Implementation of an insurance benefit manual: a time-study at De Paul rehabilitation hospital

Bernadette Marie Merten

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IMPLEMENTATION OF AN INSURANCE BENEFIT MANUAL:  
A TIME-STUDY AT DE PAUL REHABILITATION HOSPITAL

By
Bernadette Marie Merten

A thesis
submitted in partial fulfillment
of the requirements for the degree of
Master of Science in Management
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APPROVAL SHEET

This thesis has been approved by the following committee:

Project Advisor  Date

Second Reader  Date

P.M.A. Director/Representative  Date
Abstract

IMPLEMENTATION OF AN INSURANCE BENEFIT MANUAL:
A TIME-STUDY AT DE PAUL REHABILITATION HOSPITAL

Bernadette Marie Merten

Patients receiving services at specialty hospitals are usually involved in treatment programs for extensive periods of time. Therefore, these facilities rely heavily on obtaining accurate insurance information to plan for patients' treatment needs. This thesis is centered around the development of an insurance benefit manual at De Paul Rehabilitation Hospital (DPRH), a comprehensive alcohol and drug treatment facility located in Milwaukee, Wisconsin.

In Chapter I, it was indicated that a significant amount of time was previously utilized at DPRH to verify insurance, by making a phone call to the employer or insurer of each patient being admitted. It was proposed that this time could be minimized by referring to the manual instead of making a phone call for each verification. Hypothetically, it was stated, such a manual could be useful, save a significant amount of time, and remain accurate. To evaluate the effectiveness of the project, a time study was conducted during two target months, August, 1983 (one month prior to the introduction of the manual) and September, 1983 (one month after the implementation of a draft of the manual). Accuracy was checked by comparing benefit pages within the manual with payments made on patient accounts.

Literature on insurance, technical writing, and time studies was reviewed in Chapter II and relevant foundations issues were addressed.
Results of the time study were described and analyzed in Chapter III. Statistically, it was determined that at the end of one month in operation, the manual could be used for 42.4% of the verifications, a composite time decrease of 37.4% occurred, and accuracy of information was maintained at 95%. The hypotheses were thus proven valid. Based on the findings from this project, it is recommended that other specialty hospitals develop and use insurance benefit manuals to verify coverage instead of always making a phone call to do so.
Acknowledgements

This project was made possible through the efforts of various people who assisted and encouraged me during the past year. First of all, I would like to thank my grandmother, Rose Barbara Zastrow, who was very supportive of my decision to continue my education and gave me strength to endure the initial stages of this project. Rose died May 21, 1983, but in my heart she will live on forever. Second, I would like to thank my parents who saw the best and worst of me throughout the past year and shared every joy and sorrow with me. Then too, some gratitude must be expressed toward my cousins Geraldine, Norman, James, Kathy, Dean, and Gina for tolerating my "rudeness" during the past year; especially when I had notebooks and papers in front of me frequently at family get-togethers. Appreciation is deeply expressed toward Mrs. Winifred LaFond, the Controller at De Paul Rehabilitation Hospital for all the time she gave me while I was developing the manual. Heartfelt thanks go to the Business Office staff at De Paul for putting up with me while I was back in school; their extra support and understanding did not go unnoticed. Caroline Widmer typed some of the benefit pages in Part II of the manual and I am grateful to her for that; while others were celebrating and "awing" over the fireworks on the Fourth of July weekend, she was "firing" away on her typewriter. Pat Johnson, Project Typist, should be commended for her fine work; her patience and the accommodations she made for me were superb -- she truly became an extension of my right hand within the past year. To Walt Ritter, my advisor, goes my deepest respect, his 'courtesy' toward my 'pestering' him with frequent calls concerning the
thesis and manual was unmatchable by far; as long as he doesn't send me the bills for tying up his phone lines.

All these people, and other friends, boosted my spirits and cheered me onward toward the completion of my degree and to all of them I now say, Thanks, many, many, thanks -- You're all special, I love you all.

Sincerely,

Bernadette Marie Merten
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CHAPTER ONE

Purpose of the Project

The purpose of this project was to develop an insurance benefit manual for use in the business office at De Paul Rehabilitation Hospital. Results of this manual provided the business office with a tool which enabled them to assist other departments of the hospital such as Admitting, Inpatient, and Outpatient in making financial plans for patients' treatment needs. Included in this manual were sections on the employers and the insurance carriers of the patients receiving services at De Paul Rehabilitation Hospital. The project was implemented by making copies of actual insurance verifications on file, reviewing insurance handbooks, contacting some of the insurance carriers themselves by telephone, and by discussing methods of obtaining insurance information with staff members from the business offices at other alcohol and drug treatment facilities within the Milwaukee area. Books on technical writing, time studies, and insurance helped the researcher to construct this manual. It was evaluated for its usefulness by monitoring how often it was referred to for insurance verifications during two target months which will be discussed in more detail later on in this chapter. This manual was then evaluated in terms of time by monitoring how long it took to refer to a given benefit page when verifying insurance coverage, compared to the traditional manner in which this had been performed in the past, i.e., a phone call to the insurance company or employer of each patient being serviced at this hospital. Finally, this project was evaluated for its accuracy by comparing insurance payments received on patient accounts with benefit
sheets within the manual and looking for any discrepancies which occurred between the recorded information and actual money received for services provided at De Paul.

Statement of Problem

Alcohol and drug treatment facilities within the Milwaukee area have traditionally spent a considerable amount of time verifying insurance benefits for patients they serviced by calling their employers and insurance carriers. At De Paul Rehabilitation Hospital, on some days, at least four hours of a standard eight-hour work day were utilized for this task by the insurance specialist. When this researcher contacted the insurance specialist at Dewey Psychiatric Hospital, which also services some alcohol and drug patients, she was informed that sometimes more than half a day was utilized for this purpose.

Another problem De Paul Rehabilitation Hospital faced was not having a centralized knowledge base available on health insurance benefits for the patients it formerly serviced. This resulted in some staff members of the business office having to go through several file boxes and drawers before they could give the necessary financial information to counselors and others requesting it.

This researcher saw the value of an insurance benefit manual as an effective reference tool the business office at De Paul Rehabilitation Hospital could use to provide better and prompter service to other departments in making financial plans for patients' treatment needs. It was also believed that the amount of time utilized for insurance verification purposes could be minimized by referring to the benefit manual.
instead of making a phone call for each patient. Therefore, this researcher recommended this project to Mrs. Winifred LaFond, the controller at De Paul Rehabilitation Hospital, and after receiving her approval, proceeded with this project.

Project Title, Location, and Duration

The title of this project was "Implementation of an Insurance Benefit Manual: A Time-Study at De Paul Rehabilitation Hospital."

The geographical site of the project was De Paul Rehabilitation Hospital located on the south side of Milwaukee, Wisconsin. The project activities for the most part were carried out at that location. Initial research which was needed to develop this manual was conducted at various libraries within the Milwaukee area.

This project was carried out from November, 1982 through October, 1983. Materials were gathered to develop this manual between November, 1982 and September, 1983. The two target months for evaluating the effectiveness of the project were August and September, 1983. The final results and recommendations concerning this project were given in November, 1983.

Also, in a sense, part of this project continues to the present time as new benefit sheets continue to be added to the manual so it can remain as accurate and useful as possible.

Participants

The project was carried out primarily by this researcher who made copies of the insurance verifications of each day and contacted insurance
companies and alcohol and drug treatment centers in the Milwaukee area to develop the manual. Literature on insurance, technical writing, and time studies were reviewed prior to designing the manual. Suggestions by the controller at De Paul Rehabilitation Hospital were given as to what to incorporate into the manual. Procedures to evaluate the effectiveness of the project were established with the assistance of the controller. The first part of the manual was typed by Pat Johnson, project typist, and the second part of the manual, which contained the benefit pages, was typed by this researcher with some assistance from Caroline Widmer, an employee in the business office at De Paul Rehabilitation Hospital. Copies of the manual were printed at De Paul Sertoma Industries Printshop.

Those receiving services from the project in being able to directly utilize this insurance benefit manual included employees in the business office who had experience in accounts receivable and billing duties. These positions included the business manager, the accounts receivable supervisor, inpatient and outpatient billers, a credit and collection specialist, and the insurance specialist.

This project also was beneficial to the Admitting, Inpatient, and Outpatient departments at De Paul, and the satellite unit of De Paul at Saint Alphonsus Hospital in Port Washington, Wisconsin. Because of the implementation of this insurance benefit manual, some of these departments were supplied with more financial information than they previously obtained from the business office.
Objectives

Developmental Objective 1

By December 1, 1983 the researcher developed an insurance benefit manual for use in the business office at De Paul Rehabilitation Hospital.

Implementation activities. To prepare the manual, by July 31, 1983, his researcher:

1. Made copies of insurance verifications done each day, typed a standard insurance benefit sheet based on the information contained on each one, and then incorporated these sheets into Part II of the manual.

2. Reviewed insurance books, technical writing, and time study materials. Some insurance companies and other alcohol and drug treatment facilities within the Milwaukee area were also contacted.

3. Met with the controller to outline Part I of this manual.

To prepare the final draft of the manual, the following activities are conducted by November 30, 1983:

1. Benefit sheets for Part II of the manual were sent to De Paul Sertoma Industries Printshop for printing.

2. Part II was distributed to the Admitting Departments at the 3th Street location and the Port Washington unit. (One set of these sheets was also kept for the business office.)

