# HEALTH INSURANCE RESOURCES

## OPTIONS FOR PEOPLE WITH A CHRONIC DISEASE OR DISABILITY

DOROTHY E. NORTHROP, MSW, ACSW
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*A Guide for People with Chronic Disease and Disability*

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*A Guide for People with Chronic Disease and Disability*

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and

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# Dedication

This book is dedicated to Pamela Cavallo, MSW, CSW, now deceased, who, as Director of Clinical Programs of the National Multiple Sclerosis Society, recognized that people with disabilities and pre-existing conditions must have understandable and usable health insurance information. It was her vision that this manual would maximize health insurance coverage, promote patient rights, and provide strategies and resources for people with chronic conditions as they negotiate our very complex health insurance system.

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# Contents

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# Preface

Health insurance is one of society's most pressing issues. The United States is the only industrialized nation in the world that does not provide health insurance for everyone. The uninsured as well as those with inadequate health insurance coverage are increasing at alarming rates. In 1992, 38 million people in this country were without health insurance. Today it is estimated that over 43 million Americans lack health insurance coverage. Most of the uninsured are under 65 years of age, as Medicare covers virtually all elderly Americans (Kaiser Commission on Medicaid and the Uninsured).

In addition to the uninsured, millions of people have health insurance that is inadequate to meet all of their health care needs, particularly those with chronic disabilities. In an informal survey of people with multiple sclerosis (MS), the most frequently cited unmet needs included:

- Medications
- Home care
- Rehabilitation services (physical therapy, occupational therapy)
- Durable medical equipment
- Mental health counseling

It is expected that these same problems occur with a range of other chronic disorders.

There are many causes for this lack of adequate insurance coverage. These include:

- Refusal by some health insurance companies to sell insurance to people with pre-existing illnesses and disabilities.
- Seriously restricted coverage for some people with pre-existing illnesses and disabilities.
- Unemployment, self-employment, or employment by small companies that cannot afford to offer health insurance coverage.

- Changes in people's life circumstances—divorce, separation, death of a working spouse.
- Widespread lack of knowledge about insurance options and lack of understanding about how to make one's way through the health insurance system.
- Gaps and weaknesses in the system.

Drastic changes are needed in the United States health insurance system. These changes may take years to accomplish, however, as most change is incremental in nature. In the meantime, we need to make the current system work better. We need to disseminate information about insurance options and increase people's understanding of how to make their way through our complex insurance system.

This book contains information about a wide variety of options that will be of assistance to individuals who are uninsured, underinsured, or who have questions about insurance and don't know where to begin. The first section presents an overview of health insurance plans, Social Security, Medicare, Medicaid, and federal legislation that impacts health insurance coverage. The second section includes directories and resources to assist in researching health insurance options.

This book was developed to assist people with disabilities and chronic health conditions, and health care professionals, to understand the health care system and can maximize rights and entitlements within that system. It is important that this information be supplemented and updated with local and state legislation and regulations on an ongoing basis.

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# 1

# HEALTH INSURANCE: MANAGED CARE AND INDEMNITY PLANS

## HISTORICAL OVERVIEW

Not too long ago, most people with health coverage went to whatever physician they wanted whenever they wanted and their insurance company reimbursed them a certain amount of their medical bills. Health care consumers or employers had to pay part of the price plus a hefty deductible. When this type of fee-for-service or indemnity plan became too expensive, managed care seemed like a good solution because it promised to deliver affordable quality care if consumers, doctors, and hospitals agreed to certain cost-containing restrictions.

Although managed care was not viewed as a viable health insurance option until the mid-1990s, the concept is not new. In fact, its origins can be traced to the early 1900s. Other forms of health coverage existed some 100 years earlier.

The earliest form of health services in the United States dates to 1798, when Congress established the U.S. Marine Hospital Services for seamen. Compulsory deductions for hospital services were made from the salaries of the sailors.

Early insurance policies frequently protected against lost income due to accidents. The first accident policy, written by the Franklin Health Assurance Company in 1850, provided that for a 15 cent premium, the policy would pay the bearer $200 in the case of an injury caused by a railway accident. If the accident caused total disability, the bearer would receive $400.

In 1910, Montgomery Ward and Co. provided a health insurance plan for its employees covering illness and injury. The plan is regarded as the nation's first group health insurance policy and paid weekly benefits equal to one-half the employee's weekly salary with a minimum benefit of $5 and a maximum of $28.85 per week, if the employee was unable to work due to illness or injury.

