CHAPTER OUTLINE

What Is Health Insurance?  Major Developments in Health Insurance
Automobile, Disability, and Liability Insurance  Health Insurance Coverage Statistics

OBJECTIVES

Upon successful completion of this chapter, you should be able to:

1. Define key terms.
2. State the difference between medical care and health care.
3. Differentiate among automobile, disability, and liability insurance.
4. Discuss the history of health care reimbursement from 1860 to the present.
5. Identify and explain the impact of significant events in the history of health care reimbursement.
6. Interpret health insurance coverage statistics.

KEY TERMS

Administrative Simplification Compliance Act (ASCA)
Ambulatory Payment Classification (APC)
Association of Medical Care Plans automobile insurance policy
Balanced Budget Act of 1997 (BBA) base period
Blue Cross Association (BCA)
BlueCross BlueShield Association (BCBSA)
CHAMPUS Reform Initiative (CRI)
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
Civilian Health and Medical Program—Uniformed Services (CHAMPUS)
Clinical Laboratory Improvement Act (CLIA)
CMS-1500 coinsurance
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) consumer-driven health plan
copayment (copay) deductible
Dependents’ Medical Care Act of 1956 diagnosis-related group (DRG) disability insurance
Employee Retirement Income Security Act of 1974 (ERISA)
end-stage renal disease (ESRD)
Evaluation and Management (E/M)
Federal Employees’ Compensation Act (FECA) fee schedule
Financial Services Modernization Act
Gramm-Leach-Bliley Act
group health insurance
group medical practices
HCFA-1500
health care
health insurance
INTRODUCTION

According to the *American Heritage Concise Dictionary*, insurance is a contract that protects the insured from loss. An insurance company guarantees payment to the insured for an unforeseen event (e.g., death, accident, and illness) in return for the payment of premiums. The types of insurance include automobile, disability, liability, malpractice, property, life, and health. (This textbook covers health insurance in detail.) This chapter includes information about terms and concepts as an introduction to health insurance processing. These terms and concepts are explained in greater detail in later chapters of this text.

WHAT IS HEALTH INSURANCE?

To understand the meaning of the term health insurance as used in this text, differentiation between medical care and health care must be made. Medical care includes the identification of disease and the provision of care and treatment such as that provided by members of the health care team to persons who are sick, injured, or concerned about their health status. Health care expands the definition of medical care to include preventive services, which are designed to help individuals avoid health and injury problems. Preventative examinations may result in the early detection of health problems, allowing less drastic and less expensive treatment options.
Health care 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 health care professionals. Because both the government and the general public speak of “health insurance,” this text uses that term exclusively. 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).

AUTOMOBILE, DISABILITY, AND LIABILITY INSURANCE

Automobile Insurance

An automobile insurance policy is a contract between an individual and an insurance company whereby the individual pays a premium and, in exchange, the insurance company agrees to pay for specific car-related financial losses during the term of the policy. Available coverage typically includes the following:

- Collision (pays for damage to a covered vehicle caused by collision with another object or by an automobile accident; a deductible is required);
- Comprehensive (pays for loss of or damage to a covered vehicle, such as that caused by fire, flood, hail, impact with an animal, theft, vandalism, or wind; a deductible may apply);
- Emergency road service (pays expenses incurred for having an automobile towed as a result of a breakdown);
- Liability (pays for accidental bodily injury and property damage to others, including medical expenses, pain and suffering, lost wages, and other special damages; property damage includes damaged property and may include loss of use);
- Medical payments (reimburses medical and funeral expenses for covered individuals, regardless of fault, when those expenses are related to an automobile accident);
- Personal injury protection (PIP) (reimburses medical expenses for covered individuals, regardless of fault, for treatment due to an automobile accident; also pays for funeral expenses, lost earnings, rehabilitation, and replacement of services such as child care if a parent is disabled);
- Rental reimbursement (pays expenses incurred for renting a car when an automobile is disabled because of an automobile accident);
- Underinsured motorist (pays damages when a covered individual is injured in an automobile accident caused by another driver who has insufficient liability insurance—not available in every state).

Medical payments and PIP coverage usually reimburses, up to certain limits, the medical expenses of an injured driver and any passengers in a vehicle that was involved in an automobile accident. (Coverage might also be available for pedestrians injured by a vehicle.) The automobile insurance company’s medical adjuster reviews health care bills submitted to the insurance company for treatment of injuries sustained as the result of a motor vehicle accident to determine coverage. Medical expenses that may be reimbursed include ambulance services; emergency department care; laboratory services; medical supplies (e.g., crutches); physical therapy; prescription drugs; services provided by chiropractors, dentists, physicians, and specialists; x-rays; and so on. (In addition, nonau-
tomobile health insurance policies may include coverage that pays medical bills regardless of who was at fault during an automobile accident.)

