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CHAPTER 2

Health Benefits Coverage, and Types of Health Plans and Payers

LEARNING OBJECTIVES

- Understand the core components of health benefits coverage.
- Describe the sources of health benefits coverage.
- Explain the differences in bearing risk for medical costs.
- Understand the basic types of health insurers and managed care organizations.
- Describe the differences between types of payers.

Introduction

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

1. *Individuals*
   - *Members*—individuals with benefits coverage through health insurance or a health benefits plan, and who may or may not be patients;
   - *Beneficiaries*—individuals with health benefits coverage under one of the entitlement programs such as Medicare, Medicaid, and others;
   - *Patients*—individuals receiving medical care and who may or may not have healthcare benefits coverage; and
   - *Uninsured*—individuals without any type of health benefits

* The author is aware that there are more than five, but using these five serves the purposes of this book.

coverage and who may or may not be patients.

2. *Providers*, which include not only doctors and hospitals, but all licensed healthcare professionals and medical facilities.
3. *Manufacturers*, such as drug, medical device, durable medical equipment, and medical supply manufacturers; and the vendors that sell or distribute those drugs and devices.
4. *Payers*, sometimes called Payors, which includes health insurers, managed care organizations of various types, and third-party administrators (TPAs).
5. *Regulators*, which includes federal, state, and local agencies that regulate the healthcare system under various state and federal laws and regulations.

The fundamental obligation of any payer is to manage covered 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 member who is covered under that plan. This simple description, however, quickly becomes complex in the real world made up of different types of payer organizations.

A great many different types of payers exist, and it is sometimes difficult for consumers and even providers to differentiate. But each type is usually defined under various state and federal laws and regulated accordingly. The most common types of payers include health insurers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point-of-service (POS) health plans. Two additions to this stew of acronyms include the closely related high deductible health plans (HDHPs) and the consumer directed health plans (CDHPs) that are HDHPs with pre-tax savings options. Both HDHPs and the related CDHPs are wide-spread, but both are also typically built on PPO platforms. To confuse things further, any of these types of plans, as well as other types of service companies, may also function as TPAs to self-funded employers, including full-service Administrative Services Only (ASO) business, also called an Administrative Services Agreement (ASA).

As an aside, one result of the "managed care backlash" that occurred in the late 1980s through the 1990s (see Chapter 1), was the appearance of the term managed care organization (MCO) that came into common use for many different types of plans. MCO is a term that continues to be used today, albeit less frequently, and very seldom in this book. But in all cases, an MCO is one of the other types of health plans or payer organizations.

The clear distinctions between types of payers have become somewhat 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; it is one reason the term MCO remains in use. For this reason, as well as to avoid getting bogged down, this book will refer to these organizations collectively as "payers," "health plans," or even "plans" when addressing them broadly but will identify the specific types of payers when it is important to distinguish between them.

Note: Much of what is covered in this chapter will appear again in subsequent chapters, usually with a bit more detail. The purpose here is to provide an overview of the system.

Health Benefits Coverage

Before describing the different types of payers, it is important to understand the core components of how benefits coverage is structured in almost any type of plan. Managing benefits,

of course, is the fundamental obligation of any type of payer organization. Said another way, the plan manages benefits, but does not provide health care. The exceptions to this are group and staff model HMOs, some large integrated healthcare delivery systems (IDSs) that sell coverage through a subsidiary licensed payer company, and payers that acquired physician practices and/or hospitals. Of these exceptions, only group and staff model HMOs do both most of the time.

The majority of health plans 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 whether the service will or will not be paid for by the plan, and how much it will pay. 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 useful to keep in mind that health plans manage benefits, meaning payments for medical goods and services, but do not provide the care and cannot 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

In health benefits plans, defined benefits refer to what medical goods and services are covered, and under which circumstances coverage applies (subject to cost sharing and possible limitations described a bit later). In other words, the type of medical good or service is defined as the benefit, regardless of what it costs to provide coverage for that benefit. Cost in this context refers to what it costs to provide the benefit, not the cost a provider wants to charge; and benefits are always subject to meeting certain requirements.