3. Part I of this manual was written according to guidelines received from the controller.

4. Part I was typed and then sent to Sertoma to be printed.

5. Copies were distributed to Admitting, Inpatient, and Outpatient departments, the Port Washington unit, and the Oakland Outpatient Office.
VIDENCE OF COMPLETION: The evidence of completion was met when the final typed versions of the manual were completed and distributed by December 1, 1983.

Developmental: Objective 2

During the months of August and September, 1983, the researcher monitored the phone calls going out of the business office at De Paul Rehabilitation Hospital.

Implementation activities. To monitor the phone calls, this researcher:

1. Developed a form on which she noted each insurance benefit call made as to which insurance carrier or employer was contacted.
2. Used a chronograph with accurate second and minute hands to time each call and then recorded the time spent on each one.
3. Reviewed her findings with the controller.

VIDENCE OF COMPLETION: The evidence of completion was met at the end of each of these two months after the respective insurance calls were recorded and timed.

Developmental: Objective 3

By October 31, 1983, this researcher compared the results in terms of the time spent on insurance verifications in the business office at De Paul Rehabilitation Hospital during August and September, 1983.

Implementation activities. To compare the results between these two months, the following activities were conducted:
1. The number of phone calls and the amount of time spent on insurance inquiries was totalled for each month.
2. Time differences between the two months were noted.
3. Findings were reviewed with the controller.

EVIDENCE OF COMPLETION: The evidence of completion was met after the time differences were recorded and analyzed.

Evaluation: Objective I

By October 1, 1983, the business office at De Paul Rehabilitation Hospital was able to refer to the insurance benefit manual for 25 percent of the insurance verifications instead of making a phone call for each patient being serviced as measured by a tally of manual usage and phone calls made during August and September, 1983.

Implementation activities. The following activities were conducted to implement this objective:
1. An insurance benefit manual was developed for use in the business office at De Paul Rehabilitation Hospital.
2. Part II (the benefit pages) was prepared for use by September 1983 with the assistance of the controller.
3. The insurance phone calls going out of the business office during August, 1983 were monitored by keeping written records. (This is one month prior to the manual being introduced.)
4. The researcher introduced the insurance benefit manual on September 1, 1983 (Part II), and then similarly monitored the phone calls during that month, recording to whom each call was made. A
record was also kept whenever the manual was used instead of the telephone to verify coverage.

5. For each of these target months, the phone calls were totalled as well as the number of times the manual was used. The results were then compared in terms of quantity.

EVIDENCE OF COMPLETION: This objective was completed when the phone calls for each of these two months and the number of times the manual was referred to in September were compared by statistical analyses.

Evaluative: Objective 2

By October 1, 1983, the time spent on insurance verifications decreased by 20 percent as measured by a count of the minutes and seconds used to verify insurance before and during the implementation of the project.

Implementation activities. To implement this objective, the following activities occurred:

1. Part II of the manual was prepared for use in the business office by September 1, 1983.

2. A chronograph was used to time insurance calls made during August, 1983. Written records were also kept as to who was contacted.

3. The manual was introduced September 1, 1983. Again, a chronograph was used as the time measurement device. When appropriate to use, the manual was referred to. Insurance was verified by telephone when the manual could not be used.

4. Total time spent on insurance verifications was calculated for each month. Differences were then analyzed.
EVIDENCE OF COMPLETION: The time spent on insurance verifications during each of these two months was compared by statistical analyses to determine if this objective was met.

Evaluative: Objective 3

By October 1, 1983, the information contained within the manual was 95 percent accurate as measured by a comparison of insurance payments received on patient accounts and the benefit information given in Part II of it.

Implementation activities. To measure the degree of accuracy of the manual, the researcher:


2. Compared inpatient insurance payments with information contained in these sheets. (As these sheets were obtained from copies of verifications, they were representative of patients being serviced at De Paul.)

3. Noted discrepancies between payments received and insurance information on file. (A notebook was kept for this purpose.)

4. Called insurance companies to recheck the benefits on the discrepant pages of the manual.

5. Corrected the benefit sheets accordingly.

EVIDENCE OF COMPLETION: This objective was completed when this researcher compared insurance payments made on patient accounts and related benefit sheets in Part II of this manual by statistical analysis and then updated the information accordingly.
Limitations of Project Findings

Although the project proved to be beneficial, there were some factors that limited it. The manual itself was primarily designed for use at an alcohol and drug treatment facility; therefore the hospital benefits contained within it were descriptive for these diagnoses. Modifications of this manual would have to be made to expand it for use at a general hospital or other type of health-care facility. Also, the manual did not eliminate insurance phone calls entirely; what it did do was to decrease them substantially. There were certain instances when a phone call had to be made to verify insurance; i.e., when given an insurance verification for a group not already on record, when a significant amount of time had passed since a given benefit sheet for a particular group had been last used, or when a prospective patient had just been laid off or terminated from employment and a verification needed to be made to determine the insurance cancellation date. Finally, because the researcher is the insurance specialist and is knowledgeable in insurance-related matters, care had to be taken to avoid bias. This situation was remedied by having the controller review the records and findings.
Definition of Terms

This study had some unique terms which need to be defined:

De Paul Rehabilitation Hospital: A specialty hospital offering comprehensive inpatient and outpatient services for chemically dependent patients and their families. De Paul is located in Milwaukee, Wisconsin. Throughout the remainder of this project, De Paul Rehabilitation Hospital will be referred to as DPRH.

Health Insurance: "That which provides protection against expenses and income losses arising from illness or injury." In conjunction with this project, health insurance will be defined as that which provides protection against expenses and income losses arising from alcoholism and drug addiction. This insurance will be looked at in terms of inpatient and outpatient hospital benefits available for alcoholism and drug addiction.

Insurance Benefits: The amount of coverage usually specified in terms of days and dollars, provided by insurance companies, employers, and unions (sometimes) for inpatient and outpatient treatment at DPRH.
Technical Writing: "The factual recording of that experience or knowledge for the purpose of determining it." It involves treating a subject with seriousness and demands exacting clarity.

Time Study: Determining the standard time required to perform a specific task (more details about this concept will be found in Chapter II and III of this thesis).
<table>
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<td>1. Plan manual.</td>
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<td>3. Review literature, contact other specialty hospitals.</td>
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<td>5. Monitor phone calls (one month prior to introduction of manual).</td>
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<td>Jun</td>
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The total cost for this project was $2,103. The total budget included the following expenditures:

$228 - Phone calls to get insurance information initially. This amount was based on a rate of $0.12 for 650 local phone calls, and $3 for 50 long-distance phone calls.

$250 - Printing standardized forms for Part II of the insurance benefit manual; 1,000 forms at the rate of $0.25 each.

$350 - Printing Part I of the insurance benefit manual at De Paul Sertoma Industries Printshop; 15 copies at the rate of $20.

$525 - Printing 3 copies of the benefit sheets included in Part II of this manual; 2,100 sheets at the rate of $0.25 each.

$750 - Reserve fund to keep project updated during the course of the next year; this included the cost of developing and adding new benefit sheets to the manual.

The total expenditures for this project came out of the operating budget for the accounting department and business office of De Paul Rehabilitation Hospital.

Summary

Chapter one was designed to give the readers an overview of why and how the manual was developed and subsequently how it was evaluated. The readers became acquainted with DPRH and the unique characteristics at this facility which necessitated and effected the implementation of this project.
In the second chapter, the literary review, the subjects of insurance, technical writing, and time studies were discussed. The historical, psychological, philosophical, and sociological foundations of these subjects were explained as well as the impact they had on the project being developed and carried out the way it was.

The third chapter described the methods of statistical analysis used to evaluate the manual in terms of its usefulness, time saving elements, and accuracy. The researcher indicated problems which occurred in the project and made suggestions for future projects of this nature. Finally, in the appendix for this chapter, a copy of the insurance benefit manual developed for use in the business office at DPRAH was included.
CHAPTER TWO

Introduction

The purpose of this project was to develop an insurance benefit manual for use in the business office at DPRH. This manual would reduce the time previously spent on obtaining insurance coverage information for patients being serviced at this facility. It was proposed that time spent on insurance verifications would possibly be minimized by referring to the insurance benefit manual instead of making a phone call to an insurance company or a patient's employer. To test this proposal, the insurance phone calls going out of DPRH's business office for one month prior to, (August, 1983) and one month after the implementation of this manual (September, 1983) were monitored, the time spent on insurance verifications during each of these months was recorded, and the changes which occurred were analyzed.

To undertake this project, literature was reviewed in the subject areas of insurance, technical writing, and time studies. Discussions of these subjects were covered in three separate sections of the review chapter. The historical, philosophical, psychological, and sociological foundations of these categories were then addressed. Issues within the foundations areas which were relevant to the development of the insurance benefit manual and how it would be tested for its effectiveness were also discussed by the researcher.
SECTION ONE

Insurance

Literature needed to be reviewed on insurance so an effective manual could be developed. In Chapter I of this thesis, health insurance was defined as that which provides protection against expenses and income losses caused by illness or injury. The general field of insurance was examined first so that a better understanding could be gained about the significance of health insurance.

The historical significance of insurance in general was traced back by Gayle E. Richardson, in her book, *Am I Covered or Everything You Wanted to Know About Insurance But Didn't Know How to Ask*, to almost the beginning of time when people evolved from living in caves and began forming communities. When primitive people hunted for food, they went in groups as a source of protection against the prey they sought. This was the beginning of insurance in its most primitive form.