**Disability Insurance**

Disability insurance is defined as reimbursement for income lost as a result of a temporary or permanent illness or injury. When patients are treated for disability diagnoses and other medical problems, separate patient records must be maintained. It is also a good idea to organize the financial records separately for these patients. Offices that generate one patient record for the treatment of disability diagnoses as well as other medical problems often confuse the submission of diagnostic and procedural data for insurance processing. This can result in payment delays and claims denials. For example, under certain circumstances, other insurance coverage (e.g., workers’ compensation) is primary to basic medical coverage.

Disability benefits are usually paid if an individual
- has been unable to do regular or customary work for a certain number of days (number of days depends on the policy);
- was employed when disabled (e.g., individuals must have lost wages because of a disability);
- has disability insurance coverage;
- was under the care and treatment of a licensed provider during initial disability; to continue receiving benefits, the individual must remain under care and treatment;
- processes a claim within a certain number of days after the date the individual was disabled (number of days depends on the policy);
- has the licensed provider complete the disability medical certification document(s).

Individuals may be found ineligible for disability benefits if they
- are claiming or receiving unemployment insurance benefits;
- became disabled while committing a crime that resulted in a felony conviction;
- are receiving workers’ compensation benefits at a weekly rate equal to or greater than the disability rate;
- are in jail, prison, or a recovery home (e.g., halfway house) because of being convicted of a crime;
- fail to have an independent medical examination when requested to do so.

A disability claim begins on the date of disability, and the disability payer calculates an individual’s weekly benefit amount using a base period. The base period usually covers 12 months and is divided into 4 consecutive quarters. It includes taxed wages paid approximately 6 to 18 months before the disability claim begins. The base period does not include wages being paid at the time the disability began.

A final payment notice is sent when records show that an individual has been paid through the doctor’s estimated date of recovery. If the individual is still disabled, the doctor must submit appropriate documentation so that the case can be reviewed. When an individual has recovered or returned to work and becomes disabled again, a new claim should be submitted along with a report of the dates worked.

**NOTE:** Disability insurance generally does not pay for health care services, but provides the disabled person with financial assistance.

**NOTE:** The federal Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) disability programs provide assistance to people with disabilities. Both programs are administered by the federal Social Security Administration, and only individuals who have a disability and meet medical criteria qualify for benefits under either program. Social Security Disability Insurance pays benefits to you and certain members of your family if you are “insured,” meaning that you worked long enough and paid Social Security taxes. Supplemental Security Income pays benefits based on financial need.

**NOTE:** Disability insurance generally does not pay for health care services, but provides the disabled person with financial assistance.
Liability Insurance

Although processing of liability insurance claims is not covered in this text, it is important to understand how it influences the processing of health insurance claims. **Liability insurance** is a policy that covers losses to a third party caused by the insured, by an object owned by the insured, or on premises owned by the insured. Liability insurance claims are made to cover the cost of medical care for traumatic injuries and lost wages, and, in many cases, remuneration (compensation) for the “pain and suffering” of the injured party. Most health insurance contracts state that health insurance benefits are secondary to liability insurance. In this situation, the patient is not the insured. This means that the insured (e.g., employer) is responsible for payment, and the patient’s health insurance plan is billed as secondary (and reimburses only the remaining costs of health care not covered by the insured). When negligence by another party is suspected in an injury claim, the health insurance company will not reimburse the patient for medical treatment of the injury until one of two factors is established: (1) it is determined that there was no third-party negligence, or (2) in cases in which third-party negligence did occur, the liability payer determines that the incident is not covered by the negligent party’s liability contract.

**EXAMPLE:** Dr. Small treats Jim Keene in the office for scalp lacerations (cuts) from a work-related injury. Mr. Keene is covered by an employer-sponsored group health plan called HealthCareUSA, and his employer provides workers’ compensation insurance coverage for on-the-job injuries. The insurance claim for treatment of Mr. Keene’s lacerations should be submitted to the employer’s workers’ compensation insurance payer.

If the claim were submitted to HealthCareUSA, it would be subject to review because the diagnosis code submitted would indicate trauma (injury), which activates the review of patient records by an insurance company. Upon reviewing requested copies of patient records, HealthCareUSA would determine that another insurance plan should have been billed for this treatment. HealthCareUSA would deny payment of the claim, and Dr. Small’s office would then submit the claim to the workers’ compensation carrier. In this scenario, a delay in payment for treatment results.

To file a claim with a liability payer, a regular patient billing statement is often used rather than an insurance claim. Be sure to include the name of the policyholder and the liability policy identification numbers. If the liability payer denies payment, a claim is then filed with the patient’s health insurance plan. A photocopy of the written denial of responsibility from the liability payer must accompany the health insurance claim.

**EXAMPLE:** California’s Medical Care Services operates Medi-Cal, which is California’s Medicaid program, and its Third Party Liability Branch is responsible for ensuring that Medi-Cal complies with state and federal laws relating to the legal liability of third parties to reimburse health care services to beneficiaries. The Branch ensures that all reasonable measures are taken to ensure that the Medi-Cal program is the payer of last resort. As a result, in 2003, the Branch recovered more than $202 million, which was recycled back into the Medi-Cal program.

