

CHAPTER

2

Types of Health Insurers, Managed Health Care Organizations, and Integrated Health Care Delivery Systems

ERIC R. WAGNER AND PETER R. KONGSTVEDT

STUDY OBJECTIVES

- Understand the different types of health insurers and managed health care organizations
- Understand key differences between these types of organizations
- Understand the inherent strengths and weaknesses of each model type
- Understand the difference between insured and self-funded health plans
- Understand the new payer envisioned in the Patient Protection and Affordable Care Act (ACA)
- Understand the basic forms of integrated delivery systems (IDSs) and how they are evolving
- Understand the major strengths and weakness of each type of IDS, initially and how they have played out as the markets developed
- Understand the roles of physicians and hospitals in each type of IDS
- Understand new IDS models being formed due to passage of the ACA

DISCUSSION TOPICS

1. Describe the continuum of health insurer and managed health care plans and key differences for each, using examples of each.
 2. Discuss the primary strengths and advantages and weaknesses and disadvantages of each type of managed care plan.
 3. Discuss in what type of market situations might each type of managed care plan be the preferred model.
 4. Describe how a managed care plan of one type might evolve into another type of plan over time.
 5. Discuss the key elements of the different types of integrated delivery systems.
 6. Describe the conditions under which a managed care plan would desire to contract with an integrated delivery system or conversely, avoid it; describe these conditions for each model type.
 7. Discuss the challenges and opportunities facing new types of payers and IDSs due to the ACA.
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■ INTRODUCTION

Describing the types of payer and provider organizations in a field as dynamic as managed health care is much like describing what a cloud looks like on a breezy day—it looks like a lot of different things to different people, and it keeps changing right before your eyes. This is no surprise because as was shown in Chapter 1, the health care system in the United States evolves continually and change is the only constant. With the passage of the Patient Protection and Affordable Care Act of 2010 (ACA), the American health care system faces more significant change than any time since the passage of Medicare and Medicaid during the 1960s.¹ Included among ACA's many provisions are several that add new acronyms to the managed care lexicon. Because of the size and complexity of the ACA and of our system as a whole, it is not possible to predict with certainty which elements or new organizational forms will endure and which ones will not.

Originally, health maintenance organizations (HMOs), preferred provider organizations (PPOs), and traditional forms of indemnity health insurance were easily distinguishable, mutually exclusive products and mechanisms for providing coverage of health benefits. Point of service (POS) plans appeared, combining HMO-like features with indemnity coverage, blurring the landscape. Managed care elements migrated to all product types, but didn't necessarily carry the same labels. Even newer types of plans such as high-deductible health plans (HDHPs) and related consumer-directed health plans (CDHPs) with pretax savings accounts, easily distinguishable at first, became less so as traditional PPO deductibles rose to five figures.

The reality is that health insurance and managed care have, for all practical purposes, merged, whether we see it or not. And mostly we don't. Research done back in 2002 during the latter portion of the managed care backlash (discussed in Chapter 1) found that most of the commercially insured American public, the vast majority of whom were in fact enrolled in a managed care plan, did not believe that they received their health care coverage through managed care.²

Further confusing the taxonomic landscape are different types of provider organizations collectively referred to as integrated health care delivery systems (IDSs)* that initially appeared in reaction to managed care, and to HMOs in particular. Just like managed care organizations (MCOs), IDSs evolved, morphed, and lurched from one form to another.[†] This dynamic continues today. For example, under

pressure from the Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program, new IDS models have come about, including primary care medical homes (PCMHs) and accountable care organizations (ACOs), which were also specifically given impetus in the ACA. Another example of continuing change is the striking degree to which physicians are no longer practicing independently, but are being hired by hospitals, a topic discussed briefly in this chapter and in more depth in Chapter 4.

The blurring of distinctions between types of health plans is a result of the adoption of managed care activities by different types of plans. When HMOs first appeared, for example, no other types of plans focused on managing inpatient utilization, so that activity was considered an attribute of HMOs. Because of the rising cost of inpatient care, however, most types of plans also began to address inpatient utilization. The same dynamic occurred in most medical management, covered in Part III of this book.

Despite this, very real distinctions between different types of managed care plans remain, and are worth understanding. Doing so means focusing not on particular processes or activities, but on how the plans are organized; what their relationship is with hospitals and, in particular, with physicians; what requirements are placed upon members and providers around health benefits coverage; and how they are licensed and regulated. For example, HMOs are licensed differently than are health insurers or PPOs, and have unique regulatory requirements.

■ TAXONOMY

It's bad enough that we must sometimes struggle to distinguish an HMO from a PPO from a POS plan or a CDHP. We must struggle equally with how we name these things. Recall that the term "MCO," which came to mean any kind of HMO, POS, or PPO as an indirect result of the managed care backlash discussed in Chapter 1, is now being used less often than it once was. It is now more or less interchangeable with another generic term, "payer,"[‡] referring to any organization that administers health benefits and pays providers.

The term "health plan" is often used colloquially as interchangeable with MCO, payer, and health insurer. That colloquial use occurs in this chapter as well as throughout the book, but is technically incorrect. The health plan is actually the health benefits plan, and that means the entity responsible for setting the benefits and bearing the risk for medical costs. As discussed next, a considerable amount of

* No reason that the "H" doesn't get used in this acronym other than "IDS" rolls off the tongue better, but IDS is the term commonly used.

† Just to add to the confusion, some of these types of IDSs are even required to be licensed by the state if they accept risk for medical costs. In California, for example, HMOs must have a Knox-Keene license, and IDSs that accept risk must have a "limited" Knox-Keene license.

‡ "Payer" as applied to a managed health care organization or a health insurer, in turn used to be spelled "payor," and is still used that way by many. On behalf of its editor, this book accepts its share of the blame for once pushing it that way, and now pushing it back.

coverage in this country is through employer-sponsored self-funded benefits plans in which the employer sets the benefits and bears the risk for medical costs, not the insurer. Legally speaking, the health plan is the employer while the payer organization is only an administrator, although it's still the payer because it actually processes claims payments. It's an important distinction for many purposes, but unimportant for others. It is therefore used interchangeably with MCO and payer except when it's necessary to make the distinction.

Some also use the term "health insurer" or even "insurer" to mean any kind of payer. Technically that too is incorrect because HMOs are licensed differently than are insurers, and an insurer may only administer the benefits for a self-funded benefits plan, but not hold the insurance risk for medical costs as just noted. This chapter, like the book, will use the terms "health insurer" or "insurer" broadly and will only distinguish by plan type or between being the insurer and being the administrator of a self-funded benefits plan when necessary to do so.

From a legal and regulatory standpoint, there is no difficulty with taxonomy. All of these different organizations are defined under laws, licensed accordingly if subject to licensure, and regulated as unique types of entities. That aspect is explored in Chapters 28–30. Because the content of this chapter and the rest of the book is from an operational standpoint, taxonomy is used consistent with the industry overall, not regulators. That's the reason for all of these terms sometimes being used differently depending on whatever point is being made.

To recap: For purposes of this chapter, the reader may assume that anytime the terms "MCO" or "payer" are used, it applies to all types of payer organizations. When the term "health plan" is used, it too is interchangeable with MCO and payer unless it's necessary to distinguish between an insured and a self-funded benefits plan. When describing a particular feature or function specific to a specific type of plan such as an HMO, POS, PPO, CDHP or self-funded health benefits plan, those specific terms will be used.

Along similar lines, the term "IDS" is also used generically, with more specific IDS types identified as appropriate. But that can wait until later in the chapter.

■ INSURED VERSUS SELF-FUNDED BENEFITS PLANS

Before delving into the different types of payers, it is worth looking at the differences between insured and self-funded benefits plans. Less than half of all employer group health benefits plans actually are covered under health insurance. As of 2010, over 59% of all group health coverage was through employer self-funded group health benefits plans, a percentage that has been slowly increasing, as shown in **Table 2-1**. The larger the employer group, the more likely it is to self-fund its plan. The proportion of insured to self-funded business will vary from payer to payer. National companies have a lot of self-funded accounts, and local or regional companies have more insured business. HMOs also tend to have more insured accounts than self-funded ones, but that too varies.

In health insurance, employers or individual subscribers pay premiums and the health plan is at risk for the cost of covered medical services. But under provisions in the Employee Retirement Income Security Act (ERISA; see Chapter 29), employers are allowed to self-fund their benefits plans. In a self-funded plan, the employer is at risk for the cost of covered medical services, and the money used to pay claims is provided by the employer only at the time claims are paid on its behalf, not from premiums paid to an insurer or HMO.

By self-funding an employer avoids paying state premium taxes or complying with most (though not all) state laws and mandated benefits. It also means keeping any profit an insurer would make on the premiums. On the other hand, the level of risk is high and only predictable when looking at large numbers of covered lives. A small risk pool, meaning a small number of individuals covered

TABLE 2-1

Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999–2010

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3–199 workers	13%	15%	17%	13%	10%	10%	13%	13%	12%	12%	15%	16%
200–999 workers	51	53	52	48	50	50	53	53	53	47	48	58*
1,000–4,999 workers	62	69	66	67	71	78	78	77	76	76	80	80
5,000 or more workers	62	72	70	72	79	80	82	89	86	89	88	93
ALL FIRMS	44%	49%	49%	49%	52%	54%	54%	55%	55%	55%	57%	59%

Source: "Employer Health Benefits 2010 Annual Survey (#8085), p.170. <http://ehbs.kff.org/pdf/2011/8225.pdf>." The Henry J. Kaiser Family, September 2010. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

under the plan, is subject to chance more than anything else; for example, an employer with 23 healthy marathon-running employees may have very low costs, until one of those runners is hit by a bus, has four surgical repairs and a new hip, and spends 8 months in rehabilitation. For that reason, typically it's only the large employers that self-fund, but the number of mid-sized firms that self-fund has been increasing recently.

Self-funded employer groups typically purchase reinsurance to protect themselves against very high costs. Some large health insurers and Blue Cross Blue Shield (BCBS) plans in fact sell reinsurance to self-funded customers, but a substantial portion of reinsurance is purchased from commercial reinsurance firms, both domestic and international. Some companies even use what is called a “captive” insurance or reinsurance company, meaning one they own themselves and use primarily for their own purposes. Captives are often domiciled offshore where they are regulated differently than U.S. Insurers.

Reinsurance, however, is not health insurance. It is not required to provide the same breadth of coverage, and is not subject to the ACA or ERISA. For example, an employer with a self-funded plan will be required to provide certain benefits and may not discriminate among employees, but a reinsurer may decline to cover certain benefits (e.g., transplants) or even certain individuals in the plan (e.g., a severely ill neonate). This is known as “applying a laser” or “lasering” the reinsurance policy, meaning a highly focused exclusion or exclusions. Not all reinsurers use lasers, but when they do, it's typically upon renewal after the condition(s) have been identified, not when the initial policy was sold, so the restriction(s) only applies going forward. The employer, however, is still responsible for covering employee benefits, but will have no reinsurance protection for excluded high-cost conditions or cases and will be unable to buy affordable reinsurance from another carrier.

Another difference between reinsurance and health insurance is the period during which a cost may be covered, and under what conditions. In health insurance, coverage begins when a member is both eligible and enrolled, and coverage may be retroactive. It ends when the member is either no longer eligible or leaves the plan. Costs incurred during that period of time are covered subject to the types of terms such as compliance with utilization management (UM), discussed later in this chapter and in Chapter 7. This is also applicable to self-funded benefits plans.

That is not the case with reinsurance. Reinsurance is typically one of several forms, including:

- **Claims made**, meaning the reinsurer has liability only when the event occurred and the insurer was informed of the potential for liability while the insurance is in

force. If informed after the policy has lapsed, the insurer has no liability.

- **Claims paid**, meaning coverage is only for medical claims paid by the health benefits plan in a specific time period (e.g., 1 year). The coverage is for any claims paid during the contract period, regardless of when the costs were actually incurred. After the period of coverage has ended, there is no further coverage for costs even if they were incurred during the period when the reinsurance was in force and the reinsurer was notified, but no claims were paid by the benefits plan.
- **Occurrence**, meaning coverage applies if the policy was in force when the event occurred, regardless of whether or not the reinsurer was notified or a claim was paid. This is most like actual health insurance, and is also either the most expensive or unavailable.