As people began to trade, acquire property, and develop beyond the primitive stages of civilization, more concrete evidence of insurance emerged. The first form of insurance can be traced back to Chinese merchants living 3,000 to 4,000 years B.C. These merchants decided to limit the risks each shipment faced on the sea by distributing each cargo of goods among all the vessels.

In 2,500 B.C., the Babylonian Empire under Hammurabi's Code of Law also had a form of insurance. If bandits attacked a caravan and stole a trader's goods, the trader didn't have to repay money borrowed to buy the goods. In this way, risk transferred from the merchant to the per-
son lending him the money and the money lenders in turn increased interest to merchants.

By 2,000 B.C., the Phoenicians had heard of Hammurabi's Code upon trading with the Babylonians. They expanded insurance by writing up contracts providing financial protection for ships and cargo. Merchants promised to transport cargo as quickly and safely as possible in return for a loan.

During the Middle Ages, in the Kingdom of Lombard, in Italy, merchants living in the 6th Century left the lower Elbe River and invaded northern Italy where they established themselves as merchants, shippers, and financiers. During the 11th Century, many of these people migrated to London, England and went into business insuring maritime traders. This was significant because they established merchant courts to settle insurance controversies. Committees of arbitration were used to assist in settling these controversies. The General Law Merchant evolved from the merchant courts and committees of arbitration. This later became the basis of European Common Law.

These maritime insurance contracts made it possible for money lenders to reduce the insurance rates charged. Contracts were written in groups on several hundred ships so loss would not be so great to one lender. The lender in turn was able to cut the interest rates charged to borrowers. This lowered the cost of consumer goods.

In 1688, Lloyd's of London had its beginnings when Edward Lloyd formed a Coffeehouse in London. Sea captains, merchants, foreign traders, and customers of Lloyd's arranged insurance for ships, cargoes, and underwriters.
Life insurance evolved shortly afterwards. In 1757, King George II of England asked to have a charter approved for a life insurance company, but it was denied.\(^{10}\) In 1761, the Equitable Life Assurance Society was formed by voluntary partnership. This idea did not spread in the United States until after 1840 because religious prejudice prevented this from happening sooner.

In 1759, Philadelphian and New York Presbyterian Synods formed the first life insurance policies in the United States but there was not rapid progress until between the years 1842 and 1870.\(^ {11}\) Mutual Life Insurance of New York was formed in 1843.

New forms of insurance protection evolved parallel to technological advances in the United States. As American industries and the economy grew, store and factory owners faced greater losses from damage suits from people injured on premises and employees at work.\(^ {12}\) Between 1850 and 1900, many companies were organized for this.

Between 1900 and 1911, worker's compensation laws emerged in the United States by which workers became eligible to receive a percentage of their wages if injured on the job.\(^ {13}\) Most states now require extensive medical benefits under these laws.

In the 1920s during the crime era, insurance against property loss emerged. Specific types of health insurance such as Blue Cross/Blue Shield and Commercial insurance developed after the Great Depression.\(^ {14}\)

Blue Cross originated at Baylor University Hospital in Texas in 1929.\(^ {15}\) A group of Dallas teachers got together that year and asked if they could secure hospital care on a guaranteed pre-paid basis. Blue Cross insurance plans spread in many states during the 1930s after the
stock market crash to guarantee payment of bills. These plans were put together by hospital administrators to share hospital costs among the sick and healthy. By 1939, Blue Cross plans covered 4,000,000 people in the United States.

Blue Shield originated in the Western United States in logging camps in California, Oregon, and Washington where these companies contracted for medical services with doctors. Medical bureaus were formed and these companies paid in advance for medical services. The loggers in turn were allowed to seek out their own doctors and were compensated for this.

Commercial insurance grew out of accident insurance in the mid-19th Century and in the beginning was very profit oriented. It is interesting to note that before the 1930s it was not profitable enough for many commercial carriers to be interested in health insurance, but by 1935, because of increased social demands, 38,000 American employees were covered under commercial health insurance plans.

Medicare and Medicaid evolved in the United States during the Johnson Administration. Medicare Part A was founded in 1965 to provide protection against hospital inpatient services and post-hospital extended care facilities and some health agency services. Part B was established to cover doctor's services, outpatient care, lab work, and home care. Medicare was established as a federal program and Medicaid was left to the states. Medicare and Medicaid were established to provide health care for the poor, old people, dependent children, and those who could not afford to pay health care costs.

Historically, many of these health insurance plans excluded cover-
age for alcoholism and drug addiction.\textsuperscript{19} It is just more recently that alcoholism, drug addiction, and mental illness have become payable illnesses by insurance companies. This still varies from state to state.

During the 1970s, some states passed laws which mandated coverage for alcoholism, drug addiction, and mental illness. The state of Wisconsin legislature ratified coverage for these diagnoses during May, 1976.\textsuperscript{20}

Section 632.89 of the Wisconsin Statutes dated May, 1976 "mandates coverage in some circumstances for inpatient and outpatient hospital treatment of alcoholism, drug abuse, and mental and nervous disorders."\textsuperscript{21} This law applies to group insurance policies only, and contracts issued in Wisconsin "which provide hospital treatment coverage and to comparable policies issued to a group based in another state if more than 25 percent of the insured persons are Wisconsin residents."\textsuperscript{22} This law requires a minimum of 30 days of inpatient benefits to be paid the same as any other illness, for these conditions and a minimum of $500 be paid in full on an outpatient basis each calendar year.

Insurance, health insurance, and coverage for alcoholism and drug addiction within the State of Wisconsin have now been discussed historically. The philosophical foundations of health insurance were found to be parallel to the historical ones.

Richardson stated that insurance provides protection against the uncertainties of human existence faced by people since the beginning of time.\textsuperscript{23} "By the very essence of living, all degrees of life are exposed to some peril. Insurance serves to decrease losses caused by these perils."\textsuperscript{24}
Edwin Hoyt contended that health insurance in the United States was formed for the mutual protection and public responsibility for the health of American citizens.25 This was the basic philosophy under which health insurance spread and grew so rapidly during the 1930s.

Robert I. Mehr and Emerson Cammack believed health insurance was established to assure the quality of American life by providing relief from extensive financial loss.26 Because of health insurance, losses were traditionally redistributed more equitably.

The psychological foundations of insurance and health insurance were related to the philosophical foundations. Richardson contended that insurance served to help control uncertainty for individuals.27 It provided an individual with some type of financial security. Mehr and Cammack agreed with Richardson. They saw insurance as a way losses got redistributed so that a group of people shared them.28 Thus, no individual was made to suffer financial losses he could not afford.

One author stated that health insurance should do more than this on an individual basis. With rising health-care costs, it is the responsibility of each individual person to become familiar with medical insurance coverage and analyze the benefits provided under the terms of a given policy.29 If gaps or weaknesses are then found, a better group policy or supplemental coverage policy should be considered. Some items that need to be considered in evaluating a medical insurance policy are: outpatient benefits payable at least at 80 percent without a high dollar deductible amount; plans providing coverage for a wide range of surgical procedures, illnesses, and diseases from the date they become effective; major medical plans that pay beyond a specified day limit in the event...
of a chronic condition or serious illness; plans that minimize out-of-pocket expenditures to be incurred by an individual or family; policies that have been reviewed by the proper state or federal authorities; and the maximum benefits allowed as the Health Insurance Association of America recommended $250,000 be allowed for each person covered by a policy.

Health insurance was addressed on the individual level. Next, health insurance needed to be looked at on the societal and organizational level.

Sociologically, insurance was found to help solve complex social problems. It was also traditionally the basis of the credit system and thought to relieve worry. Financially speaking, insurance in the past contributed to the national economy by decreasing the chance of loss and providing a channel for investible funds. Finally, it was stated that it consumed much labor capital and space.

There is however increasing evidence that health insurance is currently not adhering to many of the historical, philosophical, psychological, and sociological principles upon which it was formerly based in the United States. Hoyt believed that health insurance as it existed was inadequate. He contended Blue Cross plans varied too widely as some did not cover pre-existing conditions, some plans also had 270-day waiting periods, and alcoholism and drug addiction were excluded in many of them. Commercial insurance, he stated, had also failed in that many commercial mail order plans had two year pre-existing clauses and one year waiting periods. If a person could not pay the insurance premium, the health protection was lost. Hoyt further saw a big
discrimination in health insurance in that the person who didn't work for a big company paid more for it and was covered for less than a person who worked for a large corporation.

Tony Cohen in "Voodoo Medical Economics" in the March 19, 1983 issue of The Nation also espoused that health insurance is not providing the care it was intended to when it was established in the United States. "The cost of medical care has gotten so steep in the past decade that only people with group health insurance policies and the affluent can afford private treatment for anything worse than the minor cold." 32

Also, the current scope of insurance in the United States indicates that while most Americans are covered by health insurance, there are still a significant amount of Americans without it. "More than 187 million Americans have health insurance. But as many as 30 million have none. If you don't have money, you can't get into most health care facilities." 33

Also, there appear to be some myths Americans have about health insurance coverage and payments for hospital bills. Americans figure medical insurance is supposed to work and pay the entire bill, but very rarely does it work this way.

About 85% of the U.S. population is covered by health insurance; group plans through employers, unions, trade associations, or professional societies, individual policies and government paid Medicare or Medicaid. Nonetheless, 7.5 million families this year will spend at least 10% of their income on uninsured medical expenses. In addition, millions of middle class as well as poor people would be financially dev­astated if struck by a catastrophic illness or chronic disease requiring long-term treatment. 34

Furthermore, Americans have traditionally viewed health care and
health insurance as rights rather than privileges.