**NOTE:** Third-party payers implement a “pay and chase” method to aggressively pursue the recovery and coordination of payment for health care expenses from liability payers (e.g., malpractice cases, public property injuries, and automobile accidents). Third-party payers review diagnosis codes reported on claims (e.g., trauma) to determine whether a liability payer should be considered primary. Once this initial determination has been made, third-party payers often outsource the recovery and coordination of payment for health care expenses from liability payers to subrogation vendors, which further screen data to identify potential liability claims and recover reimbursement paid on claims by third-party payers. Subrogation refers to the contractual right of a third-party payer to recover health care expenses from a liable party. (For example, if a patient is injured on the job, the workers’ compensation payer is responsible for reimbursing for the patient’s health care expenses.) Third-party recovery standards for investigation of liability coverage and the process for filing a lien (securing a debtor’s property as security or payment for a debt) in a potential liability case vary on a federal and state basis.
MAJOR DEVELOPMENTS IN HEALTH INSURANCE

Since the early 1900s, when solo practices prevailed, managed care and group practices have increased in number, and health care services (like other aspects of society in this country) have undergone tremendous changes (Table 2-1).

HEALTH INSURANCE COVERAGE STATISTICS

U.S. Census Bureau data from 2006 estimate that almost 85 percent of people in the United States are covered by some form of health insurance; of that percentage:

- approximately 60 percent are covered by employment-based plans
- approximately 27 percent are covered by government plans (e.g., Medicare, Medicaid, TRICARE)

The reason the insurance coverage breakdown does not total 85 percent is because approximately 10 percent of people in the United States are covered by more than one insurance plan (e.g., employment-based plan plus Medicare).