Because of the guaranteed issue requirement in the ACA, an employer that cannot obtain unrestricted reinsurance will still be able to purchase actual health insurance beginning in the year 2014. However, only premiums for small employer groups are pooled together under community rating (see Chapter 22). Large groups may be experience rated. In other words, beginning in 2014, a large employer with high costs but a lasered reinsurance policy will be able to purchase unencumbered health insurance—but it won't be cheap.

From an operational point of view, self-funded employer groups contract with an administrator to manage their plans on a day-to-day basis under an administrative services only (ASO) contract. The administrator is paid only to administer the benefits plan on behalf of the plan sponsor, but is not paid to assume risk for medical costs and does not hold the money used for claims payment. Self-funded employers usually (but not always) contract with payers such as HMOs, commercial insurers, or BCBS plans to administer their benefits plan, and the payer's logo will appear on ID cards and correspondence. Doing so allows the self-funded plan to take advantage of a payer's network (the topic of Part II in this book), medical management (Part III), and claims adjudication and member services capabilities (Part IV). To everyone except the employer and the plan administrator, there is no obvious difference between insured or self-funded.

Health insurers have few barriers to being the administrators of self-funded plans. But HMO regulations of some states preclude HMOs from offering self-insured benefits plans. HMOs avoid these prohibitions by incorporating related corporate entities that use the HMO's negotiated provider agreements, management systems, utilization protocols, and personnel to service the self-insured line of business. They also use contract amendments or appendices

that add the HMO-related entity to the contractual terms, and typically use a logo that is nearly indistinguishable from the regular logo.

There are several reasons to discuss self-funding in the context of this chapter. The first reason is to dispel the notion that every time a payer does something to lower medical costs, they pocket the money. But when savings apply to self-funded business, it lowers the amount the employer pays but has no impact on the payer’s administrative fees.* The second reason is to explain why certain inconsistencies may appear in how medical benefits are covered. ERISA allows an employer with a self-funded plan a great deal of latitude in benefits design; they will be more limited beginning in 2014 under the ACA (see Chapter 30), but still allowed to differ from insured benefits in some regards. This latitude means they can choose to cover a benefit differently than how the payer typically does, although as a practical matter they usually go with existing payer policy. Finally, because ERISA defines the self-funded employer as the plan sponsor (the payer organization is simply the administrator), they can and sometimes do set up their own unique health plans, and on occasion even “private label” them. ERISA is discussed further in Chapter 29.

■ THE MANAGED CARE CONTINUUM

Before discussing each specific type of insurer or managed health care plan, it helps to look at how the most common types of payers array along the continuum illustrated in **Figure 2-1**. This is done by looking at a combination of structural and functional differences, bearing in mind that the functional differences are less pronounced than they once were.

On one end of the continuum is managed indemnity with simple precertification of elective admissions and

* Typical ASO contracts do not pay the administrator—the payer organization—for medical savings. Performance requirements are usually limited to claims payment speed, member services responsiveness, and so forth.

large case management, superimposed on a traditional indemnity insurance plan. Similar to indemnity is the service plan, which has contractual relationships with providers addressing maximum fee allowances, prohibiting balance billing, and using the same UM techniques as managed indemnity. Indemnity or service plans typically remain the licensed entity upon which other types of managed health care plans other than HMOs are built, however.

Further along the continuum are PPOs, POSs, open-panel (both direct contract and individual practice association [IPA] types) HMOs, and finally closed-panel (group and staff model) HMOs. Progressing from one end of the continuum to the other, new and broader elements of management and accountability are added, the complexity and the associated overhead increases, and the potential for control of cost and quality increases as well.

CDHPs, which combine a high-deductible insurance policy with a PPO network and a unique pretax medical savings plan, do not fit neatly on this continuum, although they are closer to PPOs than the other traditional types. Because of that, as well as their continued evolution, they are separately described later in the chapter. Even further afield from this model are third-party administrators (TPAs) that provide á la carte, barebones services to self-funded plans, and they too are separately addressed later in the chapter.

Types of IDSs, including new organization models and approaches envisioned in the ACA such as ACOs and PCMHs, have some attributes applicable to this continuum, but are even less easy to classify than different types of MCOs. Furthermore, they are primarily in the business of providing health care, not managing the health care benefit. Therefore, they are addressed separately later in the chapter. The last major topic addressed in this chapter is vertical integration.

■ TYPES OF HEALTH INSURERS AND MANAGED CARE ORGANIZATIONS

With the clear understanding that functional features of one type of plan often appear in another, what follows is a

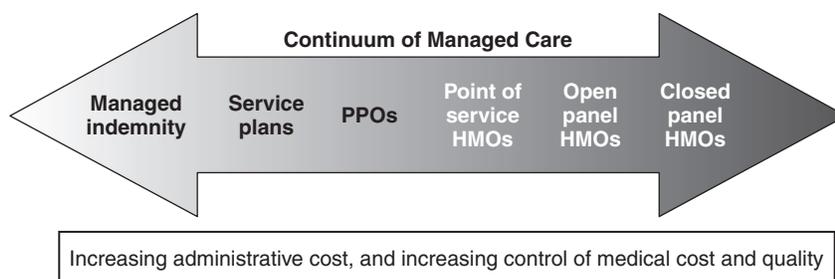


FIGURE 2-1 Continuum of Managed Care

discussion of the broad types of health insurers and managed care organizations. As noted earlier, the terms “insurer,” “MCO,” “payer,” or “health plan” may be used to cover the whole array of plan types. But distinctions between types of MCOs are not mere historic relics; there are differences that matter, and the terms themselves still enjoy wide usage (or misuse in some cases).

Unless one works in the industry, it’s hard to grasp just how many different legal designations exist for payer organizations. It is common for a single company to be made up of multiple variants, each licensed under different sets of laws and regulations. States also usually require HMOs and insurers to be licensed as a state corporation. As of 2011, for example, a partial list of company names used by the national payer company Aetna included:

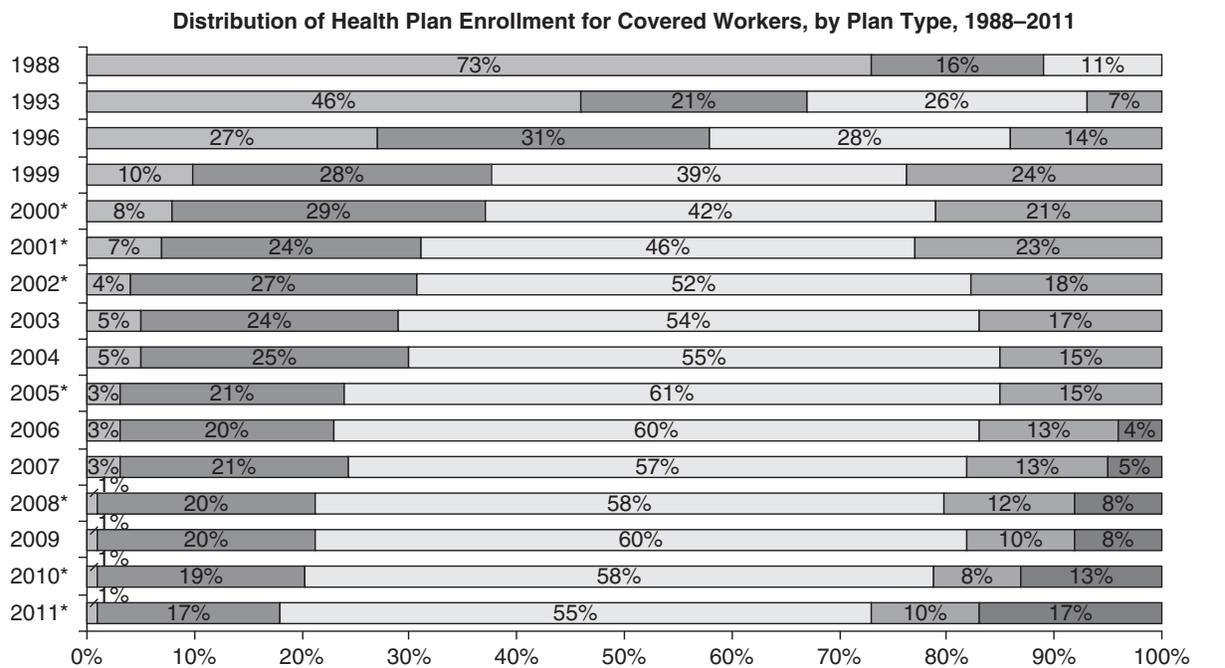
- Aetna Health of [State]* Inc. (HMO corporations in the states in which they operate);
- Aetna Health Insurance Company;

- Aetna Life Insurance Company;
- Aetna Life Insurance Company HMO;
- Aetna Health Inc. Preferred Provider Benefit Plans; and
- Aetna Dental of [State] Inc.³

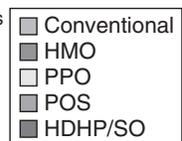
There are also distinctions that are important for reasons that may have little or nothing to do with what the payer sells and manages. To the average consumer, for example, there is no difference between a not-for-profit insurance company and one organized as a mutual insurer; neither pays dividends to stockholders. To take it further, a mutual uses financial surpluses to the benefit of its policyholders (usually putting it toward premiums) because policyholders technically “own” the company, similar to a health care cooperative (co-op). These types of distinctions will only be referenced if it’s important to do so, but will otherwise not be discussed further.

Figure 2-2 shows how the major different types of plans have grown or declined between 1988 and 2010. This section is not confined to only these, however, and many types of plans, such as HMOs, have many variants of their own.

*[State] means the name of each individual state, where applicable.



* Distribution is statistically different from the previous year shown (P<0.05). No statistical tests were conducted for years prior to 1999. No statistical tests are conducted between 2005 and 2006 due to the addition of HDHP/SO as a new plan type in 2006.



Note: Information was not obtained for POS plans in 1988. A portion of the change in plan type enrollment for 2005 is likely attributable to incorporating more recent Census Bureau estimates of the number of state and local government workers and removing federal workers from the weights. See the Survey Design and Methods section from the 2005 Kaiser/HRET Survey of Employer-Sponsored Health Benefits for additional information.

FIGURE 2-2 Distribution of Health Plan Enrollment for Covered Workers, by Plan Type, 1988–2011

Source: “Employer Health Benefits 2011 Annual Survey, (#8225),” p. 61. <http://ehbs.kff.org/pdf/2011/8225.pdf>. The Henry J. Kaiser Family, September 2011. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. The Kaiser Family Foundation is a nonprofit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.

Indemnity Insurance or Indemnity Coverage

Indemnity type of health insurance is simply that: it indemnifies the beneficiary from financial costs associated with health care. Indemnity insurance and service plans (see later) were the main type of health plan prior to the advent of managed health care, with notable exceptions, as discussed in Chapter 1. Originally, few controls were in place to manage cost, and coverage was only for illness, not for wellness; preventive services such as immunizations; or prescription drugs. The insurance company usually paid based on billed charges, but it might also determine what a maximum appropriate charge should be for a professional visit, and base coverage on that rather than the billed amount. Providers were free to bill the beneficiary for anything not paid by the insurance company. In some cases, the insurance company paid the money directly to the beneficiary and the provider was required to collect unpaid amounts from the beneficiary.

Rising health care costs hit traditional indemnity health insurance hard during the 1980s and early 1990s. Their initial response was to add a managed care overlay, which is discussed shortly. But overall, as managed care grew, indemnity insurance shrank. It now makes up only 1% of the market, making it rare but not quite extinct. It may also be a component of another type of plan such as a POS plan.

But the disappearance of traditional health insurance does not mean the disappearance of the health insurance industry. Traditional health insurance was (and for the tiny amount still in the market is) a product, not a company. Health insurers consolidated as most traditional health insurance carriers exited the business by selling the health insurance book of business to another insurer or by being acquired. The remaining carriers built PPOs on their insured products, using their existing licenses, along with building or acquiring various other types of managed health care plans.

