

Health Benefits Coverage and Types of Health Plans

LEARNING OBJECTIVES

- Understand the core components of health benefits coverage
- Describe the sources of health benefits coverage
- Explain the differences in risk bearing
- Understand the basic health insurer and managed care organization models
- Describe the differences between models

INTRODUCTION

At its simplest, the U.S. healthcare system is made up of five types of people or organizations:

1. *Patients*
2. *Providers*, which include not only doctors and hospitals, but all licensed professionals and medical facilities
3. *Manufacturers*, such as drug and medical device manufacturers as well as the vendors that sell those drugs and devices
4. *Payers*, referring to health insurers and managed care organizations
5. *Regulators*, referring to those who apply the various state and federal laws and regulations

The fundamental obligation of any payer is to manage benefits for healthcare goods and services, meaning which goods and services will be paid for and under which circumstances, how much will be paid by the benefits plan when something is covered, and how much will be paid by the patient who is covered under that plan. This simple description, however, quickly becomes complex in the real world when done by different types of payer organizations.

The generic terms “health plan,” “payer,” and “payer organization” apply to any type of organization that pays for healthcare benefits. A great many different types of payers exist, and defining these different types is an ever-evolving challenge. Thirty years ago, it was relatively easy to distinguish among different types of payers. Back then, health insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) health plans were distinct types of organizations and were identified as such. Later, the broader term “managed care organization” (MCO) came into common use for many different types of plans; this term continues to be used today, albeit less frequently. Around 20 years ago, there was no such thing as a consumer-directed health plan (CDHP), but that entity has joined the fray. The Patient Protection and Affordable Care Act of 2010 (ACA) has directly affected the definitions of health benefits and health plans as well.

The clear distinctions between types of payers have become progressively blurred over time, and organizational elements and features that had appeared previously in only one type of payer have found their way into other types of payers. For all these reasons as well as in recognition of the widespread use of managed care techniques in all types of plans, we will refer to these organizations as “payers,” “MCOs,” “health plans,” or simply “plans” when addressing them broadly, but will identify the specific types of payers when it is important to distinguish between them.

DEFINED BENEFITS, COST SHARING, AND COVERAGE LIMITATIONS

Before describing the different types of payers, it is important to understand the core components in place in any type of health benefits plan. While managing benefits is the fundamental obligation of any type of payer organization, it is important to bear in mind that a health plan does not actually provide health care (with the exception of group and staff model HMOs). It can only manage what services it will and will not pay for, and under which circumstances. In other words, health plans cannot prevent someone from receiving a medical service, but it can determine that this service will or will not be paid for by the plan. This is not to say that health plan benefits coverage policies and decisions have no impact: It is hard to argue that a plan’s denial of coverage for a \$50,000 elective procedure would have no impact on

a person's decision to have that procedure done. Nevertheless, it is critical to keep in mind that health plans manage benefits, meaning payments for medical goods and services, but do not provide the care and cannot actually prevent a doctor from doing a procedure or a patient from getting a treatment, drug, or device.

There are three interrelated core components of healthcare benefits:

- Defined benefits
- Cost sharing
- Coverage limitations

Defined Benefits and Cost Sharing

“Benefits” means that a health plan provides some type of coverage for particular types of medical goods and services, and under particular circumstances. “Cost sharing” means that some amount of a covered benefit is not paid by the plan, but rather is paid out-of-pocket by someone covered under the benefit plan. Each term is a reflection of the other, so they are addressed together here.

Defined Benefits in General

Defined benefits refer to what is covered, and under which circumstances coverage applies. In other words, the actual benefit is defined, regardless of what it ultimately costs to provide coverage for that benefit, although coverage may depend on meeting various requirements. This mechanism differs from a defined contribution benefits plan, which defines a fixed amount of money that may be put toward a benefit. For example, a defined benefit would be coverage of an inpatient stay regardless of cost. A defined contribution, in contrast, would be coverage of only \$250 of the cost of that stay, regardless of what it actually costs. All types of health plans discussed in this text, as well as in the ACA, are defined benefits plans.

Even in a defined benefits plan, the rules and requirements governing when coverage may apply also vary by type of health plan. For example, HMOs typically cover nonemergency services only when they are authorized or when authorization is not required per the HMO's policies; they will not cover the cost of nonemergency care provided by noncontracting providers or nonauthorized costly services. Other plan types may provide some level of coverage for nonemergency care provided by noncontracting providers that HMOs do not, although the amounts and conditions vary by plan type. Coverage may also depend on whether a treatment is considered reasonable based on a person's medical condition, particularly when there is more than one way to treat that condition.

To review a plan's defined benefits, existing members and individuals looking for coverage are required under the ACA to be provided with a standardized

document called the summary of benefits and coverage (SBC), also called a summary of coverage (SOC). This document also summarizes how the plan defines “medical necessity,” meaning how it determines whether coverage is appropriate based on a person’s clinical condition and other factors, as discussed in the *Utilization Management, Quality Management, and Accreditation* chapter.

Defined Benefits Under the ACA

The ACA also defines essential health benefits (EHBs), meaning services or goods that must be covered. EHBs apply to all types of plans, but the amount of cost sharing or levels of coverage may differ for various plans (with one exception—no cost sharing is allowed for preventive and wellness services). Table 2-1 lists the EHBs as defined by the ACA. The ACA also limits plan participation in the insurance exchanges to qualified health plans (QHPs) covering the EHBs. The details of EHBs may differ slightly from state to state for reasons discussed shortly.

State-Mandated Benefits Coverage

In addition to the overall EHBs under the ACA, states have mandated benefits coverage requirements. In other words, state laws may require health plans to cover the costs of certain defined types of care and medical services as well as services provided by certain types of providers. States typically have multiple mandated benefits.

Table 2-1 Essential Health Benefits Under the ACA

Benefit	Cost Sharing Allowed
Ambulatory patient services	Yes
Emergency services	Yes
Hospitalization	Yes
Maternity and newborn care	Yes
Pediatric services	Yes
Preventive and wellness services	No; first-dollar coverage required
Prescription drugs	Yes, but type may differ from cost sharing for medical benefits
Laboratory services	Yes
Mental health and substance use disorder services	Yes, but may <i>not</i> differ from cost sharing for medical benefits
Chronic disease management	Yes
Rehabilitative and habilitative services and devices	Yes

Coverage mandates in the states apply only to insured plans; that is, they do not apply to self-funded plans (the difference between insured and self-funded plans will be described a bit later). Examples of typical state coverage mandates for clinical conditions include in vitro fertilization, cancer screening, and the treatment of autism. Examples of mandates involving types of provider include requirements to cover care provided by chiropractors or by nonphysician mental and behavioral healthcare providers.

Detailed definitions of EHBs are defined by each state, although they must comply with the broader definitions used in the ACA. States construct their unique definitions by looking at the largest commercial plans in the state and basing coverage definitions on their offerings. As a result, mandated benefits are incorporated into coverage sold through the exchanges.