**TABLE 2-1 History of health care reimbursement**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>1860</td>
<td>First health insurance policy</td>
<td>The Franklin Health Assurance Company of Massachusetts was the first commercial insurance company in the United States to provide private health care coverage for injuries not resulting in death.</td>
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<td>1880</td>
<td>Expansion of private health insurance</td>
<td>Sixty additional insurance companies offer health insurance policies. Such policies covered loss of income and a limited number of illnesses (e.g., typhoid, scarlet fever, and smallpox).</td>
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<tr>
<td>1900</td>
<td>Self-pay prevails</td>
<td>Most Americans continued to pay their own health care expenses, which usually meant either charity care or no care.</td>
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<tr>
<td>1908</td>
<td>Workers’ compensation</td>
<td>President Theodore Roosevelt signed legislation to provide workers’ compensation for certain federal employees in unusually hazardous jobs. Workers’ compensation is a program mandated by federal and state governments, which requires employers to cover medical expenses and loss of wages for workers who are injured on the job or who have developed job-related disorders.</td>
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<tr>
<td>1915</td>
<td>Campaign for health insurance begins</td>
<td>The American Association of Labor Legislation (AALL) drafted model health insurance legislation, which limited coverage to the working class and others who earned less than $1,200 a year, including their dependents. The American Medical Association (AMA) supported this legislation, but it was never passed into law.</td>
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<tr>
<td>1916</td>
<td>FECA</td>
<td>The Federal Employees’ Compensation Act (FECA) replaced the 1908 workers’ compensation legislation, and civilian employees of the federal government were provided medical care, survivors’ benefits, and compensation for lost wages. The Office of Workers’ Compensation Programs (OWCP) administers FECA as well as the Longshore and Harbor Workers’ Compensation Act of 1927 and the Black Lung Benefits Reform Act of 1977.</td>
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<tr>
<td>1920</td>
<td>Introduction of prepaid health plans</td>
<td>The first contracts between employers and local hospitals and physicians were developed. Participating hospitals and physicians performed specified medical services for a predetermined fee that was paid on either a monthly or yearly basis. These prepaid health plans were the forerunner of today’s managed care plans.</td>
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<tr>
<td>1921</td>
<td>Indian Health Service</td>
<td>The Snyder Act of 1921 and the Indian Health Care Improvement Act (IHCIA) of 1976 provided legislative authority for Congress to appropriate funds specifically for the care of Native Americans, creating and supporting the Indian Health Service (IHS).</td>
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<td>YEAR</td>
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<tr>
<td>1929</td>
<td>First Blue Cross policy</td>
<td>Justin Ford Kimball, an official at Baylor University in Dallas, introduced a plan to guarantee schoolteachers 21 days of hospital care for $6 a year. Other groups of employees in Dallas joined, and the idea attracted nationwide attention. This is generally considered the first Blue Cross plan.</td>
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<tr>
<td>1930</td>
<td>Health care reform is initiated</td>
<td>The Committee on the Cost of Medical Care (CCMC) was funded by charitable organizations to address concerns about the cost and distribution of medical care. It recommended the allocation of national resources for health care and that voluntary health insurance be provided to cover medical costs. This initiative failed.</td>
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<tr>
<td>1939</td>
<td>Wagner National Health Act of 1939</td>
<td>The Tactical Committee on Medical Care drafted the Wagner National Health Act, which proposed that a federally funded national health program be administered by states and localities. The proposal called for compulsory national health insurance and a payroll tax. Extensive national debate occurred, but Congress did not pass it into law.</td>
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<tr>
<td>1940s</td>
<td>Group health insurance</td>
<td>To attract wartime labor during World War II, group health insurance was offered to full-time employees. The insurance was not subject to income or Social Security taxes, making it an attractive part of an employee benefit package. Group health insurance is health care coverage available through employers and other organizations (e.g., labor unions, rural and consumer health cooperatives); employers usually pay part or all of premium costs. It was during this time that more group medical practices were formed, which consisted of three or more health care providers who shared equipment, supplies, and personnel, and who divided income by a prearranged formula.</td>
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<tr>
<td>1945</td>
<td>Universal comprehensive national health insurance</td>
<td>Harry Truman was one of the first American presidents to support a plan for universal comprehensive national health insurance, including private insurance for those who could afford it and public welfare services for the poor. This legislation was not passed into law.</td>
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<tr>
<td>1946</td>
<td>Hill-Burton Act</td>
<td>The Hill–Burton Act provided federal grants for modernizing hospitals that had become obsolete because of a lack of capital investment during the Great Depression and WWII (1929 to 1945). In return for federal funds, facilities were required to provide services free or at reduced rates to patients unable to pay for care.</td>
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<td>1947</td>
<td>Taft-Hartley Act</td>
<td>The Taft-Hartley Act of 1947 amended the National Labor Relations Act of 1932, restoring a more balanced relationship between labor and management. An indirect result of Taft-Hartley was the creation of third-party administrators (TPAs), which administer health care plans and process claims, thus serving as a system of checks and balances for labor and management.</td>
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<tr>
<td>1948</td>
<td>ICD</td>
<td>The World Health Organization (WHO) developed the International Classification of Diseases (ICD), which is a classification system used to collect data for statistical purposes. Codes were later reported for hospital inpatient and physician office reimbursement purposes. <strong>Inpatients</strong> are admitted to a hospital for treatment with the expectation that the patient will remain in the hospital for a period of 24 hours or more.</td>
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<td>Blue Shield symbol is informally adopted. The Blue Shield symbol was informally adopted in 1948 by a group of nine plans known as the Associated Medical Care Plans, which eventually became the National Association of Blue Shield Plans.</td>
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<tr>
<td>1950</td>
<td>Major medical insurance is offered</td>
<td>Insurance companies began offering <strong>major medical insurance</strong>, which provided coverage for catastrophic or prolonged illnesses and injuries. Most of these programs incorporate large deductibles and lifetime maximum amounts. A <strong>deductible</strong> is the amount for which the patient is financially responsible before an insurance policy provides payment. A <strong>lifetime maximum amount</strong> is the maximum benefits payable to a health plan participant.</td>
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<tr>
<td>1956</td>
<td>Dependents’ Medical Care Act of 1956</td>
<td>The Dependents’ Medical Care Act of 1956 was signed into law and provided health care to dependents of active military personnel.</td>
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<tr>
<td>1960</td>
<td>Blue Cross Association</td>
<td>The commission of the American Hospital Association (AHA) was replaced with the Blue Cross Association (BCA), with formal ties to the AHA ending in 1972.</td>
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<tr>
<td>1966</td>
<td>Social Security Amendments of 1965 were implemented</td>