Service Plans

Service plans, the majority (though not all) of which are Blue Cross and Blue Shield (BCBS) plans, have their origins with the providers themselves, as discussed in Chapter 1. Traditional service plans are similar in some ways to indemnity insurance from a benefits standpoint, but differ in a very important way: they have a contracted provider network. The contract brings several highly significant elements found in all managed care plans (Chapter 6), elements that grow stronger further down the continuum:

- The plan contracts directly with providers (physicians, hospitals, and so forth);
- Provider contracts specify that the plan will pay them directly and they may only bill the patient (member) for coinsurance, copays, or deductibles;

- The plan has a method of calculating
 - The maximum professional fee(s) for all procedures or provider visits, and
 - The appropriate payment to hospitals;
- As long as a member receives services from a contracted provider, the member is protected from balance billing; that is, a provider cannot bill the member for
 - Charges denied by the plan, or
 - For any differences between the amount the provider charged and what the service plan determined is the maximum allowable amount, referred to as “allowed charges.”

Unmanaged service plans were subject to the same pressures as indemnity insurance in regard to medical costs, and suffered the same fate. The difference is that their traditional insurance products may have disappeared but the service plan itself did not. Like the traditional health insurance carriers, service plans easily evolved into PPOs, but they also continue to exist as distinct contracted networks alongside the PPO. In that case, a service plan contracted provider that chooses not to participate in the service plan’s PPO will still be bound by the terms of the service plan contract when seeing PPO members. The other major legacy of service plans is that they often had, and still have, the largest networks in a community, which provides a competitive advantage even now, although not for the original traditional product.

Managed Indemnity

As HMOs began to succeed in controlling the utilization and cost of health services, traditional carriers responded by developing managed care overlays that could be combined with traditional indemnity insurance, service plans, or indemnity-like self-funded benefits plans (the term *indemnity insurance* is being used to refer to all three forms of coverage in this context). These managed care overlays were intended to provide some measure of cost control for indemnity plans, while retaining the individual’s freedom of choice of provider, and coverage for out-of-plan services.

These managed care overlays are also still present in the market, having evolved to be applicable to other types of products. Although traditional indemnity health insurance is now rare because of the high cost, other forms of nonhealth indemnity health coverage exist in which they are used, such as workers’ compensation.* They are also used by large self-funded plans that choose which services to overlay on their plan and which they may forgo. The services are provided by the payer or by separate companies

*Workers’ compensation benefits are regulated under labor laws. When insured rather than self-funded, the insurance is a form of property/casualty insurance, not health insurance.

that specialize in that service, and more than one company may provide services to a self-funded account.

The following are the most common types of managed care overlays:

- *General utilization management.* These companies offer a menu of UM activities that can be selected by individual employers or insurers.
- *Large case management.* Some firms have developed to assist employers and insurers with managing very costly cases, also called large or catastrophic cases, regardless of the type of care involved. This service includes screening to identify catastrophic cases, collection of information required for timely notification of a reinsurer, ongoing monitoring of the treatment, providing assistance in managing the case, and negotiating provider payments for high-cost cases.
- *Specialty utilization management.* Firms that focus on utilization review for specialty services have become common. Behavioral health (see Chapter 12) and dental care are two examples of specialty UM overlays.
- *Disease management.* Free-standing disease management (DM) companies or an insurer's internal program may focus on specific common, chronic diseases such as diabetes rather than on utilization more broadly. See Chapter 8 for a detailed discussion of DM.
- *Rental networks.* Some offer networks of contracted providers within individual markets and bear strong resemblances to PPOs (discussed later and in Chapter 4).
- *Workers' compensation utilization management.* In response to the rapid increases in the cost of workers' compensation insurance, firms have developed managed care overlays to address both standard UM and some unique aspects involved with workers' compensation benefits.

Indemnity insurance companies that remained in the business of health insurance typically carried these concepts several steps farther along the continuum by transforming themselves into PPOs, and through acquisitions of HMOs and other managed care companies. In fact, all of the major indemnity insurance companies that existed at the beginning of the 1990s have either sold their health insurance business lines to other companies or acquired major managed care companies.

Preferred Provider Organizations

PPOs, which are currently the dominant type of managed care plan, are entities that contract with a network of participating providers, who are therefore considered "preferred." Participating providers contractually agree to accept the PPO's payment structure and payment levels, and the PPO agrees to pay the provider directly rather than send the check to the member. In these two ways, PPOs are similar to service plans. However, PPO providers also agree

to abide by stronger UM requirements and other procedures implemented by the PPO, and any consequences of failing to abide by those requirements is borne by the provider, not the member. Payment terms also usually represent a greater discount than those found in service plans.

In return, members who see PPO providers for care have higher levels of coverage; for example, an in-network office visit may require a \$20 copayment, but an out-of-network office visit is subject to the deductible, then 40% coinsurance once the deductible is met, plus the nonparticipating provider will balance bill for the entire amount of billed charges. PPOs may limit the size of the network in order to provide more business to participating providers, but many states passed "any willing provider" laws (see Chapter 28) requiring the PPO to accept any provider meeting its credentialing criteria (see Chapter 4) who also agrees to the PPO's terms. PPOs can be broad or they can be specialty-only (e.g., behavioral health, chiropractic, or dental).

PPOs vary in how they perform UM. In many PPOs, the PPO itself is responsible for UM. Other PPOs agree to work with third-party companies that perform UM, or the PPO may own a UM company. PPOs not owned and operated by health insurers or BCBS plans typically also agree to comply with an employer's or a payer's UM program. Specialty PPOs more often perform their own UM, however. Quality management (QM) has, until recently, been almost an afterthought in PPOs, as was accreditation (see Chapter 15), but that has been changing.

PPOs may be owned by many different types of organizations, as illustrated in **Table 2-2**. Furthermore, a PPO may be operated solely for the benefit of its owner—for example, a PPO created by a BCBS plan that provides services only to BCBS members—or it may be a so-called rental PPO that was formed to offer services to any health plan under an administrative fee agreement (which may be limited to an access fee alone, or may include fees for other activities such as UM, claims repricing, etc.). Rental PPOs are discussed in more detail in Chapter 4.

When PPO coverage is insured, it is through a health insurer licensed in the states in which it operates, while single-employer self-funded PPO plans are not subject to state licensure. States may have laws limiting benefits differences between in-network and out-of-network coverage (e.g., no more than a 20% difference). Some states go further and require PPOs to be licensed as PPO entities, and a few states such as Pennsylvania further differentiate between a provider-sponsored PPO and an insurer-sponsored PPO, under the reasonable assumption that a provider-sponsored PPO is typically not in the risk business.

Like most other parts of the health care industry, the PPO segment has experienced substantial consolidation during the last decade. The number of PPO companies declined by more than half to 476 from 2000 to 2009, even as enrollment increased from approximately 100 million enrollees at

TABLE
2-2

PPO Ownership—2009

Type of owner	Number of eligible employees (millions)	Percentage of eligible employees	Number of PPOs
Employer or employer coalition	0.7	0.5	3
HMO	6.0	4.1	34
Hospital	0.2	0.1	2
Hospital alliance	8.7	6.0	51
Independent investor	29.5	20.1	36
Insurance company	90.9	62.0	304
Multi-ownership	7.3	5.0	25
Physician/hospital joint venture	2.4	1.6	9
Physician/medical group	0.6	0.4	7
Third-party administrator	0.3	0.2	2
Other	0.1	<0.1	3
Total	146.8	100%	476

Source: Sanofi-Aventis Managed Care Digest Series, *HMO-PPO Rx Digest 2010–2011*. www.managedcaredigest.com, accessed May 21, 2011. Used with permission.

the turn of the century to almost 150 million during 2009.⁴ Since the last edition of this book, enrollment has become much more concentrated in PPOs owned by insurance companies, growing from 47.9% of enrollment in 2004 to almost 62.0% of enrollment in 2009. This also meant that in the same period, PPOs owned by investors saw their share of enrollment cut in half, from 40.4% to 20.1%. Some of this change was because insurers bought previously independent PPO companies, while some is due to insurers needing less rental PPO coverage as a result of having expanded their own networks.

Exclusive Provider Organizations

Exclusive provider organizations (EPOs) are similar to PPOs in their organization and purpose. Unlike PPOs, however, EPOs limit benefits coverage only to services provided by participating providers, except urgent or emergency services. Because EPOs typically do not otherwise cover services received from nonparticipating providers, they share at least one similarity to HMOs. EPOs typically are not licensed as HMOs, but use an existing PPO network for in-network services and most often are used by self-funded employer groups or governmental benefits plans not subject to typical state regulation. In some cases the EPO was created specifically for a single employer, but most PPOs and national insurers offer EPO plans to employers using their existing PPO networks. Unlike HMOs, EPOs typically do not require a member to coordinate all specialty and facility-based care by going through a primary care provider (PCP) “gatekeeper,” as described later in this chapter.

EPOs typically are implemented by self-funded employers whose primary motivation is cost-saving. These employers are less concerned about the reaction of their employees to severe restrictions on the choice of health care provider and offer the EPO as a replacement for traditional health insurance or PPO coverage. State and local governments may take the same approach for the same reasons.*

Recently, a few large employers combined EPO-type health plans for their employees and coupled them with onsite primary care centers.[†] Under some of these programs, the employees and covered dependents are not only limited to the EPO’s provider network, they also are required to receive their primary care (and sometimes their prescription drugs too) through the onsite centers. These onsite primary care centers also usually serve as the providers of occupational medicine for the employers who implement them. In the view of the employers who offer this hybrid plan, they are striving for both higher quality care and lower costs of providing benefits. While a number of employers have expressed interest in implementing these types of EPO plans, the actual number of plans and covered individuals remains small.

* Under ERISA, state and local governmental benefits plans, as well as church-sponsored benefits plans, are technically not considered self-funded, but may administer their plans as though they are a single-employer self-funded plan. Federal employee health benefits plans are subject primarily to regulation only through the Office of Personnel Management.

[†] As an example, Cerner Corporation, which is a large health care information technology company, offers such a health benefit plan to its Kansas City–based employees and dependents.

Point-of-Service Plans

POS plans essentially combine an HMO (or HMO-like health plan) with indemnity-type coverage for care received outside of the HMO. HMO members covered under POS benefit plans may decide whether to use HMO benefits or indemnity-style benefits for each instance of care. In other words, the member is allowed to make a coverage choice at the *point of service* when medical care is needed.

They originated in the second half of the 1980s as a way for large self-funded employers to provide a managed care plan that would combine the cost savings of an HMO without completely losing coverage for care provided out of network. This would address the fears of individuals who worried they might need care from a renowned specialist for a rare (and expensive) disorder and that the HMO would not authorize it or cover the cost.

POS plans also provided a way for HMOs to broaden their appeal and gain enrollment. It was also very appealing for large insurers that owned HMOs, but who never were completely comfortable with the concept. Soon nearly all insurers with HMOs offered POS plans. Independent HMOs were slower to adopt POS plans, however. Because HMOs are licensed differently than are health insurers, free-standing HMOs needed to obtain a health insurance license to offer such coverage. As the managed care backlash grew (Chapter 1) a few states even passed laws mandating that all HMOs provide out-of-network coverage, effectively converting their HMOs to POS plans in a stroke.*

The indemnity coverage available under point-of-service options from HMOs typically incorporates high deductibles and coinsurance to encourage members to use HMO services within-network instead of out-of-plan services. Payment may also be limited to the amount the HMO would have paid an in-network provider, which typically is much less than the amounts charged by out-of-network providers. Members who use the non-HMO benefit portion of the benefit plan may also be subject to utilization review such as preadmission certification and continued stay review (Chapter 7).

POS plans and PPOs both provide differing benefits coverage levels for in-network and out-of-network services, but they are not equivalent. **Table 2-3** provides a comparison between them.

Once touted as yet another wave of the future, they grew in the mid-1990s, only to decline in popularity as their hoped-for cost savings failed to materialize, as charted in Figure 2-2.

Health Maintenance Organizations

HMOs are classified primarily by the type of relationship it has with the physicians who provide services to

*This only applied to HMO coverage for which the HMO was at risk. Under ERISA, self-funded HMO coverage is not subject to such state laws.

TABLE 2-3

Differences between Typical PPOs and POS Plans

Feature	PPO	POS
Licensed as HMO	No	Yes
Licensed as insurer	Yes	Yes
Level of benefits when provided by in-network providers	Good	Comprehensive
Must go through PCP “gatekeeper” for highest level of benefits for nonemergency care	No	Yes
Deductible prior to any coverage for in-network, facility-based services	Yes	Usually not
Coinsurance versus copay for in-network services	Varies	Copay
Differential between in-network and out-of-network benefits limited to 20%	Yes	Varies, but often higher
Confined to HMO service area	No	Yes

Source: Copyright P. R. Kongstvedt. Used with permission.

its members, which was codified in the HMO Act of 1973 (Chapter 1). Early forms of HMOs such as prepaid group practices, co-ops, and early foundation model (IPA-like) HMOs existed prior to 1973, but most coverage at the time was through traditional indemnity insurance or service plans with no coverage restrictions related to who provided medical services. HMOs had such restrictions, so the Act required HMOs to have a health care delivery system in place that members would use for most health care services. Specifically, the Act defined an HMO as: “...a public or private entity which is organized under the laws of any State and which [...] provides basic and supplemental health services to its members† in the manner prescribed by subsection (b) of this section.”