Coverage Mandates for Individuals and Employers

The ACA also addresses defined benefits by requiring almost everyone to be covered under an individual plan, an employer-sponsored plan, Medicare, Medicaid, or some other equivalent benefits plan. This mandate is intended to balance out the guaranteed issue requirement under the ACA, which specifies that health insurers and HMOs must sell coverage to any individual or employer group that requests it, at least during the open enrollment period in each state. Without the mandate that all people obtain coverage, sicker people would seek coverage while healthier people might avoid it, thereby increasing the cost of coverage (money paid in by healthy people covers the costs for sicker people).

These mandates actually refer to potential financial penalties for individuals and for employers that fail to obtain health insurance. There is no enforcement provision in the ACA and failure to pay the penalty is not a crime. However, the Internal Revenue Service, which is charged with determining and enforcing these penalties, can withhold unpaid penalty amounts from any tax refunds.

For individuals, this penalty started out relatively low in 2014, but increases each year until it reaches the greater of \$695 or 2.5% of taxable income in 2016. After 2016, the amount is increased every year by any increase in the overall cost of living. Many exemptions to the individual penalty exist, however, with most being related to low income.

For employers that have 50 or more full-time employees (FTEs) and that do not offer a health plan, if even one FTE receives a tax-credit subsidy for coverage purchased through a health insurance exchange, then the employer must pay a penalty of \$2000 per employee, not counting the first 30 employees. The penalty is even higher for employers with 50 or more FTEs that *do* offer coverage, but where at least one FTE receives the premium tax credit

through an exchange. Employers with fewer than 50 FTEs are exempt from any penalties, but the ACA provides tax incentives to encourage them to offer coverage.

Cost Sharing in General

Cost sharing refers to the amount of money a member must pay out-of-pocket for each type of covered benefit. It applies only to services that are covered by the plan, not to services or goods for which there is no coverage. The three basic types of cost sharing are as follows:

- **Copayment**, meaning a fixed amount of money per type of service—for example, \$30 each time a member goes to the doctor
- **Coinsurance**, meaning a percentage of the total dollar amount that is covered—for example, 20% of what the plan will cover for a hospital stay
- **Deductible**, meaning the amount a member must pay out-of-pocket before coverage begins to apply—for example, a \$1000 deductible for hospital stays, after which coinsurance applies

All three types of cost sharing may be found in a typical health benefits plan. Deductibles and coinsurance may apply to the same benefit, whereas copayments typically apply to services that are not usually subject to a deductible. For example, a visit to a primary care physician (PCP) who is in the network of a PPO may have a \$20 copayment, while a visit to a physician who is not in the network may be subject to a \$500 deductible before the PPO makes any payment, but even then the member must pay 20% of the covered amount as well as any amount over what the plan covers.

Cost sharing may also differ by type of service. For example, PCP visits may have a \$20 copayment, whereas a hospital stay may be subject to a \$1000 deductible and then 10% coinsurance after the deductible is met.

Cost Sharing Under the ACA

The ACA defines levels of allowable cost sharing for QHPs and insured coverage (self-funded plans may be somewhat different). For preventive services, the ACA does not allow any cost sharing at all for any type of plan. For other covered benefits listed in Table 2-1, the ACA defines four basic levels of cost-sharing percentages for EHBs in the individual, group, and insured markets:

- Platinum, defined as 10% or less total cost sharing
- Gold, defined as 20% total cost sharing

- Silver, defined as 30% total cost sharing
- Bronze, defined as 40% total cost sharing

The ACA also defines a special type of benefits plan that may be offered to individuals younger than the age of 30, which has a higher level of cost sharing but a very low premium.

Cost sharing is based on the average total amount of cost sharing for nonemergency services provided by network providers. In other words, it is the combination of copayments, coinsurance, and deductibles—not just one type of cost sharing. It is based on the average total amount of cost sharing for all members, rather than the amount of cost sharing by any particular member. The percentages also reflect how much a plan pays its network providers, such that members who receive nonemergency care from non-network providers are covered only up to the amount a plan would pay based on in-network services. These different tiers apply only to plans sold to individuals and small groups, but all plans must offer at least 60% coverage regardless of plan type.

The ACA also limits the maximum out-of-pocket cost for individuals and for families, after which no further cost sharing may be applied. The dollar amounts are set by the U.S. Treasury Department each year. For example, in 2014, the maximum out-of-pocket costs could be no more than \$6,350 for an individual and \$12,700 for families.

Grandfathered Benefits Plans

Grandfathered health benefits plans refer to plans that were in effect on March 23, 2010, the date of enactment of the ACA. Such plans do not need to comply with all of the ACA's requirements as long as they maintain the grandfathered status. A grandfathered plan loses that status if it changes in any substantial way, such as by changing the benefits or amounts of cost sharing, changing the employee contribution to the cost, or changing insurers.

Grandfathered plans may be exempt from many of the ACA's requirements, but not all of them. Even they must comply with certain requirements, some of which went into effect upon passage of the ACA and others of which went into effect in 2014:

- Grandfathered plans cannot exclude individuals because of a preexisting condition or discriminate based on health status for children younger than age 19.
- They cannot have any lifetime limits on coverage.

- They cannot have any annual limits on coverage.
- They must extend coverage to an employee's dependents until age 26.

Coverage Limitations

Several different types of coverage limitations exist, including the following:

- A benefit may be covered only if it is provided through a contracted provider. For example, a plan that has different levels of coverage for nonemergency services provided by in-network versus out-of-network providers may cover long-term rehabilitative services only when they are provided by a contracted provider.
- The maximum dollar amount of coverage may be based on what the plan pays providers in its network, not what a provider charges.
- Limits may be placed on the number of services or devices covered in a time period. For example, coverage may be limited to one pair of foot orthotics every two years.
- Coverage may be based on medical necessity. For example, the plan may not provide any coverage for care that is experimental or investigational (unless part of an authorized study as defined in the ACA), care that is for the convenience of the patient or provider, and so forth.
- Some services may not be covered under any circumstances. For example, coverage is usually not provided for people who need custodial care because they cannot care for themselves.

In the past, many plans used to limit coverage to a total dollar amount paid in a year, in a person's lifetime, or both. The ACA, however, now prohibits this.

SOURCES OF BENEFITS COVERAGE AND RISK

The sources of benefits coverage refer to where an individual's health benefits come from, while risk refers to who or what is at risk for the cost of payment for those benefits. These two concepts are closely related, but are not identical and are not the same for each group or individual. At its most basic, there are three basic types of coverage sources and three basic types of risk bearing.

Three basic sources of benefits coverage include the following:

- Entitlement programs
- Individual coverage
- Group health benefits plans

Three broad forms of risk bearing include the following:

- Government bears the risk
- Health insurer bears the risk
- Employer bears the risk

These sources of coverage and risk are not mutually exclusive, and health insurance or health benefits coverage for any individual will be some combination of them. Table 2-2 summarizes the sources of coverage and risk.

