Understanding Health Insurance Plan Models

One of the (many) things that separates the business of medicine from so many other industries is the complexity of healthcare reimbursement. The healthcare reform process in the United States is shining an unrelenting spotlight on the price variances between identical services and the inscrutable way that providers set their fees. Since a large portion of the services rendered are negotiated and paid for by a third party, medical managers deal with a different set of challenges and require a specialized understanding of how payment mechanisms operate.

As we are all patients, we can all benefit from a basic understanding of the most popular types of insurance plana, and how they work for subscribers. Understanding health insurance is critical to understanding medical management as well as how healthcare is changing under reform.

Indemnity plans (often called 80/20 plans)

These plans typically have a deductible – the amount the patient pays before the insurance company begins paying benefits. After the patient’s covered expenses exceed the deductible amount, benefits are paid as a percentage of actual provider charges, often 80 percent. These plans usually

provide the most flexibility in choosing where and from whom to get healthcare.

Preferred Provider Organization (PPO) plans (also called a network plan)

In these plans the insurance company enters into contracts with selected hospitals and physicians to furnish services at a discounted rate. Patients may see a provider within the network without a referral. Patients with this plan may be able to seek care from a doctor or hospital that is not a preferred provider (considered “out-of-network’ providers) but the patient will have to pay a higher deductible or co-payment. Exceptions exist if covered medical services are not available inside the network.

Exclusive Provider Organizations (EPOs)

Very similar to HMOs, EPOs may limit coverage to providers inside their networks, however EPOs do not generally require referrals to see in-network specialists. EPOs are often the insurance plan of choice for self-insured hospitals and large medical systems.

Health Maintenance Organization (HMO) plans (also called gatekeeper plans)

These plans have patients choose a primary care physician (PCP) from a list of HMO providers. The PCP is responsible for coordinating all healthcare for their HMO patients. If patients need care from any network provider other than the PCP, the PCP usually must provide a referral. Only care provided by a participating HMO provider will be paid. Treatment received outside the network is usually not covered, or is covered at a significantly reduced level. HMO plans often have the lowest premiums, deductibles and co-pays, but can be restrictive on when and where patients can get care.

Point of Service (POS) plans

These plans are a hybrid of the PPO and HMO models. They are more flexible than HMOs, but do require patients to select a primary care physician (PCP.) Like a PPO, patients can go to an out-of-network provider and pay more of the cost. However, if the PCP refers you to an out-of-network doctor, the health plan will pay the cost.

Catastrophic Health Insurance Plan

A catastrophic health insurance plan covers essential health benefits but has a very high deductible. This means it provides a kind of “safety net” coverage in case patients have an accident or serious illness. Catastrophic plans usually do not provide coverage for services like prescription drugs or shots. Premiums for catastrophic plans may be lower than traditional health insurance plans, but deductibles are usually much higher. This means patients must pay thousands of dollars out-of-pocket before full coverage kicks in.

Some patients are combining catastrophic health insurance plans with **Direct Primary Care (DPC),** where for a monthly fee, a primary care physician provides office visits and some additional care such as lab tests and flu shots.

Consumer-Driven Health Plans (CDHP)

CDHP describes a wide range of approaches to give patients more incentive to control the cost of either their health benefits or health care. Patients have greater freedom in spending health care dollars up to a designated amount, and they receive full coverage for in-network preventive care. In return, they assume significantly higher cost sharing expenses after having used up the designated amount.

Health Reimbursement Arrangement (HRA)

Health Reimbursement Arrangements are a common feature of Consumer-Driven Health Plans. They may be referred to by the health plan under a different name, such as Personal Care Account. They are also available to enrollees in High Deductible Health Plans who are ineligible for an HSA. HRAs are similar to HSAs except an enrollee cannot make deposits into an HRA, a health plan may impose a ceiling on the value of an HRA, interest is not earned on an HRA, and the amount in an HRA is not transferable if the enrollee leaves the health plan.