Subsection (b) referenced in that definition went on to describe a set of comprehensive benefits, fixed payments to the HMO, and a number of other provisions, including the requirement that:

“...at least 90 percent of the services of a physician which are provided as basic health services shall be provided through

- (i) members of the staff of the health maintenance organization,
- (ii) a medical group (or groups),
- (iii) an individual practice association (or associations),
- (iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

†Members were defined as an “enrolled population,” similar to how all health plans view members.

- (v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.”⁵

In other words, HMOs are not only responsible for handling the financial aspect of benefits coverage, which is also what traditional health insurers and service plans did, but they were also responsible for creating and maintaining a health care delivery system to provide those covered services. The provisions of Subsection (b) defined the basic types of HMO health care delivery systems, and we continue to define them that way today. In discussing them in this section, however, the order of subprovisions (iv) through (i) will be reversed for two reasons: (1) it more closely aligns with the continuum of managed care shown in Figure 2-1 and (2) it aligns with decreasing market presence.

Almost all HMOs contract directly with hospitals and health systems, with some rare exceptions, so the relationship between an HMO and the hospitals in its network has traditionally had no bearing on what type of HMO it is. In the short term, the rapid increase in health systems employing large panels of physicians, as well as the appearance of new IDS structures such as PCMHs and ACOs, is unlikely to have much impact on plan type. Whether or not this remains the case is hard to predict, especially for IDSs and HMOs heavily involved in Medicare and/or Medicaid. Furthermore, issues germane to closed-panel HMOs can and do resonate with issues faced by health systems with large panels of employed physicians.

It is worth emphasizing one particular HMO feature: with limited exceptions, states allow only HMOs to share risk with providers. That once was a true statement for Medicare as well, but some of the payment reform models described in the ACA for traditional fee-for-service (FFS) Medicare contain language that implicitly and explicitly have elements of financial risk, although not the full-risk model that sank the PSOs. States may well adopt some of these to help ameliorate their growing Medicaid costs and allow them for non-HMO health plans as well. Risk-sharing and other payment topics are addressed in Chapter 5.

All HMOs, regardless of model type, share a few things in common that differentiate them from health insurers. There are also a few things common to almost all HMOs, but exceptions exist. Both are listed here, and the appropriate chapter in the book is identified in brackets.

Important differentiating elements common to *all* HMOs include:

- Licensed by states under different laws and statutes than health insurers are, and are subject to more stringent rules and regulations [Chapter 28].
- Must provide adequate access to providers within its service area, defined by states and/or Medicare as appropriate [Chapter 4].

- Must include “no balance billing” clauses in all provider contracts that are stronger than those found in non-HMOs, in which a provider agrees to never bill a patient covered under the HMO for charges that the HMO is obligated to pay, even if disagreements arise between the provider and the HMO or the HMO goes out of business altogether [4].
- Must allow direct access to PCPs and ob/gyn physicians [Chapters 5, 7, and 30].
- Must have written policies and procedures for
 - Physician credentialing [Chapter 5];
 - UM [Chapter 7]; and
 - QM [Chapter 14].
- Must maintain defined minimum levels of capital reserves (called claims reserves) to be able to continue to pay claims even if they are losing money [Chapter 21].

Elements common to *most* HMOs include:

- Usually share some level of financial risk with some physicians [Chapter 6]
 - Usually only with primary care
 - Can be with a medical group
 - Can be with the entire physician network or an independent practice association (IPA)
 - Level of financial risk usually modest, and limited by law for Medicare HMOs.
- Most require members to see a PCP for routine services and to access specialty care [Chapter 7].
- Most are accredited by one of three accreditation organizations [Chapter 15]:
 - The National Committee on Quality Assurance (NCQA);
 - URAC*⁵; or
 - The Accreditation Association for Ambulatory Health Care (AAAHC).

Types of Health Maintenance Organizations

Broadly speaking, HMOs may be viewed as either open-panel plans or closed-panel plans. Open-panel HMOs contract with private physicians who agree to provide care to the HMO’s members, and are therefore considered open to private physicians who agree to the HMO’s terms and conditions and who meet the HMO’s credentialing criteria (see Chapter 4). In other words, open-panel HMOs do not themselves provide care to members, but rely on private physicians to do so.

Closed-panel HMOs provide most of the care to members through either a single medical group associated with the HMO or through physicians employed by the HMO, and are therefore considered closed to private physicians. In other

*URAC used to stand for Utilization Review Accreditation Commission, but URAC is now simply URAC.

words, closed-panel HMOs do provide care to members, although even closed-panel HMOs contract with private physician specialists for some services. A third category is the true network model HMO, found primarily in the western United States. HMOs also may employ more than one model type.*

There are two types of open-panel HMOs and two types of closed-panel HMOs. Most HMOs use more than one approach but one will predominate, and that is typically how the HMO is classified. Their distribution as of 2009 is shown in **Table 2-4**. Each is addressed in more detail next.

Independent Practice Association Model

IPA model HMOs make up almost half of all operating HMOs in the country, as shown in Table 2-4. In this model, the HMO contracts with an association of physicians—the IPA—to provide physician services to their members. The HMO does not contract with the IPA physicians directly. The IPA is a distinct legal entity, and its physician members are independent private practitioners. IPA physicians continue to see their non-HMO patients and maintain their own offices, medical records, and support staff. The term “independent” relates only to the relationship the physician has with the HMO and with the IPA; in other words, the physicians are not employees of the HMO or the IPA, but are independent contractors. Physicians in an IPA can, however, be employees of medical groups or health systems.

IPAs typically seek to contract with physicians from all specialties. Broad participation of physicians allows the IPA to provide all necessary physician services through participating physicians and minimizes the need for IPA

physicians to refer HMO members to nonparticipating physicians for care. The IPA also performs credentialing[†] and network management (see Chapter 4) and often some medical management such as referral authorizations (see Chapter 7).

IPAs usually follow one of two different approaches in relationship to HMOs: (1) the IPA has been independently established by community physicians and it contracts with more than one HMO in the community or (2) the HMO works with community physicians to create the IPA, which then contracts with the HMO on an exclusive basis. As health systems grow their base of employed physicians, they may form health systems–specific IPAs that would resemble nonexclusive IPAs in their approach to HMO contracting.

Physician payment is discussed in detail in Chapter 5, but is briefly addressed here to show that the payment methodology used by an HMO may not always align with how practicing physicians are actually paid.[‡] Most (though not all) HMOs pay the IPA through capitation for all physician services. Independent IPAs typically use the capitation money to pay participating physicians using either FFS or a combination of FFS for specialists and capitation for PCPs, although an IPA may also capitate certain specialists. When using FFS, IPAs typically pay all their participating physicians using a fee schedule, but withhold a portion of each payment for incentive and risk-sharing purposes. An IPA made up predominantly of employed physicians, one associated with a health system, for example, may pay physicians a salary with a productivity bonus.

Unlike the direct contract model described next, the IPA provides a vehicle for otherwise independent physicians to negotiate as a group with the HMO. While it provides the physicians with some of the negotiating benefits of belonging to a group practice, it differs in that individual members of an IPA retain their ability to negotiate and contract directly with the HMO. Because of their acceptance of combined risk through capitation payments, IPAs are generally immune from antitrust restrictions on group activities by physicians as long as they do not prevent or prohibit their member physicians from being able to contract directly with an HMO. As a practical matter, it is uncommon for physicians to bypass the IPA.

Direct Contract Model

As the name implies, direct contract model HMOs contract directly with independent physicians or medical groups to provide physician services to their members. Because there is no IPA, the HMO does the credentialing (an HMO could

*NB: The terms “open panel” and “closed panel” are useful for understanding HMO structure, but are used in less often in general discussions than they once were, in favor of more specific HMO identifiers.

TABLE 2-4

Distribution of Enrollment by HMO Model Type, 2009

Model Type	Operating HMO plans		HMO enrollment	
	Number	Percentage	Number (Millions)	Percentage
IPA	218	49.9%	34.8	46.2%
Network/direct contract	170	38.9%	23.8	31.6%
Group	36	8.2%	15.1	20.1%
Staff	13	3.0%	1.5	2.1%
TOTAL	437	100.0%	75.3	100.0%

Source: Managed Care Digest Series, HMO-PPO Digest 2011, data source SDI. Copyright Sanofi-Aventis U.S., LLC and SDI. www.managedcaredigest.com. Used with permission.

[†]The IPA performs credentialing on behalf of the HMO, using the HMO’s standards.

[‡]If the reader has no knowledge about different payment terms, it will be useful to return to this section after reviewing Chapter 5, which describes varied approaches to provider payment.

still delegate to a credentialing verification organization, as discussed in Chapter 4), network management, and UM. Direct-contract HMOs pay physicians through capitation and FFS, in various combinations. Payment to the physicians is also direct, although a medical group or health system may still pay their physicians through a methodology different from what the HMO uses. Direct contracting is the second most common type of HMO model.

Because the network of both the direct contract model HMO and an IPA model HMO is composed of independent physicians, they appear similar to an outside observer. It is, therefore, common for this type of model also to be referred to as an IPA, despite the lack of the legal entity of an IPA. Like so many terms in managed health care, there is little purity of taxonomy. However, the reader should be aware of the differences because the presence or absence of an actual IPA has an effect on the HMO and its management needs.

Group Model

In pure group model HMOs, the HMO contracts with a multi-specialty medical group practice to provide all physician services to the HMO’s members. The physicians in the group practice are employed by the group practice and not by the HMO, and share facilities, equipment, medical records, and support staff. Medical offices often have ancillary services such as laboratory and X-ray. Some may have full or limited pharmacies, and larger centers may have additional services such as physical therapy. The group may contract with the HMO on an all-inclusive capitation basis to provide physician services to HMO members. Alternatively, the group may contract on a cost basis to provide its services, in which case it shares attributes of the staff model, as described next.

In group model HMOs, the medical group may be captive to the HMO, or the HMO may be captive to the group. There are significant cultural differences between the two, although they share many similar attributes as well, including strong physician leadership and a physician management structure, having enough physicians on staff to provide for most of the care typically needed by members, having an internal peer review and QM function, more ability to invest in and use support systems such as an electronic medical record system, and the adoption of similar practice behaviors.

In the captive group model, the group practice exists solely to provide services to the HMO’s beneficiaries. In some cases, the HMO originally formed the group practice to serve its members and provides administrative services to the group. The most prominent example of this type of HMO is the Kaiser Foundation Health Plan, where the Permanente Medical Groups provide most physician services for Kaiser’s members. The Kaiser Foundation Health Plan, as the licensed HMO, is responsible for marketing the benefit plans, enrolling members, collecting premium payments, and performing other HMO functions. The Permanente Medical Groups are responsible for rendering physician services to Kaiser’s members

under an exclusive contractual relationship with Kaiser. Kaiser is sometimes mistakenly thought to be a staff model HMO because of the close relationship between it and the Permanente Medical Groups. Although not the only example, Kaiser is clearly the most robust, particularly in California.

In the captive HMO model, an established independent medical group is the sponsor or owner of the HMO. An example of this is the Geisinger Health Plan based in Danville, Pennsylvania. The Geisinger Clinic, which is a large, multi-specialty physician group practice, is a long-established independent medical group that provides medical care to members of the Geisinger Health Plan as well as non-HMO patients. The HMO also contracts with independent physicians to ensure adequate coverage of its entire service area, focusing mainly on primary care, ob/gyn, and similar specialties, while having the entire network refer complex cases to the group. Physicians in the group are paid a salary plus incentives based on their performance and productivity.

Staff Model

In a staff model HMO, the physicians who serve the HMO’s covered beneficiaries are employed by the HMO. These physicians typically are paid on a salary basis and usually also receive bonus or incentive payments. Like group models, staff model HMOs must employ physicians in all the most common specialties to provide for the health care needs of their members, but unlike large established medical groups, these HMOs are more likely to contract with private physician specialists as well.