This differs from a defined contribution 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 costs. All types of health plans discussed in this text, as well as in the Patient Protection and Affordable Care Act of 2010 (the ACA),* are defined benefits plans.

Even in a defined benefits plan, the rules and requirements governing when coverage may apply 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 (e.g., seeing a primary care physician or a gynecologist); they will not cover the cost of nonemergency care provided by non-contracting providers, unless authorized by the HMO, or unauthorized services that require authorization.

Other plan types may provide some level of coverage that HMOs do not, although the amounts and conditions vary by plan type. For example, PPOs or POS plans may provide less coverage for out-of-network care than for in-network care, but that's more coverage than none at all.

Coverage may also depend on whether a treatment is considered reasonable based on a

* NB: At the time of publication, the ACA had survived an attempt to repeal it despite Republicans controlling both houses of Congress and the White House, though control of the house passed to Democrats in 2019. However, various elements of the ACA have been eliminated and the administration has declined to enforce other elements, identified in this book where appropriate. The ACA has been and remains politically contentious, so what is described in this chapter may have changed by the time you read it.

person's medical condition, particularly when there is more than one way to treat that condition. Said another way, a medical good or service may be covered in some circumstances but not in others; for example, certain types of plastic surgery may be covered to repair damage from disease or trauma, but not covered if done for cosmetic reasons.

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 or summary of coverage. That 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. There is a far bulkier document that members have access to that is called an Evidence of Coverage that has greater detail about the plan, including greater specificity for coverage and medical necessity.

Essential Health Benefits Defined in the ACA

The ACA further defines essential health benefits (EHBs), meaning services or goods that must be covered, but those are defined only at a high level. EHBs apply to individual and small group 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.

Under the ACA, health plans must also comply with the following benefits-related requirements:

- Health 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.

The Impact of State-Mandated Benefits and Definitions of EHBs

The ACA requires insurers to cover EHBs, and, for most benefits, there is little difference from state to state. But the ACA only listed the EHB categories seen in Table 2.1, it did not define them. Defining exactly what was included in each type of EHB was delegated to the states, who were instructed to base it on benefits provided in their three largest insured products in the individual and small group markets; that included any state-mandated benefits in place at the time. Note that large and self-funded employer group plans are not necessarily required to comply with the EHBs, but most do so anyway.

The definition of a new EHB, habilitative care, was also delegated to states, which posed a challenge because it was not usually defined or included as a covered benefit when the ACA went into effect; even now, it is not standardized. The biggest impact of state-mandated benefits and state definitions of habilitative care has been on coverage of ancillary services such as specialized testing and therapeutic interventions by non-physician professionals. For example, most states mandate coverage of treatments for autism spectrum disorder, a condition for which treatment approaches can vary widely, and typically involves many different types of therapeutic ancillary services. However, exactly which of those different treatments must be covered is not uniform from state to state.

There are even larger state-to-state differences for habilitative services. Some states adopted the definition created by the National Association of Insurance Commissioners (NAIC), but many other states crafted their own definitions. Examples of state-to-state

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 differ from cost sharing for medical benefits
Laboratory services	Yes
Mental health and substance use disorder services	Yes, but may *not* differ from cost sharing for medical benefits
Chronic disease management	Yes
Rehabilitative and habilitative services and devices	Yes

Data from Sec, 1302 [U.S.C. 18022] of the Patient Protection and Affordable Care Act (Pub. L. 111-148).

differences of habilitative services definitions include one or more of the following:

- Confining it to a condition such as autism spectrum disorder
- Limiting it to those younger than 25
- Prohibiting limits on coverage
- Limiting coverage to a yearly set dollar amount or number of treatment sessions

Cost Sharing

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 benefits that are covered by the plan, not to services or goods for which no coverage is offered.

Basic Types of Cost Sharing

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 the payment amount to a hospital for an inpatient stay, based on in-network payment rates.
- *Deductible*, meaning a fixed amount of money that a member must pay out-of-pocket before any coverage begins to

apply—for example, a $1000 deductible for hospital stays.