It goes well with the notion that a society can be fairly judged by the way it treats its citizens. But like any other right in a free society, this one has limits, and we need a common approach that respects those limits. Otherwise, the costs will continue to climb, and the nation will be propelled to a two-tier system in which the indigent may receive less than the necessary quality of care, and people who need the largest amounts will be driven to the wall.35

Richardson, a Certified Life Insurance Underwriter, did not see many problems with the health insurance system as it had evolved in the United States. She felt people could still find excellent insurance policies if they looked at what established companies had to offer.36

The writer of this paper agreed with Hoyt, Cohen, Bronson, and Shapiro and accepted as valid what they said about the current situation of health insurance in the United States. These authors indicated that health insurance needs to be reformed because all Americans are not equitably covered by it. They also implied that health care costs are presently quite high in the United States.

Shapiro offered a suggestion on how to contain health care costs in the United States. In his opinion, each American citizen, as well as government, health care professionals, and business are responsible for reducing health care costs.

Individuals need to assume more responsibility for their own health. Health care administrators must recognize they are managing a complex, changing business, that should be run professionally. The president should create a national commission on health care to analyze the overall system. Prevention needs to be emphasized.37

Because this project involved developing an insurance benefit manual
for use at a hospital, it was necessary to address who hospitals should benefit. Herbert Denenberg, a former Insurance Commissioner for the State of Pennsylvania, said, "Most hospitals are community hospitals and are supposed to be run by and for the benefit of the public." He contended patients have rights while they are hospitalized. These include: 1) the right to quality of care, 2) the right to economy of care (in which hospital management operates efficiently and eliminates waste), 3) the right to consumer input and participation in the decision-process (each patient has a voice to be heard in the control and planning of the hospital), 4) the right to access to information and answers about treatment, 5) the right to personal dignity, 6) the right of control of one's body and one's life, 7) the right to action on complaints and problems, 8) the right to disclosure of data about the hospital --(assets, expenses, costs, etc.), 9) the right of disclosure of conflict of interest problems, 10) the right to access to information about the stay and records of the case (including financial and billing information), 11) the right to continuity of care, and 12) the right of consumer advocacy (the hospital should act affirmatively and aggressively to protect the patient and her or his interests rather than to rubberstamp the demands of doctors, also the hospital should provide leadership in improving the health-care for the community).

Insurance monies and their importance to hospitals also needed to be discussed in this paper. Third-party insurance payments provide most of the money received by hospitals. One-third of this money comes from Medicare and Medicaid. Blue Cross/Blue Shield and Commercial insurance also contribute substantially to this revenue.
Many payers don't pay for all services provided and the individual patient is often liable for part of the bill. These payers also differ in the types of benefits they provide. The extent of coverage varies for given sets of benefits.

Social and public policy exists because of this.

From the hospital's viewpoint, the patient must receive the amounts and mix of resources appropriate for his/her care. As far as the purchaser of insurance is concerned, these differences in benefits and coverage permit choices with respect to the risk the individual assumes. Problems arise when risk-maximizing consumers purchase limited coverage and then can not afford to pay the balance of the bill, when this happens, the hospital is at risk for any unpaid balance. A related problem is caused by the income limitations established for participation in government programs.

Hospitals are expected to provide appropriate care to all people in need of their services. Therefore, these institutions must obtain sufficient funds to cover the reasonable costs of providing care. There is a revenue shortage if the cost of debt-collection is greater than the revenue that can be recovered.

In this first section on insurance, several foundational issues were addressed. Insurance was discussed as it evolved and expanded over the years. Current problems facing health care and insurance were also exposed. It was also mentioned that patients have rights while they are hospitalized which include access to financial information. Hospitals can provide better financial information if they have a benefit manual to refer to.
David Fear stressed the psychology of language usage. Words have a variety of different meanings to different people. Therefore, the technical writer must supply the necessary details to give the readers clear, usable understanding.

Weisman emphasized the psychology of human relations approach to technical writing. The writer should use "You psychology" and put one's self in the reader's shoes as facts and attitudes are communicated. This approach shows the writer has the advantage of the knowledge of human behavior and understands human relationships.

In his later edition, Weisman also expounded on the psychology of language. Since man through countless generations has conventionalized and developed the system of symbolic painting which we call language, we can all generally find suitable words to direct other people's attention to what we wish, provided that is the commonplace thing of life that we wish to direct their attention to.

There are three elements of communication: the communicator, the thought or message communicated, and the person receiving the message. As such, the communication system can be no better than the poorest link because each person is both an encoder and decoder receiving and transmitting messages only within the framework of his/her experience and knowledge.

The sociological significance of technical writing to Weisman was that it enabled people to record and communicate experience and knowledge. Because of this written experience, each generation was able to pick up where the other one left off. Further growth and progress was
thus stimulated by technical writing so we could continuously move ahead rather than behind.

Weisman also elaborated on the social importance of communication. Communication is the way information is exchanged. The word itself has Latin origins meaning between cells of the same organism. Commonness is implied by communication. We share commonality which is the basis of social existence. Communication is "basic to the development of the individual, to the formation and healthy existence of groups, and to the functioning interrelations among groups, organizations, cities, and nations." Communication then links person to person, every person to the group, and the group to a larger, encompassing social structure.

Technical writing is a part of this communication. "Technical correspondence is a channel in which we live, warm-blooded human beings share experiences, exchange thoughts and ideas, and persuade one another to take or not take a course of action."

Experiences, feelings, and thoughts are communicated through language. Anthropologists tell us language brought about the birth of civilization. Weisman said Aldous Huxley observed that human behavior as we know it became possible only with the establishment of relatively stable systems or relationships between things and events on the one hand and words on the other. Behavior is not human in societies where no such relationships have been established, that is to say, where there is no language. Only language makes it possible for man to build up the social heritage of accumulated skill, knowledge, and wisdom and enables man to profit by the experience of past generations as though it were his own. Man's mastery over reality, both technical and social, depends on his knowledge of how to use words.
In this section, the foundations issues of technical writing were addressed. Several of these issues related technical writing to communication. Communication was seen as being basic to the function of an organization. The manual served to communicate patients' financial information at DPRH. This was important to the organization's function to rehabilitate chemically dependent patients and their families.

SECTION THREE

Time Studies

Barnes noted the time study originated by Taylor to determine the time standards required to perform a given task. As part of the proposed project was evaluated by a time study, it was logical to include a section on this subject in Chapter II.

Historically, Barnes traced many of the time study techniques utilized by Taylor at the Midvale Steel Plant after he began working there in 1878. At Midvale, Taylor proposed scientific management, invented high speed steel, and conducted shoveling experiments. These endeavors were significant in that because of them, methods were developed to perform each task as quickly and efficiently as possible.

A field of study often found in conjunction with time study is motion study. Motion study was a concept originated by Gilbreth to improve the methods in which tasks were performed. Gilbreth was a building contractor who in the early 1900s had his own business. He discovered that no two men did work the same way. Photography was important in Gilbreth's motion studies. He would take pictures of elements of an operation using a timing device to then find the most efficient method
of performing it. Gilbreth felt it was important to look at the human factor as well as the materials, tools, and equipment involved in a particular duty or task.

In the early days, time studies were used more frequently than motion studies. There was a movement during the 1930s to find simpler and better ways of doing work. Motion and time studies were used together in that time period. These studies were also very popular during World War II years in factories that produced war materials.

The scope of time studies became much broader in the early 1960s as office work had more than doubled by then. Time study then became synonymous with work measurement and motion study with methods design. Ideal and practical ways of performing tasks were found by defining a problem and then logically finding the solution.

Time and motion studies have since expanded to banks, department stores, supermarkets, and even more recently to hospitals.

Some professional lasting societies which were formed because of Taylor's and Gilbreth's endeavors include The American Society of Mechanical Engineers, The Conference of Scientific Management, The Taylor Society, The Society of Industrial Engineers, The Society for the Advancement of Management, and The American Management Association.

Many of the philosophical foundations of time studies can be found in Taylor's original book, The Principles of Scientific Management, which was published in 1916.

The reasons Taylor wrote his book were because, 1) he saw a great loss in the country as we were suffering through inefficiency in our daily acts, 2) the remedy for the inefficiency he believed was in
scientific management rather than searching for extraordinary employees,
and 3) the best form of management, he said was a true science with rules,
laws, and principles, applicable to all human activities, and when
 correctly applied, the results could be astounding.\textsuperscript{76}

To him, the principle objective of management was to secure maximum
prosperity for the employer and the employee. Maximum prosperity meant
"Not only large dividends for company or owner, but the development of
every branch of the business to its highest state of excellence so that
the prosperity may be permanent."\textsuperscript{77}

Taylor also believed many employees in factories worked too slow
and not in the most efficient manner and felt that should be done away
with.

It will be shown later in this paper that doing away
with slow working and soldiering in all its forms and
so arranging the relations between employer and employee
so that each workman will work to his very best advantage
and at his best speed, accompanied by the intimate coop­
eration with the management and the help (which the
workman should receive) from the management, would
result on the average in nearly doubling the output of
each man and each machine.\textsuperscript{78}

Taylor saw three reasons for slow work and inefficiency. These
included, 1) a wide-spread fallacy endorsed by many labor unions at that
time that a material increase in the output of each person or machine in
the trade would result in the end in the throwing of a large number of
people out of work, 2) the defective systems of management which he saw
in common use and made it necessary for each worker to soldier or work
slowly, in order that he might protect his own best interests, and 3) the
inefficient rule of thumb methods which were universal in all trades
that resulted in the worker wasting a large part of effort.\textsuperscript{79}
He believed that engineers and managers should lead in his movement to educate the whole country. He said many employers were ignorant of the proper amount of time in which various kinds of work should be completed.  

