What Is Health Insurance?

In the United States, health insurance often covers a blend of predictable and unpredictable kinds of health care. As such, many people draw small amounts from the pool of insurance dollars every year, a few draw large amounts every year, and others draw large amounts just a few times over their lifetimes.

Some health problems—for example, injuries from a sports activity or having a premature baby—do not occur very often but can cost thousands of dollars when they do. Just like other types of insurance, when a lot of people buy health insurance, the costs for these rare, expensive events are spread out over the large group of people who bought policies, reducing the cost to the unlucky few who actually need the help in a given year.

In this way, **health insurance is a transfer of money from those who don’t get sick or injured this year to those who do.** The people who need care vary from year to year. Most of us will receive funding from that pool of money at some point during our lives.
Health Care Is Getting More Expensive—And Costs Keep Going Up

- **Costs are rising sharply**—Our costs for health care were estimated to be about $6,400 annually per person in 2004, and are projected to increase to $11,000 annually per person by 2014.

- **We spend more now than we did in the past**—In 1960, we spent about a nickel out of every dollar on health care in the United States. Today, our spending has tripled to 15 cents out of every dollar, and that proportion is expected to rise sharply over the next ten years.

- **We’re making fundamental choices in our own lives based on the costs of health care**—The need for employer-sponsored health insurance to cover the high costs of medical care is why some workers postpone retirement, why some mothers re-enter the workplace, and why some people decide against starting their own small businesses.

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**Health Care Economics**

**National Health Spending in Billions**

- Health spending reached nearly $1.9 trillion in 2004—a billion a day.

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**Health Care Costs ’94 Spending & Trends**

Health Care Economics

**National Health Spending**
as a Share of Gross Domestic Product

Health care’s share of the economy continues to grow and is projected to reach 20 percent by 2011.

Historic Payment Sources

**Historic Payment Sources**

Over time, the share of federal spending has increased, most dramatically following the creation of Medicare and Medicaid.
Breaking Down the Spending

Spending Distribution by Category, 2004

- Hospital Care 20%
- Physician and Related Services 20%
- Professional and Technical Services 10%
- Outpatient Services 10%
- Home Health Care 7%
- Meals on Wheels 5%
- Dental/Other Services 4%
- Preventive Services 4%
- Hospital Services 3%
- Administration 2%
- Other Medical Care 2%
- Other Health Care 2%
- Non-Medical 1%

ASH Side Bar: Chiropractic services are included here.

Health Care Costs YTD (as of December 31, 2005)

Hospital and physician services take the largest share of the health care dollar. Prescription drugs account for 19 percent.

Insurance Payments vs. Out-of-pocket Costs

Spending Distribution Out of Pocket vs. Private Insurance, 2004

- Hospital Care 0%
- Physician and Related Services 10%
- Professional and Technical Services 10%
- Outpatient Services 10%
- Home Health Care 0%
- Meals on Wheels 0%
- Dental/Other Services 0%
- Preventive Services 0%
- Hospital Services 0%
- Administration 0%
- Other Medical Care 0%
- Other Health Care 0%
- Non-Medical 0%

Health Care Costs YTD (as of December 31, 2005)

Insurance spending is concentrated on physician and clinical services, while prescription drugs, dental and other professional services, consume a greater share of the out-of-pocket dollar.
Where is the Market Share?

Where is the Money Going?
What is the Bottom Line?

Comparing California Premiums

Annual Growth in Private Health Insurance Premiums

Health Care Costs 101: Operating Funds

Premium increases in California and the U.S. have dropped into the single-digits for the first time in 5 years.
Decreasing Health Insurance Coverage

Impact of Deductible on Out-of-pocket Expense
Fewer Small Businesses Are Offering Health Coverage

According to a new survey from SurePayroll, an online pay service provider for small firms (Wall Street Journal; August 14, 2006):

- Only about 58% of small businesses have health insurance plans for their employees.
- 11% of small-business owners who do offer coverage are considering dropping the plans next year.
- Among firms that do not offer benefits, 44% do not expect to change their policies, but 46% said they had some interest in health care.


Shift to Consumerism

- Consumerism is defined as "promoting informed and responsible spending by employees for health care."

- In 2005, 2% of all employers offered a Consumer-Directed Health Plan (CDHP); by 2006, up to 13% of employers likely will be offering CDHPs and by 2007, 17% likely will be offering the plans, according to the annual national survey of employer-sponsored health plans by Mercer Health & Benefits LLC.

- When all employers were asked in the Mercer survey about the significance of various cost-management strategies in the next 5 years, consumerism was listed as very significant by 34% of the respondents. This was the highest among 6 strategies listed.
Health Savings Accounts (HSAs) and More

- HSAs and CDHPs combine a high-deductible plan with preventive coverage and a personal spending account funded by the consumer and/or the plan purchaser that pays part of the deductible.

