IN THE KNOW
...developing **top-notch** CNAs, one inservice at a time

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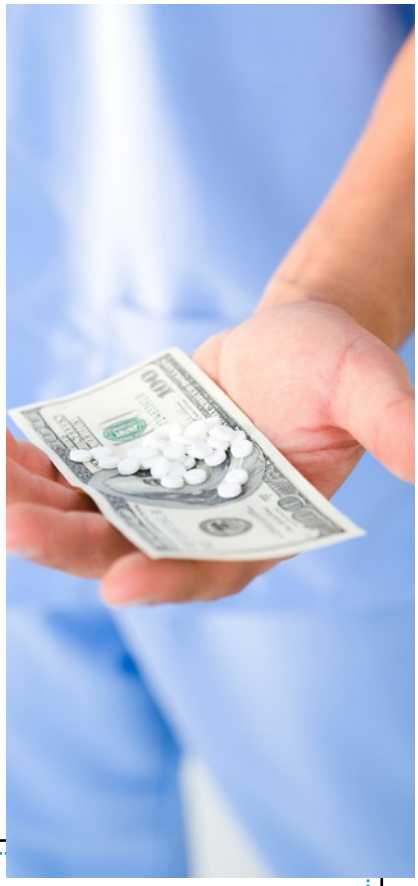


A Health Care Module:

HEALTH CARE FINANCING

IN THE KNOW

Developing Top-Notch CNAs, One Inservice at a Time

A Healthcare Module:
Understanding Healthcare Financing

Inside This Inservice:

SONYA'S COSTLY SLIP-UP

Sonya dreamed of making it big as a dancer in New York City. At age 22, she left her home town to follow her dreams. She took a job as a waitress and began going on auditions.

While her waitress job paid enough to cover her rent, it did not provide health insurance...nor did it leave her with enough money at the end of the month to buy her own insurance.

One snowy day, Sonya was rushing to the subway to catch a ride to work. As she tried to make her way down the crowded staircase, she slipped and fell. Strangers called for an ambulance and Sonya was taken to the Emergency Room.

The fall left Sonya with a broken ankle and a torn meniscus (cartilage of the knee). It meant she would be off her feet for a while. And, without expensive rehabilitation, she learned she may never dance again.

Since Sonya was unable to work, her boss was forced to replace her. Then, the bills started rolling in. They totaled nearly $6,000.

Sonya had no savings and only about $300 in her checking account. She did not come from a rich family, so asking for money was not an option. Within weeks, Sonya was forced to give up her dream and move back home.

The hospital continued to send bills and, eventually, the bills went into collections. Sonya's credit rating dropped.

When Sonya got her next job, she was offered health insurance, but the insurance would not cover any bills associated with her fall. It was considered a preexisting condition. Sonya never got the rehabilitation she needed.

Because she was uninsured, and because healthcare costs are so high, this one slip and fall impacted Sonya's entire life.

Sonya is just one of nearly 46 million Americans who are uninsured. The majority of the uninsured are working people who simply cannot afford health insurance, and who are not eligible for public programs.

What would you do if you were in Sonya's shoes? What would you do if you were the owner of the hospital? Keep reading to learn about all the ways healthcare is paid for in the US. And, find out how the new Affordable Healthcare Act is helping people like Sonya.

WHO PAYS FOR HEALTHCARE?

Americans rack up healthcare bills totaling $2.6 trillion a year—or $8,402 per person. Where does all that money come from? Most healthcare costs are covered by these four sources:

THE GOVERNMENT: The government covers about 45% of all healthcare expenses in the United States. There are currently 49 million people on Medicare and 47 million people on Medicaid. Of course, the payments don't come out of the government's "pocket" . . . these programs are funded by taxes. And, taxes are paid by citizens, just like you!

PRIVATE HEALTH INSURANCE: About 30% of all health care expenses are paid for by private insurance companies. The policy holder pays a monthly fee and the insurance company pools and then distributes a portion of that money out for "covered" medical services. Some private insurance is covered by an individual's employer. Others pay for it on their own.

OUT-OF-POCKET EXPENSES: People who don't have insurance (or *enough* insurance) and those who do not qualify for government programs pay health care cost out of their own pocket. It is estimated that middle class families currently spend about one-fourth of their income on health care services—and that's not including their insurance premiums.