Sources of Coverage

The sources of coverage refer to where that coverage comes from. This entity may be the company handling the claims, but is not always the same. It is also not always clear what that source is depending on which type of payer is providing the coverage. Nevertheless, the easiest way to consider this issue is to look at these three sources:

- Government entitlement programs
- Individual health insurance
- Employer group health benefits plans, also referred to as group health benefits plans (dropping the word “employer”)

Entitlement Programs

In the United States, the federal and state governments actually pay for more than 40% of healthcare costs. Coverage is provided to anyone who is eligible to

		Sources of Benefits Coverage		
		Entitlement Programs	Individual Coverage	Group Health Benefits Plans
Bears Risk for Costs of Covered Health Benefits	Government	Traditional Medicare and Medicaid	N/A	Military health benefits plans
	Health Insurer	Medicare Advantage, managed Medicaid	Individual Health Insurance	Employment-based group health insurance
	Employer	Retiree health benefits coverage	N/A	Employment-based group health benefits coverage

get it, meaning that person is entitled to that coverage. Government entitlement programs, which may or may not include all or some managed care features, include the following:

- Medicare
- Medicaid
- Military programs (both direct care by military providers and the Tricare program under the Civilian Health and Medical Program of the Uniformed Services [CHAMPUS])
- Veterans Administration
- U.S. Public Health Service
- Indian Health Service

The largest entitlement programs are Medicare and Medicaid. The Centers for Medicare & Medicaid Services (CMS), a branch of the U.S. Department of Health and Human Services (DHHS), administers Medicare. Medicare provides health-care benefits for the elderly, for many individuals with end-stage renal disease, and for individuals with some other conditions and disabilities. The states manage their own Medicaid programs, which rely on state and federal funds and provide healthcare benefits to the poor and many disabled or institutionalized individuals. Managed care techniques have been applied to all types of government programs, with specific types of health plans being developed for Medicare and Medicaid. The ACA included language to broaden eligibility for low-income individuals and families for Medicaid; the U.S. Supreme Court invalidated that part of the law, however, so some states have not expanded their Medicaid coverage.

In traditional Medicare and Medicaid programs, the federal or state government uses private payers, such as Blue Cross Blue Shield plans or commercial health insurers, to administer the program. Those private entities, which are called intermediaries, provide only administrative services, so the government (i.e., taxpayers) remains at risk. In contrast, in some private Medicare Advantage and managed Medicaid plans, the risk is transferred from the government to the private plan.

The Federal Employees Health Benefit Program (FEHBP) is an employee benefits program for federal employees. Likewise, state and local governments typically provide benefits to their full-time employees. These are not entitlement programs, however, but rather employer group health benefit plans.

Individual Health Insurance

Several different sources of coverage are available to individuals. For example, individuals may purchase health insurance policies directly from commercial

insurance companies. In general, individual health insurance policies are more expensive for the same level of coverage than are group health benefits plans. Under the ACA, as of January 2014 individuals became able to purchase coverage either directly from a health insurer or through a health insurance exchange, as discussed in the *Sales, Governance, and Administration* chapter. Prior to 2014, individuals often needed to pass “medical underwriting,” meaning their health status determined whether they could get coverage. That is no longer the case: Individuals cannot be refused coverage based on health status.

Except in the case of “life events,” individuals can buy such coverage only during designated periods of the year, typically one month per year, although the ACA allows states to extend these open enrollment periods if they so choose. Individuals’ benefits and premiums are affected by provisions of the ACA but managed by the states. The ACA also created an obligation for most people to have coverage, either through their employer or as individuals. Individuals with low incomes or other hardships may be excluded from that requirement, but others face a financial penalty for not purchasing coverage. Subsidies are also available for qualifying low-income individuals and families.

Individuals may also obtain coverage following certain “life events,” also called “special eligibility events,” such as marriage or divorce, losing a job, or child birth or adoption. They must apply for this coverage within 60 days of the life event or they will lose their eligibility. One option is to obtain coverage through the health insurance exchange.

Another option following a “life event” is to obtain coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA requires employers with 20 or more employees to offer certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. The individual must pay the full cost of that coverage, but it is usually less expensive than an individual policy unless the individual qualifies for subsidized coverage under the ACA. Coverage under COBRA is limited to 18 months in most cases, and the end of that period of coverage is considered a life event for purposes of obtaining coverage through the insurance exchange. (See the chapters titled *Sales, Governance, and Administration* and *Laws and Regulations in Managed Care* for further discussion of the ACA and COBRA.)

When COBRA coverage runs out, that is also a “life event,” and in the past, individuals with medical problems could obtain coverage only under the terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This was an important right for individuals who had medical conditions that made it

difficult or impossible for them to buy coverage because insurers would not sell to people with preexisting conditions. HIPAA coverage was (and still is) very costly and the benefits poor, however. When the ACA made coverage available to all individuals during an open enrollment or following a life event, that became a far better option than is coverage under HIPAA.

Group Health Benefits Plans

Employer-based group health benefits plans are the largest source of health benefits coverage in the United States, accounting for almost half of all coverage. While employers are not compelled to provide coverage, the ACA requires all employers with more than 50 full-time employees to offer qualified health benefits coverage plans or pay a penalty,* and it provides tax incentives to encourage small employers to offer coverage. Large employers must automatically enroll new employees into their plan, though the employee can opt out. Even when an employer does offer health insurance, not all employees may be considered eligible, however; in fact, temporary or part-time employees are seldom eligible to participate in an employer's health insurance benefits plan.

Group health benefits plans have several advantages:

- The cost of the coverage is paid on a pretax basis.
- Employers can either purchase group health insurance or self-fund the benefits plan.
- Employers, especially large employers, are usually able to obtain more favorable pricing than individuals can.
- Large employers often provide employees with different options for type of health plan or amount of cost sharing.
- Healthcare coverage benefits may be combined with other types of benefits (e.g., flexible spending accounts, health payment accounts, or life insurance).
- The employer—not the individual employee—manages administrative needs such as payroll deductions and payment of premiums.

If costs for a group health benefits plan increase, as they usually do each year, the employer generally absorbs much of that cost increase. Employees typically contribute part of their pretax earnings toward the cost of the coverage, usually around 25% of the total cost. As a consequence, as health plan costs rise, the dollar amount

* The penalty applies only if any employees receive subsidized coverage through an insurance exchange. This penalty also applies if the employer does offer a benefits plan, but it is not considered “affordable,” and at least one employee obtains subsidized coverage through the exchange.

of the payroll deduction also rises even though it is the same on a percentage basis. An employer may set that payroll deduction (i.e., the amount that the employee must pay) to favor lower-cost choices; for example, there may be a lower payroll deduction if the employee chooses a lower-cost plan. Because healthcare costs usually rise faster than overall inflation, some of the money an employer might have used for pay raises ends up being used to pay for health benefits, so that higher employee payroll deductions affect the amount of total take-home pay.

In all cases, however, the cost of the benefits plan paid by the employer as well as the payroll deduction are pretax expenses, meaning they are not considered taxable income to employees. That is not the case for individual health insurance: Individuals must pay their premiums with after-tax dollars, meaning they cannot deduct it from their income taxes (with some exceptions).