Health Savings Account (HSA)

A Health Savings Account allows individuals to pay for current health expenses and save for future qualified medical expenses on a pretax basis. Funds deposited into an HSA are not taxed, the balance in the HSA grows tax-free, and that amount is available on a tax-free basis to pay medical costs. To open an HSA, you must be covered under a High Deductible Health Plan and cannot be eligible for Medicare or covered by another plan that is not a High Deductible Health Plan or a general purpose Health Care Flexible Spending Account (HCFSA) or be dependent on another person’s tax return. HSAs are subject to a number of rules and limitations established by the Department of Treasury.

High Deductible Health Plan (HDHP)

A High Deductible Health Plan is a health insurance plan in which the enrollee pays a deductible of at least $1,250 for individual coverage or at least $2,500 for family coverage. The annual out-of-pocket amount (including deductibles and co-payments) the enrollee pays cannot exceed $6,250 for individual coverage or $12,500 for family coverage. These dollar amounts are for 2013.

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The Direct Pay Physician Practice Model: An Interview With Scott Borden

Most readers know that I have a special interest in helping physician practices survive and thrive, and have been writing recently about different models of care that physicians are adopting to make private practice financially viable. Here's an interview with Scott Borden of Direct Pay Consulting, who helps practices convert to a Direct Pay Model. ~ Mary Pat Whaley

Mary Pat: What is your background, Scott?

Scott: I am a passionate Health Savings Account (HSA) expert. My background has been in health insurance marketing and management for 23 years. I have been heavily involved with Consumer Driven Healthcare for the past 15 years. I have been both a talk radio show host and guest on hundreds of shows over the past 8 years. I have also been featured on several television broadcasts and been a guest speaker for dozens of organizations.

Mary Pat: Your company is called Direct Pay Consulting and you help primary care practices transition to a Direct Payment Care (DPC) model – will you explain what that model is?

Scott: DPC is where the patient pays the physician directly without any third-party insurance company or government program being involved with the payment or treatment plan. It

is also known as Direct Primary Care or simply Direct Pay. This usually involves an annual membership fee and sometimes a per visit fee. There are hybrid versions available where insurance is billed above the annual membership fee, but we know any payment from an insurance company or government entity will include intrusive control over how the physician practices medicine. And it significantly increases paperwork.

The original version known as "Concierge Medicine" started in the late 1990's in Seattle and has been slowly picking up steam. Both Concierge and DPC allow physicians the time necessary to treat the root cause instead of simply medicating symptoms. Additional benefits include same or next day appointments, less (or no) waiting times, cell phone / email / Skype access, coordination of care with specialists and even house calls. Concierge physicians may charge $1,500 – $20,000 or more per year so it may be cost-prohibitive for many Americans. DPC offers nearly the same benefits as a Concierge Physician at an affordable rate almost anyone can afford.

Mary Pat: Why do you think now is the right time for this model?

Scott: There are many things currently happening that each point towards DPC as the solution. Together they are turning what would have been a gradual movement into a potential mass exodus.

The first issue frustrating all physicians is decreasing reimbursements. The "Doc Fix" is unlikely this year as Medicaid payments will match Medicare in 2014 meaning the fix would be much more expensive this time. The odds are further reduced by the lack of an election this fall pressuring congress to delay the planned cuts again. Many independent physician practices are being bought by larger hospital groups. Since reimbursements are not tied to the amount of time spent per patient, these groups typically pressure physicians to see more patients per day. They have been known

to require treatment plans based on maximizing reimbursements instead of better patient outcomes. So unfortunately many doctors today feel like they're working for insurance companies and hospitals instead of their patients.

Second is the shortage of physicians. Nearly 50% of a primary care physician's time is spent writing letters and filing claims in order to receive payments from insurance companies. And whatever payments they actually do receive seem to arrive late. Forecasts show that physician access will be significantly worse once the Affordable Care Act (Obamacare) subsidizes health insurance for 30 million people that will be searching for a primary care physician instead of using the Emergency Room for minor medical needs. This will even further reduce the amount of time available with each patient.

And the most important driver is the pent-up demand from patients. People are afraid Obamacare will take their doctor away. They already hate being being herded through a system of long waits and limited access, and they know it's not going to get any better. Many middle class Americans are willing to pay a little more to receive excellent medical care from a doctor they have chosen.

