Health Insurance and Claims

Information for APAC Data Users About Insurance Types, Claim Details and Processes

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APAC
ALL PAYER • ALL CLAIMS

Oregon Health Authority

Health Insurance Types

- There are three main types of insurance in APAC:
  - Commercial
  - Medicaid
  - Medicare
- The insurance policy specifies the health services that will and will not be paid and any limitations (covered services)
- Insurers contract with providers, hospitals, surgery centers and laboratories and specify the amount that will be paid for health services

Commercial Insurance Types

- Employer purchased from an insurance company
- Employer self-insured (claims paid directly by employer or through third party administrator)
- Health Exchange (Affordable Care Act)
- Individuals purchase directly from an insurance company
- Groups purchase from an insurance company
- Groups pay claims directly

Medicaid

- Jointly funded by Federal and State government
- Eligibility-Income limits for different categories
  - Children
  - Pregnant women
  - Elderly adults
  - People with disabilities
  - Adults
- Web sites for more information
  - https://www.medicaid.gov/medicaid/index.html
  - https://www.oregon.gov/oha/hsd/ohp/pages/apply.aspx

Medicare

- Most people aged 65+ eligible
- People under the age of 65 may qualify if determined disabled
- Part A covers hospitalizations (no premium)
- Part B covers doctor and outpatient visits (premium required)
- Part C is Medicare Advantage (alternative to Part A & B-commercial insurance)
- Part D is prescription drug coverage (premium required)
- https://www.medicare.gov/

How Insurers Pay Claims

Fee-for-Service

- Some insurers pay providers for each claim submitted

Managed care or Coordinated care

- Some insurers pay providers a monthly capitation payment

Mixed models

- Some services paid with a monthly capitation payment
- Some services paid fee-for-service

Payments Paid by Insured Person

Deductible

- Some insurers require people to pay a certain amount before the insurer pays (based on the policy terms)

Coinsurance

- Some insurers require people to pay a certain percent for each visit or service and the insurer pays a certain percent (based on the policy terms)

Copayment

- Some insurers require people to pay providers a set amount for each visit or service and the insurer pays the rest based on the policy terms

What is a Claim?

An Example

A person goes to an emergency department for a visit

- A provider examines their condition
- Blood is drawn and sent to the laboratory for tests
- X-rays, MRI or other images are completed
- Surgery, stitches or other treatments are completed

Each of the following entities may submit a claim for the visit

- The emergency department facility
- The laboratory
- The imaging service
- The emergency room physician/provider
- Other physicians/providers who provide services

Claims Payment Process

Providers/facilities submit claims to insurers for payment

The insurer determines if the claimed services are covered by the policy

The insurer pays the provider based on the contract with the provider

The insurer calculates the amount owed by the person based on the policy

- Deductible
- Copayment
- Coinsurance
- Any service not covered by the policy

The insurer provides an explanation of benefits to the insured person

Providers bill the insured person after insurer pays or around the same time

If disagreement occurs-claims adjudication and resolution (for denied claims)

Claims are not visits

- **Visits generate multiple claims**
  - Providers
  - Facilities
  - Laboratory
  - Imaging

- **Some people are covered by more than 1 insurer**
  - Each insurer receives claims for the same visit
  - The primary insurer pays first and coordinates with other payers
    - Commercial insurance is always the primary payer
    - Medicare pays after commercial insurance and before Medicaid
    - Medicaid is the last payer

- **A visit includes**
  - Claims from all of the providers & facilities for the visit
  - Claims paid by all of the insurers for the visit

Claim Details

- Providers use standardized codes to identify the diagnosis or diagnoses (ICD9 and ICD10) for a visit
- Providers use standardized codes to identify the treatment or procedures (CPT, HCPCS) delivered during a visit
- Pharmacies use standardized codes to identify pharmaceuticals dispensed (NDC)
- Claims can have a single or multiple lines. Some lines can be paid and some can be denied

Medical Claim Parts

- Bill type
- Diagnosis codes
- Modifier codes
- Procedure codes
- Present on admission codes
- Place of service codes
- Revenue codes
- Hospital admission and discharge dates & status (inpatient hospitalizations)
- Date of service(s)
- Billed charges
- Attending provider information (name and identifiers)
- Insurer information
- Patient information (name, demographics, address, insurer ID)
- Subscriber information (spouse or parent who purchases insurance directly or through employer)

Pharmacy Claim Parts

- National drug codes
- Quantity dispensed
- Days supply
- Refill number
- Date of service
- Charges
- Dispensing fee
- Ingredient cost/list price
- Prescribing provider information(name and identifiers)
- Insurer information
- Patient information (name, demographics, address, insurer ID)
- Subscriber information (spouse or parent who purchases insurance directly or through employer)

Glossary

- ICD: International Classification of Diseases (version 9, version 10)
- CPT: Current Procedural Terminology (outpatient & office procedures)
- HCPCS: Healthcare Common Procedural Coding System
- NDC: National Drug Code
- Modifier code: Provides extra details about procedure
- Present on admission codes: Indicates diagnoses present at the time of admission and conditions that develop during inpatient hospitalization
- Place of service codes: Place where service occurred
- Revenue code: Services provided by a facility