Health systems employing a large panel of PCPs and specialists such as ob/gyns, general surgeons, and other high-volume specialists are also staff models, though not HMOs. However, if such systems contract with an HMO under capitation or a similar risk-based payment model, they will face most of the same management issues faced by a staff model plan; for example, physician productivity is usually much lower than it is for private physicians. This is partially offset by their ability to use their leverage to negotiate high payment rates, however. There were once a number of staff model HMOs, but most of them are either gone or have since shed their physician components. Examples included Harvard-Pilgrim Health Plan (the physicians became an independent medical group that is no longer exclusive to Harvard-Pilgrim), Group Health Association of Washington, DC (no longer in existence), FHP (no longer in existence), HealthAmerica (sold several times), and others.

Insurance companies dabbled off and on with creating staff model systems, usually abandoning them after a while. But recent problems with access to primary care, exacerbated by the growing shortage of PCPs, once again led some payers to experiment with establishing primary care centers. In these new experiments, centers may be staffed with a combination of PCPs and mid-level practitioners (see Chapter 4).

Advantages and Disadvantages of Open- and Closed-Panel HMOs

The advantages of open-panel HMOs are:

- They are much more easily marketed and sold because they include a large panel of private physicians;
- Because participating physicians are located throughout the HMO's service area, it's easier for members to find one that is conveniently located;
- Routine medical management functions may be delegated to the IPA in IPA model HMOs; and
- They are much easier and less costly to set up and maintain.

The disadvantages of open-panel HMOs are:

- Because the HMO is not involved with providing medical care itself, it has little ability to manage the care being provided and must rely primarily on the use of benefits determinations and medical necessity criteria; and
- Premiums are often somewhat higher than those of closed panels.

The advantages of closed panel HMOs are:

- The ability to more closely manage the medical care provided by the medical group;
- Delegation of many routine medical management functions to the group, thereby reducing administrative costs; and
- The convenience of "one-stop shopping" for members as most group and staff model HMOs use large office buildings that house doctors' offices and small procedure rooms, and often have basic X-ray and pharmacy services, for example.

The disadvantages of closed-panel HMOs are:

- They are not as easily marketed to new members when people already have an established relationship with a doctor and do not want to change it;
- Locations of the HMO's medical offices may not be convenient for all members;
- Closed-panel HMOs are really only feasible in medium to large cities where the market is large enough; and
- They are more complex and costly to set up and maintain compared to any other form of health plan.

True Network Model

The term "network model" is often applied to any open-panel plan, or sometimes is used synonymously with the direct contract model. But it is useful to differentiate a "true" network model in which the HMO contracts with more than one large medical group or physician organization. To an outside observer, it looks like an open-panel HMO with a large community-based network. But structurally, the HMO is not limited to a

single IPA or medical group, but does not have thousands of individual contracts either. Operationally, it more resembles a capitated group or strong IPA model in which the physicians take on a significant portion of utilization and QM.

The group practices may be broad-based, multispecialty groups; large group practices without walls (GPWWs); IPAs; physician-hospital organizations (PHOs); or some combination of these (all are described later in this chapter and in Chapter 4). One example of this type of HMO is the Tufts Area Health Plan in Massachusetts, which contracts with multiple PHOs; another is HealthNet in California, which contracts with several large GPWWs and IPAs. True network models predominate in California where there are a number of existing large medical groups (with and without walls), unlike most other parts of the country where groups tend to be smaller. Recently, they have been associated with high costs despite low utilization due to the group's ability to demand high rates of payment.⁶

As noted previously and discussed in more detail in Chapter 4, health systems are increasingly employing primary and specialty care physicians. At some point this creates the infrastructure for a true network model plan. For example, two or three large health systems with many employed physicians could form a true network model plan, either by contracting with an HMO or other payer, or perhaps even as a "private label" network for large employers. They could also be the delivery system for a true network model Medicare Advantage plan (see Chapter 24), leveraging that experience to improve their performance under the new Medicare FFS and bundled payment models used for ACOs and PCMHs. The true network model may well play a larger role in coming years.

Mixed Model HMOs

As the term describes, many HMOs or MCOs are actually mixes of different model types. It is far more common for closed-panel types of MCOs to add open-panel components to their health plan than the reverse, but there are examples of large open-panel HMOs adding a staff model component through a contract with an IDS, for example.

Open-Access HMOs

Open access usually refers to a benefits plan most closely resembling a hybrid of a POS plan and an EPO. Like a POS plan, the member selects a PCP and gets the highest level of benefits by using the HMO system, but may bypass that system and access specialty care directly, albeit with less coverage. Like an EPO, however, only services provided by in-network providers are covered, regardless of whether accessed through the PCP "gatekeeper" or by going directly to a specialist. Some open-access HMOs dispense with the PCP "gatekeeper" approach entirely and simply require a higher copayment for specialist care, but still restrict any coverage to services from in-network providers. Open-access HMOs

are not as common as PCP-based HMOs. Many were created in the 1970s and 1980s and then abandoned. However, new ones appeared in the late 1990s and were reasonably successful.

Consumer-Directed Health Plans

CDHPs combine an HDHP with some form of individually based, pretax savings account. They are often associated with a PPO network as well. At its most basic, health care costs are paid first from the pretax account and when that is exhausted, any additional costs up to the deductible are paid out of pocket by the member. Preventive services are not subject to the deductible, however, both by convention and now under requirements in the ACA for all qualified health plans.

There are two basic forms of CDHP benefits plans: employer-based using a health payment account (HRA) and individual-based using a health savings account (HSA). A simplified example of a CDHP benefit design for an individual is illustrated in **Figure 2-3**.

HRAs are funded solely by the employer on a pretax basis, and are not considered taxable income to the employee. The employer determines how much pretax money to put into the account and how much of any unused money in an HRA may be rolled over from year to year. An HRA is also considered a group health plan subject to COBRA continuation requirements (see Chapter 29) if and when an employee leaves the company.

HSAs for individuals were created as part of the Medicare Modernization Act. As of 2011, only individuals covered by a HDHP with an annual deductible of at least \$1,200 (or \$2,400 if it's family coverage) may make tax-deductible contributions to an HSA. The HDHP is also limited to maximum

out-of-pocket expenses of less than \$5,950 (or \$11,900 if it's family coverage). Both of these amounts are determined on an annual basis by the Treasury Department. Individuals eligible for Medicare, claimed as a dependent on somebody else's tax return, or covered under another policy are not eligible to contribute to an HSA. Any money left in an HSA at the end of the year may be rolled into the next year. Banks charge fees for holding the HSA, however, so funds can go down even if never used for medical expenses.

CDHPs are not considered managed health care plans by some, who consider them as more akin to simpler indemnity-type insurance plans from the past. This is because of the presence of a high-deductible health insurance policy as the primary product, combined with new pretax funding mechanisms for at least a portion of the costs. Furthermore, one of the initial tenets behind CDHPs is that the consumer has become shielded by traditional managed care plans as to how much health really costs; in other words, consumers have come to believe that an office visit really only costs \$20 or that a sophisticated diagnostic test only costs \$20. The CDHP is therefore constructed to make cost a factor in consumer decision making through the use of both the pretax fund and the bridge, with the CDHP providing information to consumers to help them make decisions based on cost and quality of services.

CDHPs have not entirely shed all aspects of managed health care, however. Most are associated with a PPO to provide the value of the negotiated discount to the consumer. From the provider viewpoint, this is a mixed blessing at best because while the provider's fee is discounted, they must still collect any amounts due under the deductible from the member. As discussed earlier in regard to service plans,

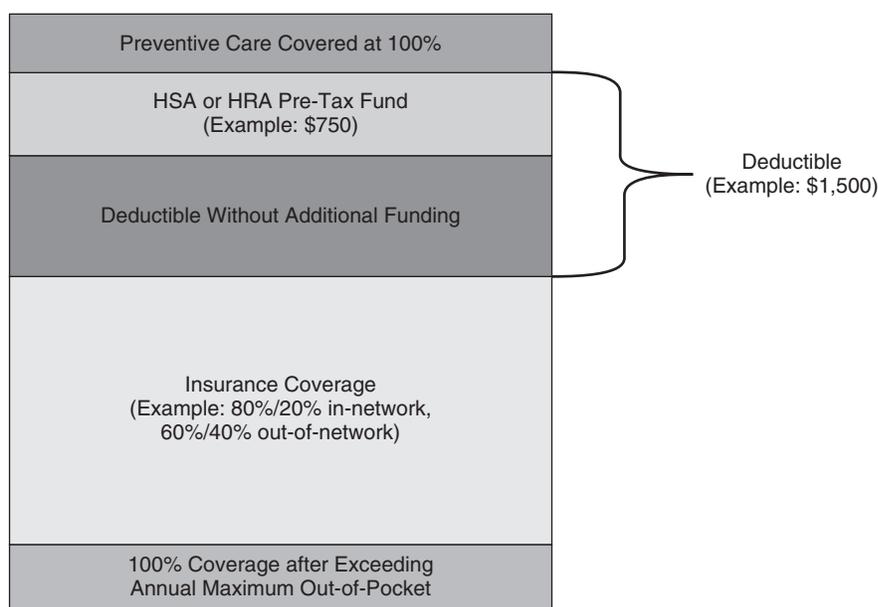


FIGURE 2-3 Example Construct of a Basic CDHP Individual Benefit

collecting from individuals is far harder than getting paid directly by the payer, which was the major attraction of the service plan in the first place.

This problem is not confined to CDHPs. As noted in Chapter 1, the average deductible for PPOs has risen dramatically in recent years, often exceeding \$1,000, blurring the line between a basic PPO and a CDHP.

Payers have tried to address this collection problem in several ways. Integrating the functions of the HRA or HSA through a debit card or attaching a credit facility to the HRA or HSA are two approaches. These have not been entirely satisfactory, but have helped. Most large payers are also able to provide real-time information about any remaining deductible amounts so the provider can collect at the time of service, but not all providers are able to access this or it may only be available through certain channels. Some payers also allow a member to authorize a direct provider payment from their HRA or HSA at the time the claim comes in. Also, the ACA requires ID cards to be machine readable in 2013, including eligibility and cost-sharing information.

Simply integrating with an existing PPO is the most common but not the only aspect of managed care that CDHPs retain. Integration of medical management into the new plan designs remains an evolving aspect as well, particularly with CDHPs offered by the larger and more established companies. Basic PPO-level UM and DM are most frequently applied because even in CDHPs a small proportion of the membership accounts for a disproportionately high percentage of medical costs. In those cases, medical costs can quickly move past the pretax fund and the bridge and trigger the high-deductible insurance, where focus on managing chronic disease is exactly the same as it is for any other type of managed health care plan. Having said that, how a CDHP applies DM in the early stages of a chronic disease, when costs are still applicable to the pretax fund and the bridge, is still evolving.

Third-Party Administrators

A TPA is a company that administers benefits for a self-funded employer group, but does not have all the capabilities of a major payer organization. They are not considered managed care plans per se, although they may provide some managed care services. Services may be barebones, such as enrollment and claims processing only, and the employer purchases other services such as UM or access to a rental PPO (see Chapter 4) on an *à la carte* basis from one or more companies. In some cases, the TPA is able to provide many of these additional services, but they are sold as separate services.

TPAs are not licensed insurers, and the TPA itself assumes no risk. It often has arrangements with reinsurers and may assist the employer group in obtaining it. In other cases, a reinsurer may bring the business to the TPA. TPAs have

well-defined responsibilities to administer the employer group's health plan. Although TPAs are not licensed insurers, more than 30 states require TPAs to be licensed in their own right and have regulations that govern a TPA's written agreement with a reinsurer. States may also regulate the TPA's provider payment methodology and timeliness of claims payments.

Consumer Operated and Oriented Plans

Section 1322 of the ACA (see Chapter 30) created a "Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers" to be called a ". . . Consumer Operated and Oriented Plan (CO-OP)."⁷ These are new payer organizations, not existing health care cooperatives like Group Health Cooperative of Puget Sound, although the concept of member ownership is the same. The ACA specifically calls for the CO-OPs to offer coverage to small groups and individuals through the new state health insurance exchanges (see Chapters 16 and 30).