HEALTHCARE PROVIDERS: Doctors and hospitals must find a way to offset nearly $60 billion in unpaid medical bills each year. In addition to the bad debt, many hospitals also provide some form of "Charity Care." Charity care covers services when the hospital does not expect to receive payment because it determines, with the assistance of the patient, that the patient is simply unable to pay.

WHAT'S NEW?

*Grab your favorite highlighter! As you read this inservice, **highlight five things** you learn that you didn't know before. Share this new information with your co-workers!*

TERMS

- **Centers for Medicare and Medicaid Services (or CMS).** The CMS manages the Medicare program, and the federal portion of the Medicaid program for the entire United States.
- **Claim.** For example: the nursing home sent a *claim* to the insurance company for all the care they have provided to Mrs. Kelly that month. The insurance company will pay the claim.
- **Co-payment.** Every time Mrs. Masters visits her doctor, she has to pay a $5 *co-payment*. Her insurance company pays the rest of the bill.
- **Deductible.** Mr. Thomas has a $500 *deductible* on his health insurance policy. So, every year, he has to spend $500 of his own money on health care *before* his insurance company will pay any bills.
- **Medically necessary.** The doctor believes that a CAT scan is medically necessary to diagnose your health problem. But, your insurance company says the doctor should start with a cheaper test.

WHAT EXCITES YOU?

THE DIRECT-PAY MODEL

A surprising new trend is growing among healthcare providers across the US.

Doctors like Brian Forrest of Apex, NC have made healthcare more affordable by cutting out the insurance companies!

"We don't file or accept insurance of any type," Forrest says. Eliminating this paperwork saves his practice about $250,000 a year.

"We can pass those savings directly onto the patients," Forrest said. His prices are generally 80 to 85 percent *less* than they are in a traditional medical office.

The direct-pay model does what many people want in Healthcare Reform— it increases access for the uninsured and decreases costs.

Forrest is training some 250 practices nationwide to open up with or convert to the direct-pay model.

THE HISTORY OF HEALTH INSURANCE

1920s In 1929, a local hospital made a deal with a group of school teachers to provide medical services to them for a low monthly rate. This was the beginning of health insurance as we know it today.

1930s Kaiser Industries was the first company to establish a managed care organization. They set up special medical facilities and hired physicians to provide health care to Kaiser employees.

1950s After World War II, more companies began offering health care insurance as an employee benefit. At that time, most health insurance policies covered hospital expenses only.

1960s In the 1960's, private health insurance expanded to cover the cost of hospital care, surgeries and doctor visits.

At the same time, the U.S. government established Medicare (to provide health care for the elderly) and Medicaid (to provide health care for the poor).

1990s In 1996, HIPAA (The Health Insurance Portability and Accountability Act) was passed. HIPAA ensures many patient rights, including the right to portability of medical coverage for pre-existing conditions.

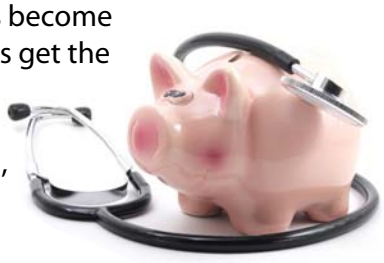
TODAY On September 23, 2010 the Affordable Care Act, (headed by President Obama) was passed to end some of the worst abuses of the insurance industry. (Read more about the Affordable Healthcare Act on page 4 of this packet.)

SO, WHAT'S WRONG WITH THIS SYSTEM?

Here's the good news . . . the health care system in the United States is one of the best in the world! **Now, here's the bad news . . .** the American health care system is also one of the most expensive!

- Around 46 million Americans are uninsured.
- Many people who have insurance have inadequate coverage and pay big out-of-pocket expenses.

Unfortunately, the American political system has become deeply divided over how to make sure Americans get the healthcare they need, when they need it. This has caused a standoff between the President and the Congress . . . and has caused an ongoing, and nearly unsolvable debate between Democrats and Republicans.



THE AFFORDABLE CARE ACT

On September 23, 2010 the Affordable Care Act, (headed by President Obama) was passed to end some of the worst abuses of the insurance industry.

New patient rights under this law includes the right to:

- Receive cost-free preventive services: New health plans must cover routine physicals, preventive screenings, vaccinations and counseling without any cost to the patient.
- Keep young adults on a parent's plan until age 26: Parents can now keep children on their plan until they turn 26 years old, if needed.
- Choose a primary care doctor, ob/gyn and pediatrician: New health plans must allow patients to choose their own primary care doctor, pediatrician or OB-GYN *without* a referral.
- Use the nearest emergency room without penalty. New plans can't require prior approval or higher copayments or co-insurance for out-of-network emergency room services.