Bearing Risk for Medical Costs

Bearing risk for medical costs refers to being responsible for paying for covered healthcare benefits, not the cost of the insurance premium. Contrary to popular belief, a health insurance company does not always bear the financial risks associated with the medical costs of its customers or members. In fact, insurers bear the risk in fewer than half of all group benefits plans, and it is the employers who bear the risk. In other cases, the federal and/or state government bears the risk.

Because many day-to-day payer operations are not tied to who is bearing the risk for medical costs, distinctions about who bears the financial risk will be made throughout this text only when this issue is important, such as its impact on benefits design or on how a plan is regulated.

Government Entitlement Programs

The government is at risk for the traditional entitlement programs. However, commercial Medicare Advantage plans and commercial managed Medicaid plans may contract with the government to provide and administer those benefits, in which case they assume the risk for medical costs (though some managed Medicaid plans share the risk with the state), though most operate under different requirements than purely commercial plans do. Managed care plans in both of the entitlement programs are discussed further in the *Medicare and Medicaid* chapter.

Health Insurance

People purchase healthcare insurance to protect themselves from unexpected medical costs. The insurer provides coverage of medical costs and charges

premium rates to groups or individuals that are calculated to cover those costs on average. This is often referred to as “private” or “commercial” health insurance. A private or commercial insurer can be a for-profit or nonprofit organization.

The central point of health insurance is that the risk for medical expenses belongs to the payer. In other words, in exchange for the payment of insurance premiums, the payer is responsible for paying some or most of the cost of medical care provided to individuals, subject to cost sharing and coverage limitations. Whether the actual costs for a group or an individual are higher or lower than average, the premium payment does not change during the period the insurance policy is in effect.

Federal laws and regulations under the ACA, HIPAA, and Employee Retirement Income Security Act of 1974 (ERISA) apply to health insurance, but generally speaking, regulation of insurance is the responsibility of the state governments. Because the regulatory system is highly complex, it is described throughout this text when applicable and addressed specifically in the *Laws and Regulations in Managed Care* chapter.

Self-Funded Employer Health Benefits Plans

Most large corporations do not actually purchase health insurance to cover their employees. Instead, it is the employer that bears the risk benefits plan, a practice called “self-funding.” Said another way, in a self-funded plan, the employer is the insurer and the entity that is at risk. Self-funding is mostly used in large groups, although some medium-sized employer groups have also moved to this practice. It is found in large groups because a risk pool (i.e., a group of covered people) must be large enough to be able to predict costs. In a small group, the impact of chance and luck—good and bad—is higher than in a large group, where chance and luck average out.

Assuming the risk of medical costs makes it possible for a large employer to avoid paying state premium taxes, offering state-mandated benefits, or being subject to state laws regarding health insurance. Costs in a self-funded group are based only on who is actually covered under the plan (i.e., the company’s employees and their dependents, and in some cases the company’s retirees) and are not affected by costs incurred by other groups or individuals. Self-funded plans also do not pay the charge that insurers build into their premiums for the cost of taking on risk and to ensure the insurer’s profits or margin contributions. The cost of taking on risk is real, however, so self-funded employers also purchase reinsurance.

Self-funded benefits plans are not regulated by the states, but they are regulated by the U.S. Department of Labor and to some degree by the U.S. Department of the Treasury. Self-funded plans are also exempt from some, but not all, requirements under the ACA—although as a practical matter, they do comply with most of the

important requirements. As long as an employer complies with the benefits plan requirements under ERISA and the ACA, there is very little regulation involved.

Self-funded plans may mimic any type of health plan. Employers with self-funded plans typically contract with third-party administrators (TPAs) to perform the plan's administrative activities, such as handling enrollment and eligibility, processing claims, and managing appeals. In many cases, the third-party administrator is actually a large health insurance company, a Blue Cross Blue Shield plan, or an HMO, which may cause confusion among both members and providers as to who the insurer actually is. Such commercial payers not only provide administrative services but also pass along to the employers any discounts from the providers. In other cases, a TPA that is not itself an insurer administers the plan but remains behind the scenes, and the self-funded plan contracts with different companies for different services such as accessing a discounted provider network, managing utilization, managing drug benefit claims and so forth.

Provider Risk

In some forms of provider payment, a contracted provider may assume some portion of risk. The most common arrangement is HMO capitation, in which the provider receives a fixed payment for each member each month regardless of which services those members actually obtain from the provider. This type of provider risk is usually limited and does not apply to all medical costs, although some large health systems may take on substantial risk in the form of fixed payments. This important topic is discussed in more detail in the Provider Payment chapter.

Reinsurance

Reinsurance is a high-level type of indemnity insurance that applies only to high-cost cases or higher than predicted overall costs. Large payers are often able to manage risk themselves, but other payers purchase reinsurance that usually is uniform across all of its insured policies. For example, a reinsurer will pay 80% of costs above \$1,000,000 for a single case, up to a limit of \$5,000,000; or 60% of total costs if they exceed 120% of projected costs, up to a limit of \$20,000,000.

Almost all self-funded employer groups also purchase reinsurance. Most states have rules regarding how much reinsurance a self-funded health benefits plan can have before it is considered a commercial group health insurance plan and, therefore, becomes subject to state regulation. For example, if an employer purchases reinsurance to cover expenses that are less than 10% higher than what was budgeted

for, the state may claim that the employer is insured and not self-funded, which means it must comply with all state laws and regulations for health insurance.

Reinsurance is not the same as health insurance. It comes in many different forms and is regulated differently from health insurance. A reinsurer can, however, apply different rules for defining when something is covered and when it is not. Benefits plans must treat all of their beneficiaries equally and cannot deny ongoing coverage to an individual based on that person having high medical costs—but a reinsurer can do just that, resulting in the self-funded plan having to continue to pay the benefits costs but having no financial protection from the expenses incurred by the individual.

Prior to 2014, self-funded plans facing reinsurance coverage exclusions or dramatic rate hikes had no options because other reinsurers would include the same coverage exclusions or high premium rates, and health insurers would refuse to underwrite the group as a whole. However, the ACA now requires insurers and HMOs to provide coverage to any individual or group that seeks it, at least during an open enrollment season, although large groups with high costs would still face high premiums.

TYPES OF PAYER ORGANIZATIONS

Serious challenges are associated with attempting to describe the types of payer organizations in a field as dynamic as health insurance and managed care. The health-care system has been continually evolving in the United States, and change is the only constant. Nevertheless, distinctions remain between different types of payers.

Originally, HMOs, PPOs, and traditional forms of indemnity health insurance were distinct, mutually exclusive products with different approaches to providing healthcare coverage. Today, an observer might be hard pressed to uncover the differences among these and many newer products without reading the fine print. Further confusing this issue is the existence of provider-based integrated delivery systems (IDSs), described in the chapter titled *The Provider Network*.

As a result of these changes, the descriptions of the different types of payer organizations that follow provide only a guideline to the various types of payer organization models or structures. In many cases (or in most cases in some markets), a specific payer will be a hybrid of several specific types.