<td><strong>Medicare</strong> (Title XVIII of the SSA of 1965) provides health care services to Americans over the age of 65. (It was originally administered by the Social Security Administration.) <strong>Medicaid</strong> (Title XIX of the SSA of 1965) is a cost-sharing program between the federal and state governments to provide health care services to low-income Americans. (It was originally administered by the Social and Rehabilitation Service [SRS].) Amendments to the Dependents’ Medical Care Act of 1956 created the Civilian Health and Medical Program—Uniformed Services (CHAMPUS), which was designed as a benefit for dependents of personnel serving in the armed forces and uniformed branches of the Public Health Service and the National Oceanic and Atmospheric Administration. The program is now called TRICARE.</td>
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<td></td>
<td>CPT is developed</td>
<td>Current Procedural Terminology (CPT) was developed by the American Medical Association in 1966. Each year an annual publication is prepared, which includes changes that correspond to significant updates in medical technology and practice.</td>
</tr>
<tr>
<td>1970</td>
<td>Employer-based self-insurance plans</td>
<td>Many large employers determined they would be able to save money by self-insuring their employee health plans rather than purchasing coverage from private insurers.</td>
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<td></td>
<td>OSHA</td>
<td>The Occupational Safety and Health Administration Act of 1970 (OSHA) was designed to protect all employees against injuries from occupational hazards in the workplace.</td>
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<tr>
<td>1972</td>
<td>PSROs</td>
<td>Created as part of Title XI of the Social Security Amendments Act of 1972, Professional Standards Review Organizations (PSROs) were physician-controlled nonprofit organizations that contracted with HCFA (now called CMS) to provide for the review of hospital inpatient resource utilization, quality of care, and medical necessity. (PSROs were replaced with Peer Review Organizations [PROs], as a result of the Tax Equity and Fiscal Responsibility Act of 1982, or TEFRA.)</td>
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<tr>
<td>1973</td>
<td>Medicare benefits expanded</td>
<td>Medicare coverage became available to those also entitled to receive Social Security or Railroad Retirement disability cash benefits after 24 months of disability based on SSA criteria, most persons with end-stage renal disease (ESRD), and certain individuals over the age of 65 who were not eligible for paid coverage but elected to pay for Medicare benefits. <strong>End-stage renal disease (ESRD)</strong> is a chronic kidney disorder that requires long-term hemodialysis or kidney transplantation because the patient's filtration system in the kidneys has been destroyed.</td>
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<tr>
<td>CHAMPVA</td>
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<td>The Veterans Healthcare Expansion Act of 1973 authorized Veterans Affairs (VA) to establish the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) to provide health care benefits for dependents of veterans rated as 100 percent permanently and totally disabled as a result of service-connected conditions, veterans who died as a result of service-connected conditions, and veterans who died on duty with less than 30 days of active service.</td>
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<tr>
<td>HMO Act of 1973</td>
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<td>The Health Maintenance Organization Assistance Act of 1973 authorized federal grants and loans to private organizations that wished to develop health maintenance organizations (HMOs), which are responsible for providing health care services to subscribers in a given geographic area for a fixed fee.</td>
</tr>
<tr>
<td>1974</td>
<td>ERISA</td>
<td>The Employee Retirement Income Security Act of 1974 (ERISA) mandated reporting and disclosure requirements for group life and health plans (including managed care plans), permitted large employers to self-insure employee health care benefits, and exempted large employers from taxes on health insurance premiums. <strong>Managed care</strong> allows patients to receive care from a group of participating providers to whom a copayment is paid for each service. A <strong>copayment (copay)</strong> is a provision in an insurance policy that requires the policyholder or patient to pay a specified dollar amount to a health care provider for each visit or medical service received. <strong>Coinsurance</strong> is the percentage of costs a patient shares with the health plan. For example, the plan pays 80 percent of costs and the patient pays 20 percent.</td>
</tr>
<tr>
<td>1977</td>
<td>HCFA</td>
<td>To combine health care financing and quality assurance programs into a single agency, the Health Care Financing Administration (HCFA) was formed within the Department of Health and Human Services (DHHS). The Medicare and Medicaid programs were also transferred to the newly created agency. (HCFA is now called the Centers for Medicare and Medicaid Services, or CMS.)</td>
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<tr>
<td>1980</td>
<td>DHHS</td>
<td>With the departure of the Office of Education, the Department of Health, Education and Welfare (HEW) became the Department of Health and Human Services (DHHS).</td>
</tr>
<tr>
<td>1981</td>
<td>OBRA</td>
<td>The Omnibus Budget Reconciliation Act of 1981 (OBRA) was federal legislation that expanded the Medicare and Medicaid programs.</td>
</tr>
<tr>
<td>1982</td>
<td>BCBS Association</td>
<td>The Blue Cross Association and the National Association of Blue Shield Plans merged to create the BlueCross BlueShield Association (BCBSA), which is an association of independent Blue Cross and Blue Shield plans.</td>
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<th>YEAR</th>
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<tbody>
<tr>
<td>1983</td>
<td>TEFRA of 1982</td>
<td>The <strong>Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)</strong> created Medicare risk programs, which allowed federally qualified HMOs and competitive medical plans that met specified Medicare requirements to provide Medicare-covered services under a risk contract. TEFRA also enacted a <strong>prospective payment system (PPS)</strong>, which issues a predetermined payment for services. Previously, reimbursement was generated on a <strong>per diem</strong> basis, which issued payment based on daily rates. The PPS implemented in 1983 is called <strong>diagnosis-related groups (DRGs)</strong>, which reimburses hospitals for inpatient stays. <strong>Peer review organizations (PROs)</strong> (now called quality improvement organizations, or QIOs) were also created as part of TEFRA, replacing PSROs. PROs review medical necessity issues, determine appropriateness of care provided through retrospective analysis of medical records, assess specific aspects of care (e.g., cesarean sections) to determine whether variations in practice patterns exist, conduct physician office site reviews, and review reimbursement appeals to evaluate medical necessity and appropriateness of services denied by third-party payers.</td>
</tr>
<tr>
<td>1984</td>
<td>Standardization of information submitted on Medicare claims</td>
<td>HCFA (now called CMS) required providers to use the <strong>HCFA-1500</strong> (now called the <strong>CMS-1500</strong>) to submit Medicare claims. The HCFA Common Procedure Coding System (HCPCS) (now called Health Care Procedure Coding System) was created. CPT was adopted as level I in the three-level system. HCFA created national (level II) codes. Local carriers created regional (level III) codes (no longer in use). Commercial payers also adopted HCPCS coding and use of the HCFA-1500 claim.</td>
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<tr>
<td>1985</td>
<td>COBRA</td>
<td>The <strong>Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)</strong> allows employees to continue health care coverage beyond the benefit termination date.</td>
</tr>
</tbody>
</table>
| 1988 | TRICARE | The **Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)** resulted in a new program, TRICARE, which includes three options: TRICARE Prime, TRICARE Extra, and TRICARE Standard. (Chapter 16 covers TRICARE claims processing.)  
**ICD-9-CM reporting on physician office claims**  
Medicare began requiring physician offices to submit ICD-9-CM codes on HCFA-1500 (now called CMS-1500) claims. |
| 1989 | Medicare requires claims submission | HCFA (now called CMS) requires all physicians to submit claims on behalf of Medicare patients, regardless of the physician’s participation status in the Medicare program. |
| 1991 | E/M codes created | The American Medical Association (AMA) and HCFA (now called CMS) implemented major revisions of CPT, creating a new section called **Evaluation and Management (E/M)**, which describes patient encounters with health care professionals for the purpose of evaluation and management of general health status. |
| 1991 | HCFA-1500 (1-90) new version released | HCFA (now called CMS) also released a new version of the HCFA-1500 (now called CMS-1500) claim and required its use for all government claims. |