HERE ARE SOME MORE HIGHLIGHTS OF THE NEW LAW

If you have insurance . . .

- Your insurer can't impose a lifetime limit on your benefits, meaning you don't have to worry about your coverage maxing out if you come down with a costly illness, like cancer.
- Health insurers can't cancel your coverage if you get sick, unless they can prove some type of fraud has occurred.

Sick children CANNOT be denied . . .

- Children under age 19 can't be denied coverage because of health problems or pre-existing conditions.

Plans for people with pre-existing medical conditions . . .

- Coverage for people with pre-existing medical conditions is available through the new Pre-existing Condition Insurance Plan (PCIP). This coverage is for individuals who have been uninsured for at least six months and have been denied coverage because of a pre-existing condition.
- It's not free. Premiums vary by age (but not by health status) and are tied to average rates for healthy people in the individual's state.

Help for small business owners . . .

- Employers can receive a tax credit for up to 35% of what they spend on coverage for employees. On Jan. 1, 2014, this tax credit increases to 50%.
- Businesses must have fewer than 25 full-time workers, pay average salaries under $50,000, and cover at least 50% of the employees' premiums.

THE NEXT STEP!

YOU ARE THE PRESIDENT

Imagine you are the President of the USA.

- What would you do to make sure every American gets the healthcare they need when they need it?
- How would those services be paid for?
- Would you be willing to pay higher taxes or share some of the burden so that those who are less fortunate can receive the care they need?
- What would you tell people who are unwilling to pay higher taxes or share the burden?
- How would you help decrease the cost of healthcare and insurance so that more people could afford it?

It's a tough job—but somebody HAS to do it!

A CLOSER LOOK AT MEDICARE AND MEDICAID

UNDERSTANDING MEDICARE

Most Americans who are 65 years or older qualify for the Medicare program. In addition, people who have been disabled for at least 24 months or who have End Stage Renal Disease are entitled to Medicare benefits.

Medicare benefits don't come to people automatically just because they become disabled or turn 65 years old. When the times come, they must apply for the program.

- Medicare is a federal health insurance plan for older and disabled Americans. However, keep in mind that it was never meant to pay all of someone's health care expenses. **On the average, Medicare pays about 55% of a person's medical bills.**

Medicare is divided into two parts: Medicare Part A which pays for acute care and Medicare Part B which pays for "extra" things like lab tests, wheelchairs and outpatient therapy. Medicare Part A is free, but people must pay a monthly premium to receive Part B benefits (so it's optional).

Some people who are covered by Medicare buy a private insurance—called a "Medigap" or "Supplemental" policy—to pay the bills that Medicare doesn't cover. But, not everyone can afford these extra insurance policies.

Remember that Medicare:

- Pays mostly for acute care—not long term, chronic care.
- Pays for only 2% of all nursing home stays. (For example, Medicare will pay for Mr. Collins to stay in a nursing home for three weeks after his hip surgery, but they won't pay for him if he needs to be a permanent resident.)
- Requires that clients must be homebound in order to receive home care services (except for hospice).
- Does not pay for "meals on wheels", dental care, eyeglasses, hearing aids or most prescription drugs.

UNDERSTANDING MEDICAID

Medicaid is different than Medicare because:

- It pays for health care for people with very low incomes—regardless of their ages.
- Only half the money for the Medicaid program comes from the federal government. The other half comes from each state government.
- Each state manages its own Medicaid program—with help from CMS.

Not every person with a very low income is eligible for Medicaid benefits. Those who may receive Medicaid include families with children under age six, pregnant women, children under the age of nineteen, the elderly and people who are blind or who have other disabilities.

- Over half of all Medicaid recipients are children. Every year, Medicaid spends an average of $1200 per child.
- Eleven percent of Medicaid recipients are senior citizens. Medicaid spends nearly $10,000 per year on them.

