THE COVERAGE, REIMBURSEMENT, DELIVERY, ALHPABET "MIX"

			INDEMNITY	SERVICE	P.P.O.	I.P.A.	H.M.O.
COVERAGE	Partial	service limits, or copayments (from recipients)	•				" • "
		service limits, or deductibles (from recipients)		•	•	•	
	Full	(comprehensive, unlimited)					•
REIMBURSEMENT FOR SERVICES	Postpayment	to recipient	•				
		to provider		•	•		
	Prepayment	to "provider"				•	•
COMPONENT AUTONOMY	Recipient	choose any primary care provider	•	•	" • "		
		choose any speciality provider	•	•	" • "		
	Provider	deliver services to non plan recipients	•	•	•	•	
		set rates and bill recipients for uncovered balances	•	•	" • "	" • "	

EVOLUTION OF FEDERAL ACCESS FOCUSED POLICIES. Strategy: provide funds. Purpose: increase access.

LEGISLATION and Other activity	*Concepts introduced* and Tactics employed	Coverage	Recipient of federal funds (and basis)
NHI. in T.R.'s election platform (1912)	*Universal coverage, federal involvement*	*(All)*	
Workmen's Compensation (1930)	Funds for services; disadvantaged group 1	Injured workers	(varied)
NHI. a national issue during depression	*Increasing federal involvement*		
Social Security Act, Title V: M.C.H. (1935)	Funds for services; disadvantaged group 2	Children (and expectant mothers)	States
National Labor Relations Act (1935 ff)	Indirect federal influence, disadvantaged group 3	Uninjured workers	
NHI. sponsored by F.D.R. (1944)	*Increasing federal involvement*		
Vendor Amendment Act (1945)	Funds for services; disadvantaged group 4	Indigents on relief (public assistance)	States (matching)
Hill-Burton Act (1946)	Funds for facility construction; free care requirement		Facilities (varied, "contractual")
D.D.E. proposes "broadening and pooling" (1954)	*Increasing indirect federal influence*		
Kerr-Mills Act (1960)	Funds for services; disadvantaged group 5	Elderly indigent (not necessarily on relief)	States (matching)
Regional Medical Planning Act	Funds for medical education		Medical schools (capitation)
P.L. 89-97 (1965)	Funds for services, active federal participation		
Title XVIII (Medicare)	Disadvantaged group 6	Elderly (not necessarily indigent)	Providers (not matching)
Title XIX (Medicaid)	Disadvantaged group 7	Indigent (not necessarily elderly)	States (matching)
Tax Equity and Fiscal Responsibility Act (1982)	Funds for services	*"All"*	Providers (prospectively)

EVOLUTION OF FEDERAL COST FOCUSED POLICIES. Strategy: control facilities. Purpose: reduce costs.

Legislation	Tactics employed	"Interest" dominance	Participation	Control locus
Social Security Act, Title V: M.C.H. (1935)	Cordination (planning) of service availability and receipt			Federal, state
Hill-Burton Act (1946)	Increase in number of providers 1	Provider	"Voluntary"	Federal, state
Regional Medical Planning Act	Increase in number of providers 2	Provider	Voluntary	Federal, state
Comprehensive Health Planning (Public Health Service Act, 1961)	Planning (networking) to eliminate duplication	Consumer	"Mandatory"	State
Professional Standards Review Organizations Act (1972)	Capital equipment expenditure review (Section 1122)	Provider	"Mandatory"	State
National Health Planning and Resources Development Act (1974)	Facilities and services expenditure review	Consumer, provider	"Mandatory"	State
Tax Equity and Fiscal Responsibility Act (1982)	Prospective pricing		Mandatory	Federal

KINDS OF MEDICAL INSURANCE

Group insurance. Insurance acquired through employment (called "group" because the employees [and family members] comprise the group). Group insurance is often the least expensive kind of health insurance because, in many cases, the employer pays part or all of the cost. Some employers offer only one health insurance plan; some offer a choice of plans. A Federal law, COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) makes it possible for an employees, who work for businesses of 20 or more employees, to continue group health coverage for a 18 months after leaving a job or being laid off (or widowed or divorced "dependents, or "children" after finishing school); this "continued" coverage typically costs more than group coverage, or offers less protection.

Individual insurance. If an employer does not offer group insurance (or if an employee elects not to purchase group insurance through an employer), an individual insurance policy can be purchased. Coverage and costs for individual policies vary and many do not offer benefits as broad as those of those group plans.

Fee-for-Service insurance. This is " traditional" health insurance where the insurance company reimburses providers part of their fees for services rendered to recipients covered by the policy. Fee-for-service plans typically offer the most choices of doctors and hospitals, but some services may be limited or not covered at all. The recipient typically pays deductibles and is responsible for filling out forms and keeping track of medical expenses (receipts). Most fee-for-service plans also have a "cap" (the most the policy-holder will have to pay for medical bills in any one year). There are two kinds of fee-for-service coverage: basic and major medical. Basic protection pays toward the costs of a hospital room and care in the hospital; it covers some hospital services and supplies, such as x-rays, prescribed medicine, surgery, and some doctor visits. Major medical insurance takes over where basic coverage leaves off; it covers the cost of long, high-cost illnesses or injuries. Some policies combine the two kinds into one plan called a "comprehensive plan."