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### TABLE 2-1 (continued)

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<th>YEAR</th>
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<tbody>
<tr>
<td>1992</td>
<td>RBRVS is implemented</td>
<td>A new fee schedule for Medicare services was implemented as part of the Omnibus Reconciliation Acts (OBRA) of 1989 and 1990, which replaced the regional “usual and reasonable” payment basis with a fixed fee schedule calculated according to the Resource-Based Relative Value Scale (RBRVS) system. The RBRVS system is a payment system that reimburses physicians’ practice expenses based on relative values for three components of each physician’s service: physician work, practice expense, and malpractice insurance expense. Usual and reasonable payments were based on fees typically charged by providers by specialty within a particular region of the country. A fee schedule is a list of predetermined payments for health care services provided to patients (e.g., a fee is assigned to each CPT code).</td>
</tr>
<tr>
<td>1996</td>
<td>NCCI</td>
<td>HCFA (now called CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. NCCI edits are developed based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.</td>
</tr>
<tr>
<td>1997</td>
<td>BBA of 1997</td>
<td>The Balanced Budget Act of 1997 (BBA) addresses health care fraud and abuse issues. The DHHS Office of the Inspector General (OIG) provides investigative and audit services in health care fraud cases. The State Children’s Health Insurance Program (SCHIP) was also established to provide health assistance to uninsured, low-income children, either through separate programs or through expanded eligibility under state Medicaid programs.</td>
</tr>
<tr>
<td>1998</td>
<td>SNF PPS</td>
<td>The Skilled Nursing Facility Prospective Payment System (SNFPSS) is implemented (as a result of the BBA of 1997) to cover all costs (routine, ancillary, and capital) related to services furnished to Medicare Part A beneficiaries. The SNFPSS generates per diem payments for each admission; these payments are case-mix adjusted using a resident classification system called Resource Utilization Groups (RUGs), which is based on data collected from resident assessments (using data elements called the Minimum Data Set, or MDS) and relative weights developed from staff time data.</td>
</tr>
<tr>
<td>1999</td>
<td>HH PPS</td>
<td>The Omnibus Consolidated and Emergency Supplemental Appropriations Act (OCE-SAA) of 1999 amended the BBA of 1997 to require the development and implementation of a Home Health Prospective Payment System (HHPPS), which reimburses home health agencies at a predetermined rate for health care services provided to patients. The HH PPS was implemented October 1, 2000, and uses the Outcomes and Assessment Information Set (OASIS), a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.</td>
</tr>
</tbody>
</table>

**Financial Services Modernization Act**

Financial Services Modernization Act (or Gramm–Leach–Bliley Act) prohibits sharing of medical information among health insurers and other financial institutions for use in making credit decisions.