Mary Pat: How can physicians evaluate whether DPC is a good fit for them?

Scott: Although every physician should consider DPC, very few will be able to transition without the typical "income dip" that occurs when all insurance and Medicare reimbursements stop.

We have developed tools to help determine whether a physician should go full DPC or start out with a hybrid version while the DPC side builds along with potential revenue projections. These tools don't account for every situation such as those physicians that are wanting to semi-retire without reducing income. Every situation is different.

Mary Pat: What is the scope of services you provide?

Direct Pay Consulting provides all of the services a physician needs to convert his/her practice:

- Conversion planning and execution
- Patient insurance education and guidance
- All announcements and ongoing communication
- Patient sign-up management
- Patient agreements
- Online tools and calculators for patients
- Custom web pages for the doctor
- Management of the wait-listed patients

The idea is for the doctor to continue to do what they do best while we manage the conversion and ongoing patient participation. We have partners that can provide services from setting up an office to management of day-to-day operations for those doctors who are breaking away from a group. All of this is completed at fair and reasonable costs.

Mary Pat: Is it scary for physicians to take the "leap of faith" necessary to make the switch over from fee-for-service to DPC?

Scott: Actually I think the scary option would be to remain in the current system allowing insurance companies and government bureaucrats to take over virtually every business and patient decision! Many doctors who take on the conversion as a lone wolf find that it takes much more time than expected. They experience many pitfalls and delays. Many times they are forced to completely stop their practice to allocate the time needed which is very costly. If they don't have enough patients sign up then physicians are forced to begin the even more difficult process of finding new patients. The idea behind Direct Care Consulting is to have the doctor continue to file insurance until a predetermined number of patients sign up thus limiting the risk.

Mary Pat: What expenses are eliminated when DPC is adopted? What new expenses, if any, arise? Are any staff positions eliminated?

Scott: Each conversion is vastly different. The primary expenses that go away are those related to coding and filing for payment from insurance providers and government agencies. Rarely are there any new expenses. For many practices this can eliminate one or two clerical positions.

Mary Pat: How does it work if physicians want to continue to see Medicare patients? Does the physician have to opt out of Medicare?

Scott: No physician would be forced to opt out, however most DPC physicians will choose to stop taking Medicare. They don't want anyone (let alone a government agency) dictating how they are to treat patients. Accessing some benefits outside the DPC practice for Medicare patients such as durable medical equipment might be more complicated, but not impossible. Medicare patients may find it more difficult to find physicians willing to accept them in the near future, so Medicare patients could very well become the fastest growing adopters of DPC.

Mary Pat: I've heard you are called the "HSA Guy." What do HSAs have to do with DPC?

Scott: HSA-qualified High Deductible Health Plans (HDHP) offer the catastrophic protection everyone needs at a significantly lower cost than low deductible co-pay health insurance plans. I call HSA-qualified plans "DPC friendly" since they are not allowed to have office visit co-pays which wouldn't be accepted by a DPC physician anyway. This insurance premium & tax saving tool allows many middle income patients to transition to a DPC practice without breaking their budget. HSAs make DPC affordable for (almost) anyone.

Mary Pat: Why did you transition from 20+ years of health

insurance consulting into Direct Pay Consulting?

Scott: Last year I had no idea how much pent-up demand there was from both physicians and patients for DPC. Then I was approached by Dr. Douglas Brooks who has been a long time talk radio show listener that was ready to go Direct Pay.

But Dr. Brooks' wife wasn't convinced. She was concerned about the dreaded income dip that normally accompanies quitting insurance and Medicare cold-turkey. She was especially concerned since Dr. Brooks was already one of the top 1% compensated primary care physicians in the country. But Dr. Brooks was so fed up with the various hospital groups he had worked for that he was willing to go for it. He asked me for my help and we put together a business and marketing plan.