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 only for services that are not 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, at which point the member must pay 20% of the covered amount as well as any charges over what the plan covers; this is called balance billing and is discussed later in the chapter and in Chapter 3.

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 may also differ, and be separately counted, for drug coverage than it is for all other benefits.

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 as 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, and as a practical matter these concepts are used by nearly all health plans.

The ACA also limits the maximum out-of-pocket cost for individuals and 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 2019, the maximum out-of-pocket costs could be no more than $7,900 for self-only for group plans coverage, and $15,800 for family coverage; 2019 HDHP limits are $6,750 and $13,500 respectively. Many health plans actually set their maximum out-of-pocket limits at a lower level, however.

Coverage Limitations

Several different types of coverage limitations exist. For example:

- A benefit may be covered only if it is provided through a contracted provider. For example, a plan that has different levels

* Technically, the percentage is the "actuarial equivalent" of 10% based on in-network payment rates. This does not necessarily mean that all covered services have 10% coinsurance because some may have a bit more and some a bit less. The same concept applies to all of the so-called metal levels of benefits.

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 is usually 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 2 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, care for which a lower cost but equally effective alternative exists, 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, prohibits qualified plans from imposing an annual or lifetime limit on coverage.

Following the elections in the fall of 2016, the new administration moved to allow some plans to have significant limits on benefits, high levels of cost-sharing, and/or eliminate some specific benefits included in the EHBs. There were two primary ways this could happen: Limited Benefits Plans and Association Health Plans (AHPs). The amount of time a company could provide a Limited Benefits Plan, which is a type of defined contribution plan sometimes called a "mini-med," was lengthened. The administration also ordered that AHPs made up of groups of small employers or individuals could offer coverage that did not comply with ACA requirements for including all of the EHBs, or exclusions or limits based on preexisting conditions, without incurring a penalty.

Sources of Benefits Coverage and Risk

The sources of benefits coverage refer to how groups or individuals obtain health benefits coverage, 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 types of coverage sources and three forms of risk bearing.

Three Basic Sources of Benefits Coverage:

- Entitlement programs
- Individual coverage
- Group health benefits plans

Three Broad Forms of Risk Bearing:

- Government bears the risk
- Payer 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 can 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")

TABLE 2.2 Sources of Coverage and Risk

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

* Health benefits for government employees are considered group health benefits, where the government is the employer.

Entitlement Programs

In the United States, approximately 40% of all national health expenditures were paid by the federal and state entitlement programs. Coverage is provided to anyone who is eligible to 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
- Uniformed Services through TRICARE* for the:
  - United States Army
  - United States Navy and Marine Corps
  - United States Air Force
  - United States Coast Guard
  - United States Public Health Service Commissioned Corps
  - National Oceanic and Atmospheric Administration Commissioned Officer Corps
- Veterans Administration
- Indian Health Service

The largest entitlement programs are Medicare and Medicaid. The Centers for Medicare & Medicaid Services, a branch of the U.S. Department of Health and Human Services, administers Medicare. Medicare provides healthcare benefits for the elderly, for many individuals with end-stage renal disease, and for individuals with some other conditions. The states manage their own Medicaid programs, which rely on state and federal funds and provide healthcare benefits to eligible individuals or families with low or no income; eligible individuals who are aged, blind, or disabled; and eligible 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.

In traditional Medicare and Medicaid programs, the federal or state government uses private payers, such as Blue Cross Blue Shield

* TRICARE is the program for coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); some care for members of the uniformed services are provided directly by military professionals and military treatment facilities.

plans or other private companies, 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 private Medicare Advantage and managed Medicaid plans, the risk is transferred from the government to the private plan.

The Federal Employees Health Benefit Program 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, but rather employer group health benefit plans.

Finally, the ACA provides federal assistance to certain low- or modest-income individuals or families, which is a form of entitlement, but that is not the same as being at risk for medical costs.

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 or require more cost sharing than do 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. Prior to 2014, individuals often needed to first 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, at least during open enrollment.