(continues)
TABLE 2-1 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>OPPS</td>
<td>The Outpatient Prospective Payment System (OPPS), which uses Ambulatory Payment Classifications (APCs) to calculate reimbursement, is implemented for billing of hospital-based Medicare outpatient claims.</td>
</tr>
<tr>
<td></td>
<td>BIPA</td>
<td>The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires implementation of a $400 billion prescription drug benefit, improved Medicare Advantage (formerly called Medicare+Choice) benefits, faster Medicare appeals decisions, and more.</td>
</tr>
</tbody>
</table>
|      | Consumer-driven health plans | Consumer-driven health plans are introduced as a way to encourage individuals to locate the best health care at the lowest possible price with the goal of holding down health care costs. These plans are organized into three categories:  
1. Employer-paid high-deductible insurance plans with special health spending accounts to be used by employees to cover deductibles and other medical costs when covered amounts are exceeded.  
2. Defined contribution plans, which provide a selection of insurance options; employees pay the difference between what the employer pays and the actual cost of the plan they select.  
3. After-tax savings accounts, which combine a traditional health insurance plan for major medical expenses with a savings account that the employee uses to pay for routine care. |
| 2001 | CMS   | On June 14, 2001, HCFA changed its name to the Centers for Medicare and Medicaid Services (CMS). |
|      | ASCA  | The Administrative Simplification Compliance Act (ASCA) establishes the compliance date (October 16, 2003) for modifications to the Electronic Transaction Standards and Code Sets as required by HIPAA. Covered entities must submit Medicare claims electronically after October 16, 2003, unless the Secretary of DHHS grants a waiver. |
| 2002 | IRF PPS | The Inpatient Rehabilitation Facilities Prospective Payment System (IRF PPS) is implemented (as a result of the BBA of 1997), which utilizes information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case- and facility-level adjustments. |
|      | QIOs  | CMS announced that peer review organizations (PROs) will be known as quality improvement organizations (QIOs), and they will continue to perform utilization and quality control review of health care furnished, or to be furnished, to Medicare beneficiaries. |
|      | EIN   | The employer identification number (EIN), assigned by the Internal Revenue Service (IRS), is adopted by DHHS as the National Employer Identification Standard for use in health care transactions. |
|      | Medical privacy standards | DHHS develops federal privacy standards to protect patients’ medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Implemented April 14, 2003, these standards are a provision of HIPAA, entitled Medical Privacy—National Standards to Protect the Privacy of Personal Health Information. |
| 2003 | Standards for the security of electronic protected health information are adopted for implementation by April 21, 2005, by all covered entities except small health plans, which had until April 21, 2006, to implement. |

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### TABLE 2-1 (continued)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>EVENT</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) adds new prescription drug and preventive benefits and provides extra assistance to people with low incomes. The Medicare contracting reform (MCR) initiative established as a result of the MMA replaces current Medicare carriers and fiscal intermediaries with a Medicare Administrative Contractor (MAC) to improve and modernize the Medicare fee-for-service system and to establish a competitive bidding process to appoint MACs.</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>IPF PPS</td>
<td>The Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) is implemented on January 1, 2005, as a requirement of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA). The IPF PPS includes a patient classification system that reflects differences in patient resource use and costs; the new system replaces the cost-based payment system with a per diem IPF PPS. About 1,800 inpatient psychiatric facilities, including freestanding psychiatric hospitals and certified psychiatric units in general acute care hospitals, were impacted.</td>
</tr>
<tr>
<td>NPI</td>
<td>The Standard Unique Health Identifier for Health Care Providers, or National Provider Identifier (NPI), is implemented. Providers began applying for NPIs starting May 23, 2005, and complied with implementation by reporting it on electronic claims no later than May 23, 2007. Covered entities complied with implementation effective May 23, 2007, except for small health plans, which must comply by May 23, 2008.</td>
<td></td>
</tr>
<tr>
<td>Patient Safety and Quality Improvement Act of 2005</td>
<td>Amends Title IX of the Public Health Service Act to provide for improved patient safety and reduced incidence of events adversely affecting patient safety. It encourages the reporting of health care mistakes to patient safety organizations by making the reports confidential and shielding them from use in civil and criminal proceedings.</td>
<td></td>
</tr>
<tr>
<td>Office of E-Health Standards and Services (OESS) is created</td>
<td>The CMS Office of HIPAA Standards (OHS), which is responsible for enforcing HIPAA’s transactions and code sets rule, changed its name to the Office of E-Health Standards and Services (OESS) (to reflect expanded responsibilities of coordinating and supporting CMS internal and external e-health activities). OESS operates independently from CMS and its Medicare and Medicaid-related activities.</td>
<td></td>
</tr>
<tr>
<td>Deficit Reduction Act of 2005</td>
<td>Created the Medicaid Integrity Program (MIP), which is a fraud and abuse detection program.</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>Physician Quality Reporting Initiative (PQRI)</td>
<td>The Tax Relief and Health Care Act of 2006 (TRHCA) authorized implementation of a physician quality reporting system that establishes a financial incentive for eligible professionals who participate in a voluntary quality reporting program.</td>
</tr>
<tr>
<td>2007</td>
<td>Wired for Health Care Quality Act (pending legislation, which means the president has not yet signed the act into federal law)</td>
<td>Amends the Public Health Service Act by adding a new title, “Health Information Technology and Quality” to enhance the adoption of a nationwide interoperable health information technology system, improve health care quality, and reduce the U.S. health care costs.</td>
</tr>
</tbody>
</table>

**NOTE:** Wired for Health Care Quality Act (S.1693) was introduced in June 2007.
SUMMARY

Health insurance is a contract between a policyholder and a third-party payer or governement program for the purpose of providing reimbursement of all or a portion of medical and health care costs. Automobile insurance coverage includes medical payments and PIP; disability insurance provides an individual with reimbursement for lost wages; liability insurance covers losses to a third party caused by the insured or on premises owned by the insured.