I felt we needed 1,000 patients to sign up in order to replace his salary. He reached that level in three months. Let's just say Mrs. Brooks is no longer concerned. I now know this level of success is extremely rare. I'm not sure it has ever been done before. Ignorance is bliss. The biggest reason he was able to transition so quickly is because he is a very popular physician with a large number of loyal patients. Many of them attended one (or both) of our seminars. Our insurance office fielded hundreds of phone calls from his patients along with dozens of appointments ,helping them understand why they should switch to HSA- qualified plans. Dr. Brooks estimates 40% of his DPC patients are now paying his fees with tax-deductible HSA dollars. HSA participation is around 5% nationally.

We know the direct patient contact necessary for a successful transition will limit the number of physicians we are able to work with to a maximum of 20 this year. There are currently less than 5000 DPC physicians. Yet there are over 300 million Americans that want more access to their physician. HSAs and DPC make it affordable for almost everyone.

Scott Borden is the founder of **Direct Pay Consulting** and can be reached at 913-980-4694 (mobile) or at SBorden@DirectPayConsulting.com.

A Guide to Healthcare Buzzwords and What They Mean: Part One (A through L)

Welcome to our guide to Healthcare Buzzwords!

ACO

An acronym for “Accountable Care Organization”, an ACO is a model of healthcare delivery in which a group of healthcare providers agree to accept payment for their services based on the aggregated health outcomes of the patients they see, as

opposed to the total number of services performed. ACOs reward providers in a “fee for health” model, as opposed to a traditional “fee for service” model. Although the term ACO can apply to a variety of types of organizations, regulations for establishing ACOs to participate in the Medicare Shared Savings Program specifically were included in the Patient Protection and Affordable Care Act of 2010.

Big Data

“Big Data” is a blanket term used to describe the tremendous amount of raw data that we create as part of our everyday lives. As we become more proficient in capturing, storing, and analyzing these massive data sets – and the increasingly complex tools needed to do so – there is tremendous hope in the ability for industries to glean insights from the mountain of data they already have. Healthcare, with the tremendous amount of data that is already collected and stored in the form of medical records, is considered one of the areas with the most to gain from advances in “Big Data” tools.

CCHIT

An acronym for “Certification Commission for Healthcare Information Technology”, CCHIT is one organization authorized by the Office of the National Coordinator of the Department of Health and Human Services to certify Electronic Health Record products for quality, security and interoperability. This certification is necessary for providers to receive “stimulus” funds from Medicare or Medicaid as reimbursement for achieving “Meaningful Use” of the EHR. Other organizations providing certifications include Drummond Group, ICSA Laboratories, Inc. and InfoGuard Laboratories, Inc.

Cloud vs. Closet

The “Cloud” versus the “Closet” is a way of defining the two most common ways of managing and sharing software products in a medical practice. The “Closet” is the traditional model where a server is installed, often into an extra closet where the phone system is also kept that runs the Practice Management and/or Electronic Medical Record software on the desktops in the practice. Generally, the practice owns their own software and hardware, and pays for it upfront as a capital expense. In the “Cloud” model, which is rapidly gaining favor, a constant Internet connection allows the server hardware to be kept offsite in the vendor’s data center. The software is paid for on a monthly, operational expense basis, and security, upgrades and maintenance are all outsourced to the vendor.

EMR/EHR

Acronyms for “Electronic Medical Record” and “Electronic Health Record.” The two terms are generally used interchangeably to describe any software that that documents medical services delivered between providers and patients. There is however a general distinction between the two, highlighted **in this blog post from the ONC**. An Electronic Medical Record generally refers to the digitized version of a paper record that is kept in an office as a record of the patient’s services from that provider. In other words, only the patient’s interactions with the providers of that office. An Electronic Health Record on the other hand generally refers to the complete history of a patient’s life and conditions as they visit different providers in different health settings. With the EHR’s focus on health as opposed to medicine, and portability with the patient as opposed to static and office-based, EHR tends to be the “official” term used by the ONC.

eRx

“eRx” is an abbreviation for “e-prescribe”, or the ability to transmit information from a provider to a pharmacy and back to facilitate filling prescriptions with a completely electronic process. By eliminating the paper scripts and the patients having to take them to their pharmacy, eRx facilitates more accurate, timely information between prescriber and pharmacy, and ensures that the information is accurately logged into the patient’s EHR. The ability to e-prescribe is a component of achieving Meaningful Use for providers to receive stimulus funds.

