King Saud University

College of Business Administration

Department of Health Administration

Executive Master in Health Administration

EHHA 506 – Health Insurance Administration

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PRIVATE HEALTH INSURANCE

Learning objectives

- **Understand how private health insurance operates.**
- **Understand the difference between various types of insurance plans.**
- **Be able to discuss the evolution of health insurance plans from Traditional health plans to managed care**

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What Is Health Insurance?

- **The term Health Insurance refers to a variety of insurance policies, ranging from those that cover the costs of doctors and hospitals to those that meet a specific need — like long-term care or dental coverage.**
- **When most of us talk about health insurance, however, we refer to the kind of plan that covers doctor bills, surgery and hospital costs.**
- **You may have heard terms like "Managed Care," "Fee-for-Service" and "Indemnity." These words define different types of coverage or health plans widely used by today's consumers.**

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What Is Health Insurance?

- **Healthcare insurance or health insurance** is a contract between a policyholder and a third-party payer or government program to reimburse the policyholder for all or a portion of the cost of **medically necessary treatment** or preventive care provided by healthcare professionals.
- **Health insurance is available** to individuals who participate in group (e.g., employer sponsored), individual (or personal insurance), or prepaid health plans (e.g., managed care).

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Group health insurance

- **Traditional healthcare coverage subsidized by employers and other organizations (e.g., labor unions, rural and consumer health cooperatives) whereby part or all of premium costs are paid for and/or discounted group rates are offered to eligible individuals.**
- **Group health insurance plans are designed to be more cost-effective for businesses. Employee premiums are typically less expensive than those for an individual health plan.**

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Individual health insurance

- **Private health insurance policy purchased by individuals or families who do not have access to group health insurance coverage.**
- **Applicants can be denied coverage, and they can also be required to pay higher premiums due to age, gender, and/or pre-existing medical conditions.**
- **Individual health insurance is a policy purchased by an individual for themselves and their family based upon personal needs and budget.**

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What Is Indemnity Insurance?

- **Indemnity insurance is a type of insurance policy where the insurance company guarantees compensation for losses or damages sustained by a policyholder to a certain limit—usually the amount of the loss itself.**
- **Insurance companies provide coverage in exchange for premiums paid by the insured parties.**
- **These policies are commonly designed to protect professionals and business owners when they are found to be at fault for a specific event such as misjudgment or malpractice.**
- **They generally take the form of a letter of indemnity.**

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What Is Indemnity Insurance?

- **Under an Indemnity plan, you may see whatever doctors or specialists you like, with no referrals required.**
- **Though you may choose to get the majority of your basic care from a single doctor, your insurance company will not require you to choose a primary care physician.**
- **An Indemnity plan may also require that you pay up front for services and then submit a claim to the insurance company for reimbursement.**

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What is an Indemnity Health Plan?

- **Indemnity plans allow you to direct your own health care and visit almost any doctor or hospital you like.**
- **The insurance company then pays a set portion of your total charges. Indemnity health insurance plans are also called fee-for-service.**
- **These are the types of plans that primarily existed before the rise of HMOs, PPOs, and other network-type plans.**
- **With indemnity plans, the insurance company pays a pre-determined percentage of the reasonable and customary charges for a given service, and the insured pays the rest.**

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What is an Indemnity Health Plan?

- **With an indemnity plan, there's no provider network, so patients can choose their own doctors and hospitals.**
- **But that means that the providers can balance bill the patient for any billed amounts above what the insurance company pays, since the providers don't have contracts with the insurer requiring them to accept the insurer's "reasonable and customary" amounts as payment in full.**

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What is an Indemnity Health Plan?

- **A reasonable and customary fee is the amount of money that a particular health insurance company (or self-insured health plan) determines is the normal or acceptable range of payment for a specific health-related service or medical procedure.**
- **If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.**
- **Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.**

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What is fixed indemnity coverage?

- **Traditional health insurance charges its enrollees a monthly premium, in exchange for paying for some or all of the health care services an individual receives.**
- **Fixed indemnity (also called hospital indemnity) coverage is designed differently, with payments made on a "per time period" basis.**
- **Rather than paying health care providers for providing specific services, fixed indemnity coverage provides a payment for each day (or month, or other time period) an individual is hospitalized or experiencing illness.**

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What is fixed indemnity coverage?

- **Hospital indemnity insurance supplements your existing health insurance coverage by helping pay expenses for hospital stays.**
- **Depending on the plan, hospital indemnity insurance gives you cash payments to help you pay for the added expenses that may come while you recover.**
- **Typically plans pay based on the number of days of hospitalization.**
- **Even if your medical insurance covers most of your hospitalization, you can still receive payments from your hospital indemnity insurance plan for extra expenses while recovering.**

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What is fixed indemnity coverage?

- **Like many supplemental insurance plans, hospital indemnity insurance is typically lower in cost, depending on the plan and coverage. Affordable hospital indemnity plans are worth considering if your existing health insurance plan has limits on hospitalization coverage.**
- **Hospital indemnity insurance is just one type of supplemental coverage that can support your health insurance with financial protection.**
- **Supplemental insurance plans can also protect you and your family in the event of a serious accident or provide financial assistance during an illness.**

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What is fixed indemnity coverage?

