Health Insurance

Objectives

- Students will be able to:
  - Differentiate between various types of health insurance plans
  - Describe the features of each type of health insurance plan

Healthcare Systems

- Types of healthcare systems vary by country.
- Different types:
  - Public/National Healthcare system
  - Private Healthcare System
  - Mixed System

Public/National Healthcare System

- Mainly funded by taxes and social security insurance.
- Advantage – Every citizen is guaranteed health care regardless of economic status.
- Disadvantages – Health care is not always comprehensive and taxes may be higher.
- Who has this type of system?
  - Norway, France, the United Kingdom, and Canada

Private Healthcare System

- Mainly funded by private insurance agencies and out-of-pocket payments.
- Advantages – Coverage is often comprehensive, taxes may be lower, and economic growth is stimulated.
- Disadvantage – Not every citizen is guaranteed health care.
- Who has this type of system?
  - United States and Switzerland

Mixed System (7 ½ min)

- Very few countries have a purely public or private system
- Most countries create a mixed system by using various funding sources to cover healthcare expenses.
- Who has this type of system?
  - Canada and the United States

History of Health Insurance in the United States (2 min)

- In the 1920's, the United States developed a system of health insurance to help cover the cost of medical expenses.

Health Insurance Terms

- **Premium** – the amount paid to an insurance agency for a health insurance policy
- **Deductible** - the amount that must be paid by the patient before the insurance agency will begin to make payments
- **Co-payment** - an amount paid by the patient for a certain service
- **Out-of-pocket** - a medical bill that must be paid by the patient

Health Insurance Terms cont.

- **Individual insurance** is when a person purchases a policy and agrees to pay the entire premium for health coverage.

- **Group insurance** is generally purchased through an employer. The premium is split between the employer and the person being insured.

Managed Care Vs. Fee for Service Health Insurance

- Managed health care plans are dependent on a network of key players, including health care providers, doctors, and facilities that establish a contract with an insurance provider to offer plans to their members
- Fee for service insurance is where services are unbundled and paid for separately. It gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.

Main types of Managed Care (1 min)

- Health Maintenance Organizations
- Preferred Provider Organizations
- Point of Service
- High deductible Health Plan (2 min)

Health Maintenance Organizations

- Pay premium and co-payments and usually no deductible or a very low one.
- Must choose a PCP-primary care provider and get referrals before seeing specialists.
- Limit the choices of MDs you can see
- Focus on preventative care and treatments.

Preferred Provider Organization

- Pay premium, deductible, and co-payments.
- Clients do not have to choose a primary care physician so the most freedom and choice with these plans
- Clients may visit non-network physicians, but coverage is greater with in-network physicians.
- Premiums are generally higher than with HMOs.

Point of Service

- Requires that you get a referral from your primary care physician (PCP) before seeing a specialist.
- Slightly higher premiums than an HMO
- Plan covers out-of-network doctors, though you'll pay more than for in-network doctors.
- This is an important difference if you are managing a condition and one or more of your doctors are not in network.

High Deductible Health Plan

- Lowest premiums
- Pay deductible before insurance pays anything
- The higher the deductible, the lower the premium
- Sometime in conjunction with a Health Saving Account (HSA)

Government Programs/Insurance

- In the 20th century, the United States government began to realize the need for public medical assistance.

- In 1965, President Lyndon B. Johnson instituted two medical assistance programs to help those without health insurance.
  - Medicaid
  - Medicare

Medicaid

- Income or needs based insurance program
- Designed by the federal government, but administered by state governments
- Usually includes individuals with low incomes, children who qualify for public assistance, and individuals who are blind or physically disabled.

Medicare

- Insurance program for any U.S. citizen age 65 or older
- Administered by the federal government
- After an individual pays a deductible, Medicare will cover 80% of all medical expenses.

Medicare Services

- **Part A: Hospital Care**
  - Free to anyone that meets qualification requirements.
  - Covers:
    - Hospitalization
    - Skilled nursing facilities
    - Home health care
    - Hospice care
    - Long-term care facilities

Medicare Services

- **Part B: Outpatient Services**
  - Must enroll in this separately
  - Generally costs around $150 per person/month
  - Medical expenses, including therapy, medical equipment, and testing
  - Preventive Care
- **Part D: Pharmaceuticals**
  - Must enroll in this separately
  - Cost depends on the plan

Government Programs/Insurance

- Tricare
  - Coverage for all active duty members and their families
  - Coverage for survivors of military personnel and retired members of the Armed Force
  - Care for military veterans

Worker's Compensation

- Provides treatment for workers injured on the job
- Administered by the state
- Reimburses the worker for wages lost because of on-the-job injury

Overview/review of the U.S. Healthcare system

Health Insurance Portability and Accountability Act--HIPAA

- Passed in 1996
- Compliance with all components was required as of April 2005
- Required creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
- Prohibits discrimination against individuals based on health status.

Main components of HIPAA

- HIPAA Privacy and Security Rules protect the privacy and security of individually identifiable health information. HIPAA Rules have detailed requirements regarding both privacy and security.
  - The HIPAA Privacy Rule covers protected health information (PHI) in any medium
  - The HIPAA Security Rule covers electronic protected health information (ePHI).

National Healthcare Plan

- The high cost of healthcare and a large number of uninsured individual created a demand for a national healthcare plan
- What is the Affordable Care Act and how does it work?? (5 min)

Affordable Care Act

- Signed into law March 2010
- Most provisions in place by 2014

Affordable Care Act

- Primary provisions:
  - Insurers must charge same premium to all applicants
  - Prevents rescinding coverage (dropping someone from the plan) as long as premiums are paid
  - Expanded Medicaid eligibility to include more people
  - Created affordable insurance exchanges to provide more organized market to find desirable plans

Affordable Care Act

- Primary provisions cont:
  - Mandates ALL people have health insurance or pay a fine
  - Subsidies (financial asst) for low-income families
  - Young adults eligible to be covered under parent's plan till age 26
  - Enforces "shared responsibility payment" between individual and employers
  - Improved Medicare and prescription drug coverage