Nonprofit, For-Profit, and Member-Owned Payer Organizations

There are three different ways that most payer organizations are structured around ownership and governance. These arrangements are described only briefly here

because the types of ownership and governance have little real impact on general operations or marketplace behavior.

In a **nonprofit** plan, the payer is not owned by investors or members and cannot therefore distribute profits to its owners. Any profits or margins that a nonprofit organization earns belong only to the nonprofit plan. If a nonprofit organization is sold to a for-profit company, or if it converts from nonprofit to for-profit status, that is considered a type of sale. The nonprofit's assets and marketplace value must benefit the community overall, not any private person or group.

In a **for-profit plan**, the company is owned by investors and has the ability to distribute profits to its investors. Many of these organizations are publicly traded, meaning their stock is listed on the stock market. Others are owned as a for-profit subsidiary of either a for-profit or a nonprofit company; nonprofit companies typically establish for-profit subsidiaries so that the subsidiary's profits can be paid to its corporate parent.

Member-owned means the plan's members own the plan on a collective basis, albeit not in the same way as the shareholders own a publicly traded company. Member-owned plans are technically neither nonprofit nor for-profit entities. Three types of member-owned plans exist:

- Mutual insurers in which policy holders own the company on a mutual (shared) basis.
- Cooperatives (co-ops), which are similar to co-ops found in agriculture or other industries, in which the members of the co-op receive the co-op's services.
- Consumer-owned and -operated plans (CO-OPs), a plan type that was created specifically under the ACA as a means of increasing competition in the health insurance exchanges. CO-OPs are similar to co-ops or mutual insurers but have specific requirements that co-ops and mutual insurers do not have. For example, the ACA is very specific about who may and may not be on a CO-OP's board of directors. The ACA also provided special funding for start-up CO-OPs, but that funding was cut by the Taxpayer Relief Act of 2012.

Nonprofit, for-profit, and member-owned plans are all generally subject to the same state and federal requirements for insurers and/or HMOs. As a practical matter, a payer can have any one of these structures and that choice will have little or no impact on the different types of health plans offered. In other words, all types of payer organizations compete in the same marketplace and are indistinguishable to most people.

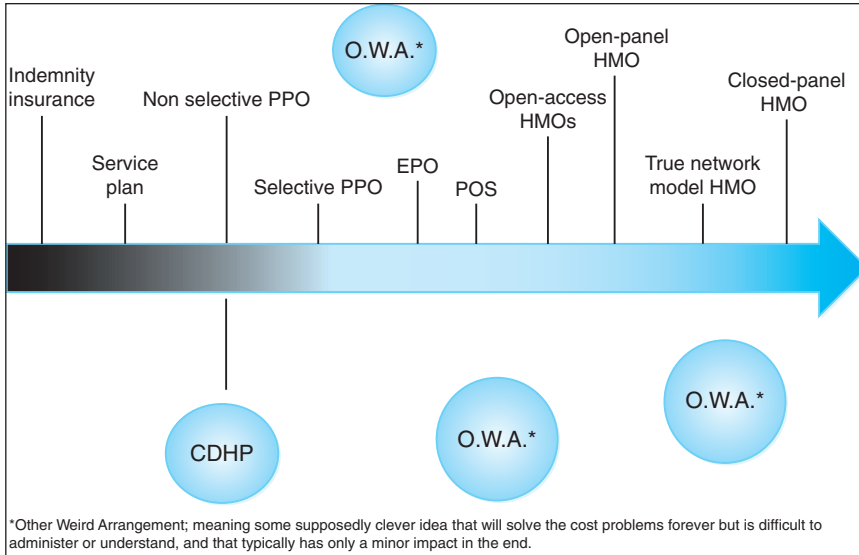


FIGURE 2-1 Continuum of Managed Care

The Continuum of Managed Care

Health insurance and managed care may be thought of as a continuum of models (Figure 2-1). These models are generally classified as follows:

- Indemnity insurance with precertification, mandatory second opinion, and case management
- Service plan with precertification, mandatory second opinion, and case management
- PPO
 - Traditional PPO
 - CDHP plan
- Exclusive provider organization (EPO)
- POS plan
- HMO
 - “Open-access” HMO
 - Open-panel HMOs
 - Independent practice association (IPA)
 - Direct contract HMO
 - True network model HMO
 - Closed-panel HMOs
 - Group model
 - Staff model

As models move toward the managed care end of the continuum, the following features begin to appear and continue:

- Provider contracts defining terms and requirements
- Tighter elements of control over healthcare benefits
- Addition of new elements of control
- More direct interaction with providers
- Increased overhead cost and complexity
- Greater management of utilization
- A net reduction in rate of rise of medical costs

Although it would be comforting to classify all payers using the models defined here, payers are anything but uniform and often offer most or all of the various types of plans other than closed-panel HMOs. The classification of health plans that follows has little to do with which party carries the actual risk for medical expense, or what the organization's ownership status is. All of these types of plans are licensed by states as health insurers except for HMOs, which are licensed separately.*

In the discussion here, various forms of provider payment and medical management approaches will be mentioned when they differ from one type of plan to another, but will not be fully described. Provider payment is the topic of the *Provider Payment* chapter, and medical management is the focus of the *Utilization Management, Quality Management, and Accreditation* chapter.

Traditional Health Insurance

Basically, two types of traditional health insurance exist: indemnity insurance and service plans. This type of plan is called traditional because it was the dominant form of coverage in the past—not because it still is. The costs of traditional health insurance rose rapidly beginning in the early to mid-1970s, such that it became very expensive compared to managed care plans and therefore could not effectively compete in the U.S. marketplace. The share accounted for by traditional insurance has now shrunk to less than 1% of the total market for healthcare coverage, although many of the companies that began as traditional insurers remain robust, as they changed along with the market.

* Technically, insurers are licensed while HMOs are issued a Certificate of Authority. Insurance licenses are only required for products for which the plan bears the risk. When they administer self-funded benefit plans, they are usually separately licensed as Third Party Administrators as well.

Indemnity Insurance

Indemnity health insurance protects (indemnifies) the insured (i.e., the policy holder) against financial losses from medical expenses. A person covered under an indemnity plan may receive coverage from any licensed provider. The insurance company may reimburse the subscriber for medical expenses, or it may pay the provider directly, although it has no actual obligation other than to pay the subscriber unless required to under a state's laws. Payment to physicians and other professional providers is subject to usual, customary, or reasonable (UCR) fee screens, whereas payment to institutional providers is generally based on charges. There is no contract between the insurer and the providers.

Benefits are generally subject to a deductible and coinsurance (except for preventive services as required by the ACA). Any charges by the provider that the insurance company does not pay are strictly the responsibility of the subscriber. Most plans usually require precertification of elective hospital admissions and may apply a financial penalty to the subscriber who fails to obtain precertification. Case management may also be used to help control the very high costs of catastrophic cases (e.g., a severely premature infant, a trauma case). Second opinions may be mandatory for certain elective procedures (e.g., surgery for obesity).