- When the deductible is satisfied, the health plan pays for most, if not all, of the care.

- Unused money in the account earns interest or can be invested, and year-end balances roll over to the next year and continue to accumulate.

- Many plans and/or employers provide HSA members with information resources to help them make more informed health care decisions. It is designed to encourage members to select lower-cost but higher quality care (i.e., to choose lower-cost generic drugs over expensive branded medicines, or to cut back on unnecessary physician visits).

The 10 Most Costly Chronic Conditions Of Adult Americans

- Asthma
- Cancer
- Cerebrovascular disease
- **Chronic back / neck problems**
- Chronic obstructive pulmonary disease
- Diabetes
- High blood pressure
- Ischemic heart disease
- **Joint disorders like arthritis or rheumatism**
- Mood disorders like depression

More than 39 million adults have two or more chronic conditions. Health care for people with chronic diseases accounts for 75% of the nation’s total health care costs.
Understanding the Evolution of Health Insurance
In the United States

- Over the past 30 to 35 years, health care insurance has changed significantly.
- In order to better understand managed care, it is important that we look at some of the major historical events that have resulted in complementary health care integration into managed health care benefits.
- It is these complementary health care benefits that insurance carriers, employers, and the public as a whole desire.

Summarizing the History

<table>
<thead>
<tr>
<th>Year</th>
<th>U.S. Historical Events</th>
<th>Managed Care Historical Events</th>
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<tbody>
<tr>
<td>1970:</td>
<td>Apollo 15 drives lunar module on moon</td>
<td>HMO Act passes congress</td>
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<td>1974:</td>
<td>Hank Aaron hits 715th home run</td>
<td>ERISA becomes law</td>
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<td>1977:</td>
<td>Elvis Presley dies / Jimmy Carter is President</td>
<td>Health care inflation exceeds all others</td>
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<td>1980:</td>
<td>U.S. hockey team wins gold</td>
<td>Medicare and Medicaid HMOs start</td>
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<td>1984:</td>
<td>Average home price is $100,000</td>
<td>HMOs go public, PPOs developed</td>
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<td>1985:</td>
<td>Compact disc introduced</td>
<td>HMOs start to merge and consolidate</td>
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<td>Divers find Titanic</td>
<td>PPO enrollment tops 1,000,000</td>
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<td>1996:</td>
<td>President Clinton gets line-item veto power</td>
<td>Managed care is in every community</td>
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<td>2003:</td>
<td>MP-3 players introduced to the market</td>
<td>President Bush signs Medicare Mod Act</td>
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<td>2005:</td>
<td>Deadliest / most expensive hurricane season ever</td>
<td>South Carolina becomes 41st LAc State</td>
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<td>2006:</td>
<td>Italy wins the World Cup over France via shoot-out</td>
<td>Medicare D is implemented for seniors</td>
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Trends

- Measuring and rewarding health care providers who use evidence-based health care—Provider Profile
- Medical malpractice liability insurance tied to provider use of evidence-based health care (EBHC)
- Electronic clinical documentation
- Consumerism: High-deductible health plans (HSAs)

Aetna Targets Costs, Expands Tiered Network of Specialists

- Aetna is planning to expand the availability of a "tiered" insurance product that rewards patients for choosing physician specialists who are classified as being cost-effective and clinically superior.
- Employers in more markets will be able to offer workers Aexcel, which also measures doctor quality.

AMNews. July 28, 2005
Rewarding Providers: Culinary Health Fund

Provides health insurance to about 120,000 Las Vegas workers who are members of Culinary Local 226 (part of the Hotel Employees and Restaurant Employees International Union).

Employees do not pay a premium for coverage—employers pay 100% of the cost. Benefits include a free pharmacy of certain generic drugs as well as low copayments for physician visits, medical services, and prescription drugs. To control costs and provide incentives for better quality care, the Culinary Fund rewards providers for providing high-quality care through a pay-for-performance system that uses 32 evidence-based quality indicators, and pays bonuses to physicians who provide high-quality care.

United States Moving Toward a Required Electronic Health Care Documentation Process

• Earlier this year, the national coordinator for health information technology at the U.S. Department of Health and Human Services told the National Governors Association:
  – Every year in the United States, between 50,000 and 100,000 people die in hospitals because of preventable errors
  – An additional 2 million people are injured resulting from a lack of advanced information technology
  – U.S. health care system could save as much as $150 billion annually if states begin investing in health information technology

• White House is supporting this process
• Hurricanes (Katrina/Wilma)
• California: AB1672 (Richman/Nation)
Electronic Claims Processing

Many companies are beginning to offer or require providers to utilize electronic portals for exchange of information. For example, ASH:

- Prioritizes electronic claims before non-electronic claims
- Processes electronic claims within 3 business days
- Automatically pays into your account within 5 business days if you are registered for electronic funds transfer
- Adjudicates claims with an electronic explanation of benefits that is sent within 5 business days
- Offers consideration for additional financial incentives, based on the amount of electronic use

Welcome to ASHLink.com

American Specialty Health's (ASH) ASHLINK web site offers a convenient way for providers to access information online and conduct business electronically.