Medicaid usually pays for:

- Doctor visits.
- Prenatal care & vaccines for children.
- Hospital expenses.
- Laboratory & x-ray services.
- Prescriptions. (benefits vary from state to state.)
- Prescribed medical equipment.
- Long term care (such as nursing home stays and home health care).
- Over half of all people on Medicaid receive their health care services from an HMO.
- Medicaid pays for over 90% of all nursing home stays that last over four months.
- In at least 35 states, the Medicaid program pays for people to live in assisted living facilities. (This is often cheaper than the cost of a nursing home.)

TRADITIONAL HEALTH INSURANCE

Many Americans get private health insurance through their jobs or because a family member has insurance at work. This is known as "group" insurance and is the cheapest kind of private insurance. People who are unemployed or self-employed may choose to purchase an individual insurance plan.

Employers and individuals have many insurance options, including:

- **HMO Plans.** An HMO is a "members only" health care plan. Each HMO has its own facilities, physicians, nurses and laboratories. Each member of the HMO is assigned to a primary physician (or "gatekeeper") who oversees every aspect of that person's medical care.

  The benefits of an HMO are low out-of-pocket expenses for patients and an emphasis on preventing illness. (HMO physicians know that it's cheaper to keep people well than to treat them after they are sick.)

  The main drawbacks to an HMO are that members are limited to seeing doctors who are part of the HMO—even if they've been seeing a favorite doctor for years. And, they must use the hospital assigned by the HMO. Sometimes this means they must travel to another city because they are not allowed to go to their local hospital.

- **PPO Plans.** A **P**referred **P**rovider **O**rganization is a group of health care providers, organized by an insurance company. Doctors, hospitals and clinics sign contracts with the insurance company to provide care to its insured members. These providers must agree to accept the fee schedule and guidelines for medical care, defined by the insurance company.

  Advantages of a PPO include prescription services which provide prescription drugs at a reduced cost; and the cost for a PPO is usually less than for individual health coverage.

- **High Deductible Plans.** An alternative to the plans offered by HMOs and PPOs (which promise low deductibles but charge high premiums), a High Deductible Health Plan costs a lot less, but has very a very high deductible. For example, a typical PPO plan may cost $150 per month and have a $500 deductible. A High Deductable Plan may cost only $50 per month, but carries a $5,000 deductible.

- **Health Savings Accounts.** An HSA is a savings account devoted solely to health expenses. It is usually combined with a high deductible plan. HSAs replace high cost insurance policies that may be out of the reach of many Americans. It can also be used to supplement retirement for healthy individuals because the money can stay in the account and grow over time.

- **Discount Plans.** Discount health plans provide discounts or savings on medical, dental, vision, hearing, prescription, counseling, and more, depending on the plan. It is important to note that these discount plans are not "insurance" and are not a substitute for having an actual health insurance policy.

TIME TO LAUGH!

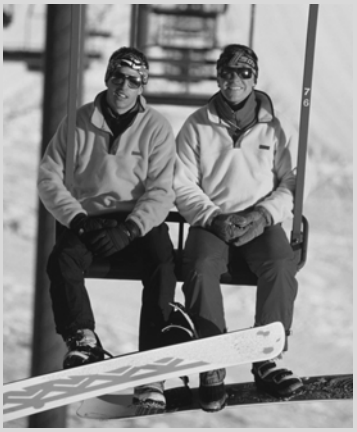
A young man was skiing when a bizarre accident occurred.

While fumbling his way off a chair lift, another chair hit him from behind and knocked him out cold.

He woke up with a headache in a hospital bed and immediately called his insurance company.

After explaining what happened the insurance rep said, "We cannot cover anything on this claim."

"You hit yourself in the head with a chair on a ski lift. You are reckless ***and*** uncoordinated. And that is a pre-existing condition."



THINK ABOUT IT!

HOW MUCH IS IT?

Your mechanic gives you a quote before he ever raises a wrench.

Your favorite restaurant gives you a menu—complete with prices before you ever eat.

Would you ever purchase a product in a grocery store without knowing the price?

Would you go to a salon to get your hair done if you didn't know the fee?

Furthermore, once you know how much something costs, how often do you shop around for the best price?

- ***Chances are, there are very few things you do or buy without knowing and comparing prices first.***

So, why are doctors, hospitals, clinics and long term care providers allowed to do all the work they do without disclosing their prices until well after the service is given?

Do you think this is a fair practice? If not, what do you think you can do change this system?

OTHER TYPES OF INSURANCE

VETERAN'S BENEFITS: Veterans of the United States military (and their families) are eligible for health care services from VA around the country.