While traditional indemnity insurance has nearly vanished as a stand-alone product, it is still used for coverage of out-of-network services by certain types of plans. Most traditional carriers that remained in the health insurance sector have evolved to offer the other products described here, using the same insurance license.

Service Plans

Technically speaking, a service plan is not insurance, but rather a form of prepaid health care, and it applies primarily, though not exclusively, to Blue Cross and Blue Shield (BCBS) plans. At the time service plans came into being, they were controlled by the hospitals and/or physicians providing the services, but that is no longer the case. Service plans are now much more like traditional health insurers.

In service plans, relatively few restrictions are placed on licensed providers who sign a contract with the plan. This first appearance of a contract is an important milestone, and a feature of all types of plans except indemnity insurers. A service plan's provider contract typically contains certain key provisions:

- The plan agrees to pay the provider directly, eliminating collection problems with patients.
- The provider agrees to accept the plan's fee schedule as payment in full and not to bill the subscriber for any charges that exceed the

amount the plan pays, other than any deductible, coinsurance, and/or copayments.

- The provider agrees to allow the plan to audit the provider's records related to billed charges.
- Like indemnity insurance, service plans may require precertification, case management, and second opinions.

The principal advantage of a service plan over indemnity insurance lies in the provider contracts and the providers' agreement to accept the service plan's payment terms and not "balance bill" the plan's members for any charges above the amount allowed by the service plan. This, too, is a feature found in all of the other types of plans except indemnity insurance. It applies only to contracted providers, however; noncontracted providers can and do balance bill patients.

Professional fees allowed under the fee schedule represent a discount to the plan. More importantly, the plan usually obtains discounts at hospitals that indemnity plans do not. The hospitals grant these discounts for a variety of reasons, the most important of which is timely and direct payment. Some large service plans require providers to give them "most favored nation" pricing; in other words, a provider may not offer a better discount to a competitor than it does to the service plan. Such favored-nation pricing has become less common because of regulatory and legal pressure, and it is even prohibited in a number of states.

Most, but not all, service plans have evolved into PPOs, but they remain an underpinning for the non-HMO products the plans offer, as well as the basis for coverage of out-of-network benefits by other types of plans.

Preferred Provider Organizations

Although PPOs are similar to service plans, there are some important differences. A PPO typically has a smaller panel of providers than does a service plan, sometimes substantially smaller (e.g., to 30% of the total number of providers available in the area). Most PPOs have more terms and conditions for participation by providers compared to service plans, such as a requirement that physicians be board certified. PPO provider discounts are generally higher than those obtained by non-PPO service plans. The exception occurs when a large service plan has a favored-nation agreement with providers (such agreements are increasingly uncommon) or has already negotiated a significant discount. In that case, the service plan's payment terms are adopted by the PPO.

PPO networks may contract with “any willing provider” (AWP*) or they may be selective about accepting providers into the network. In the former approach, any provider who wishes to participate in the organization and who meets the conditions and agrees to the terms of the PPO’s contract is offered a contract. Selective PPOs, by comparison, apply some objective criteria (e.g., location-based network need, credentials, or practice pattern analysis) before contracting with a provider. Any-willing-provider PPOs are common, particularly as numerous state laws require this arrangement, but the use of criteria-based selection still occurs, particularly with expensive or highly specialized services (e.g., for cardiac surgery). It is also being used by many insurers that offer products through the health insurance exchanges.

Precertification and case management are almost always components of PPOs, and many include some concurrent hospital stay review as well as some level of disease management. A major difference between PPOs and traditional or service plans is that failure to comply with PPOs’ utilization management requirements results in a financial penalty to the provider, not the member. As with service plans, a contracting provider may not bill the member for any balance that the PPO does not pay, and that includes any payment penalties associated with the provider not complying with precertification.

A hallmark of a PPO is that benefits are reduced if a member seeks nonemergency care from a provider who is not in the PPO network. A common benefits differential is 20% based on allowed charges. For example, if a member sees a network provider, coverage is provided at 80% of allowed charges; if a member sees a provider who is not in the network, the coverage may be limited to 60% of allowed charges. If the nonparticipating provider charges more than the allowed charges, the member is responsible for all charges above what the PPO paid and what the provider charged. An example of how this works may be seen in the *Provider Payment* chapter in the table titled “Example of the Use of Maximum Allowable Charge in a PPO.”

Providers agree to discount their services to a PPO because the smaller network combined with the benefits coverage differentials serve to channel patients toward participating providers. Of equal importance, this approach eliminates the risk of losing patients who switch to participating providers. PPOs are less expensive than traditional insurance, but usually more expensive than HMOs. Because they have fewer restrictions and typically contract with larger networks than do HMOs, PPOs have the largest share of the market.

* Not to be confused with “AWP” referring to “Average Wholesale Price” in prescription drug coverage.

Risk-Bearing PPOs

PPOs can be either risk bearing or non-risk bearing. A risk-bearing PPO combines the insurance, or payment, function with the management of the network of providers. As a risk-bearing entity, it must be licensed as a health insurer itself or owned by a health insurer and offered as one of the insurer's products.

Non-Risk-Bearing or Rental PPOs

Most payers have their own networks, but no payer—other than the federal Medicare program—has a network in place in all parts of the United States. Mid-size to large employers, however, frequently have employees who live and/or work in locations where a payer may not have a contracted network. In those areas, this potentially means the PPO may have to pay for care delivered based on full charges, and members may not have the protections found in most provider contracts. Self-funded employer groups that use third-party administrators instead of a full-service payer face a similar issue because TPAs typically do not have a network of their own.

Blue Cross and Blue Shield plans address this risk through their BlueCard program, in which a member of one BCBS plan is able to access another BCBS plan's network providers when away from home. This mechanism is based on an agreement among the Blues plans because those plans are independent, but does provide for seamless access to any Blues network.

Non-BCBS plans must take a different approach for supplementing their own networks, as do self-funded employer groups that use TPAs. The solution in both cases is to contract with one or more rental networks. A rental network comprises a network created either by the providers themselves or by a company that is not affiliated with a single payer. Some payers do rent their networks to noncompetitor payers, but that is not common. Rental networks are almost always PPO networks, rather than HMO networks (which have more requirements than do PPOs). Any PPO created by providers must not violate antitrust requirements, meaning it cannot act as a means of suppressing competition.

Rental PPOs typically charge an access fee, as well as separate fees for other services they may provide, such as utilization or case management services. Usually the rental PPO's providers send the claims to the rental PPO, which then reprices them and sends the claims on to the payer or TPA for processing. The rental PPO usually keeps a percentage of the difference between the full charges and the discount.

Depending on the state, non-risk-bearing PPOs may not need a license if they simply provide access to contracted providers. If the PPO also performs, it may need

to be licensed as a utilization review organization of some type. Likewise, if it performs any other administrative functions, including prepricing of claims, it may need to be licensed as a TPA even though it does not otherwise process the claims.