The history of health care reimbursement can be traced back to 1860, when the Franklin Health Assurance Company of Massachusetts wrote the first health insurance policy. Subsequent years, through the present, have seen great changes and advances in health care insurance and reimbursement, from the development of the first Blue Cross and Blue Shield plans to legislation that resulted in government health care programs (e.g., to cover individuals age 65 and older), payment systems to control health care costs (e.g., diagnosis-related groups), and regulations to govern privacy, security, and electronic transaction standards for health care information.

INTERNET LINKS

- California Department of Health Services
  Go to dhs.ca.gov, click on the CDHS Organization link, scroll down and click on the Medical Care Services link, and click on the Medi-Cal Health Insurance Recovery link to learn more about their Third Party Liability (TPL) Branch, which is responsible for the recovery of Medi-Cal (Medicaid) funds.
- Consolidated Omnibus Budget Reconciliation Act (COBRA)
  Go to www.cobrainsurance.com to learn more about COBRA.
- InsureU—Get Smart About Insurance, sponsored by the National Association of Insurance Commissioners (NAIC)
  Go to www.insureonline.org, and click on the applicable link and complete the life stage course about health insurance (e.g., HEALTH 101). Then, scroll down and click on NAIC consumer guides links.
- THOMAS (Library of Congress)
  Go to thomas.loc.gov, and enter a bill number (e.g., S.1418) to determine its current status. (The name THOMAS was selected “in the spirit of Thomas Jefferson,” to provide legislative information available from the Library of Congress.)

STUDY CHECKLIST

- Read this textbook chapter and highlight key concepts.
- Create an index card for each key term.
- Access the chapter Internet links to learn more about concepts.
- Answer the chapter review questions, verifying answers with your instructor.
- Complete WebTutor assignments and take online quizzes.
- Complete Workbook chapter, verifying answers with your instructor.
- Form a study group with classmates to discuss chapter concepts in preparation for an exam.
MULTIPLE CHOICE  Select the most appropriate response.

1. Which was the first commercial insurance company in the United States to provide private health care coverage for injuries not resulting in death?
   a. Baylor University Health Plan
   b. Blue Cross and Blue Shield Association
   c. Franklin Health Assurance Company
   d. Office of Workers’ Compensation Program

2. By 1880, how many insurance companies offered health insurance policies?
   a. 60
   b. 500
   c. 1,000
   d. 10,000

3. In the early 1900s, most Americans continued to pay for their own health care, which usually meant that
   a. their employers reimbursed them for reasonable medical expenses.
   b. they either received charitable health care services or no care at all.
   c. the federal government provided them with health care coverage.
   d. physician medical group practices pooled resources to provide care.

4. Which U.S. president signed legislation to provide workers’ compensation for certain federal employees in unusually hazardous jobs?
   a. Hill-Burton
   b. Kimball
   c. Roosevelt
   d. Truman

5. Workers’ compensation is an insurance program that requires employers to cover medical expenses and
   a. create medical service bureaus.
   b. implement prepaid health plan services.
   c. limit lifetime maximum amounts of coverage.
   d. provide lost wages for injured workers.

6. Which organization drafted model health insurance legislation in 1915 to limit coverage to the working class who earned less than $1,200 per year?
   a. AALL
   b. AHA
   c. AMA
   d. FECA

7. In what year were prepaid health plans introduced?
   a. 1915
   b. 1916
   c. 1920
   d. 1929
8. Which replaced the 1908 workers’ compensation legislation and provided civilian employees of the federal government with medical care, survivors’ benefits, and compensation for lost wages?
   a. Black Lung Benefits Reform Act
   b. Federal Employees’ Compensation Act
   c. Longshore and Harbor Workers’ Compensation Act
   d. Office of Workers’ Compensation Programs

9. The first Blue Cross policy was introduced by
   a. Baylor University in Dallas, Texas.
   b. Harvard University in Cambridge, Massachusetts.
   c. Kaiser Permanente in Los Angeles, California.
   d. American Medical Association representatives.

10. Health care reform was initiated in 1930 when the _____ was funded by charitable organizations to address concerns about the cost and distribution of medical care.
    a. Committee on the Cost of Medical Care
    b. Hill-Burton Act
    c. Tactical Committee on Medical Care
    d. Wagner National Health Care Act

11. In 1939 the AHA adopted the _____ symbol as the national emblem for plans that met certain guidelines.
    a. Blue Cross
    b. Blue Shield

12. Which concept was developed from lumber and mining camps of the Pacific Northwest, in which employers provided medical care for workers through medical service bureaus?
    a. Blue Cross
    b. Blue Shield

13. In the 1940s, group health insurance was offered as part of a full-time employee benefit package to attract wartime labor. This insurance was
    a. not subject to income and Social Security taxes.
    b. subject to income and Social Security taxes.

14. Which term describes three or more health care providers who share equipment, supplies, and personnel, and who divide income according to a prearranged formula?
    a. corporation
    b. group medical practice
    c. health maintenance organization
    d. sole proprietorship

15. Which organization was created in 1946 as a coordinating agency for physician-sponsored health plans?
    a. Association of Medical Care Plans
    b. Blue Cross and Blue Shield Association
    c. Blue Cross Association
    d. National Association of Blue Shield Plans