The enormous saving of time and therefore increase in the output which it is possible to effect through eliminating unnecessary motions and substituting fast for slow and inefficient motions for the men working in any of our trades can be fully realized only after one has personally seen the improvement which results from a thorough motion and time study, made by a competent man.  

Although tradesmen had many ways for doing the same thing using a variety of implements, there was always one method and one implement which was better and quicker than any of the rest. This method could only be found by a scientific study and analysis of all the methods and implements in use together with an accurate, precise motion and time study.  

Under the old rule of thumb type of management, each workman had the final responsibility for doing the job as he thought best with little help from management in doing so. Under scientific management, there was an equal division of labor between management and the workers. Management was to help and guide the workers and to assume responsibility for their results. Preparatory acts would then be taken by management, so the workers could be quicker and better than they otherwise would be. A close, intimate, personal cooperation could then be achieved between labor and management.  

Under scientific management, managers assumed new duties and responsibilities including the development of science for each element of work,
the selection, training, education, and development of each employee, cooperation with subordinates to assure all work is being done in accordance with the principles of science, and planning ahead the work for each employee and the department. Management would also encourage workmen to suggest improvements in both methods and implements. Then, these new methods would be analyzed by conducting experiments to determine their relative merits.

In summary, the four great underlying principles of scientific management were: 1) the development of a true science, 2) the scientific selection of the workman, 3) the scientific education and development of the workman, and 4) intimate, friendly cooperation between management and the workman. Scientific management was constituted by: 1) the use of science, not rule of thumb, 2) harmony not discord, 3) cooperation not individualism, 4) maximum output in place of restricted output, and 5) the development of each man to his greatest efficiency and prosperity.

Also, Taylor saw the rights of the American people over the rights of the employer or employee. Of this, he said, "The whole people receive the greater part of the benefit coming from industrial improvement." Taylor used comparatively, simple analyses in his time study experiments. He studied the movements required by the workmen to do small parts of their work by the use of a stop-watch and ruled notebook.

He recommended that five steps be used in conducting a time study:

1. Find ten or fifteen men especially skilled in doing the particular work to be analyzed.
2. Study the series of elementary operations or motions which each of these men uses in doing the work.
3. Study with a stop-watch the time required to make each movement and then select the quickest way of doing each element of the work.

4. Eliminate all false movements, slow movements, and useless movements.

5. Now collect into one series the quickest and best movements as well as the best implements. 88

Barnes, a more recent theorist in the field of time studies, expounded further on time study techniques. Five steps were proposed by him to be included in a time study:

1. Develop the preferred method by giving consideration to the entire system and to each individual operation which would go to make up the system by using a problem-solving approach.

2. Analyze the problem by obtaining the facts. Describe the present activity if it is already in effect.

3. Search for possible solutions; use creative imagination and elimination approaches.

4. Evaluate the alternatives by determining the preferred solution; that based on lowest cost or quickest method.

5. Recommend findings for action by preparing written reports. Allow questions to be asked. 89

Barnes said that in a time study, many times the person solving the problem wouldn't be the one to recommend it for future action or approval. 90 Therefore, it needed to be communicated well, straightforward, logically, and concisely. Then a solution should be followed up and restudied for improvement. In most businesses and industries, there could be no final solution to a given problem; a given solution was just put into effect until a better one could be found.
A more recent theorist, Mundel believed time and motion studies could enhance an organization's productivity and effectiveness.

Productivity was defined as "the ratio of units of output per unit of input," and effectiveness as "the success of an organization in achieving its objectives." Mundel also saw managerial uses for time studies.

Motion and time study may well be used to provide a means for communication and cooperative activity among the various divisions of an organization in selecting, planning, or designing, and controlling the proper integration of materials, design of product or work achieved, process, tools, workplaces, and human activity. Motion and time study techniques are aids for systematically performing certain managerial tasks.

The psychological significance of a time study is that it is a systematic approach affecting an individual's work. Time studies focus on the effective utilization of an individual in industry. Everything about the individual doing the job and the job itself must be questioned when a time study is being conducted. Questions which need to be answered include: 1) What is done? Why should it be done? 2) Who does the work? Why does this person do it? Who can do it better? Can a person with less skill do it if changes are made? 3) Where is the work done? Why is it done there? Can it be done somewhere else? 4) When is the work done? Why should it be done? Would it be better to do it some other time? 5) How is the work done? Why is it done this way?

Different people could be affected differently by time and motion studies depending on their past experiences, mental outlooks, social relationships, and general economic conditions. Time studies often change substitutes as the known is sometimes traded for the unknown.
This sometimes results in fear. Attitudes too, often are involved. These could include real or imagined economic aspects of change, criticisms of past organizational practices, and innovations found. The psychology of human relations is deeply involved with time studies. There is a need for successful communication within the organization on individual, departmental, interdepartmental, and organizational levels. Motivation should also be involved with time studies as there is a need for active acceptance of the changes they may produce. A great deal of understanding should exist between those doing the study and those who will be affected by it.

The sociological significance of time studies is that if working hours are unproductive society loses out. It must, however, be borne in mind that unless working methods continually improve, unless each working hour continually becomes more productive, a society will become economically static; and the standard of living will no longer rise. Indeed, such a condition includes factors that will inevitably depress the standard of living.

Mundel emphasized that motion and time studies may affect many different levels in an organization. In order for time and motion study to achieve fullest and most fruitful use, it must be thought of as a series of techniques applicable to problems affected by all the functions of all the individuals in an organization. ...If the techniques that follow are understood by all concerned, cooperative action for selecting economical operating procedures may take place much more easily than if all the initiative and action originate in a single staff department.

Furthermore, motion and time studies could only be of value if they were carried on in a manner designed to serve the organization's
objectives. The work of a group is usually aided when it has, 1) policies and procedures for routine activities, 2) an adequate reporting system to higher levels of management, and 3) formal and informal training in its field of work.97

Tourlentes stated that at a hospital, when doing a motion and time study, the type of institution it is, as well as where its activities are concentrated should be taken into account.98 Young, who also wrote on productivity-monitoring systems for hospitals, stated the type of patients served must also be taken into account.99 He stated further that these studies could assist several levels of hospital management in making timely and accurate decisions about staffing requirements.

As the process of hospital governance and management has become more sophisticated, hospital executives have realized that traditional work measurement techniques used by production-related industries can be modified and employed in their institution to bring objectivity to the staffing process. As used in a hospital, work measurement is the act of gauging input or output in terms of a common standard, such as hours of care, meals, tests or other units of production. A work-measuring standard provides a basis for expressing work characteristics in quantitative terms. The most frequently used standards are expressed in terms of the time required to complete a task.100

Young described three productivity/time study methods he considered adaptable for hospital use and these included, 1) estimating the time required to perform a given task, 2) a classical time and motion study, and 3) a historical data evaluation approach.101 He was critical of method one because it is difficult to estimate the time required to perform a given task.102 This is often a subjective, inaccurate process. Therefore, it was not recommended for use at a hospital.
Method two was seen by Young as being the most accurate of the three techniques. This was the original technique proposed by Taylor and Gilbreth which was discussed in detail earlier in this paper. Young proposed a series of time observations in this approach. However, he said it could involve a complex process as it usually involved personnel with specialized training in time and motion study techniques. Several months could be involved in conjunction with a time study because much data would need to be collected and adjusted before standards could be set.

Method three was seen by Young as the most desirable for hospitals. Essentially, it involved the development of a data base of hospital productivity results from an individual cost center. The data base would include the total hours worked during a given time period divided by the total production units per period. Then in each department, a productivity standard would be set to show improvement over past productivity.

For this project, method three was not applicable because the emphasis was not on setting a productivity standard for the business office or the whole hospital. Accuracy was high on the priority list. The type of patients served by DPRH was also taken into account. A time study approach was thus decided upon to be used in evaluating the effectiveness of the project.

In this section the foundations issues concerning time studies were discussed. The concept as originally proposed by Taylor was expressed at some length. Changes in time and motion studies as they occurred over the years were also emphasized. Finally, the impact of productivity/
time studies on hospitals was also addressed.

Summary

This literature review addressed the foundation issues related to insurance, technical writing, and time studies.

The evolution of insurance in the United States was traced in Section I. Some of the problems the current health insurance system faces were also discussed. State laws as they pertain to alcoholism, drug addiction, and nervous/mental disorders were explained. The rights of patients while they are hospitalized were explored. Some emphasis was also given to the importance of insurance revenues to hospitals.

In Section II, the growth of the field of technical writing in the United States since World War II was explained. The need for the technical writer to constantly consider the audience was stressed. The psychology of language and human relations was emphasized. Communication was also addressed as it related to the function of groups and organizations.

Section III showed how time studies originated with Taylor at Midvale Steel. Taylor's philosophy on time studies and scientific management was explained. Methods of conducting time studies were also discussed. The effects of these studies on individuals and within organizations were addressed. Examples of how to conduct productivity/time studies at hospitals were given by Young.