In decades past, payers did not always make it clear when they contracted with rental PPOs, and there was no indicator on the member's identification (ID) card about any rental PPOs. Providers that contracted with the rental PPO but not directly with a payer would find themselves receiving the PPO payment and not the billed charges, requiring them to write down the difference. This could even happen in an area in which both a payer and a rental PPO had networks, but did not include all the same providers. At the time this was occurring, the arrangement was known as a "stealth" or "silent" PPO. Silent PPOs are now uncommon after several lawsuits were filed challenging this practice, and payers that contract with rental PPOs now typically put the logo(s) of the rental PPO(s) someplace on the member's ID card, usually on the back.

High-Deductible Health Plans and Consumer-Directed Health Plans

Each year, the Internal Revenue Service determines what the minimum and maximum deductibles need to be to qualify as a high-deductible health plan (HDHP). For 2014, the minimum deductible was \$1200 for individuals and \$6350 for families; the maximum allowable deductible was \$2500 for individuals and \$12,700 for families. In all cases, preventive services are not counted toward the deductible. HDHPs are usually associated with PPO networks, and the amounts paid toward the deductible are based on in-network costs, not out-of-network costs, just as with any other type of PPO. The maximum deductible amounts for HDHPs are the same as the maximum amount of out-of-pocket spending allowed under the ACA for all insured health plans, and fall within the coverage requirements for a bronze-level plan.

A consumer-directed health plan is an HDHP combined with a pretax savings account. A pretax account set up as part of an employer group health benefits plan is referred to as a health reimbursement account (HRA), and a pretax account applied to individual coverage is referred to as a health savings account (HSA). While they have differences, the overall concept is the same for both types of accounts.*

* Some other types of pretax benefits accounts exist, such as flexible spending accounts (FSAs), but those are beyond the scope of this text.

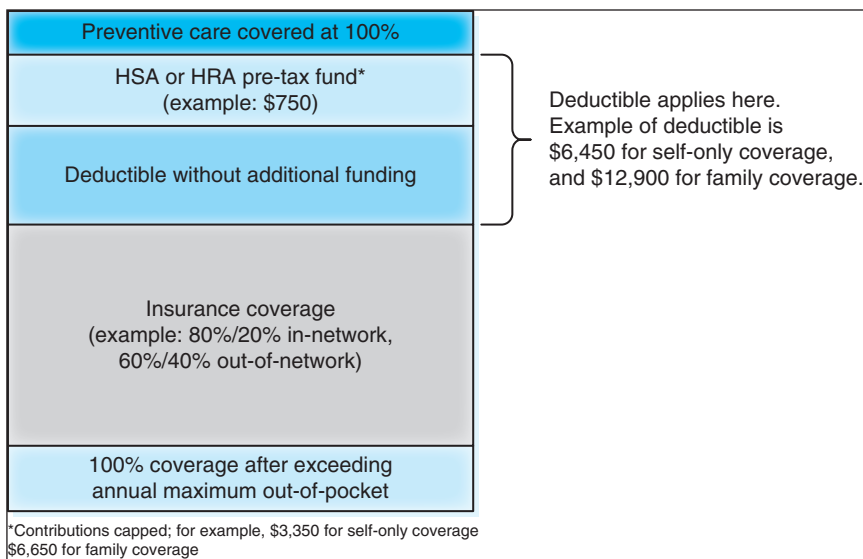


FIGURE 2-2 Example of Basic Construct of a Consumer-Directed Health Plan

In a CDHP, qualified healthcare costs (except preventive care) are paid first from the pretax account; when that is exhausted, any additional costs up to the deductible are paid out-of-pocket by the member (this gap is sometimes referred to as a bridge or a doughnut hole). The IRS also defines what is considered a qualified medical cost, but it is similar to what would be considered a medical cost in any coverage plan. To be paid from an HRA or HSA, costs must have been incurred while the account existed. A simplistic schematic of a CDHP appears in Figure 2-2.

Point-of-Service Plans

POS plans combine features of HMOs and traditional indemnity health insurance plans, so are similar to PPOs in some ways. In a POS plan, members may choose which system to use at the point at which they obtain the service. For example, if a member uses his or her PCP and otherwise complies with the HMO authorization system, minimal cost sharing is required. If the member chooses to self-refer or otherwise not to use the HMO system to receive services, the POS plan still provides insurance coverage but with higher levels of cost sharing, including a higher deductible and coinsurance instead of a copayment.

POS plans are typically based on HMOs, but even then there are two common forms they can take. The first is a POS plan with two options for cost sharing: (1) minimal cost sharing if the member chooses to stay within the HMO

system and (2) significantly higher levels of cost sharing if the member chooses to go outside the HMO system. The difference between coverage for in-network services and out-of-network services is usually in the range of 30% to 40%.

The second type of POS plan is a triple-option plan in which there is minimal cost sharing when the HMO system is used, but there is also an option to use a PPO that is part of the plan, so the amount of cost sharing will be higher than when the HMO is used, but more closely follows typical PPO benefits design. In other words, cost sharing in this middle tier is less than the amount of cost sharing required for using providers who are not in either the HMO or PPO network. The differences between coverage for HMO in-network services, PPO in-network services, and out-of-network services are usually approximately 20% between the HMO level and the PPO level, and from 40% to 50% between the HMO and out-of-network levels.

Some states, such as California, require all HMOs to offer POS benefits. While POS plans were initially popular, they have become less so over the years because their costs are often higher than either PPOs (with more cost sharing) or HMOs (with more controls).

Exclusive Provider Organizations

EPOs are similar to open-access HMOs, though most are not actually HMOs. Except in the case of a medical emergency, benefits are available only when services are provided by the EPO's network providers. EPOs' management of utilization and quality is similar to the mechanisms applied by PPOs and does not involve any requirements to go through a PCP to access specialty care. EOPs are relatively uncommon, being mostly used in self-funded employer group benefits plans for a single employer or in plans offered to government employees. Commercial payers may offer their existing HMO or PPO networks to an employer to be used for that company's EPO, although an EPO can be based on a rental PPO's network as well. EPOs do not necessarily need to be licensed if the EPO serves only an employer's self-funded health benefits plan.

Health Maintenance Organizations

HMOs are unique in many ways. The majority of HMOs manage utilization and quality to a greater degree than do PPOs. Except for emergency care or when a state requires HMOs to offer POS benefits, benefits coverage in an HMO applies when services are provided by the HMO's providers in compliance with the HMO's authorization policies and procedures. Exceptions may be made on occasion when the HMO authorizes benefits for non-network services based on specific medical

needs. Benefits obtained through the HMO almost always have much lower cost-sharing than is found in any other type of health plan. Payment for services received from non-HMO providers is the responsibility of the subscriber, not the HMO, unless the HMO is also a POS plan. Services delivered by contracted providers who fail to obtain proper authorization are the responsibility of the provider, who may not bill the subscriber for any fees not paid by the HMO. At least some providers in most HMO networks are paid using risk-based payment models.