HDHP

An acronym for “High Deductible Health Plan”, an HDHP is a type of insurance coverage where more of the initial cost of care is shifted to the responsibility of the patient. Using higher deductibles, as well as co-pays or co-insurance, high-deductible health plans are often combined with Health Savings Accounts to provide heath coverage at lower premiums for patients and/or employers. As health insurance costs continue to rise, HDHPs are becoming more popular as a coverage model.

HIE #1 (Health Information Exchange)

A Health Information Exchange is a central hub where different health providers and locations can “exchange” electronic medical information so that a patient’s medical history is available to any provider or care setting in which the patient receives treatment. The exchange allows for the health data to be shared across different types of software in different places, so access to the exchange insures access to the most accurate patient data available. Health Information Exchanges are being set up in regional, state and national settings, and

were a key part of Patient Protection and Affordable Care Act (PPACA or ACA) of 2010.

HIE #2 (Health Insurance Exchange)

A Health Insurance Exchange is a controlled marketplace where consumers can compare and purchase health insurance, as well as find out about any subsidies or tax benefits they can take advantage of to offset the cost of coverage. Each state has the option of setting up their own state-level exchange, or participating in the federally-run exchange. The exchange also sets minimum coverage levels for each state, and mandates that insurance companies disclose actuarial percentages and coverage levels of similar plans so that consumers can make informed decisions about coverage.

HIM

Health Information Management is the field of study that deals with overseeing and maintaining health care information for a patient population. Although HIM refers to the management of both paper-based and electronic health records, the field increasingly focuses on the storing, securing, and disclosing of electronic data. Issues like ethics, health informatics, and health information policy are changing the way Health Information Management is viewed in the larger context of the healthcare system.

HIPAA

An acronym for the “Health Insurance Portability and Accountability Act of 1996”, HIPAA is a federal statute that was designed to regulate health insurance to make it easier to “carry” coverage with you after leaving a job, as well as to set standards for the protection and transmission of protected health information. HIPAA was appended by the HITECH Act of

2009 to set disclosure reporting requirements in the case of a breach as well as define business associates as entities covered under HIPAA. Generally, when people refer to “HIPAA Requirements” they are talking about the privacy restrictions of the two bills.

HSA

An acronym for “Health Savings Account”, an HSA is a specialized bank account that allows its holder to defer federal tax liability in order to save for future medical expenses. Money deposited in an HSA is not subject to Federal Income Tax. HSAs, like a flexible spending account, or a health reimbursement account are combined with a high deductible health plan to replace traditional health insurance with money from the HSA covering short term costs and helping with patient responsibilities while the HDHP covers catastrophic injuries or illness.

ICD-10

ICD-10 is an abbreviation for “International Statistical Classification of Diseases and Health Related Problems, 10th revision”. The ICD system is the set of alphanumeric codes that are used to classify diseases and bill medical payers for services. The United States currently uses the ICD-9 system, but is set to switch to the new standard on October 14, 2014. ICD-10 is much more complex than ICD-9, with almost five times as many available codes, and a much more specific hierarchy. ICD-10 is also referred to as **“I-10.”**

Interoperability

Interoperability is the concept that information stored in EHR software should be usable by any other software package. Interoperability is key to coordinating and improving care,

because the health information is worthless without the software compatibility to share it between providers. This “breaking down of barriers” between different EHR software packages is crucial not only to sharing health information, but to creating a thriving and innovative healthcare information technology marketplace. Examples are a hospital system EMR’s interoperability with a private practice EMR, and both system’s EMR interoperability with a reference laboratory’s Information System.

IPA

An acronym for “Independent Practice Association”, an IPA is a group of independent physicians, or groups representing independent physicians to contract their services to managed care organizations and payers. IPAs can be formed to collaborate on care in a region, promote the political effectiveness of the independent physician, as well as to negotiate professional fees for their members, although it is important to note that the IPA does not negotiate on behalf of its members for services delivered outside managed care agreements because of federal trade laws.

What are some of the buzzwords you are hearing, wondering about, and maybe even growing tired of? Let us know in the comments!