All the above-mentioned issues were significant to the proposed project of developing an insurance benefit manual for use in the business office at DPRH and then later evaluating it. Such a project could not
have been undertaken without addressing them! More specific information on how some of these issues affected the manual and the time study conducted during August and September, 1983, can be found in Chapter 3.
CHAPTER THREE

Historical Review of Project

Purpose

Throughout this project, an insurance benefit manual was developed for use in the business office at DPRH to provide assistance in making financial plans for patients' treatment needs. (DPRH is a specialty hospital for alcoholism and drug addiction in Milwaukee, Wisconsin.)

The project was also implemented to decrease the amount of time previously utilized to verify insurance, in which a phone call was made to the employer or insurance carrier of each patient admitted. It had been proposed that this time could be minimized by referring to the manual instead of making a phone call for each verification.

There were three hypotheses this project was based on. These included, 1) an insurance benefit manual would be utilized for at least 25 percent of the verifications after the first month it was introduced, 2) after the manual was in use for one month, the time spent on verifications would decrease by 20 percent, and 3) accuracy of information within the proposed manual could be maintained at 95 percent. Essentially, then, it was believed, such a manual could be useful, save a significant amount of time, and remain accurate.

Participants

The researcher was the main participant in this project as she conducted the activities to develop and evaluate the manual. Being the insurance specialist at De Paul and having almost five years of
experience with health insurance as it pertained to alcoholism and drug addiction enabled the researcher to undertake the project. Assistance was provided by Mrs. Winifred LaFond, the controller at DPRH, who had over twenty years of experience in hospital administration. Pat Johnson, the project typist, typed Part I of the manual. Benefit pages contained in Part II of the manual were typed by Caroline Widmer, an employee in the business office at DPRH, and the researcher.

Those benefitting from the project by being able to directly use the manual were employees in the business office having billing and accounts receivable responsibilities. Other departments such as Admitting, Inpatient, and Outpatient also benefitted somewhat from the project. Because of the manual, these departments received some basic insurance information to use as a financial guide in planning patients' treatment programs.

Implementation of Activities

Materials (i.e., copies of insurance verifications on file, insurance handbooks, and contacts with staff members from business offices in other specialty hospitals within the Milwaukee area) were gathered to develop the manual between November, 1982 and September, 1983. During two "target" months; August, 1983 (one month prior to the introduction of the manual), and September, 1983 (one month after the implementation of a draft of the manual), the phone calls going out of the business office were monitored, the time spent on insurance verifications was recorded, and the differences were analyzed. Periodically, payments received on patient accounts were compared with benefit sheets.
within the manual to "check" the project for accuracy. Final copies of the manual were printed and distributed in November, 1983.

Presentation of Findings

Evaluation Design

<table>
<thead>
<tr>
<th>Use of Manual</th>
<th>Time to Verify</th>
</tr>
</thead>
<tbody>
<tr>
<td>(old method) August</td>
<td></td>
</tr>
<tr>
<td>(new method) September</td>
<td></td>
</tr>
</tbody>
</table>

Manual Accuracy

Basically, a before and after effect was used to evaluate the project. A time study was conducted to determine the length of time to verify insurance using phone calls (the old method) for one month. The next month, the insurance manual (the new method) was introduced. The length of time required for verifications was also determined for that month. Then, results were analyzed to determine the usefulness of the manual in verifying insurance coverage and whether a significant amount of time could be saved by referring to it or not.

It was also important to evaluate the accuracy of the manual. To do this, a comparison was made between benefit sheets and insurance payments received, periodically, i.e., every two months. Discrepancies were noted and the degree of accuracy maintained was then computed.

Evaluation Objectives

There were three evaluation objectives established to determine the project's effectiveness. These included:

1. By October 1, 1983, the business office at DPRH was able to
refer to the insurance benefit manual for 25 percent of the insurance
verifications instead of making a phone call for each patient as
measured by a tally of manual usage and phone calls made during August
and September, 1983.

2. By October 1, 1983, the time spent on insurance verifications
decreased by 20 percent as measured by a count of the minutes and seconds
used to verify insurance before and during the implementation of the
project.

3. By October 1, 1983, the information contained within the manual
was 95 percent accurate as measured by a comparison of insurance pay­
mements received on patient accounts and the benefit information within it.

To evaluate this project, some instruments were used. These in­
cluded a chronograph to time verifications, a phone-monitoring sheet
designed by the researcher to record time spent on each phone call, and
a notebook to record manual usage in September. To determine the
manual's accuracy, a notebook was used to record discrepancies which
were found.

Findings for Each Evaluation Question

EVALUATION QUESTION 1: By October 1, 1983, the business office was able
to refer to the manual for 25 percent of the insurance verifications
instead of making a phone call for each patient being serviced.

The phone monitoring form and the notebook on manual usage assisted
in answering this question. Results of each of these instruments were
tallied.

During August, there were 199 phone calls made to verify insurance
coverage. (Since the manual was not used in August, all verifications were done by phone.)

Table 1 shows the number of times the manual was used to verify insurance coverage during September, 1983 compared to the number of times a phone call had to be made to do so.

Table 1. Comparison between manual and phone use for verifications during September, 1983

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Calls</th>
<th>Times Manual was Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>9-1</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>9-2</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>9-3</td>
<td>NONE</td>
<td>NONE</td>
</tr>
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Table 1. - cont'd

<table>
<thead>
<tr>
<th>Date</th>
<th>Number of Calls</th>
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<td>9-30</td>
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<td>9</td>
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<tr>
<td>TOTALS</td>
<td>257</td>
<td>148</td>
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</table>

During September, 1983, there were 257 verifications. For 109 of these, the manual was used. By October 1, 1983, the manual could be used for 42.4% of the verifications.

EVALUATION QUESTION 2: By October 1, 1983, the time spent on insurance verifications decreased by 20 percent as measured by a count of the minutes and seconds used to verify insurance before and during the implementation of the project.
The chronograph, phone-monitoring form, and manual-usage notebook were used to examine this question. Total time was tallied for each month. Calculations were then made based on the percentage of time decrease between the two months.

During August, phone calls amounted to 1,273 minutes and 30 seconds. For September, both phone calls and manual usage totalled 922 minutes and 47 seconds. This indicated a decrease of 27.6% by October 1, 1983.

Further evaluation of this objective was reached by calculating the average length of time it took to verify insurance coverage during August and September. Table 2 shows the results of this comparison.

**Table 2. Comparison of average length of time to verify insurance during August and September, 1983.**

<table>
<thead>
<tr>
<th>Total minutes and seconds used to verify coverage.</th>
<th>August</th>
<th>September</th>
</tr>
</thead>
<tbody>
<tr>
<td>1273 min. 30 sec.</td>
<td>922 min. 47 sec.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Total number of verifications.</th>
<th>199</th>
<th>257</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average length of time required to verify coverage</td>
<td>6 min. 40 sec.</td>
<td>3 min. 59 sec.</td>
</tr>
</tbody>
</table>

There was a decrease of 2 minutes and 41 seconds on the average to verify insurance in September compared to August, 1983. On the average, this amounted to a decrease of 45 percent.

EVALUATION QUESTION 3: By October 1, 1983, the information contained in the manual was 95 percent accurate as measured by a comparison of insurance payments received on patient accounts and the benefit pages within it.
A notebook where discrepancies were noted was helpful in evaluating this question.

The manual was found to be 95 percent accurate when benefit sheets and insurance payments were compared during January, March, May, July, and September, 1983.

Conclusions

STATEMENT OF EVALUATION QUESTION 1: By October 1, 1983, the business office was able to refer to the insurance benefit manual for 25 percent of the verifications instead of making a phone call for each patient.

Description of Results. This objective had significant results. The manual was used for 17.4% more of the verifications than originally hypothesized.

For insurance verification purposes, the manual had proved to be useful. At the end of one month, it could be used for more than one-third of the verifications.

It can be concluded from these results that an insurance benefit manual can be useful for a specialty hospital in verifying coverage for the patients it serves. Furthermore, such a manual can serve as a direct guide in making financial plans for patients' treatment needs.

STATEMENT OF EVALUATION QUESTION 2: By October 1, 1983, the time spent on insurance verifications decreased by 20 percent as measured by a count of the minutes and seconds used to verify insurance before and during the implementation of the project.

Description of Results. As the total time spent on insurance verifications decreased by 27.6% at the end of September, 1983, this
objective was surpassed by 7.6%. By taking the average time spent on verifications during August and September, 1983, it can be further stated that the objective was also excelled by 25 percent in some cases. Both of these evaluation statistics were averaged out to then show a composite decrease of 37.4%.

Analyses of this objective demonstrated that the business office saved time by using the insurance benefit manual instead of the telephone to verify coverage. Because of the introduction of the manual, the time spent on insurance verifications decreased during September, 1983.

Specialty hospitals can save time by using an insurance benefit manual to verify coverage instead of making a phone call for each patient.

STATEMENT OF EVALUATION QUESTION 3: By October 1, 1983, the information in the manual was 95 percent accurate as measured by a comparison of insurance payments received on patient accounts and the benefit information given in Part II of it.

Description of Results. The results indicated the manual was 95 percent accurate.

Information was found to be consistently accurate within the manual. Accuracy was maintained throughout the duration of the project.

Furthermore, it can be concluded from this analysis that specialty hospitals can obtain accurate financial information upon referring to a benefit manual instead of making a phone call to verify insurance coverage.
Implications

For Evaluation Question 1

The significant amount of manual usage at the end of September was due to the new method of verifying insurance coverage.