Individuals can buy such coverage only during designated periods of the year, typically 1 month per year, although the ACA allows states to extend these open enrollment periods if they so choose (none have). Individuals' benefits and premiums are affected by provisions of the ACA but managed by the states (unless the state will not do it, in which case the federal government takes responsibility). As noted earlier, subsidies are also available for qualifying low-income individuals and families.

The ACA also created an obligation, referred to as the "individual mandate," for most people to have coverage, either through their employer or as individuals. Individuals with low incomes or other hardships were excluded from that requirement, but others faced a financial penalty for not purchasing coverage. This penalty was only through the government withholding the penalty amount from any tax refund. The reason for this mandate was to ensure that enough healthy, or at least less sick, individuals were contributing money into the risk pool to cover the costs of very sick people. But as part of the 2018 budget bill, the individual mandate was eliminated as of January 1, 2019. As a result, insurers participating in the exchanges increased rates even more than they had in the past to try and cover the adverse selection.* In response, a few states imposed their own individual mandates, and a few others instituted reinsurance programs for participating plans to try to offset the increased costs.

Individuals may also be eligible for coverage following certain "qualifying 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 qualifying event or they will lose their eligibility. The coverage change may be to their existing benefits plan (e.g., adding a dependent), or to eligibility to obtain coverage.

Coverage may also exist through the Consolidated Omnibus Reconciliation Act of 1986

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* Adverse selection means that the insurer's risk pool has a higher than average proportion of sick people to healthy people. It can be caused by several factors.

(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 plus 2%, 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 qualifying event for purposes of obtaining coverage through the insurance exchange.

Individuals could also obtain coverage under the terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) once their COBRA coverage ran out. 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 very costly and the benefits were poor, however. When the ACA made coverage available to all individuals during an open enrollment or following a qualifying event, there was little need for 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, but an employee can opt out. Even when an employer does offer health insurance, temporary or part-time employees do not have a right to participate in an employer's group health 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 and coverage 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 of the payroll deduction also rises even though it is the same on a percentage basis. In addition, employers have been steadily increasing the amount of required cost-sharing in their benefits plans in order to keep premiums lower. 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

* The penalty on employers that do not offer coverage applies only if any employees receive subsidized coverage through an insurance exchange.

payroll deductions also 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).

Access to Coverage

Employer groups and individuals in the commercial market must have the means to access and purchase coverage, and payers must have the means to access customers in order to sell coverage. This can occur through many different "distribution channels." That topic is covered in Chapter 6 however, so is not addressed here.

Bearing Risk for Medical Costs

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. 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 (as in this section). Here we will briefly look at the most common forms of bearing risk for medical costs.

Government Entitlement Programs

The government is at risk for the traditional entitlement programs. However, commercial Medicare Advantage plans and private managed Medicaid plans may contract with the government to provide and administer those benefits, in which case they assume the risk for medical costs.

Health Insurance

People purchase health insurance to protect themselves from unexpected medical costs. The insurer provides coverage of medical costs and charges premium rates that are calculated to cover those costs on average. A commercial payer 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 only described throughout this text when applicable and specifically in Chapter 8.

Self-Funded Employer Health Benefits Plans

Most large corporations do not actually purchase health insurance to cover their employees. Instead, they fund the benefits plan themselves, 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 experience increasingly outweighs chance as the group gets larger.

Assuming the risk of medical costs makes it possible for a large employer to avoid paying state premium taxes, offering state-mandated benefits, or any other state regulation of benefits. Costs in a self-funded group are based only on the actual costs incurred by 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 contribute the insurer's profits or underwriting margins. The cost of bearing 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, most 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 TPAs, or through ASO contracts with full-service insurers or HMOs. This last type of contract may cause confusion among both members and providers when the benefits and policies of a self-funded plan do not match the payer's insured products. TPAs and ASO contracts are addressed later in the section on Types of Payers.

Association Health Plans

AHPs are plans in which several employers combine their health benefits plans to self-fund or to qualify for a health insurance policy with experience-rated premiums. AHPs usually are under the umbrella of an association. Those that self-fund, including similar types of plans called Multiple Employee Welfare Associations (MEWAs) or Multiple Employer Trusts (METs), self-fund for the same reasons that large employers do so, but are usually less likely to offer all of the benefits required under the ACA.