The ACA further requires that a CO-OP not be run by a state or local government, and that neither it nor any related entity was a health insurance issuer on July 16, 2009. It will need to be licensed by the state and comply with all state insurance laws. Although a CO-OP may not have been a payer before, it can purchase certain administrative services such as claims processing services, information technology, and so forth. A CO-OP must be governed by a board that is subject to the majority vote of its members, as further described in Chapter 3.

At the time of publication, no CO-OP has been created. Small new payer organizations do not have a good track record of survival, though, so it is unclear how many will be created, if any, and of those how many will survive.

■ INTEGRATED HEALTH CARE DELIVERY SYSTEMS

Just as there are myriad types of MCOs, there are myriad types of IDSs. Because there is such wide variation in IDS structures, only the more common forms are discussed here. With a few exceptions, types of IDSs are also difficult to label, so terms or identifiers may not always match up to an IDS's structural or organizational design.

At the very least, an IDS represents providers coming together in some type of legal structure for the purposes of managing health care and contracting with health plans such as HMOs, PPOs, or health insurance companies. Some IDSs even combine different types of IDSs as well. The common denominator, however, is the physician; many types of organizations can exist in health care for purposes of managing health care and contracting with health plans that do not involve physicians, but unless there is a significant physician component, it would not be considered an IDS.

The presence of the four most common types of IDSs is shown in **Figure 2-5** later in the chapter.

Independent Practice Association

IPAs have been discussed earlier in this chapter and in Chapter 4, so will not be repeated here except to note it may be a component of another type of IDS.

Physician Practice Management Companies

Physician practice management companies (PPMCs) arrived on the integration scene in the mid-1990s. They typically were publicly traded companies, placing great pressure on the need to report positive earnings. Hospitals were not involved. Most failed and some went bankrupt, while others exited the business altogether. A few do remain, or reemerged as smaller and more focused companies, however.

Several reasons contributed to their failure. One common problem was decreased physician productivity. PPMCs purchased physician practices only to find that once the physician had “cashed out” his or her practice, there was no longer sufficient incentive for them to be highly productive. PPMCs also found that there was in fact little profit margin to be had in practices in which the primary cost was for compensation, despite small improvements in practice overhead costs from economies of scale. Most of them also entered into full-risk capitation arrangements with HMOs, and did no better managing it than PSOs did for Medicare.

The PPMCs that thrived were more specialty-focused than the massive PPMCs that had acquired primary and specialty care practices alike, for example, a PPMC focusing solely on neonatal critical care, or one focused on radiology. Unlike a group practice, the physicians were (and are) employees of the PPMC, which not only manages the practice but provides managed care services as well. Some PPMCs that focused solely on managing the office and that also remained relatively small in scope also managed to survive.

Group Practice Without Walls

The GPWW, also known as the clinic without walls, is a step toward greater integration of physician services. The GPWW does not require the participation of a hospital and, indeed, is often formed as a vehicle for physicians to organize without being dependent on a hospital for services or support. In some cases, GPWW formation has occurred to leverage negotiating strength not only with MCOs but with hospitals as well. In other cases, a hospital sponsors and supports a GPWW as a component of the IDS.

The GPWW is composed of private practice physicians who agree to aggregate their practices into a single legal entity, but the physicians continue to practice medicine in their independent locations. In other words, the physicians appear to be independent from the view of their patients,

but from the view of a contracting entity such as an HMO, they are a single group. This is differentiated by two salient features from the for-profit, physician-only management services organizations (MSOs) described later. First, the GPWW is owned solely by the member physicians and not by any outside investors. Medical groups can and do hire physicians as employees, however, so not all physicians providing care are owners of the group. Second, the GPWW is a legal merging of all assets of its member physicians’ practices rather than the acquisition of only the tangible assets (as is often the case in an MSO).

To be considered a medical group, the physicians must have their personal income affected by the performance of the group as a whole. Although an IPA will place a defined portion of a physician’s income at risk (that portion related to the managed care contract held by the IPA), the group’s income from any source has an effect on the physician’s income and on profit-sharing in the group. That being said, it is common in this model for an individual physician’s income to be affected most by individual productivity.

The GPWW is owned by the member physicians, and governance is by the physicians. The GPWW may contract with an outside organization to provide business support services. Office support services are generally provided through the group, although as a practical matter the practicing physicians may notice little difference in what they are used to receiving.

The GPWW model continues to exist in markets with substantial amounts of full-risk capitation such as California, where it can represent a significant amount of revenue. But even when capitation is for direct services only, the GPWW can potentially achieve enhanced revenues through pay-for-performance programs, as discussed further in Chapter 5. Outside of such markets, the GPWW model is currently much less common. Overall market consolidation, combined with pressures on Medicare payments and new performance-based payment models, may lead to a renewed interest.

Physician–Hospital Organizations

The PHO is an entity that, at a minimum, allows a hospital and its physicians to negotiate with payers. PHOs may do little more than provide for such a negotiating vehicle, although this could pose an antitrust risk. PHOs may actively manage the relationship between the providers and payers, or they may provide more services, to the point where they may more aptly be considered MSOs, as discussed next. Some PHOs even accept capitation and function as small IPAs.

By definition, a PHO requires the participation of a hospital and at least some portion of the admitting physicians. They are considered the easiest type of integrated system to develop (although they are not actually that easy, at least if done well). They also are a vehicle to provide some

integration while preserving the independence and autonomy of the physicians. In the mid-1990s, PHOs were formed primarily as a defensive mechanism to deal with an increase in managed care contracting activity. Even then, it was not uncommon for the same physicians who joined the PHO already to be under contract with one or more managed care plans. Since then, fewer PHOs were created, though existing ones continue to operate. The weakest form of PHO is the messenger model. This means that the PHO analyzes the terms and conditions offered by an MCO and transmits its analysis and the contract to each physician, who then decides on an individual basis whether to participate.

More commonly, the PHO participants develop model contract terms and payment levels and use those terms to negotiate with payers. The PHO usually has a limited amount of time to negotiate the contract successfully (e.g., 90 days). If that time limit passes, then the participating physicians are free to contract directly with the payer; if the PHO successfully reaches an agreement with the payer, then the physicians agree to be bound by those terms. The contract is still between the physician and the payer, or between the hospital and the payer. In some cases, contracts between the providers and the payer are relatively brief and incorporate the contract between the PHO and the payer by reference.

The reader should note that the “PO” portion of a PHO may be a different model entirely. As an example, a GPWW or an IPA could represent the physician portion of the PHO, although most commonly the physicians remain independent and contract individually with the PHO.

One final note concerning PHOs and other types of physician organizations: the Federal Trade Commission (FTC) toughened its scrutiny of such organizations during the early 2000s. Physician organizations that are not paid on a capitation basis, or that do not accept substantial financial risk through some other mechanism, now find it much more difficult to operate within the FTC’s antitrust safety zone. Although it is beyond the scope of this chapter, those interested in physician organizations are urged to consult with competent antitrust counsel during the formation and operational stages.*

Within the last several years, some PHOs began to take advantage of *clinical integration* as a rationale under the antitrust laws to justify negotiation with MCOs on behalf of otherwise unrelated physicians and other providers. Because of the public benefit associated with improving health care quality and reducing unnecessary utilization, federal antitrust agencies established an exemption to allow PHOs to negotiate payment terms with MCOs provided that those

financial terms were an essential component of the PHO’s achievement of defined quality or utilization objectives. In other words, an antitrust exemption was deemed appropriate for organizations whose providers are clinically integrated even if they are not financially integrated. Advocate Healthcare in the Chicago area has been one of the more prominent examples of a clinically integrated PHO through its Advocate Physician Partners organization.

One of the hallmarks of clinically integrated organizations is their focus of the same types of metrics used by more traditional managed care organizations. For example, such organizations often set targets for and publicly report performance against the Healthcare Effectiveness Data Information Set (HEDIS®) quality measures used by NCQA to evaluate HMOs and PPOs. In addition, clinically integrated organizations may set utilization goals, such as reducing emergency department visits or hospital inpatient readmissions. Their focus on these efforts can help the payers with which they contract to achieve their own quality goals, which is why some payers have embraced them. Finally, the same accreditation organizations used by HMOs have created recognition standards for clinically integrated IDSS such as PHOs.

Management Services Organizations

An MSO represents the evolution of the PHO into an entity that provides more services to the physicians. Not only does the MSO provide a vehicle for negotiating with MCOs, but it also provides additional services to support the physicians’ practices. The physician, however, usually remains an independent private practitioner. MSOs are typically based around one or more hospitals, but there are some physician-only MSOs that are closer to PPMCs than hospital-based MSOs.

In its simplest form, the MSO operates as a service bureau, providing basic practice support services to member physicians. These services include such activities as billing and collection, administrative support in certain areas, electronic data interchange such as electronic billing, and other services. Recently, existing MSOs are being considered excellent vehicles to provide the electronic backbone for the electronic medical record and other forms of electronic connectivity addressed in Chapter 23.

The physician can remain an independent practitioner, under no legal obligation to use the services of the hospital on an exclusive basis. The MSO must receive compensation from the physician at fair market value, or the hospital and physician could incur legal problems. The MSO should, through economies of scale as well as good management, be able to provide those services at a reasonable rate.

An MSO may also be considerably broader in scope. In addition to providing all the services described earlier, the MSO may actually purchase many of the assets of the physician’s practice; for example, the MSO may purchase the

*Interested readers may also want to review the FTC’s opinion in the Matter of North Texas Specialty Physicians and other resources on this case. A summary with further links may be found at: www.ftc.gov/opa/2005/12/ntsp.shtm, accessed August 2, 2011.

physician's office space or office equipment (at fair market value). The MSO can employ the office support staff of the physician as well. MSOs can further incorporate functions such as QM, UM, provider relations, member services, and even claims processing in those markets where there is significant full-risk capitation. This form of MSO is usually constructed as a unique business entity, separate from a PHO. These too show overlap with PPMCs, as earlier described.

Like PHOs, MSOs do not always have direct contracts with health plans, or the contract does not take the place of direct contracts between a payer and the MSO's providers. This is for two reasons: (1) many plans insist on having the provider be the contracting agent and (2) many states will not allow health plans (especially HMOs) to have contracts with any entity that does not have the power to bind the provider. The physician may remain an independent private practitioner under no contractual obligation to use the hospital on an exclusive basis.

Foundation Model

A foundation model IDS is one in which a hospital creates a not-for-profit foundation and actually purchases physicians' practices (both tangible and intangible assets) and puts those practices into the foundation. This model usually appears when there is a legal or regulatory barrier, for example, a state law against the corporate practice of medicine, meaning a hospital cannot employ the physicians directly or use hospital funds to purchase the practices directly. It must be noted that to qualify for and maintain its not-for-profit status, the foundation must prove that it provides substantial community benefit. Once more common than today, they are now mostly confined to a few states.

A second form of foundation model does not involve a hospital. In that model, the foundation is an entity that exists on its own and contracts for services with a medical group and a hospital. Recall from Chapter 1 that in the early days of HMOs, many open-panel types of plans that were not formed as IPAs were formed as foundations; the foundation held the HMO license and contracted with one or more IPAs and hospitals for services.

The foundation itself is governed by a board that is not dominated by either the hospital or the physicians (in fact, physicians may represent no more than 20% of the board) and includes lay members. The foundation owns and manages the practices, but the physicians become members of a medical group that, in turn, has an exclusive contract for services with the foundation; in other words, the foundation is the only source of revenue to the medical group. The physicians have contracts with the medical group that are long term and contain noncompete clauses.

Although the physicians are in an independent group, and the foundation is also independent from the hospital, the relationship in fact is close among all members of the

triad. The medical group, however, retains a significant measure of autonomy regarding its own business affairs, and the foundation has no control over certain aspects, such as individual physician compensation.

Provider-Sponsored Organizations

A provider-sponsored organization (PSO) is an archaic use of the acronym that now stands for today's Patient Safety Organization. It is included primarily to illustrate a very important lesson from the past. As discussed in Chapter 1, PSOs were a cooperative venture of a group of providers who controlled an integrated provider system engaged in *both* delivery and financing of health care services. On its surface, that sounds like a co-op HMO or similar type of early closed-panel HMO. And on its surface, that was true. The problem lay beneath the surface.