Health Maintenance Organization (HMO). A managed care, prepaid plan, an HMOs is essentially an insurance-provider "network" where an recipient (or employer) prepays for complete comprehensive care (doctors' visits, hospital stays, emergency care, surgery, check-ups, laboratory tests, x-rays, and therapy); there are usually small copayments and large restrictions on choices of doctors and hospitals (with exceptions for emergencies). In a "pure" HMO, physicians are salaried (work for the HMO), have offices in an HMO, and provide services directly (or purchase it for recipients through referrals to other providers specifically identified by the HMO). In an adaptation of HMO principles, physicians in private practice contract with an HMO to take care of HMO recipients; these are called independent practice associations (IPAs).

Preferred Provider Organization (PPO). A managed care plan, a PPO is essentially a combination of traditional fee-for-service and HMO with a limited number of physicians and hospitals who agree to cap their fees at predetermined rates. When a recipient uses those "preferred providers" a much larger part of their medical bills are covered. There are usually small copayments and there may also be deductibles. A recipient can also use providers who are not a "preferred" part of the plan and still receive some coverage, but will likely pay a larger portion of the bill personally (and also fill out the claims forms).

Medicare. Medicare is the Federal health insurance program for Americans age 65 and older and for certain disabled Americans. Medicare has two parts: hospital insurance (Part A, which is free) and supplementary medical insurance (Part B, for which a premium is charged) which provides payments to physicians and for related services and supplies ordered by a physician. Medicare pays for many health care expenses, but not all of them; in particular, it does not cover most nursing home care, long-term care services in the home, or prescription drugs. There are also special rules on when Medicare pays bills that apply if you have employer group health insurance coverage through your a job or the employment of a spouse. Traditional Medicare coverage is fee-for-service type, but HMOs and similar forms of prepaid health care plans are also available to Medicare enrollees in some locations. Some Medicare recipients also buy private insurance, called "Medigap" policies, to pay medical bills that Medicare does not cover; some Medigap policies cover Medicare's deductibles; most pay the coinsurance amount; some also pay for health services not covered by Medicare.

Medicaid. Medicaid provides health care coverage for some low-income recipients, some who are blind or otherwise disabled, and certain people in families with dependent children. Medicaid is a Federal program operated by States, and each State decides who is eligible and the scope of health services offered.

Disability insurance. Disability insurance replaces income lost as a result of a long-term illness or injury that precludes the ability to work; it typically does not cover the cost of rehabilitation.

Hospital indemnity insurance. Indemnity insurance offers limited coverage; it typically pays a fixed amount for each day of hospitalization, up to a maximum number of days. The recipient receives the reimbursement and decides haw to use the money. Some policies pay a specified daily amount even if the recipient has other health insurance; others may coordinate benefits, so that the money received does not equal more than 100 percent of the hospital bill.

Long-term care insurance. Extended care insurance is designed to cover the costs of nursing home care, which is usually not covered by health insurance (except in a very limited ways).

SOME ADDITIONAL INSURANCE TERMS

Coinsurance: amount a recipient is required to pay for medical care in a fee-for-service plan after a deductible has been met. The coinsurance rate is usually expressed as a percentage; for example, if the insurance company pays 80 percent of the claim, the recipient pays 20 percent.

Coordination of benefits: a system to eliminate duplication of benefits when a recipient is covered under more than one plan; benefits under the two plans usually are limited to no more than 100 percent of the claim.

Copayment: a specified portion of total charges a recipient pays every time a medical service is received (for example, some amount or percent for every visit to the doctor or every day in the hospital); the insurance company pays the rest.

Covered expenses: most insurance plans, whether fee-for-service, HMOs, or PPOs, do not pay for all services (for example, some may not pay for prescription drugs, others may not pay for mental health care); covered expenses (the medical procedures that the insurer agrees to pay) are explicitly identified in a policy.

Customary fee. most insurance plans will pay only what they call a reasonable and customary fee for a particular service (for example, if a doctor charges $1,000 for a hernia repair while most doctors in an area charge only $600, the recipient will likely be billed for the $400 difference) in addition to the deductible and coinsurance.

Deductible: an accumulated total amount of money a recipient must pay each year, out-of-pocket (for identified expenses), before insurance payments either begin (typically a certain percentage) or pay in full.

Exclusions: specific conditions or circumstances for which an insurance policy will not provide benefits.

Gatekeeper: primary care doctor or other medical "professional" (stipulated by a managed care plan or identified by a recipient in a managed care plan); it is often a family physician or internist, but can be pediatrician, or, sometimes, a gynecologist.

Managed care: euphemism for managed costs; HMOs and PPOs are managed care strategies.

Maximum out-of-pocket: the most money a recipient is required pay a year for deductibles and coinsurance; it is a stated dollar amount set by the insurance company, in addition to regular premiums.

Noncancellable policy: a "guaranteed renewable" policy is one in one in which a recipient is guaranteed insurance coverage under the policy as long as the premiums are paid; the insurance company can raise the cost of the premiums, but cannot cancel coverage. A "conditionally renewable" policy is one in which the insurance company can cancel all similar policies, just not any single policy.

Preexisting condition: health problem that existed before the date insurance became effective.

Premium: amount a recipient or employer pays in exchange for insurance coverage.