ASHLINK’s online features include:

- Verifying patient eligibility and benefit information
- Submitting electronic treatment forms, reconsiderations and claims
- Setting up sub-accounts for office staff to use ASHLINK on your behalf
- Getting paid faster with direct deposit of your claims payments
- Accessing forms and other online resources
- Sending and receiving messages between your office and ASH
- Receiving special discounts from participating Value-Added Vendors

ASHLINK is a FREE online service available to participating providers of ASH's provider network. Once you become an ASH provider, you will automatically receive information on how to activate your ASHLINK account.
Provider Challenge

To understand the difference between managing patients and managing money.

The goal is to know what your cost per patient of doing business is and making the right business choices with respect to provider plan participation.

In order to know what your cost of doing business per patient is, you must know every aspect of your overhead, as well as how you can continue to reduce your overhead.
Reimbursement Considerations

Consider 20% to 25% in each of the following:
- Personal injury (litigated vs. non-litigated)
- Workers’ compensation (fixed fee schedule)
- California labor code lists LAcS as primary treating physicians
- Managed care (fixed fee schedule)
- Cash $$$ (usually fixed fee per office visit)

Managed Care 101

What to look for in a carrier:
- Credibility of company
- Reimbursement
- Credentialing criteria
- Participation fee
- Member / patient access
- Clinical criteria
Managed Care 101

What to look for in a carrier:
• Contract with evidence-based providers
• Offer contracts to all eligible providers in a geographic service area
  – First-year graduates can apply
• Direct contracts with all providers
  – No sub-contracts with IPAs or other networks
• Utilize standardized national agreements
  – State requirements incorporated
• No fees required for provider participation

Credentialing Criteria

• Graduate from an institution accredited by the CCE
• Maintain a current license in good standing
• No Medicare sanctions
• Possess malpractice insurance
  – Require $1 million / $3 million limits
• Complete a site visit
• Submit medical records for peer review
• Disclose your clinical criteria
  – X-ray guidelines, techniques, procedures, DDx
Defining the Standard of Care

The term "standard of care" does not represent guidelines, nor does it represent a "cookbook" methodology. Similarly, the standard of care does not represent scope-of-care laws. Scope-of-care laws, which vary from state to state, represent the legal dictates defining what therapeutic procedures a licensed chiropractor may or may not utilize and on what bodily regions.

The legal definition of the standard of care may vary slightly from state to state, but the essential concept is: "What a (licensed) prudent, competent Chiropractor in the same region would do in the same or similar circumstances."

The standard of care represents conduct that has been established with scientific, empirical, and/or clinical evidence. Consensus opinions including such factors as how widely used the form of treatment is, where it is taught, and how appropriate it is for the condition(s) upon which it is utilized are considered.

The standard of care represents the safest and most efficacious realm within which a chiropractor should conduct himself or herself professionally.

If you conduct your professional affairs within the chiropractic standard of care, it is considered less likely that your patients will suffer an adverse event from your treatment.
When Chiropractic Care Is Medically / Clinically Necessary

- Care is focused on rapid attainment of a defined, objective functional outcome
- History and examination result in an accurate NMS diagnosis to ensure chiropractic management is an appropriate intervention
- History and examination result in accurate physical assessment for potential contraindications to acupuncture treatment which result in appropriate referral or co-management
- Treatment planning and treatment interventions are evidence-based and are likely to result in reaching the defined functional outcome

What Is the Member’s Financial Responsibility?

By becoming a health plan provider, you are agreeing to a specific fee schedule and need to be aware what services are covered benefits for that particular health plan.

In terms of covered services, typically a member is only responsible for his/her copayment. You cannot charge a patient for a covered service that has not been clinically approved.

Examples of non-covered benefits, for which the patient can be billed, are vitamins, massage, and/or maintenance care.
Strive for Clinical Excellence

- Treat with the goal to rapidly resolve the patient's complaint(s) and restore function
- Select the most appropriate method of treatment for the presenting condition
- Teach preventive strategies (e.g., work and ADL modifications)
- Co-manage and refer when appropriate
- Encourage active care: remember to keep it simple!

Conclusion

Participating in managed health care is a business decision. The goal of this presentation is to give you enough first-hand information to allow you to make a well-informed decision on how you will position yourself in the future.

For specific information on ASH's x-ray guidelines and a list of clinical techniques and procedures related to network participation, please visit our Web site:

www.ASHCompanies.com
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