AHPs, MEWAs, and METs have a troubled history. In the past, plan administrators sometimes simply pocketed the "premiums" paid by the employers until the plan collapsed. In other cases, the reinsurance that was purchased "lasered" certain conditions or individuals as described later, and the participating employer groups cannot bear the costs. One of the biggest problems, however, is that smaller employer groups with low utilization and medical costs are likely to leave the association or trust because they do not want to pay the costs of the groups with high expenses, leaving the overall risk pool unable to provide enough funding.

The federal government eventually modified the ERISA regulations to allow states to regulate MEWAs and METS to a limited degree, but it was enough to stop the frequent failures. At the time of publication, the administration and Congress are considering making it easier for AHPs to operate and to avoid meeting all of the ACA's benefits requirements, but how that will play out is unpredictable.

Multiple Employer Plans, aka Taft-Hartley Trusts

Multiple Employer Plans, also called Multiple Employer Trusts, Taft-Hartley Trusts, Taft-Hartley Plans, and Joint Trusts, are not to be confused with the MEWAs or METs described above, though they bear some superficial similarity. A multiple employer fund is formed as a result of a collective bargaining agreement between employers and organized

labor, usually in the same industry; for example, Teamsters or the Screen Actors Guild.

Multiple Employer Plans are a type of self-funded plan that is administered by boards of trustees on which labor and management are equally represented. They were created primarily around pension benefits but may be used for health benefits as well.

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 how many or what type of services those members receive 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 is not the same as a provider-owned or sponsored health plan in which a health system also functions as an insurer, which is discussed later in this chapter.

Reinsurance

Reinsurance is a type of insurance insures the party bearing risk, but it applies only to very high-cost cases or higher than predicted overall costs. Large payers are often able to manage risk themselves, but smaller payers purchase reinsurance for its insured policies. Almost all self-funded employer groups purchase reinsurance, albeit specific to their group only.

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 only 5% 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 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 for high cost diseases or people—but a reinsurer can do just that, through "lasering" resulting in the self-funded plan having to continue to pay the benefits costs but having no financial protection from the costs.

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

Types of Payers

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 healthcare 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 IDSs. Provider-owned or sponsored health plans fall into the broad categories described here, but also have

some particular challenges that will be looked at separately in Chapter 6.

Because of these continual 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 a payer company may offer multiple products based on many or nearly all types of payer models and called by product names that provide little clue to what type each one's plan type or benefit design.*

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 no real impact on general operations or marketplace behavior.

In a *nonprofit* plan, the payer is not owned by investors and cannot distribute profits. Such an organization is not really owned by anyone. In one sense, it owns itself, but that does not mean that any board member or employee can claim any ownership rights. 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 can distribute profits to its investors. Many of these organizations are publicly traded, meaning their stock is listed on the stock market. Others are owned by either a for-profit or a nonprofit company. Nonprofit companies typically establish for-profit subsidiaries so that the subsidiary's profits can flow back to the parent company.

In a *member-owned plan*, the plan's members own the plan on a collective basis, albeit not in the same way that 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 share some attributes of 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. Most CO-OPs that appeared right after the ACA went into effect failed and are now gone, but, at the time this is being written, four are still operating.

Nonprofit, for-profit, and member-owned plans are all generally subject to the same state and federal requirements, aside from certain specific financial and tax reporting

* Based on how often certain words are used in benefits plans' product names, payers seem to be fond of product names that contain words such as "Premium," "Select," "Value," "Prime," "Plus," and "Enhanced," often in combination, none of which tell consumers anything.

requirements. As a practical matter, a payer can have any one of these structures and that choice will have 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.