Even though the obtained results were noteworthy, there were implications in the project findings that an insurance benefit manual may never reach 100 percent usage at a specialty hospital. Changes in the patient population were observed from month to month during the time information was gathered to develop the manual. This was one area over which there was not complete control; it can not be completely predicted as to which employers and insurance plans will be representative of the patient population each month. DPRH instituted a new marketing program in Sheboygan County and expanded the impaired professional program during the course of this project. This may account for some of the shift found in the patient population.

It can be implied that an insurance benefit manual is a useful tool in determining the financial aspects of a patient's hospitalization. In most instances, the manual may be a more useful way of determining insurance coverage than always making a phone call to do so. Even though the manual cannot be used 100 percent of the time to verify coverage, it can still be used often. As the benefit pages continue to grow, the manual may prove to be more useful.

For Evaluation Question 2

The results of the comparison between August and September, 1983 in terms of time required to verify insurance coverage showed it took less
time to do so in September than August. Introducing the manual in September resulted in less time being required to verify coverage.

By conducting the analyses of this objective, it was observed also that more patients requested or received services during September than August.

At a specialty hospital, the time traditionally used on insurance verifications can be decreased by the introduction of an insurance benefit manual. However, the trends in the patient population need to be taken into account when conducting a time study at a hospital. This factor may be somewhat indicative of the amount of time it will take to verify insurance coverage information.

For Evaluation Question 3

The results of comparing benefit pages within the manual with payments made on patient accounts showed that accurate information can be obtained by using a manual instead of the telephone to verify coverage. Reviewing the benefit pages with payments received and correcting discrepancies limited the amount of errors. This strengthened the accuracy of the project.

Hospitals can maintain the accuracy of information within benefit manuals by reviewing and updating them periodically. Results of this analysis indicated further that no matter which way insurance was verified, some errors could occur. Information contained on the benefit sheets was obtained by making phone calls initially. Therefore, the human factor involved in communication needs to be taken into account.
Recommendaions

From the results of this study, it is recommended that other specialty hospitals and health care facilities develop and utilize insurance benefit manuals for verification purposes instead of always making a phone call to do so. It was proven that such a manual is useful, saves time, and can remain accurate when reviewed periodically. Because of the success of this research at DPRH, this idea is being considered for implementation at the satellite units in conjunction with St. Anthony's Hospital in Milwaukee and Sacred Heart-St. Mary's Hospital in Tomahawk, Wisconsin. Persons using the manual to determine financial information should have some knowledge about health insurance. Some training may also be required on how to use the manual most effectively. Judgment may be required in some instances in deciding when to verify coverage by telephone and when it is appropriate to use a manual for this purpose; i.e., when a given patient is employed for three months, it is suggested a phone call be made to be sure there is some type of health insurance in effect or no possibility of a rejected claim due to a pre-existing condition.

While some significant time differences could be reported and analyzed in this project, it was felt the total time recorded for insurance verifications during each of the project months may not be completely indicative of the length of time it sometimes takes. A modified time study approach was used in this project as it was believed the phone call aspect of verifications was the most time-consuming and therefore this part of the job could be somewhat eliminated. The paperwork connected with the verification process at DPRH was not taken into
account and perhaps it should have been. Taylor, the originator of
time studies, suggested all the motions connected with a task be studied
and timed to determine the quickest, most efficient way of doing each
element of the work. It is highly recommended that future time
studies of this nature take all steps connected with the job to be ana­
lyzed into account.

Because funding was limited for this project, the researcher con­
ducted the study. For future studies, it is recommended that a person
with more formal training in motion and time study techniques be involved,
at least during the initial phases of setting up the project. Young,
stated time studies were complex as they usually involved personnel
with specialized training in motion and time study techniques.

Trends in the patient population should be studied more carefully
before developing the insurance benefit manual. Although the employers
and insurance plans representative of patients being serviced at the
hospital can never be fully predicted, it may be conducive to consult
with the Research Department (or a research consulting firm if there is
none) ahead of time to determine companies or characteristics of patients
treated within the past year. Then too, if a specialty hospital is
marketing for services in a new area, a meeting with the Director of
Ventures or Development may serve as a guide in determining new benefit
pages that could possibly be incorporated into the manual.

It was discussed earlier that other departments such as Inpatient,
Admitting, and Outpatient were provided with copies of the manual.
This was significant because it was the first time the business office
attempted to communicate insurance information so formally within the
organization. These other departments were pleased with and receptive to this aspect of the project. The total usefulness of the manual to these departments was not measured in this study. Similarly, it was not determined if the manual increased the "insurance knowledge" of any of these people. Future research could be conducted to analyze those points. A control and experimental group or pre-test and post-test questionnaire would be possible methods of evaluating the effectiveness of this part of the project.

In summary then this project entailed developing an insurance benefit manual for use in the business office at DPRH to decrease the time previously spent on verifications.

To undertake this project, literature was reviewed on insurance, technical writing, and time studies. Materials were also gathered to develop the manual between November, 1982 and September, 1983. During two "target" months, August (one month prior to the introduction of the manual), and September (one month after the implementation of the manual), a time study was conducted to evaluate the effectiveness of the project. Accuracy was maintained by comparing payments made on patient accounts with benefit sheets from the manual, noting discrepancies, and correcting the recorded information accordingly. Finally, the manual was printed and distributed in November, 1983.
Endnotes

3 Ralph M. Barnes, Motion and Time Study (New York: John Wiley and Sons, 1963), p. 4.
5 Ibid
6 Ibid
7 Ibid, p. 17.
8 Ibid
9 Ibid
10 Ibid, p. 22.
11 Ibid
12 Ibid
13 Ibid
16 Ibid, p. 57.
17 Ibid, p. 72.
19 Ibid

21 Ibid
22 Ibid, p. 3.
23 Richardson, p. 13.
24 Ibid
25 Hoyt, p. 72.
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28 Mehr & Cammack, p. 3.
30 Mehr & Emerson, p. 8
31 Hoyt, p. 59.
34 Bronson, p. 72.
36 Richardson, p. 43.
37 Shapiro, p. 20.
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41 Ibid
42 Ibid
44 Ibid
46 Ibid
48 Ibid, p. 2.
49 Ibid
50 Ibid, p. 3.
51 Ibid
52 Collins and Tuttle, p. 10.
53 Ibid, p. 11.
54 Ibid, p. 67.
56 Ibid, p. 4.
57 Ibid, p. 5.
59 Collins and Tuttle, p. 16.
62 Ibid
63 Ibid, p. 18.
64 Weisman, 1975, p. 1.
67 Ibid, p. 23.
70 Barnes, p. 83.
72 Ibid
73 Ibid
74 Ibid
75 Ibid

77 Ibid, p. 9.
79 Ibid, p. 16.
80 Ibid, p. 18.
81 Ibid, p. 24
82 Ibid, p. 25.
83 Ibid
84 Ibid, p. 37.
85 Ibid, p. 140.
86 Ibid, p. 117.
87 Ibid
88 Ibid
89 Barnes, p. 5.
90 Ibid, p. 29.
92 Ibid, p. 36.
93 Barnes, p. 9.
94 Mundel, p. 21.
95 Ibid, p. 25.
96 Ibid, p. 28 & 42.
97 Ibid, p. 65.
100 Ibid
101 Ibid
103 Ibid
104 Ibid
105 Taylor, p. 117.
106 Young, p. 48.
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Reiss, John B. "A Conceptual Model of the Case-Based Payment Scheme for New Jersey Hospitals." Health Services Research, (Summer, 1980), 161-175.


Appendixes to Project Thesis
2.

Introduction

Over the years, De Paul Rehabilitation Hospital has grown immensely. As our treatment programs spread further into the Milwaukee community and other outlying areas, the patient population will continue to expand. Within the past year, the patients we serviced were representative of many corporations and health insurance plans in effect. It became apparent that a guide could assist us in making financial plans for these patients and their families. Therefore, an insurance benefit manual was proposed and developed for this purpose.

In this part of the manual, we will take a look at the Wisconsin mandated law as it pertains to alcoholism and drug addiction. Exclusions from this law will be discussed. Some basic health insurance terms will be defined. Health insurance plans pertaining to our patients will also be explained. Finally, alternative health care organizations such as Health Maintenance Organizations, Independent Practice Associations, and Preferred Provider Organizations will be explored.

It is our sincere hope that this manual will be useful to all referring to it.

Winfred D. LaFond
(Contoller)

Bernadette Mervin Kerton
(Business Office)
The Wisconsin Mandated Law*

Section 632.89 of the Wisconsin Statutes dated May 5, 1976, requires insurers to pay for certain inpatient and outpatient benefits for alcoholism, drug addiction, and nervous and mental disorders.

For inpatient treatment for alcoholism and/or drug addiction, a minimum of 30 days must be allowed each calendar year. The benefits must be paid the same way any other illness is paid under the terms of the insurance contract. On an outpatient basis, the first $500 must be payable in full each calendar year.

Inpatient benefits are only required under group plans providing hospital treatment coverage. Outpatient benefits are generally required under group policies providing both hospital and outpatient treatment coverage.

The law as it is written states outpatient services must be provided under the supervision of or referral from a physician. However, referral and supervision are not further defined. Implications are that a physician should initially authorize treatment and periodically see the patient.

Mandated benefits do not apply to: 1) individual insurance policies, 2) federal employee group plans, 3) some self-insured groups, and 4) policies not written in Wisconsin and also those issued to a group based in another state whereby less than 25 percent of the insured persons reside in Wisconsin.