- To be eligible for veteran's health benefits, a person must be retired from one of the five branches or be a member of the National Guard. You may hear the VA programs called either CHAMPUS or TRICARE.
- In general, VA benefits include preventative care, mental health care, substance abuse services, home health care, hospice and prescription medicines.
- Some treatments will only be paid for by the VA if the condition is a result of the person's military experience. For example, if Mr. Smith lost his leg while in the Army, the VA will cover expenses related to this problem. But, if he lost his leg in a car accident (after being discharged from the Army), they may not cover his care.

DISABILITY INSURANCE: Disability insurance policies cover people during times when they are unable to work and cannot earn their regular salary. Often, people are able to buy disability insurance at a low cost through their employer.

- Short term disability pays a percentage of employees' salaries if they become temporarily disabled. Normally, the payments continue for a short time—up to six months—to give people a chance to get well and get back to work.
- Long term disability "kicks in" when the short term insurance expires. It continues paying for years—often until the person reaches the age of 65.
- Each claim for disability payments is evaluated regularly by physicians and case managers.

WORKER'S COMPENSATION INSURANCE: Nearly every employer in America is required to purchase workers compensation insurance for their employees. Over 120 million employees are covered by workers compensation.

- "Workers comp" policies cover employees' medical expenses if they are hurt on the job. They may also provide money to make up for some of the wages lost because of an injury.
- Each state has its own laws about what percentage of an employee's salary must be paid.
- These insurance plans only apply to injuries that occur while someone is at work. Employees are evaluated thoroughly to make sure they receive the proper care for their injuries.

MORE TYPES OF INSURANCE

LONG TERM CARE INSURANCE: Long term care insurance is a special policy that some people buy to help cover the costs of a nursing home, adult day care, an assisted living facility and/or home health care.

- Remember that Medicare and regular private insurance normally pay for acute health problems only. For example, Mrs. Jones has a heart attack. She needs help from a nurse and an aide for a few weeks. Her regular insurance policy will pay for these services. Compare that to Mrs. Davis, who has congestive heart failure. She needs help every day with her activities of daily living—and will continue to need help for the rest of her life. Mrs. Davis has a chronic, long term medical problem.
- Medicare won't pay for chronic care. One way for Mrs. Davis to get the help she needs is by having long term care insurance.
- Keep in mind that these policies are ***expensive***. For example, people who buy long term care insurance at age 50 will pay about $800 per year. By age 70, they'll have spent $16,000 on this insurance!
- In addition, people must decide to purchase long term care insurance ***before*** they develop any chronic diseases.

MENTAL HEALTH INSURANCE: Mental health conditions include mental illnesses such as schizophrenia, depression and anxiety; drug and alcohol abuse; anorexia and bulimia; and autism.

- Most insurance policies do not offer as much coverage for mental illness as they do for physical illness. For example, some insurance plans don't cover mental illness at all. Others offer limited coverage for mental health care.
- A number of laws have been passed recently across the U.S. that require insurance companies to make mental health care more affordable. However, the cost of mental health care remains a financial challenge for most Americans.

CANCER INSURANCE: Cancer insurance is another type of special health insurance. Most of these policies pay out a lump sum of money to someone who is diagnosed with cancer.

- Keep in mind that cancer insurance is just what it says: for cancer only. It doesn't pay for heart disease, stroke, diabetes or high blood pressure.
- Most insurance experts agree that it's better for people to purchase regular health insurance plus disability insurance than to spend money on cancer insurance. Remember...only two of every five people develop cancer. So, cancer insurance could be a waste of money.

TALK ABOUT IT!

"The best way to have a good idea is to have a lot of ideas."

~ Dr. Linus Pauling

As you read through this inservice, think about ways you can cut costs, yet still maintain the highest level of care.

Come back to this page and keep a list of your ideas.

Present your ideas to your supervisor! You never know . . . your small idea might make a huge impact!

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UNDERSTANDING HEALTH INSURANCE FRAUD

Health insurance fraud is a major problem in America. Consider this: The federal government estimates between $45 billion to $75 billion is paid to health care "fraudsters" each year.

- A government report from 2011 found that nearly 10% of all Medicare payments go toward fraudulent claims.

HOW DOES ALL THIS FRAUD HAPPEN?

Typically, fraud is committed by health care professionals when they:

- Send a bill to health insurance for services that were not performed.
- Send in two bills for the same service.
- Provide a low cost service to a client but bill the insurance company for a high cost service.
- Perform services that they know are unnecessary just so they can bill the insurance company for more money.

