active and retired military personnel and their dependents**



TRICARE

➤ **TRICARE**

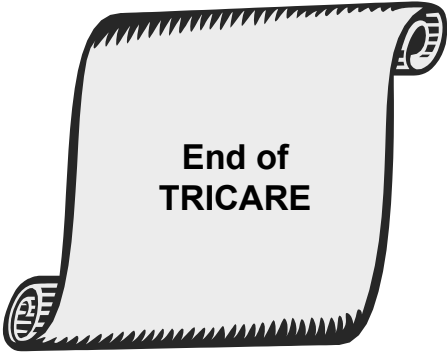
- ❖ **There are two types of TRICARE coverage**
- ❖ **Coverage depends on type purchased and military Rank/Grade**

TRICARE

➤ TRICARE

❖ TRICARE Prime = POS plan

❖ TRICARE Extra/Standard = PPO Plan



End of
TRICARE



Questions?