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 with precertification, mandatory second opinion, and case management
- Service plan with precertification, mandatory second opinion, and case management
- PPO
- CDHP plan
- POS plan
- Exclusive provider organization (EPO)
- HMO
    - Open-access HMO
    - Open-panel Traditional HMO
        - Independent Practice Association (IPA) model
        - Direct contract model
    - Network model HMO
    - Closed-panel HMO
        - Group model
        - Staff model

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

- 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 the 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,

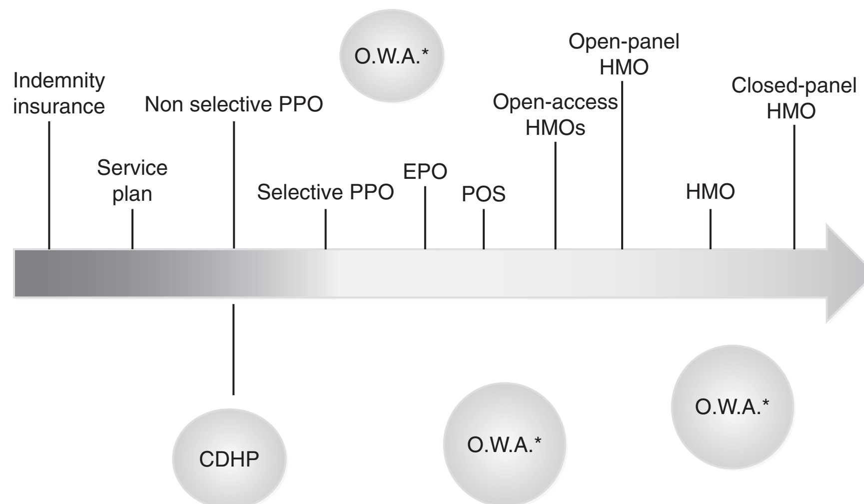

FIGURE 2.1 Continuum of Managed Care

though there are usually differences in how this is applied by type of plan.

The classification of health plans that follows has nothing to do with which party carries the actual risk for medical expense, or what the organization's ownership status is, both of which have been discussed already. For purposes of this book, plan types are assumed to perform all basic plan functions, but some self-funded employers contact with many different TPAs to perform each function separately, even if the benefit design mimics one of these types of plans.

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.

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 most types of managed care plans. Even with increases in the levels of cost sharing, traditional health insurance remained costlier than the newer types of plans and 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. Most of the traditional insurance companies remain robust, but either changed by adopting managed care, or by exiting health insurance and focusing on other types of insurance.

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 directly for medical expenses, or it may pay the provider directly, although it has no actual obligation other than to pay the subscriber unless required under a state's laws. Payment to physicians and other professional providers is subject to usual, customary, or reasonable 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. 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).

Service Plans

Technically speaking, a service plan is not insurance, but rather a form of prepaid healthcare, 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 physicians and/or hospitals providing the services, but that is no longer the case.

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 an enduring 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 payment schedule as payment in full and not to bill the subscriber for any charges that exceed the amount the plan pays, other than the normal deductible and coinsurance.
- 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 also 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, including large volume of business and timely direct payment. Most service plans have evolved into PPOs, though they commonly maintain the service plan as well. In any case, the organization technically remains a service plan for all but its HMO products.

Preferred Provider Organizations

Although PPOs are similar to service plans, there are some important differences between these types of payers. A service plan operating as a PPO remains licensed as a service plan. A PPO not operated by a service plan must be licensed as an insurer if it is a risk-bearing PPO described later in this section. Most PPOs have more terms and conditions for participation by providers compared to non-PPO service plans, such as a requirement that physicians be board certified. PPO provider discounts are generally below average billed charges and usually below service plan fees.

A PPO network contracts with fewer than the total number of providers available in an area. It may be required by law to contract with any willing provider 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 more common, particularly given that 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 used by many insurers that offer "narrow network" products through the health insurance exchanges.

Precertification and case management are almost always components of PPOs, but mandatory second opinion programs are relatively uncommon because they are no longer considered to be effective. Failure to comply with PPOs' rules result 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 (other than member cost-sharing), 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 also responsible for all charges above what is allowed.

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.

Risk-Bearing PPOs

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

Non-Risk-Bearing or Rental PPOs (Rental Networks)

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. Under the ACA, emergency care must be covered at the in-network level of benefits even for services provided by non-network providers. 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 a health plan 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 the same issue because TPAs typically do not have a network of their own.