By the early 1930s, two approaches to health insurance were emerging. The first approach used the indemnity model[1] and the second was an elementary managed care model; the earliest Health Maintenance Organization (HMO) originated in 1929 at the request of the Los Angeles Department of Water and Power. However, the growth of health insurance was slow at first, with less than 10 percent of the population—12,000,000 by 1940—covered by some sort of health insurance. The majority of the plans were indemnity policies.

A major shift in medical coverage occurred just after World War II, when health insurance became an important component of employee benefit packages. As the competition for health insurance became more intense, insurance companies recognized that they could charge different rates for different sub-groups within the population. People who were employed were generally healthier than individuals who were unable to work and were, therefore, offered coverage at lower rates.

By the late 1960s, the cost of delivering health coverage had increased substantially, making it a priority to establish a cheaper yet more effective form of coverage. In 1969, the National Governor's Association proposed a national health insurance plan that would utilize HMOs to provide coverage and still contain the increase of health care inflation. The Nixon administration, searching for a model to minimize the role of government in managing health care, also saw HMOs as a way to reverse the practice of paying physicians and hospitals for illness rather than for health. The administration proposed legislation in 1971 providing planning and startup funds for HMOs. In 1973, Congress adopted the Health Maintenance Organization Act, designed to stimulate the formation of comprehensive prepaid health care programs.

In 1970, fewer than 2 million people, or less than 1 percent of the population, were enrolled in HMOs. Because the cost of health care escalated dramatically during the next 25 years and the expense of managed care was considerably less than indemnity insurance, by 1996, about 60 percent of Americans were enrolled in some sort of managed care health plan (the most common of which were HMOs).

## ■ WHAT IS A FEE-FOR-SERVICE OR INDEMNITY PLAN?

An indemnity plan provides specific cash reimbursements for covered services, and any medical provider can be used. The insured pays a premium, usually

[1] Indemnity Model—Traditional health insurance coverage in which physicians, patients, or health institutions send medical bills to the insurance company for payment—classic "fee-for-service."

monthly, to purchase the policy, and pays charges up to the policy's deductible before insurance payments begin. After the deductible has been met, the insured will share approved medical costs with the insurance company; usually, 80 percent is borne by the company, the balance by the insured. Indemnity plans generally pay charges for prescription medications and tests, as well as for physicians and hospitals. It may not cover some charges for preventive care such as routine checkups.

There are two types of fee-for-service coverage: basic and major medical. Basic protection pays toward the cost of room and care while the insured is in the hospital. It also contributes to the cost of surgery, hospital services, and supplies such as prescribed medicine, as well as some doctor visits. Major medical insurance takes over when the benefits provided in basic coverage end. It covers the expense of lengthy, high-cost illnesses or injuries.

## ■ WHAT IS MANAGED CARE?

Managed care is a system of medical management in which patients, administrators, purchasers, and providers are linked together with the common goal of improving health care quality and reducing costs. It is a broad term encompassing many types of organizations, payment mechanisms, review processes, and collaborations.

In managed care health insurance plans, insurance companies contract with doctors, hospitals, laboratories, and other health-related facilities to meet health care needs. This linking of health care coverage with providers is the key to how the insured acquires and obtains care. The ease of access is determined by such components as the availability of medical services and their acceptability to the insured, the location of health care facilities, transportation, hours of operation, and the cost of care.

## ■ MANAGED CARE PLANS

### Preferred Provider Organization

A Preferred Provider Organization, or PPO, is the form of managed care closest to an indemnity plan. The insurance company contracts with individual providers and groups to create a network of health care facilities and medical personnel. Members of a group can choose any physician they wish for medical care, but their co-payments are significantly reduced if they choose a provider in the PPO network. Co-payments are predetermined fixed amounts paid per visit, regardless of treatment received. Going outside the network means meeting an annual deductible and paying co-insurance on higher charges.

Some of the features of a PPO include:

- Offering more services than provided by an HMO, thus making the care more costly;
- Requiring a co-payment for each visit that is generally higher than the HMO co-payment;
- Imposing an annual deductible and a higher total out-of-pocket cost than an HMO; and
- Requiring prior approval frequently for hospitalization and certain outpatient procedures.