WHAT'S THE BIG DEAL?

When our health care system loses money because of fraud, *all* Americans end up paying higher insurance premiums! In addition, health services end up being cut—especially for people receiving Medicare and Medicaid—because the government can't afford them.

WHAT HAVE WE TRIED IN THE PAST?

In 1992, health care fraud units were created by the U.S. Department of Justice. The plan was for these law enforcement officials to crack down on health care fraud. However, it ***failed*** for a number of reasons:

- The people who were committing health care fraud worked hard at being "invisible". The fraud went undetected for years.
- It was impossible for the government to spare the manpower to look for health care fraud in every city across the country.

WHAT ARE WE DOING ABOUT IT TODAY?

In 2009, The Affordable Care Act set aside $350 million to fight healthcare fraud. The Health Care Fraud Prevention & Enforcement Team (HEAT) and the Medicare Fraud Strike Force teams were formed.

In 2011, the new healthcare fraud fighters recovered $4.1 billion in fraudulent healthcare payments. . . the largest amount ever collected in a single year.

- Criminal charges were filed against 1,430 defendants for healthcare fraud-related crimes. A total of 743 defendants were convicted.
- The cases included durable medical equipment fraud; illegal marketing of medical devices or drugs for uses not approved by the FDA, unlawful pricing by drug makers; and violations of self-referral and anti-kickback laws.

Another new part of The Affordable Health Care law requires providers and suppliers who participate in Medicare and Medicaid to undergo more frequent licensure checks and site visits to confirm legitimacy.

WHAT IS THE PUNISHMENT?

When people who commit fraud are caught, they face a variety of punishments—depending on the seriousness of the fraud. These punishments include:

- Paying stiff penalties and fines.
- Being banned from billing Medicare or Medicaid in the future.
- Serving jail sentences of up to 20 years.

WHAT CAN YOU DO?

The best way that you can help control fraud is by following each client's care plan carefully and by documenting your client care exactly.

FIVE KEY POINTS!

REVIEW WHAT YOU LEARNED!

1. Americans rack up healthcare bills totaling $2.6 trillion a year, or $8,402 per person.
2. Most healthcare bills are covered by the government, private insurance, individuals and healthcare providers.
3. The health care system in the United States is one of the best in the world! But, it's also one of the most expensive!
4. The Affordable Care Act, was passed in 2010 to end some of the worst abuses of the insurance industry.
5. The best way that you can help control costs and minimize fraud is by following each client's care plan carefully and by documenting your client care exactly.

WHAT DOES HEALTHCARE FINANCING HAVE TO DO WITH CLIENT CARE?

Your client's health care plans are based on two things:

1. The care they need to meet their health care goals.
2. The limits of their insurance coverage.

Shouldn't the clinical side of health care—taking care of clients—be completely separate from the business side—paying the bills? Sure, that would be ideal. But, that's not how it is in the "real" world. Health care in the United States is a business.

Think of it this way: Let's say that ABC Hospital wants to be known as the best hospital in the country. So, they allow every health care worker to provide every possible kind of care for every patient—without worrying about whether insurance pays for it. People come from miles around to receive care from this excellent facility. However, before long, ABC Hospital finds itself running short of money. They can't even pay for the basic care that each patient needs. Because they ignored the business side of health care, they end up having to close their doors. Now, they can't help any patients at all.

- Keep in mind that insurance companies (including Medicare and Medicaid) ***don't have to pay*** for health care services just because they have been ordered by a doctor! The services still have to "pass the test" of being ***medically necessary*** for a particular client.
- Changes in a client's condition can mean that a service that was medically necessary yesterday is not necessary today. It's important for every health care worker to report changes in their client's condition.

Did you know that insurance companies can refuse to pay for the care you give your clients? It can happen if you:

- Forget to document the services you provided to a client.
- Fail to document the complete picture of what you did for your client.
- Provided care that wasn't on the client's care plan.

In addition:

- **Your clients have the right to know how much your services are costing them—even if insurance is covering the cost.** Also, people have the right to pay privately for services that their insurance company refuses to cover. Let your supervisor know if clients ask questions about their health care expenses.
- **Home care clients who receive Medicare benefits must be homebound.** What does this mean? "Homebound" means that the client finds it difficult and very tiring to leave home. The client may leave home for medical care and for short, infrequent non-medical trips.
- **Every health care worker is expected to provide quality client care in a responsible manner—so unnecessary health care expenses are avoided.** Every wasted health care dollar eventually comes out of all our pockets!