The anti-managed care backlash was building rapidly, and one expression of that was a firmly held belief by many providers that HMOs were meddlesome "middlemen" that extracted a big chunk of the money but provided no value. Under considerable pressure from organized provider organizations, PSOs were authorized by Congress under a Medicare demonstration waiver as part of the federal Balanced Budget Act of 1997, and were created so as to allow provider organizations to contract directly with Medicare on an at-risk basis for all medical services, bypassing entirely existing Medicare HMOs (called Medicare+Choice at that time). As a grand experiment, it failed miserably. Providers found to their detriment that taking on full risk for the health care costs of older adults involved more than taking the money and providing the services. In other words, "cutting out the middleman" in the form of bypassing experienced Medicare HMOs was a fast route to deep financial losses, mostly absorbed by the hospitals. They found, for example, that medical costs were made up of more than the services delivered by members of the PSO; considerable expense was also associated with care delivered by non-PSO providers, medical technology costs, and so forth. Most PSOs also continued to use existing FFS payment or otherwise failed to spread the financial risk sufficiently.

PSOs were adverse risk magnets too. Physicians and hospitals see individuals as patients, while HMOs see individuals as members, not all of whom are patients. Having a patient-centric view of the market is an excellent approach as a provider, but it also means that the patients who were seen the most often were the first ones to be signed up for coverage under the PSO. The payment model for HMOs at the time made no adjustments for acuity, so payment for a healthy 68-year-old male was the same as for a 68-year-old male with advanced heart and kidney disease.

Of equal importance as adverse risk, PSOs also typically were unable to conduct the type of UM and DM that HMOs routinely used, because part of the reason the physicians

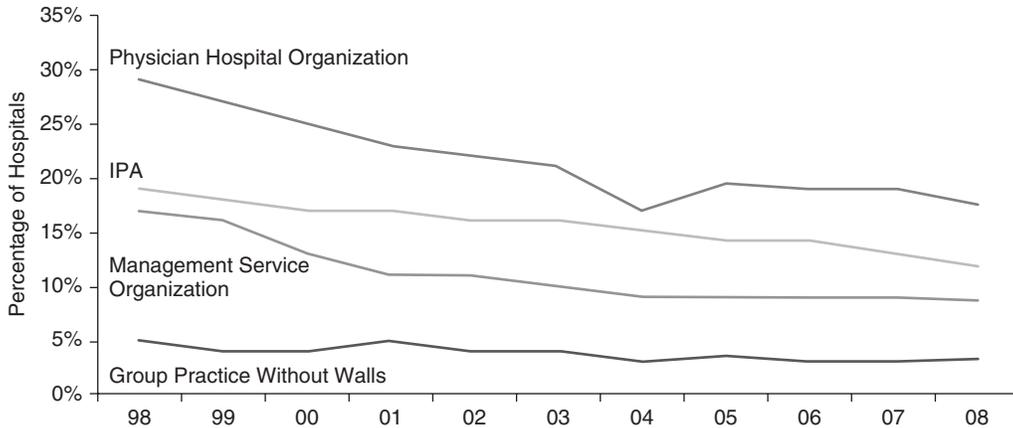


FIGURE 2-4 Changes in Hospital-Physician Affiliations, 1998–2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals in the AHA's TRENDWATCH CHARTBOOK 2010. www.aha.org/research/reports/tw/chartbook/index.shtml. Used with Permission.

and hospital formed the PSO was to get out from under what they perceived of as undue interference by HMOs. This was often exacerbated when the most prominent members of the PSO's medical staff were also the heaviest utilizers. Under traditional FFS, that meant they were a good source of revenue for the hospital, but under full risk they became a liability. Any attempt to restrain their utilization, however, risked having them leave entirely and take their entire (mostly profitable FFS) caseload with them.

The failure of nearly all PSOs meant that they essentially disappeared from the managed health care landscape. The federal waiver authority for PSOs quietly expired in 2002 with few survivors to mourn its passing. The small handful of PSOs that did manage to succeed were allowed to continue under a "grandfathering" provision as long as they met state financial and licensure requirements similar to those of an HMO. They exist today as organizations that look much like a type of successful provider-sponsored HMO described in Chapter 1, except for having no three-letter acronym.

PSOs may be gone, but there is much to learn from their demise, particularly for new organizations accepting performance-based payments under the ACA. There is a theoretical argument that PSOs may have survived if paid under today's acuity-adjusted payment method (described in Chapter 24) that is now used for MA plans (and proposed as an element for ACO payment). But adverse risk was only part of the problem. Of equal weight was their serious inability to manage utilization by their member physicians.

Health systems today that employ large groups of physicians, or new ACOs composed of hospitals and private medical groups, looking to participate in the new Medicare payment programs would do well to study the failure of PSOs with a cold and analytical eye. Participation in ACOs and PCMHs today is voluntary, but only PCMHs are a demonstration project under a waiver. ACOs are written into

the ACA, as is a mandate for changing Medicare payment models. PSOs did not have to fail; rather, they had to change the way they functioned.

Hospitals with Employed Physicians

Regardless of type, IDSs created to align private physicians with hospitals has been declining for over a decade, as illustrated in **Figure 2-4**. The other way hospitals and physicians come together is when the hospital employs PCPs and specialists. The employed-physician type of IDS first appeared in the mid to late 1990s when hospitals acquired PCP practices as a response to HMOs, most of which used a PCP "gatekeeper" model. In most, but not all, cases this was followed by serious financial losses as physician productivity plummeted. Hospitals then divested their physician service lines, sending the PCPs back out into their own practices. It is essentially the same time period, same dynamic, and same outcome as that described earlier for the giant PPMCs.

Beginning in the early 2000s, hospitals once again began to employ physicians, but now they are employing both PCPs and specialists. Hospitals both acquire practices and directly hire physicians in steadily increasing numbers. An article published in March 2011 reported a 75% increase in the number of physicians employed by hospitals since 2000, and the percentage of practices owned by hospitals now exceeds those owned by physicians.⁸ Related to that, a press release by the Medical Group Management Association in June 2010 about physician placement reported that 65% of established physicians and 49% of physicians hired out of residency or fellowship were placed in hospital-owned practices in 2009.⁹

Figure 2-5 shows the rise in the number and percentages of medical groups in IDSs from 2001 to 2010. This trend will only continue. As of 2010, 65% of hospitals said they were

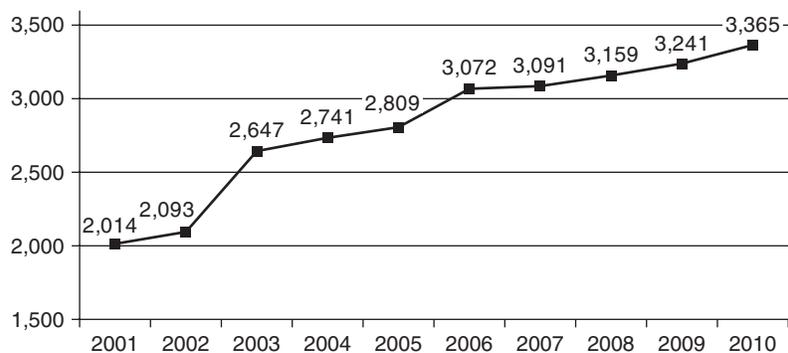


FIGURE 2-5 Number of Medical Groups in Integrated Delivery Systems, 2001–2010

Source: SDI © 2011 in the Sanofi-Aventis Managed Care Digest Series® / Hospitals/Systems Digest 2011. www.managedcaredigest.com/. Used with permission.

making efforts to increase the number of employed physicians, PCPs, hospitalists, medical specialists, and surgeons.¹⁰

There are several forces fueling this trend. In some cases, physicians can't keep up with costs and requirements such as electronic records; they see income stagnate or they seek a better lifestyle, and turn to their hospital for help. In other cases the hospital wants to prevent physicians from becoming competitors, by opening up a high-margin ambulatory procedure facility, for example. In either case, both the hospital executives and the physicians have a more realistic attitude than they did back in the 1990s.

In almost all cases, employing a large number of physicians also substantially increases the hospital's negotiating leverage, a dynamic that can only increase as demand for access to primary care increases under the ACA. This exacerbates the problem payers now have in negotiating and contracting with health systems that dominate a local area or region, described in Chapters 4 and 5. Because IDs with a large number of employed physicians encompass aspects of contracting for facilities as well as professionals, it is further discussed in Chapter 4.

There are also positive aspects of this trend, however. One major one is discussed in the next section. Other positive aspects include professional management, better electronic transactional systems such as claims and authorizations, a more rapid adoption of electronic medical records, greater ability to coordinate care across a system, greater ability to observe and manage practice behavior, better communications, and a more stable physician base.

■ ORGANIZATIONS EMERGING UNDER HEALTH REFORM

The time leading up to consideration and passage of the ACA was a period of experimentation and articulation of "new" concepts for transforming the health care system in the United States. Well before the ACA, sustained increases in health care spending that outstripped the general

inflation rate generated interest among policymakers to find methods of "bending the cost curve" to bring costs more in line with their views of the appropriate amount to be spent nationally on health care.*

Some of the new concepts did not wait for enactment of ACA, while others were given a direct boost by its passage. The intent here is not to suggest that these concepts are dependent on the ACA, but rather that they are an outgrowth of the directional movement toward health reform. The ACA specifically references four types of organizations: ACOs, PCMHs, bundled payment programs (not an organization per se, but a payment model that requires at least some type of de facto organization), and CO-OPs. CO-OPs were discussed earlier, and bundled payments are discussed in Chapter 5. ACOs and PCMHs are briefly discussed next.

Accountable Care Organizations

ACOs are among the few types of organizations specifically written into the ACA to concretely address bending the cost curve in the traditional Medicare program.¹¹ The ACA specifically requires their promotion unless Congress amends that portion of the Act. Seldom has a term or concept become so widespread and become such a repository of hope with so little in the way of "proof of concept." Most published studies demonstrating positive results and used in support of ACOs actually demonstrate the value of existing and closely managed provider systems or medical groups with significant experience in managed health care.

Where did this concept originate and what are ACOs? While it may be difficult to pinpoint the precise coinage of the ACO terminology, one of the earliest articulations of the concept and the term appeared in a *Health Affairs* "Web-exclusive" article by Elliott Fisher, Mark McClellan, and colleagues in January 2009.¹² They proposed "a new

*The health care journals and blogs from the time were full of articles and dialogue on "bending the cost curve," with many recommendations but little consensus.

approach to help achieve more integrated and efficient care by fostering local organizational accountability for quality and costs through performance measurement and ‘shared savings’ payment reform.” The authors explicitly recognized that organizations with the strongest accountability—closed-panel HMOs—were likely to be unacceptable to most Medicare beneficiaries. In other words, ACOs were formulated as a pragmatic solution to the problem that most Medicare beneficiaries (and, indeed, most Americans) are unwilling to enroll in a traditional closed-panel HMO because of the restrictions such organizations place on their choice of provider and access to health care services, and to address costs in the traditional FFS Medicare program.

CMS published the final rule regulating ACOs on October 20, 2011.¹³ In addition to addressing several related initiatives and pilot programs, the final rule defined what kind of entities are eligible to form an ACO, what structural and financial requirements an ACO would have to meet, how performance would be measured, and the shared savings program. At the time of publication, ACOs have not been implemented. Therefore the following discussion is based on what the final rule provides for, not what actually exists.

ACO Structural Requirements

According to the final rule, the following ACO participants or combinations of ACO participants are eligible to form an ACO that may apply to participate in a shared savings program:

1. ACO professionals in group practice arrangements,
2. Networks of individual practices of ACO professionals,
3. Partnerships or joint venture arrangements between hospitals and ACO professionals,
4. Hospitals employing ACO professionals,
5. Rural health clinics (RHCs),
6. Federally qualified health centers (FQHCs), and
7. Critical access hospitals (CAHs).

The final rule also requires the ACO to be a legal entity that is authorized to conduct business in each state in which it operates, and an ACO formed by two or more otherwise independent ACO participants must be a legal entity separate from any of its ACO participants. The ACO specifically must be formed for the purposes of:

1. Receiving and distributing shared savings;
2. Repaying shared losses or other monies determined to be owed to CMS; and
3. Establishing, reporting, and ensuring provider compliance with health care quality criteria, including quality performance standards.