*This section based on information from the State of Wisconsin, Office of the Commissioner of Insurance, Information for Health Care Providers Concerning Mandated Benefits for the Treatment of Alcoholism, Drug Abuse, and Mental and Nervous Disorders.
### Some Health Insurance Terms Defined

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>coinsurance</td>
<td>a portion of medical bills which the insured must share financially with the insurance company</td>
</tr>
<tr>
<td>day maximum</td>
<td>total hospitalization days allowed for a diagnosis</td>
</tr>
<tr>
<td>deductible</td>
<td>an initial amount of money under the terms of a health insurance policy that the insured is liable for</td>
</tr>
<tr>
<td>dependent coverage</td>
<td>spouses and minor children (or college &quot;children&quot;) of the insured person who are also covered on the health policy</td>
</tr>
<tr>
<td>exclusions</td>
<td>conditions, diseases, etc. not covered under the terms of an insurance policy</td>
</tr>
<tr>
<td>group medical coverage</td>
<td>health insurance an individual usually buys through a place of employment, union, or other association</td>
</tr>
<tr>
<td>health insurance</td>
<td>that which provides protection against expenses and income losses arising from (illness or injury) alcoholism and drug addiction at De Paul</td>
</tr>
<tr>
<td>health insurance benefits</td>
<td>the amount of coverage usually specified in terms of days and dollars payable for a given diagnosis or treatment program at De Paul</td>
</tr>
<tr>
<td>insurance contract</td>
<td>the written agreement by which the insurer issues health coverage to a group or individual and the group or individual accepts this health protection</td>
</tr>
<tr>
<td>insurance policy</td>
<td>the certificate of insurance; the document containing the contract made by the health insurance company with the individual or group who is insured.</td>
</tr>
<tr>
<td>insured</td>
<td>the health insurance policyholder</td>
</tr>
<tr>
<td>insurer</td>
<td>the company providing health insurance protection to an individual or group</td>
</tr>
<tr>
<td>major medical plan</td>
<td>a plan offering supplemental coverage after basic benefits are exhausted</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maximum benefits allowed</td>
<td>The total amount of health insurance protection payable per person — often indicated in terms of the life of the contract.</td>
</tr>
<tr>
<td>Pre-existing conditions</td>
<td>Health conditions which began before the health insurance policy went into effect; Under the Wisconsin mandated law, the cause of the disease itself cannot be used as a rejection for a pre-existing condition. Evidence of medical diagnosis or treatment prior to the effective date or proof of symptoms existing prior to the effective date that would cause an ordinary prudent person to seek diagnosis, care or treatment can be used as bases for claim rejections as pre-existing conditions.</td>
</tr>
<tr>
<td>Premium</td>
<td>The fee an individual or group pays within a specified amount of time to continue health insurance coverage.</td>
</tr>
<tr>
<td>Private policy</td>
<td>Health insurance coverage taken out on an individual basis; usually the benefits are more limited under private policies than on group policies.</td>
</tr>
<tr>
<td>Rider</td>
<td>A clause put on an insurance contract excluding or limiting coverage for a health condition known at the time the policy goes into effect — i.e. — if a person has a heart condition, the insurance company may offer coverage for every other disease or illness except the heart condition which would be exclusively written out of the policy.</td>
</tr>
<tr>
<td>Stop-loss</td>
<td>A maximum amount to be incurred by an individual or family (usually in a year) — when met, benefits are then payable in full.</td>
</tr>
<tr>
<td>Waiting periods</td>
<td>Sometimes for pre-existing conditions, health insurance benefits are not available until the policy has been in effect for some time; a common waiting period is 270 days.</td>
</tr>
<tr>
<td>Waivers</td>
<td>When the group buying coverage and the health insurance company agree to have all conditions or diseases payable from the effective date of the contract even if they are pre-existing.</td>
</tr>
</tbody>
</table>
6. Health Insurance Plans

Blue Cross/Blue Shield offers a variety of health care plans to companies and groups. The extent of inpatient and outpatient coverage is not the same under every Blue Cross/Blue Shield contract. On Wisconsin Blue Cross contracts, benefit and claim inquiries should be directed to Provider Services. For out-of-state Blue Cross plans, the home office should be contacted directly to determine available benefits.

Champus provides medical and hospital care to dependents of those on active military duty and retirees from the armed services and their dependents. A picture I.D. card with an effective date on the back and an expiration date on the front should be presented at the time of admission to prove Champus eligibility. Portions of inpatient and outpatient services are payable at De Paul subject to policy provisions.

Commercial Insurance. Several of our patients have commercial health insurance coverage. Under commercial plans, benefits vary widely.

Federal Employee Benefit Plans. We service several government employees. Thorough investigation is required for each of these patients to determine benefits under his/her particular option. Some federal employees are currently covered through Health Maintenance Organizations. In Wisconsin, these include Compcare, Family Health Plan, and Group Cooperative of South Central Wisconsin.

Self-Insured Companies. Some corporations are self-funded. These companies determine their own health insurance benefits. Many of them process their own claims. Others contract with insurance companies and/or benefit claims organizations to administer the health insurance plan.

Unions. Some of the patients receiving services at De Paul are insured through the unions or trade associations they belong to. The benefits and terms of these plans are negotiated through each particular contract.

Government Programs

Patients with no insurance contracts may be eligible for government programs.

51.42 Contract. Community service boards receive state and federal funds to provide services to alcoholics and drug abusers and may contract with hospitals and other agencies to provide services to individuals eligible under the established criteria.

Medicare. Many disabled and elderly people (65 and over) have health insurance through the federal Medicare program. Part A (inpatient) routinely provides acute medical services for withdrawal from alcohol
or drugs and may provide up to 21 days of intermediate care for rehabilitation. Part B (outpatient) provides benefits for active treatment of alcohol or drug abuse. Under Medicare, there is a deductible and then the benefits are payable the same as any other illness.

Wisconsin Medical Assistance Program. Medicaid is a program under which certain benefits are provided to poor and medically indigent people at the option of individual states. Some Medicaid benefits are required under law. Currently, inpatient treatment requires prior authorization of community service boards and is limited to those hospitals which have previously been determined to provide effective treatment in the most cost efficient manner. Outpatient care is limited to $500 of treatment each calendar year. Treatment of alcoholism is limited to certain diagnoses.

Alternative Health Care Organizations

In recent years, some alternative health care organizations have been formed to help contain costs. These organizations include HMOs, IPAs, and PPOs.

Health Maintenance Organizations (HMOs) offer a variety of services to their members. Much of their emphasis is on wellness and prevention. Patients joining HMOs choose from a list of doctors belonging to them. The HMO's affiliated clinics and hospitals must be used for all required medical care. Subsequently, all services requested must have the prior authorization of the HMO.

Independent Practice Associations (IPAs) are formed by groups of doctors. They get together and then authorize service in any hospital. Contracts for services are written between IPAs and hospitals.

Preferred Provider Organizations (PPOs) make arrangements with certain clinics and hospitals. Patients using the recommended facilities receive preferred benefits and rates. Those using other facilities get standard plan benefits.

Below are descriptions of some HMOs, IPAs, and PPOs some of our patients belong to.

Compcare is an HMO/IPA type organization formed in 1971. Blue Cross of Wisconsin currently administers Compcare plans. There are several Compcare units within the greater Milwaukee area. Prior authorization is required from the patient's selected Compcare clinic for all services performed.

Family Health Plan (FHP) is an HMO formed in 1979. Most persons covered through FHP reside in Milwaukee County. Services should be pre-authorized.
Group Health Cooperative is an HMO operating in Dane County by the Madison Family Institute. For Group Health authorizations and referrals, Madison Family Institute should be contacted.

Health Protection Plans (HPPs) are affiliated with Wausau Insurance Company. Several Wisconsin cities have HPPs. Participating HPP physicians must authorize all health services performed.

Maxicare is composed of affiliated, physician owned IPAs. They provide medical services to their enrolled populations. Arrangements are then negotiated with certain hospitals.

Prime Care of Wisconsin is an IPA/HMO plan directed by primary care physicians in several southeastern Wisconsin counties. Patients have open access to all these doctors. Primary care physicians refer patients to hospitals and other specialists.

Wisconsin Education Association (WEA) Insurance Trust is a self-funded trust for teachers which has just formed a PPO with the Jackson Clinic in Madison.

Part II of this manual, which has more specific health insurance information is located in the Business Office. Questions about particular health insurance plans should be directed toward the staff in this department.
INSURANCE GROUP BENEFIT SHEET
Appendix B
(Designed for and Used in Manual Part II)

Name of Company or Group:__________________________________________

Telephone Number:__________________________________________________

Name of Insurance Carrier:___________________________________________

Date Financial Information Obtained:_______________________________

Inpatient Insurance Benefits:________________________________________

Outpatient Insurance Benefits:________________________________________

Send Billing To:____________________________________________________

Additional Comments:______________________________________________
INSURANCE VERIFICATION TELEPHONE MONITORING FORM
Appendix C
(Used in Time-Study Conducted During August and September 1983)

Date: ___________________________  Time: ___________________________
A.M.                               P.M.

Insurance Company, Union, or Corporation Called: ___________________________
City and State: ___________________________
Telephone Number: ___________________________

Amount of Time Utilized to Verify Insurance: ________ Minutes ________ Seconds

Additional Comments: ________________________________________________________

__________________________________________________________________________

__________________________________________________________________________