Blue Cross and Blue Shield plans handle this 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, and it provides 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. 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 networks typically charge payers an access fee and charge separate fees for other services they may provide. Usually the rental network's providers send the claims to the rental network, which then reprices them and sends the claims on to the payer or TPA for payment. The rental network keeps a percentage of the difference between the full charges and the discount.

Some states require non-risk-bearing PPOs to be licensed, but not all. If the PPO performs any utilization management or even quality management functions, it may need to be licensed as a utilization review organization of some type. Likewise, if it performs any other administrative functions, including pre-pricing of claims, it may need to be licensed as a TPA.

In decades past, payers did not always make it clear that they had such contracts 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, though providers do not always look for it.

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 an HDHP. For 2019, the minimum deductible was $1,350 for individuals and $2,700 for families; the maximum allowable for out-of-pocket costs (meaning deductible plus any other cost-sharing) was $6,750 for individuals and $13,500 for families. In all cases, preventive services are not counted toward the deductible, 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 (CDHP) 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.*

In a CDHP, qualified healthcare costs (except preventive care) are typically 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 insurance plans, but 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 benefits 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

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

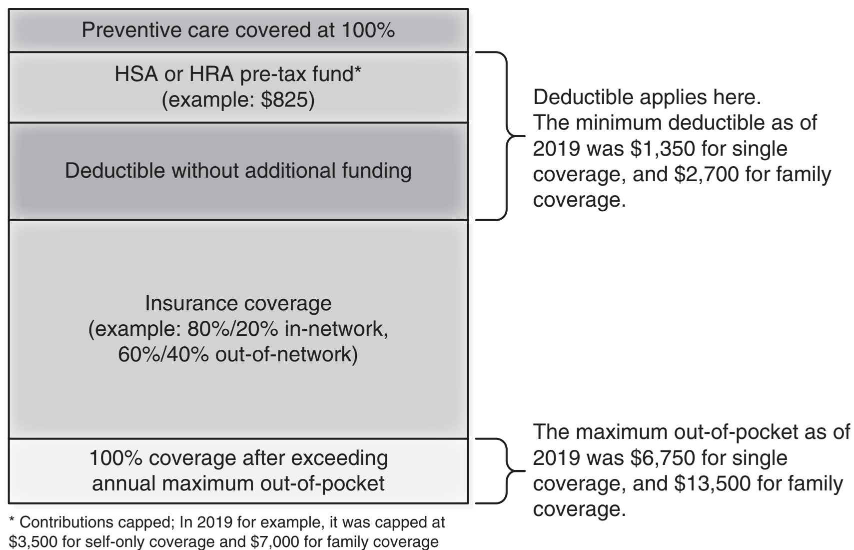

FIGURE 2.2 Example of Basic Construct of a Consumer-Directed Health Plan

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%–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. The amount of cost sharing is 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.

While they were initially popular, POS plans have become less common in recent 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 PPOs except benefits are only covered when nonemergency services are provided by the EPO's network providers, which is similar in that regard to HMOs. EPOs are really benefits design products offered by commercial payers that use their existing HMO or PPO networks, or based on rental networks in the case of some self-funded plans.

Health Maintenance Organizations

HMOs are unique in many ways. To begin with, HMOs are licensed differently than are health insurers. States issue an insurance license to health insurers, but issue a Certificate of Authority (COA) to HMOs.

Except for emergency care or when a state requires HMOs to offer POS benefits, benefits

coverage in an HMO *only* 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.

The majority of HMOs also manage utilization and quality to a greater degree than do PPOs. In most HMOs, members must access non-emergency care by going through their PCPs. Each member must 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, or 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 prior to the ACA's passage—but most HMOs still require them to choose a PCP. The exception to the use of the PCP as a "gatekeeper" is the so-called "open-access" HMO, which is really a type of EPO that uses an HMO license.

Benefits obtained through the HMO are almost always significantly more generous than those found in any other type of health plan. Payment for non-emergency services received from non-HMO providers is the responsibility of the subscriber, not the HMO, unless they have been preauthorized by the HMO. Financial penalties incurred 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 (this is also common with other types of payers, such as PPOs).