The governing body of the ACO must include a Medicare beneficiary who does not have a conflict of interest with the ACO or have an immediate family member who has a conflict of interest. At least 75% of the ACO’s board seats

must be held by ACO participants. The ACO must have a management structure in place that is similar to what is found in a nonprofit health plan, in which management is under the governance of the board. ACO participants must demonstrate a meaningful commitment, which is broadly defined in the final rule as a sufficient financial or human investment such that ACO losses would be considered to be a significant motivator.

Shared savings programs, including the potential for financial risk, are at the heart of the ACO concept. The shared saving payment methodology is discussed in Chapter 5 along with other approaches to payment. Because the model includes some risk for repayment of a percentage of claims paid, for purposes of qualification, an ACO must show that it can repay losses equal to at least 1% of the total per capita Medicare Parts A and B FFS expenditures for its assigned beneficiaries during the most recent performance year (or benchmark if there is no history). Alternatively, an ACO may demonstrate its ability to repay losses by obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit (as evidenced by a letter of credit that the Medicare program can draw upon), or establishing another appropriate repayment mechanism that will ensure its ability to repay the Medicare program.

Patient-Centered Medical Home

Strictly speaking, PCMHs are not a concept that was born during the lead-up to enactment of the ACA. Some commentators believe, in fact, that the PCMH concept “represents more of a change in labels than a real change in the model.”¹⁴ Indeed, the PCMH concept had its roots in 1967 when the American Academy of Pediatrics (AAP) described a “medical home” as an ideal approach for caring for children with special health care needs.

Subsequently, and after much work by researchers and medical professional societies, the AAP joined with the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association in February 2007 to publish “Joint Principles of the Patient Centered Medical Home.” This statement of principles articulates the key characteristics of PCMHs as viewed by their proponents and as implemented by most of those organizations that have pursued their development:

- Patients have ongoing relationships with a *personal physician* who provides first contact, continuous, and comprehensive care.
- Patients receive *care from a team* of individuals at the practice level, led by the personal physician, who take collective responsibility for providing care.
- Personal physicians take responsibility for *providing or arranging all of the health care needs* for the patient, including all types of care at all stages of life.

- The patient’s care is *coordinated or integrated across all elements* of the health care continuum and across the patient’s community.
- *Quality and safety are key parts* of the PCMH, enhanced by evidence-based medicine, continuous quality improvement, active patient engagement in decision making, use of information technology, and a voluntary “recognition process” by an accrediting group.
- Patients have *enhanced access to care* through open scheduling, expanded hours, and better communication between practices and their patients.
- Payment to PCMHs should appropriately *recognize the “added value” provided to patients*, including recognition of services outside of face-to-face visits, payment for coordination of care, recognition of case-mix differences, and provision of incentive payments associated with reduced hospitalization and quality improvement.¹⁵

There are many similarities between these PCMH principles and the roles envisioned for PCPs in the traditional “gatekeeper” PCP model HMOs discussed earlier. The PCMH concept, however, has some differences with that traditional role. First, like today’s closed-panel HMOs but unlike open-panel HMOs, it explicitly recognizes and embraces the concept of a care team aligned around the primary care PCP. The team is used both to leverage the number of patients who can receive care from an individual PCP as well as to use nonphysicians to provide support in roles that don’t require the skills and training of a physician. Some effective PCMHs include medical assistants, LPNs, RNs, advanced practice nurses and other mid-level practitioners (Chapter 4), and pharmacists on their teams to support (and be led by) the PCP.¹⁶

Second, also like HMOs, there is an enhanced focus on the quality monitoring and improvement aspects of the PCP’s role in a PCMH. This is reinforced with the suggestion that PCMHs should be subject to some type of accreditation. In 2008, NCQA established a recognition program for PCMHs with standards designed to assess the extent to which individual practices meet the PCMH principles described previously. Those familiar with NCQA’s health plan accreditation programs would see many similarities in approach to the PCMH recognition program. Similarly, URAC and AAACH have established review criteria for PCMHs. All three have similarities but are not the same.

Third, the value of patient engagement and participation in the decision-making process is explicitly a part of the PCMH concept. The role of the patient was not always clear under the traditional “gatekeeper” PCP model or even in closed-panel HMOs. In line with the Institute of Medicine’s recommendations, PCMHs are viewed as one of the key mechanisms through which patients can become more

engaged in how and when they are treated. The ACA also allows a qualified health plan participating in a state health insurance exchange (see Chapters 16 and 30) to provide coverage through a qualified PCMH* as long as it meets criteria defined by the Secretary, creating the potential for an HMO-like hybrid plan.¹⁷

While the early evidence from implementation of PCMHs has been encouraging, there are not yet sufficient examples to know whether they will be effective or appropriate in most or all settings, particularly because most of those early successes occurred in well-established systems that already had a track record (e.g., the Geisinger Clinic). These are also the same examples used to demonstrate the potential value of ACOs, further blurring the already convoluted taxonomy of IDSs.

Many organizations are actively testing PCMHs and ACOs, including large payers and BCBS plans, as well as statewide multipayer pilot programs. The next several years should provide a wealth of information to help future policymakers understand whether PCMHs are the “real deal” and can actually help bend the cost curve or, alternatively, are nothing more than a rebranding of the old PCP concept. One thing is clear, however: PCMHs as envisioned represent a true incarnation of the best principles of “managed care.”

■ VERTICAL INTEGRATION

The last major topic is vertical integration. Most of the IDSs described so far could be considered vertically integrated if they combined physicians and hospitals. But for this section, vertical integration refers to a concept once thought to be the future of the health care sector in the United States: physicians, hospitals, and insurance or benefits administration all came together under a single corporate entity. The thinking was that by so doing, all incentives would be aligned and efficiencies would prevail. This charming notion was proven to be incorrect, sometimes disastrously so, by organizations that tried it in the 1980s and early 1990s.

Vertically integrated systems of the past were made up primarily of hospitals and managed care organizations, although a few included physicians. However, executives running hospitals looked to maximize revenues, particularly for high margin services, while executives running the insurance or managed care operations looked for maximum savings. Because savings to a payer equates to less revenue to a provider, a natural conflict occurred in almost all cases where vertical integration was attempted. Physicians, generally suspicious of managed care anyway, resented what they believed to be interference in their practices (see Chapter 7).

Examples include Humana, a Kentucky-based company that began as a national hospital company, added HMOs

* Referred to in the ACA as a “primary care medical home.”

and managed care services, and ultimately divested the hospital business. Tennessee-based Equicor began as a joint venture between the Equitable Life Insurance Company and Hospital Corporation of America, but internal tensions between the hospitals and the insurer (including their HMOs) were never far below the surface, and the company was sold to the national health insurer CIGNA. Bucking the trend was Allina in Minnesota, but that state's attorney general forced it to separate the payer company from the provider company, so it is no longer integrated. Attempts at so-called "virtual integration" involving contracts and agreements quickly either disappeared or morphed into more traditional payer-provider types of relationships.

Examples of successful vertical integration do exist, however. They are typically configured around a strong regional provider such as a health system or large medical group. In most cases, the provider system or group is the dominant feature, and it is they who own and operate the HMO or PPO.

Related to that, two new developments may see forms of vertical integration reappear. The first is the rapid increase in employment of physicians by large hospital systems discussed earlier and in Chapter 4. This creates a form of integration, but has also led to payers purchasing practices to both offset the hospital system's increased leverage and to improve access for members. That too is a recurrence of a form of integration that had diminished in the past. By way of example, at the time of publication, Highmark, a Pennsylvania-based BCBS company, filed papers with the Commonwealth to merge with the West Penn Allegheny Health System in order to compete more effectively with the University of Pittsburgh Medical Center, a massive system that employs physicians and has its own health plan.¹⁸ Other examples include the purchase of practices by payers in certain parts of the country. While not yet a trend, it may represent the beginnings of one.

The ACA provides the other impetus. As noted earlier, it calls for payment changes in Medicare and new organizational approaches such as ACOs and PCMHs, discussed above. These new organizations would be paid through shared savings, but the overall trend will be downward pressure. An alternative to ACOs for health systems is found in MA (see Chapter 24) in which both upward and downward risk exists. The dismal experience of PSOs described earlier may not be replicated because the physicians are employed and not private, and health systems are not necessarily looking to take all the risk are exploring ways to partner with experienced MA plans. The creation of health insurance exchanges and new payer models under the ACA may also lead to new forms of vertical integration. It is simply not possible to predict any of these things with certainty at this time.

■ CONCLUSION

Managed health care is on a continuum, with a number of plan types offering an array of features that vary in their

abilities to balance access to care, cost, quality control, benefit design, and flexibility. The rise and evolution of integrated health care delivery systems has paralleled the industry. During the last three decades, managed health care has gone from being a relatively small part of the health care system synonymous with "alternative delivery system" to being a mainstream manner in which individuals covered under employer-based health benefits plans, individuals with health insurance, and many government beneficiaries obtain their care. Managed health care will continue to evolve, with features from one type of plan appearing in others and new features continually being developed. As consolidation in the marketplace continues, it will blur the lines further. The recent appearance of new designs such as consumer-directed health plans and the as-yet-untested ACOs makes taxonomy an even greater challenge than it was before. And although there is no one single definition of the term *managed health care* that has endured and gone unchanged from the past or will survive into the future, the basic tenets of managed health care will continue to evolve in pace with market demands and requirements, and with legal and regulatory change.

Endnotes

- 1 The Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), which was signed into law on March 30, 2010. For purposes of this chapter, the Affordable Care Act (ACA) includes both laws.
- 2 According to the 2002 Health Confidence Survey conducted by the Employee Benefit Research Institute, only 30% of the respondents think they have ever been in a managed care plan. In contrast, almost 90% of the public has been covered by managed care. See 2002 Health Confidence Survey posted results, www.ebri.org/pdf/surveys/hcs/2002/hcs02ppq.pdf, accessed May 15, 2011. See also "Health Confidence Survey: Managed Care Confusion," Employee Benefits Research Institute, October 2001.
- 3 Aetna Company Names web page at http://www.aetna.com/legal-notice/aetna_company_names.html, accessed August 1, 2011.
- 4 Sanofi-Aventis Managed Care Digest Series, HMO-PPO Rx Digest 2010–2011. Available at www.managedcaredigest.com, accessed May 21, 2011.
- 5 HMO Act of 1973, 42 U.S.C. § 300e.
- 6 Berenson RA, Ginsburg PB, Kemper N. Unchecked Provider Clout in California Foreshadows Challenges to Health Reform. *Health Affairs* 2010; 29(4).
- 7 42 U.S.C. 18042, The Patient Protection and Affordable Care Act.

- 8 Kocher R, Sahni, NR. Hospitals' Race to Employ Physicians: The Logic behind a Money-Losing Proposition. March 30, 2011. Available at: <http://healthpolicyandreform.nejm.org/?p=14045>. Accessed April 27, 2011.
- 9 Medical Group Management Association (MGMA). MGMA Physician Placement Report: 65 Percent of Established Physicians Placed in Hospital-Owned Practices. June 3, 2010. Press Release. Available at: www.mgma.com/press/default.aspx?id=33777. Accessed April 27, 2011.
- 10 American Hospital Association. The State of America's Hospitals—Taking the Pulse: Results of AHA Survey of Hospital Leaders. March/April 2010. Available at: www.aha.org/aha/research-and-trends/health-and-hospital-trends/2010.html. Accessed May 9, 2011.
- 11 ACA Section 3022.
- 12 Fisher ES, et al. Fostering Accountable Health Care: Moving Forward in Medicare. *Health Affairs* 2009; 28: w219–w230.
- 13 42 CFR Part 425 §1345-F.
- 14 Kilo CM, Wasson JH. Practice Redesign and the Patient-Centered Medical Home: History, Promises, and Challenges. *Health Affairs* 2010; 29(5):775.
- 15 "Joint Principles of the Patient Centered Medical Home," published by the Patient Centered Primary Care Collaborative, www.pcpcc.net, accessed May 23, 2011. While the principles are summarized here, serious students may wish to read the originals to ensure that the nuances contained therein are understood.
- 16 For example, Group Health Cooperative in Seattle has reported good success with this type of care team. See Reid RJ, et al. The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers. *Health Affairs* 2010; 29(5):835–843 for a good description of their program and results.
- 17 Section 1301, 42 U.S.C. 18021 (a)(3).
- 18 http://www.cbsnews.com/8301-505245_162-57320474/highmark-files-west-penn-merger-papers-with-state/. Accessed November 13, 2011.