YOU CAN HELP WITH HEALTHCARE COSTS

- The best way for you to cut health care costs is by keeping your clients as healthy as possible! Remember . . . the healthier your clients are, the smaller their health care costs will be.
- Encourage a ***balanced diet***. Whether you cook for your clients, feed them or just serve their food, you have the opportunity to help your clients get the nutrition they need to stay healthy. Learn all you can about any special diets that have been prescribed for your clients.
- Help your clients ***exercise*** on a regular basis. Even short walks or range of motion exercises improve a client's fitness level.
- Remind your clients that it's never too late to ***quit smoking*** and enjoy the health benefits of being a non-smoker.
- Do all you can to ***prevent falls*** and other injuries. Look around their living area for safety hazards. Check if the medications they take have side effects such as dizziness or lightheadedness. Make sure your clients use any assistive devices—such as canes or walkers—that have been ordered for them.
- Encourage your clients to stay as ***active*** as possible. (People who spend time with friends and who enjoy hobbies seem to stay healthier!)
- Reduce your clients weather exposure by helping them ***dress properly*** for the weather and by protecting their skin from too much sun.
- Report any physical or emotional changes in your clients so that they can get any necessary medical attention right away.
- Make healthy lifestyle choices for yourself, too! They will help you cut your own health care costs.
- Communicate regularly with other members of your health care team so that you all have the same picture of a client's condition. Insurance companies pay close attention to this issue. For example, if the RN documents "client is weak and needs bed rest", the therapist writes "client is able to walk 30 feet without assistance" and you document "client needs help getting from the bed to the bathroom", the insurance company may question who is right . . . and deny payment.
- Be sure to tell your supervisor if clients and/or family members mention that they have a new or updated insurance policy.
- Follow each client's ***care plan*** carefully. Client care tasks are assigned to you according to the client's needs and the guidelines of the client's insurance plan.
- If you are a home health aide caring for a Medicare client who must be homebound, be sure to tell your supervisor if the client becomes able to leave home. For example, if you arrive to help a client with his personal care and you find him outside mowing his lawn, he's probably no longer homebound!

WHAT I KNOW NOW!

Now that you've read this inservice on healthcare financing, jot down a couple of things you learned that you didn't know before.

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IN THE KNOW

Developing Top-Notch CNAs, One Inservice at a Time

EMPLOYEE NAME
(Please print):

_____

DATE: _____

- ***I understand the information presented in this inservice.***
- ***I have completed this inservice and answered at least eight of the test questions correctly.***

EMPLOYEE SIGNATURE:

_____

SUPERVISOR SIGNATURE:

_____

Inservice Credit:	
☐ Self Study	1 hour
☐ Group Study	1 hour

File completed test in employee's personnel file.

A Healthcare Module:

Understanding Healthcare Financing

Are you "In the Know" about healthcare financing? Circle the best choice or fill in your answer. Then check your answers with your supervisor!

1. Which of the following pays the most toward U.S. healthcare costs?

A. Government programs.
B. Uninsured people.
C. Healthcare providers.
D. Bank loans.

2. The Affordable Healthcare Act gives Americans:

A. Free preventative services.
B. Tax breaks for small business.
C. Coverage for pre-existing conditions.
D. All of the above.

3. Which of the following would NOT qualify for Medicare?

A. A 36 year old single mom who is pregnant.
B. A 45 year old man with End Stage Renal Disease.
C. A 68 year old woman who collects Social Security.
D. A 24 year old man who has been disabled for 2 years from a car accident.

4. The largest group of people who are on Medicaid are:

A. Children.
B. Retirees.
C. Prisoners.
D. None of the above.

5. True or False

A Preferred Provider Organization is a group of health care providers organized by an insurance company.

6. True or False

Worker's Comp insurance will pay costs associated with a car accident that happens while an employee is on his way to work.

7. True or False

Most insurance policies include coverage for long term care.

8. True or False

If your client asks how much his daily care costs, you should tell him not to worry because his insurance will cover it.

9. True or False

The best way for you to cut health care costs is by keeping your clients as healthy as possible.

10. True or False

Your insurance company can cancel your policy if you get cancer.