# New to This Edition

So what’s new in this edition? Too much to describe fully in a Preface – to do so would essentially rewrite the book – so what follows is a high level description of some of the more important changes.

## Chapter 1: A History of Health Insurance and Managed Health Care in the United States

This is probably the least changed chapter in the book. Obviously events that occurred after the prior edition was published are included, but some additional historical 20th century events have been added and/or clarified.

## Chapter 2: Health Benefits Coverage and Types of Health Plans

Much of this chapter is entirely new. Previously, the focus was only on the different types of insurers and managed care organizations, as well as integrated delivery systems (IDSs). IDSs have been relocated to the chapter on the Provider Network, and the descriptions of plan types remains in this chapter, though it is a somewhat more compact discussion.

Before getting to those descriptions, the chapter now includes entirely new descriptions and discussion on:

* What health benefits plans are and how they are composed of three elements:
  + Defined Benefits,
  + Cost Sharing, and
  + Coverage Limitations;
* Essential Health Benefits under the ACA;
* Cost-sharing “metallic level” tiers under the ACA;
* Coverage requirements in the individual market, the small group market, large groups and “grandfathered” health benefits plans;
* Coverage mandates for individuals and employers;
* Guaranteed issue requirements on insurers;
* Sources of coverage and how coverage is obtained;
* Who bears the risk for coverage costs and how it is paid for; and
* Reinsurance and how it differs from health insurance.

All of this new material provides an added foundation for understanding how and why the whole rest of our hugely complex system works.

## Chapter 3: The Provider Network

In prior editions, all of the material in Chapters 3 and 4 in this book were addressed in a single chapter. But how a network looks and how it is managed is now distinct from how providers are paid. This reflects better how the world actually works, and keeps the issue of money where it belongs – as a distinct issue and not wrapped up in other network aspects.

The concept of service areas and access standards has been clarified and updated, as has the discussion on credentialing. The descriptions of IDSs is both updated and compressed. New types of provider organizations has also come to be in the last five years, though only one has mercifully disappeared (the Provider Sponsored Organization), though even that is making a type of comeback under different labels. We have also seen new types of provider organizations come into being such as Accountable Care Organizations (ACOs) that were part of the ACA, and some new dynamics around some older approaches such as hospital employment of physicians, all of which affect the system.

The content of these this chapter also provides a bit more detail than that is found in other chapters because they are so critical to (here it comes again) understanding the how and why our hugely complex system works.

## Chapter 4: Provider Payment

The chapter on provider payment is the other half of what was formerly in a single chapter. Like the chapter before it, this chapter contains a bit more detail than what is found in other chapters because…well, you know how that sentence ends. For example, standardized codes sets and transactions are now found in this chapter because they directly affect how plans pay providers.

Unlike all other nations on earth, we pay for healthcare using about eleventy eight zillion different ways and an equal number of variations of each. We have also created even more new approaches such as the Shared Savings program in Medicare, new Value-Based Purchasing, payment models for drug coverage, and other new approaches to payment, many of which were spawned by the ACA.

In the case of payment (and as discussed in the book, it is payment, not reimbursement), there is one more reason to describe at least some of the ways we pay for health care, which is summed up by the singer/songwriter Randy Newman: “It's money that matters, in the USA.”[[1]](#footnote-1)

## Chapter 5: Utilization Management, Quality Management, and Accreditation

Besides moving and updating the section on Accreditation from a different chapter to this one, the most significant updates to this chapter are in the approaches to managing utilization in special populations such as people with multiple chronic conditions. The discussion about Medical Necessity and its impact on benefits coverage has been expanded, as has the use of Evidence-Based Clinical Guidelines for Coverage Determinations. Managing the prescription drug benefit is also evolving as Specialty Pharmaceuticals grow in importance and cost.

## Chapter 6: Sales, Governance, and Administration

As with the other chapters, this chapter is also affected by the ACA. In particular, how health plans underwrite, create and manage premium rates and rebates, access the market through sales and distribution channels, the appearance of new Health Insurance Exchanges for individuals and small groups, and how appeals of coverage denials have all been changed and updated due to the ACA. The discussion on enrollment and billing has also been expanded, and aspects of financial management have been clarified. The descriptions of the now-standardized eligibility, special eligibility based on life events, and coverage extensions are addressed here as well.

## Chapter 7: Medicare and Medicaid

The ACA has required major updates to this chapter as well, and it is as much rewritten as it is updated. For example, the ACA changed how the Part D drug benefit is constructed and managed; and it changed (or modified) how Medicare Advantage plans are paid, including the Quality Bonus Program. A section on eligibility and enrollment has been added. Marketing and sales in these markets is also fundamentally different than what is found in the commercial market, so the chapter now includes a discussion of what is allowed and what is prohibited. Finally, Medicaid expansion under the ACA, something that not all states have done, is addressed as is the increasing reliance of states on managed Medicaid plans.

## Chapter 8: Laws and Regulations in Managed Care

Chapter 8 is the only chapter that I only edited and did not write. It is entirely rewritten by contributor Tom Wilder, and provides descriptions of all of the major state and federal laws and regulations affecting health plans. It also provides an excellent summary of the key elements of the ACA that have an impact on health benefits plans.

## Glossary

The Glossary has nearly doubled in size, though not in the number of entries (that’s about 15%). In addition to adding new terms (and removing almost none), the reasons are the need to update and/or clarify some of the definitions, spell out many of the acronyms that prior versions only included through their initials, expand some definitions to include new meanings or uses of terms, and modify words and terms due to a redefinition under the ACA.

# Where to Next?

Whenever you hear somebody complain about how the healthcare system in the United States is undergoing turbulent times, know that it has been that way for over a century. As one acquaintance of mine remarked, “Health care is in permanent white water.” Wishing we could return to the calm and placid times in the past is the same as wishing we could return to the world of “Leave it to Beaver;” both are a complete fiction and never actually existed.[[2]](#footnote-2)

The causes for this continual turbulence also continually change. Health costs keep rising, but where once that was due primarily to overutilization, it is now due to a great many reasons including pricing, advances in technology, changing demographics and consumer demands, and more. It is the reason that health insurance and managed care are now so difficult to distinguish from each other. It is also the reason for this book, and the reason you are reading it.

But while health insurance and managed care always change, the main goal of this book has not and it is very simple—to provide its readers with a broad understanding of how health insurance and managed care actually work. If it succeeds in doing that, then some who are reading these words right now will be in a position to better contribute to the future evolution of this dynamic industry, thereby benefiting us all.

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1. Randy Newman, “It’s Money that Matters” from *Land of Dreams*, Reprise/Warner Bros. 1988. [↑](#footnote-ref-1)
2. Though the second fantasy, that of living in the world of a 1950s sitcom, makes for a wonderful movie titled “Pleasantville” (1998, New Line Cinema) starring Toby McGuire, Reese Witherspoon, William T. Macy, Jeff Daniels, Joan Allen, and among many others, the terrific Don Knotts. [↑](#footnote-ref-2)