- **Although health insurance pays for medical services after copay fees, co-insurance and deductibles are met, hospital indemnity insurance pays the policyholder if they are hospitalized.**
- **While hospital indemnity insurance only provides coverage in the event of hospitalization, other types of health care indemnity policies pay the policyholder when they experience other medical events, such as being transported by ambulance, having surgery or receiving a diagnosis of specific illnesses.**

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How Indemnity Plans Work

- **With an indemnity plan (sometimes called fee-for-service), a patient can use any medical provider (such as a doctor and hospital).**
- **The patient or the provider sends the bill to the insurance company, which pays part of it.**
- **Usually, the patient have a deductible—such as $250—to pay each year before the insurer starts paying.**

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How Indemnity Plans Work

- **Once the insured meet the deductible, most indemnity plans pay a percentage of what they consider the "Usual and Customary" charge for covered services.**
- **The insurer generally pays 80 percent of the "Usual and Customary" costs and the insured pay the other 20 percent, which is known as coinsurance.**
- **If the provider charges more than the "Usual and Customary" rates, the insured will have to pay both the coinsurance and the difference.**

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How Indemnity Plans Work

- **The plan will pay for charges for medical tests and prescriptions as well as from doctors and hospitals.**
- **It may not pay for some preventive care, like checkups.**
- **With Indemnity health plans, the insurer only pays for part of the insured doctor and hospital bills. Typically, this is what you would pay:**

a) **A monthly fee, called a premium.**

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How Indemnity Plans Work

b) A certain amount of money each year, known as the deductible, before the insurance payments begin. In a typical plan, the deductible might be $250 for each person in of the insured family, with a family deductible of $500 when at least two people in the family have reached the individual deductible. The deductible requirement applies each year of the policy. Also, not all health expenses of the insured have count toward your deductible. Only those covered by the policy do.

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How Indemnity Plans Work

- **To receive payment for fee-for-service claims, the insured may have to fill out forms and send them to his insurer. Sometimes his doctor's office will do this for him.**
- **The insured also need to keep receipts for drugs and other medical costs. He is responsible for keeping track of his medical expenses.**

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A few things to keep in mind about Fee-for-Service plans:

- **Fee-for-Service policies typically have an out-of-pocket maximum. This means that once the insured covered expenses reach a certain amount in a given calendar year, the reasonable and customary fee for covered benefits will be paid in full by the insurer.**
- **If your provider bills you more than the reasonable and customary charge, however, you may still have to pay a portion of the bill.**

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Managed Health Care

- **The traditional way of obtaining medical care has been for a patient to choose a doctor and then pay that doctor for the services provided.**
- **This "fee-for-service" model, which has been financially rewarding for doctors, gives the patient the right to choose a physician.**
- **But the fee-for-service model underwent a rapid decline in the 1980s and 1990s as the concept of managed care took hold in the healthcare industry.**

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Managed Health Care

- **Managed care is a new term for an old medical financing plan known as the HMO, or health maintenance organization.**
- **HMOs are not insured plan, they are prepaid health care systems offering services to which the member is entitled, as opposed to a dollar amount guaranteed by an insurance policy.**
- **Doctors are paid a set amount of money monthly for each patient regardless of the level or frequency f care provided.**

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Managed Health Care

- **Managed care has entered the lexicon of healthcare reform, but confusion and ignorance surround its meaning and purpose.**
- **It seeks to cut the costs of health care while maintaining its quality, but the evidence that it is able to achieve these aims is mixed.**

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Managed Health Care

- **Managed care is not a discrete activity but a spectrum of activities carried out in a range of organizational settings.**
- **Due to its constantly changing nature, managed care is a slippery concept—but all its permutations have in common an attempt to influence and modify the behavior and practice of doctors and other health professionals towards cost effective care.**

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Managed Health Care

- **Managed Care refers to types of health insurance plans that provide health care services at a lower cost. The key to these lower costs? Members of managed care plans must adhere to certain rules designed to lower the cost of medical care.**
- **Managed care plans, have agreements with certain doctors, hospitals and health care providers to give a range of quality health services at a reduced cost.**
- **The secret? Patients must stay within the plan's network of providers and health facilities to get the best benefits.**
- **HMOs, PPOs and POS plans are all types of managed care.**

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Managed Health Care

- **Most managed care is carried out in one of two basic types of organizational setting—the health maintenance organization (HMO) or the preferred provider organization (PPO).**
- **A health maintenance organization is a prepaid organized delivery system (a fixed amount of money is available to cover the health needs of members).**
- **The organization therefore assumes financial risk and may transfer some of that risk to doctors or other providers.**
- **Individuals enroll with a health maintenance organization and receive health care for a fixed premium.**

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Managed Health Care

Managed care may be thought of as a continuum of models. These models are classified as follow:

- **Indemnity with precertification, mandatory second opinion, and large case management.**
- **Service plan with precertification, mandatory second opinion, and large case management.**
- **Preferred Providers Organization (PPO)**
- **Point-of-service (POS)**
- **Health Maintenance Organization (HMO)**
  - **Open panel**
    - **Individual Practice Association (IPO)**
    - **Direct Contract**
  - **Network Model**
  - **Closed panel**
    - **Group Model**
    - **Staff Model**

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Managed Health Care

- As the models move from indemnity with precertification, mandatory second opinion, and large case management to a closed panel HMO, certain changes 0ccur. These changes include:
  - Elements of control over health care delivery become tighter.
  - New elements of control are added.
  - More direct interaction with providers occurs between the plan and provider.
  - Overhead cost and complexity increases in the health plan.
  - Greater control of utilization occurs.
  - More reduction in rate of medical cost takes place.

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Managed Health Care

Preferred Provider Organizations (PPO)

- **A PPO is an organization that contracts with health care providers who agree to accept discounts from their usual and customary fees and comply with utilization review policies in return for the patient flow they expect from the PPO.**
- **PPO plans, are one of the most popular types of plans in the Individual and Family market.**

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Managed Health Care

Preferred Provider Organizations (PPO)

- **PPOs an indemnity plans that** allows patients to visit whatever in-network physician or healthcare provider they wish without first requiring a referral from a primary care physician.
- **Patients will probably have an annual deductible** to pay before the insurance company starts covering the medical bills. they may also have a co-payment or be required to cover a certain percentage (co-insurance) of the total charges for the medical bills.

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Managed Health Care

- **Preferred Provider Organization (PPO)** Also referred to as an **"open-ended" HMO**, PPO plans encourage but do not require members to choose a primary care provider (PCP).
- **Subscribers choosing not to be treated** by a network physician must pay higher deductibles and co-payments than those utilizing network physicians.

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Managed Health Care

- **Point-of-service (POS) plan - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services.**
- **Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).**

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Managed Health Care

- **A point-of-service plan is similar to an HMO. It requires the policyholder to choose an in-network primary care doctor and obtain referrals from that doctor if they want the policy to cover a specialist's services.**
- **And a POS plan is like a PPO in that it still provides coverage for out-of-network services, but the policyholder will have to pay more than if they used in-network services.**

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Managed Health Care

- **Point-of-service (POS) plans usually offer lower costs, but their list of providers may be limited.**
- **POS plans are similar to HMOs, but POS plans allow customers to see out-of-network providers.**
- **A POS policy holder is responsible for filing all the paperwork when they visit an out-of-network provider.**

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Managed Health Care

Health Maintenance Organization

- **A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO.**
- **It generally won't cover out-of-network care except in an emergency.**
- **An HMO may require you to live or work in its service area to be eligible for coverage.**
- **HMOs often provide integrated care and focus on prevention and wellness.**

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Health Maintenance Organization

- **There are several types of HMO, each of which offers access to a different range of providers. HMOs are classified as follow:**
  - **Open panel**
    - **Individual Practice Association (IPO)**
    - **Direct Contract**
  - **Network Model**
  - **Closed panel**
    - **Group Model**
    - **Staff Model**

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Health Maintenance Organization

- **Individual Practice Association (IPA) HMO- is a legal entity organized and directed by physicians in private practice to negotiate contracts with health insurance plans on their behalf.**
- **IPA is a type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs.**
- **An IPA may contract with and provide services to both HMO and non-HMO plan participants.**

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Health Maintenance Organization

- **In a direct model, the HMO contracts directly with individual physicians to provide physician services to their members.**
- **There is no intervening entity such as an IPA.**
- **The HMO reimburses the providers directly, and perform all related management tasks.**
- **Direct contract models are currently the most common form of HMO.**

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Health Maintenance Organization

- **Network Model HMO - This model is an HMO that contracts with many IPAs and other provider groups to form a "physician network."**
- **Care can be provided in a larger geographic service area than would be possible with only one physician group.**
- **This network model offers the patient choice of physicians and managed costs.**
- **The physician groups may provide services to both HMO and non-HMO plan participants.**

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Health Maintenance Organization

- **The closed-panel HMO is a managed care plan that has an exclusive arrangement with physicians that blocks them from seeing patients from another managed care organization.**
- **The closed-panel HMO e.g., staff and group model HMO—in which covered insureds must select a primary care physician, who has control over referrals to other physicians in or out of the group.**
- **Closed panels generally do not reimburse their members for health care services used outside of the provider network.**

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Health Maintenance Organization

- **Closed Panel – Under this model, also known as the "Group Model," the Health Maintenance Organization pays a group of physicians to provide multi-specialty services to their members.**
- **Member care is administered at facilities owned by the group or the HMO. Patients under this plan need to use the group to have their medical expenses covered.**

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Health Maintenance Organization

- **Closed Panel Staff Model – This is another example of the closed panel model with a variation.**
- **In the staff model, the HMO hires physicians, specialists and ancillary care providers and house them in buildings owned by the HMOs.**
- **They are direct employees of the HMO.**
- **Members must also use these groups if they are to have their medical expenses covered.**