Traditional HMOs are generally defined by how they contract with network physicians, and currently fall into two broad categories: open panel and closed panel. These terms are no longer as widely used as in the past, but are still helpful for understanding the different types of HMOs. A third category, the network model, was once used for certain contracting situations involving very large medical groups, but is not a particularly specific term now. HMOs often combine or mix different model types in the same market, though usually not all types at the same time. With a few exceptions, HMOs contract directly with hospitals and other facilities.

Open-Panel Traditional HMOs

In an open-panel 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 see non-HMO patients as well. 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 what is found in a closed-panel plan but usually smaller than what is found in a PPO. Members must choose a PCP; they may change PCPs at certain times but only if the new PCP has the capacity to accept new patients.

Open-panel plans fall into two broad categories: IPAs, 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, an IPA, which is a legal entity, contracts with private physicians (PCPs and specialists) for purposes of then contracting with HMOs or other payers. The HMO in turn contracts with the IPA and pays it a negotiated capitation amount. 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 IPAs focusing mostly on payment terms and others taking on many routine HMO functions involving medical management and the like.

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

Closed-Panel HMOs

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 in the HMO, though they may be asked to choose a primary facility to ensure continuity of care. When specialty care is appropriate, referrals are made to specialists who are also in the HMO to the extent the HMO or group employs specialty physicians. However, even closed panel HMOs also contract with independent specialists to provide care to members who require services that the HMO does not itself provide.

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 closed panel 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 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 HMOs are not as common as they once were, but still exist as HMOs created by large integrated healthcare delivery systems (IDS) that have employed physicians.

Netw-ork Model HMOs

The term network model is often used to refer to an open-panel plan, but there is (or was) also a related type of network model in which 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 and are best thought of as a variant of the IPA model.*

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. And even large closed panel HMOs typically contract with independent physicians for some services. Mixed-model HMOs may offer the different models in the same products, or the models may operate independently of each other in different products.

Third Party Administrators and Administrative Services Only Agreements

TPAs refer to companies that administer a benefits plan on behalf of a self-funded employer to perform the benefit plan's administrative activities, such as handling enrollment and eligibility, processing claims, managing appeals, or any of the other activities described in other chapters in this book. TPAs are not shown back on Figure 2.1 because self-funded plans typically mimic the benefits designs of the other types of payers described above, at least in part. There are two common ways that self-funded plans contract to provide services, which are described next.

Contracting with Different Companies for Different Services

Some self-funded benefits plans contract with multiple companies to provide only specific services such as claims processing, access to a rental PPO network, medical management, and so forth. Because self-funded plans do not need to comply with state laws and regulations, they may not contract for other typical payer services such as quality management or disease management.

The plan pays a set fee for each service on an à la carte basis. Rental PPO networks are paid access fees, but also are typically paid a percentage of the contractual provider fee discount. When self-funded plans contract with multiple companies, the term TPA is commonly used for the company managing claims.

All but a few states require TPAs to be licensed, though with limited and narrow requirements unrelated to those for licensed health insurers and HMOs. Licensure and regulation of companies providing utilization management services is not uniform and some states require licensure (sometimes as a TPA, other times as an independent review organization), some states do not require licensure but do regulate it, and some do not require licensure or regulate it. Some states, but not all, have laws and regulations for rental networks, but there is no uniformity.

Contracting with Companies for All or Most Services

Many large self-funded plans are administered by large payers such Blue Cross and Blue Shield plans, a large commercial insurance company, or an HMO that provides all, or most, of the required services, in which case the term ASO or ASA is more likely to be used than TPA. Very large employers often contract with more than one large payer to allow employees to make a choice between types of plans, but each contracted payer still provides full services. But it is not uncommon for large groups to contract with a different company to manage pharmacy benefits, even

* Because Network Model is no longer a distinct term, it no longer appears on Figure 2.1.

when contracting with full-service payers. Payers performing ASO services must comply with the same state laws and regulations that apply to TPAs, usually creating subsidiaries to do so.

Conclusion

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

The means for providing and managing healthcare benefits 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 dynamic nature of the industry.