## Health Maintenance Organizations

An HMO is the oldest form of managed care. It is a prepaid health insurance plan that provides specified services for a fixed premium. In exchange, the insured will be entitled to comprehensive care, including doctor visits, hospital stays, emergency care, surgery, laboratory tests, X-rays, and therapy. The majority of the HMOs require the insured to pay, at most, a small co-payment when seeing an in-network doctor, charge no deductible, and require only a few out-of-pocket expenses as long as the doctors, hospital, or other providers that are used are part of the HMO. Some of the other features of HMOs include:

- Having the insured either choose or be assigned a primary care physician (PCP) within the network who monitors the individual's health and provides most of the medical care.
- Empowering that physician with the responsibility of referring the insured to a specialist or other health care provider when necessary.
- Utilizing a gatekeeper model that does not cover the cost of a specialist or other health care provider unless approved by the PCP.
- Utilizing a non-gatekeeper model that does not require a referral from the primary care provider before utilizing a specialist.

Generally, with the exception of emergency treatment, if the insured obtains care without the PCP's referral in the gatekeeper model, or obtains care from a non-network provider, he or she may be responsible for paying the entire bill.

## Types of HMOs

A. *Staff Model HMO*—In this plan, the physicians are salaried employees or partners of the HMO who may also receive bonuses, incentive payments, or a share of the

profits. Typically, doctors in all common specialties needed to deliver comprehensive care staff the organization. Such HMOs may even own their hospital systems, though more typically they contract with hospitals and other in-patient entities in their communities to provide non-physician services. This model affords greatest control over the practice patterns of physicians and typically offers "one-stop shopping" to outpatients because a wide range of services is available at the clinics.

- Advantages: Plan allows for a tight management of services and one-stop shopping.
- Disadvantages: The model may be difficult and expensive to establish, the range of care may be limited, and the network is restricted.

B. *Group Model HMO*—In this plan, the HMO contracts with a multispecialty physician group to provide all physician services to the HMO's members. Unlike the staff model, however, the group rather than the HMO employs the physicians. The best known HMO of this kind is the Kaiser Foundation Health Plan. Permanente Medical Groups provide all physician services for Kaiser members under an exclusive contract, while the Kaiser Foundation Health Plan does the HMO functions of marketing, enrollment, and collection of premiums.

- Advantages: Plan allows for a tight management of services and maintains lower overhead costs than found in the staff-model plans.
- Disadvantages: The model may be difficult and expensive to establish, the range of care may be limited, and the network is restricted.

C. *Network-Model HMO*—This plan generally contracts with more than one physician group and may contract with single or multispecialty groups. Physicians in the model are often required to undergo utilization reviews and other forms of oversight.

- Advantages: Plan allows for a tight management of services and maintains lower overhead costs than found in the staff-model plans.
- Disadvantages: The model may be difficult and expensive to establish and the range of care is restricted.

D. *Individual Practice Association (IPA)*—An organization of individual medical practices formed for the purpose of negotiating with an HMO. Typically, the HMO pays the IPA a single capitated fee, and leaves provider reimbursement to the IPA.[2] In this plan, physicians continue to practice in their own locations using their own staff.

[2] A capitated fee is a specified amount paid to a health provider for a group of specified health services. Amounts are determined by assessing a payment "per covered life" or per member. The amount of payment is fixed regardless of the nature of services delivered.

- Advantages: Plan allows for a very broad participation by community physicians; easier and cheaper to establish.
- Disadvantages: Management of physician behavior is limited.

### Point-of-Service Plan

Many HMOs offer an indemnity type option known as a Point-of-Service or POS Plan. This plan has an out-of-plan provision that offers specified coverage under special circumstances for use of nonparticipating providers. This can be especially important to enrollees with medical conditions who may desire specialists beyond those available through the HMO.

In an HMO POS Plan, the use of in-network services must be approved by a primary care physician (unlike a managed care PPO or Preferred Provider Organization where the patient selects any type of covered care from any in-network provider). When going out-of-network with the POS plan, referral by the PCP means that the HMO will pay all or most of the bill.

## ■ DEFINITIONS, TERMS, AND FEATURES OF MANAGED CARE

There are certain definitions, terms, and features associated with managed care that are used in shaping the parameters of a particular plan. They include:

- *Gatekeepers or primary care physician:* Access to services in managed care is often controlled by a gatekeeper, typically a PCP who is responsible for overseeing and coordinating all aspects of a member's care and treatment. Pre-authorization must generally be obtained from the PCP before a member is referred to a specialist for surgery or hospitalization. Members of an HMO and of some PPOs are required to choose a PCP or one will be assigned.
- *Pre-existing condition:* A condition (whether physical or mental), for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period prior to the enrollment date.

  Under HIPAA, group health plans and insurers can only apply pre-existing exclusions to a plan member or dependent who:

  – Does not enroll during the first period the individual is entitled to join;
  – Does not enroll during a special enrollment period when there is a change in family status or loss of group coverage under another plan;
  – Has never had health coverage;