Traditional HMOs currently fall into two broad categories: open panel and closed panel. These terms are no longer widely used but are helpful for understanding the different types of HMOs. A third category, the true network model, is relatively uncommon except in certain parts of the United States; that term may also be applied more broadly to open-panel HMOs. Some HMOs combine or mix different model types in the same market. Because open-access HMOs are not considered traditional HMOs, they are discussed separately from traditional open- and closed-panel plans.

Open-Access HMOs

Open-access HMOs are more like EPOs than traditional HMOs, at least regarding benefits design. In the open-access HMO model, members may access any provider in the HMO without going through a PCP. Thus, members may see any PCP or specialist in the network on a self-referral basis, as in EPOs. Unlike in EPOs, however, physicians in an open-access HMO typically share at least some level of risk for costs.

Open-access plans were popular in the late 1970s and early 1980s, especially plans sponsored by local medical societies and community physicians who saw traditional HMOs as a threat to their livelihoods. With a few exceptions, these early plans suffered substantial losses and failed. Interest in open-access plans was later revived because of consumer demands, particularly at the height of the managed care backlash. It is certainly logical for consumers to demand the following characteristics associated with open-access plans:

- Rich benefits coverage
- Low premiums and out-of-pocket costs
- Unlimited access to all providers in the community

Wanting those aspects of service may be logical but is not realistic. In reality, a health benefits plan can meet any two of those three demands, but not all three of them simultaneously.

The HMOs that currently use an open-access design assume that, because so few referral authorizations are denied, the referral requirement is not worth the

cost. However, a PCP will be able to deliver routine care more cost-effectively than a specialist. Therefore, most open-access HMOs have substantial cost-sharing differences for care provided by a specialist compared with that provided by a PCP.

Open-Panel Plans

In an open-panel HMO (not to be confused with an open-access HMO), private physicians and other professional providers are independent contractors who see HMO members in their own offices or facilities. Physicians in the network typically contract with more than one competing health plan and also see non-HMO patients. A variety of payment mechanisms may be used in an open-panel HMO. The total number of providers in an open-panel plan is larger than that in a closed-panel plan but usually smaller than that in a PPO. Each member must choose a PCP, and they go first to their PCP for medical care; any other services must then be authorized by their PCP. PCPs are defined as physicians specializing in family medicine, internal medicine, and pediatrics. Women can access their obstetrician/gynecologist (OB/Gyn) directly—direct access to OB/Gyns for women is required under the ACA but was allowed by HMOs even prior to the ACA's passage—but most HMOs still require them to choose a PCP. Members may change their PCPs at designated times if they wish as long as that PCP has the capacity to take on a new patient.

Open-panel plans fall into two broad categories: IPA models, which are the most common type of HMO, and direct contract models, which are the second most common type. Although the terms IPA and direct contract model are often used synonymously, the two models are distinct.

In an IPA model, the HMO contracts with a legal entity known as an independent practice association and pays it a negotiated capitation amount. The IPA, in turn, contracts with private physicians to provide health care to the HMO members. The IPA may pay the physicians through capitation or use another payment mechanism, such as a fee-for-service scheme. The providers are at risk under this model in that if medical costs exceed the capitation amount, the IPA receives no additional funds from the HMO and must accordingly adjust its payments to the providers. Most IPAs purchase reinsurance to protect themselves financially, and some HMOs provide a similar type of protection from high costs as part of the overall contract. Finally, the scope of what IPAs do varies, with some focusing on payment terms, and others taking on many routine HMO functions involving medical management and the like.

In the direct contract model, the HMO contracts directly with the providers; there is no intervening entity. The HMO pays the providers directly and performs all related management tasks.

Closed-Panel Plans

Unlike physicians in an open-panel plan, physicians in a closed-panel plan either are members of a single large medical group or are employed by the HMO. The total number of providers in a closed-panel plan is by far the smallest of any model type. Members usually do not have to choose a single PCP but may see any PCP or any physician in the HMO; however, they may be asked to choose a primary facility to ensure continuity of care.

Closed-panel plans fall into two broad categories: group model and staff model. In a group model plan, the HMO contracts with a single medical group to provide services to members. The HMO pays the group a negotiated capitation amount, and the group in turn pays the individual physicians through a combination of salary and risk/reward incentives. The group is responsible for its own governance, and the physicians are either partners in the group or employed by the group as associates. The group is at risk in that if the costs of the group exceed the capitation amount, physician compensation is less—although the HMO generally provides stop-loss reinsurance to the group to protect it from catastrophic cost overruns. Closed-panel HMOs also contract with private physicians to provide services that the HMO's physicians do not provide.

Several types of group model HMOs exist. In one type, the HMO and medical group are distinct entities that operate as if they were partners. The largest and best-known example of this type of group model HMO is Kaiser Permanente; the HMO is the Kaiser Foundation Health Plan, and the medical groups are the Permanente Medical Groups (there are different groups for each of Kaiser's regions). In another type of group model HMO, the medical group established the HMO. An example of this type of HMO is the Geisinger Health Plan, a large and successful HMO established by the Geisinger Clinic in Danville, Pennsylvania.

Some medical groups exist primarily on paper and actually operate strictly as cost pass-through vehicles for the HMO; that is, the costs are simply passed from the medical group to the HMO, and the group does not actually bear any risk for medical expenses. This arrangement resembles a staff model plan.

In a staff model plan, the HMO directly employs its physicians. In some cases, the physicians are employed by a medical group, but it functions like a staff-based organization. Physicians receive a salary, and there is an incentive plan of some sort. The HMO has full responsibility for the management of all activities. Staff model plans run by free-standing HMOs are almost extinct now, but still exist as HMOs created by large integrated healthcare delivery systems (IDS). In this case, the IDS owns or manages the HMO, and the physicians are employed either by the IDS or by a captive medical group.

True Network Model HMOs

The term “network model” is often used to refer to an open-panel plan, but in the “true” network model, the HMO contracts with several large multispecialty medical groups for services. The groups receive payment under a capitation arrangement, and they in turn pay the physicians under a variety of mechanisms. The groups operate relatively independently. The HMO contracts with more than one group, but the number of groups is usually limited. True network models are most common in California but are also found elsewhere (e.g., in Massachusetts and New York).

Mixed-Model HMOs

Nothing in this world is pure and simple, and HMOs—like all types of payer organizations—are no exception. Many HMOs have adopted several model types, even in the same market, to attract as many members as possible and capture additional market share. Such mixed-model HMOs may offer the different models in the same products, or the models may operate independently of each other in different products.

CONCLUSION

Any understanding of health insurance and managed care requires a basic understanding of how coverage is accessed and what the basic components of coverage are. No matter which type of health plan or payer is involved, those sources and components change only in their specifics; they are always present regardless of any other features.

The means for administering coverage exists on an ever-evolving landscape of plan types with mutating definitions and operational structures. Even so, the traditional terms such as HMO and PPO retain considerable utility, including stability in the overall aspects of their operations. This characteristic should be looked on not as a hindrance toward understanding but as a mark of the exciting and dynamic nature of the industry.