1 The Evolution of Health Plans

Health Plans and Managed Care

You have no doubt heard the terms “health plan” and “managed care,” and perhaps also “health care management.” They are used in various ways, but in general they refer to systems that integrate the delivery and financing of health care, various techniques used to manage the delivery and financing of health care, and organizations that employ these techniques.

For the purposes of this course, we will define **managed care** (**health care management**) as the integration of the delivery and financing of health care within a system, plan, or organization that seeks to manage health care costs, access, and quality. Such a system, plan, or organization is referred to as a **health plan**, also called a **managed care plan** or **managed care organization (MCO)**.

Learning Objectives

After completing this lesson, you should be able to:

- define “managed care” and “health plan.”
- describe how the HMO Act of 1973, consumer and employer demand, and government involvement have shaped the evolution of health plans.
- discuss how health plans have responded to the problems of high health care costs and reduced access to health coverage.
- discuss the efforts by health plans to promote health care quality.

The Development of Health Plans

The Emergence of Health Plans

We think of managed care and health plans as modern developments, but in fact early versions have existed since the beginning of the 20th century. A few historical milestones:

- **1910.** The earliest examples of health plans appeared in the form of prepaid group practices. These were health care systems in which plan members paid a monthly premium and in return received a wide range of medical services through an exclusive group of providers.
- **1929.** Blue Cross plans providing prepaid hospital care were established.
- **1930.** Blue Shield plans providing reimbursement for physician services were established.
- **1954.** Individual practice associations (IPAs), which contracted with physicians in independent fee-for-service practices, emerged as a competitive response to health maintenance organizations (HMOs), which were based on group practices.

The Growth of Health Plans

For many years health plans accounted for only a small fraction of all health coverage. But in recent decades they have grown dramatically, and they now cover a large portion of the U.S. population.

There have been many reasons for this growth, but we will focus on three key factors:

- The HMO Act of 1973
- Consumer and employer demand
- Government involvement

The HMO Act of 1973

One of the most important causes of the expansion of health plans was the federal **Health Maintenance Organization Act of 1973**. This legislation was designed to reduce the cost of health care by increasing competition in the health coverage market and to increase access to health coverage for individuals without insurance or with only limited benefits. The main features of the HMO Act are:

- **Federal qualification.** HMOs were given the option of becoming federally qualified. To do so, they had to meet a number of standards related to minimum benefit packages, provider network adequacy, enrollee grievance systems, financial stability, and quality assurance.
- **Dual choice.** Employers that offered indemnity health insurance to more than 25 employees had to also offer a federally qualified HMO (if an HMO requested it).
- **Federal funding.** To encourage their development, grants and loans were made available to federally qualified HMOs. Funding could be used to expand the service area of an existing HMO or establish a new HMO.
- **State law exemption.** Federally qualified HMOs were exempted from state laws that restricted their development.

The Impact of the HMO Act

Although federal qualification was optional, many HMOs sought it because of the advantages mentioned previously and because it could be cited as a “stamp of approval” in marketing. But on the other hand, in some ways the competitive position of qualified HMOs was weakened, since they had to meet the federal standards and traditional indemnity insurance that other health plans did not.

From 1976 to 1996, the HMO Act was modified by a series of amendments. These gave health plans more flexibility in designing and marketing products and increased the emphasis on quality. Many of the standards for federally qualified HMOs were reduced or eliminated, and the dual choice mandate was repealed in 1995.

The HMO Act played a major role in the early establishment and growth of HMOs, and although federally qualified status no longer carries the weight it had previously, some HMOs still maintain it.

Consumer and Employer Demand

HMOs had significant success in containing health care costs and holding down premium increases, and by the early 1990s consumers and employers sponsoring health coverage had come to embrace them.

But a traditional HMO required members to receive health care only from providers affiliated with the plan (that is, in the plan's network) and go through gatekeepers (usually a primary care physician, PCP) to see specialists. Consumers became dissatisfied with these restrictions. They wanted the lower cost of an HMO but more leeway in choosing providers.

New Plan Designs

New health plan types were developed to address this demand. Two of the most important were PPOs and POS products.

- **Preferred provider organizations (PPOs)** like HMOs, have a network of providers. But unlike traditional HMOs, they cover services delivered by non-network providers, although the member pays a greater share of costs than for network care (typically higher copayments or coinsurance). And while traditional HMOs require members to obtain a referral from their PCP to see a specialist, PPOs generally do not.

- **Point-of-service (POS) products** combine elements of traditional indemnity insurance with elements of health plans. Members do not have to choose how they receive services until they use them and may obtain care from network providers and/or non-network providers. However, as with a PPO, members pay more for out-of-network care. Visits to specialists may require a referral from a PCP.

Specialty Care

Consumers also wanted coverage of specialty health care, such as dental care, vision care, behavioral health, and prescription drugs, and employers wanted more cost-effective ways of providing such benefits.

In response, health plans developed **specialty "carve-out"** plans and products with specialized provider networks. Specialty coverage may be integrated into a comprehensive health plan or offered as standalone product.

Consumer-Directed Health Plans (CDHPs)

Around the beginning of the 21st century, health insurance premiums began to go up again, and consumers and employers looked for new solutions.

One approach is the **consumer-directed health plan (CDHP)**, a combination of a **high-deductible health plan (HDHP)** and a tax-advantaged account. The insured uses money from the account (which is tax-free and may be contributed, at least in part, by an employer) to pay for health care expenses before he or she meets the annual deductible (usually several thousand dollars) of the health plan.

This approach both makes possible a lower premium and gives consumers an incentive to make prudent health care choices, as they pay much of the cost themselves.

These and other health plan types and products will be discussed in the lessons that follow.

Government Involvement

Government has long been involved in health insurance, at both the state and federal levels.

- For over a century, states have regulated insurance companies, including health insurers. They mandate or prohibit certain policy provisions, impose financial requirements, oversee sales and marketing, and enforce many other rules.

- The federal government has historically taken a secondary role, but it does enact legislation that affects insurers and health plans.

Federal Legislation & Recent Regulation

- As we saw, in 1973 Congress enacted the HMO Act.

- In 1996 it passed the Health Insurance Portability and Accountability Act (HIPAA), which included a wide variety of requirements for health plans.

- In 2003 the Medicare Modernization Act was passed, giving older adults access to prescription drug coverage through Medicare Part D and broadening the coverage offered to them through Medicare Part C (Medicare Advantage).

- In 2010 the Affordable Care Act (ACA) was enacted. It contained broad marketplace reforms including guaranteed issue, guaranteed renewability, and a package of essential health benefits (concepts to be explained later in the course).

- In 2016, Congress enacted the 21st Century Cures Act. In addition to funding medical research, this legislation allows some small businesses to provide health coverage to their employees through qualified small employer health insurance arrangements (QSEHIAs), a form of CDHP.[1]

- In 2019, the Internal Revenue Service, Labor Department, and Department of Health and Human Services issued a joint ruling allowing employers of all sizes to take advantage of the opportunities offered by heath reimbursement arrangements (HRA) and other account-based group health plans with individual health insurance if certain conditions are satisfied. This has resulted in some companies offering individual coverage health reimbursement arrangement (ICHRA) plans to their workforces. [2]

Government as Purchaser

The government plays another important role in health plans—it is a major purchaser of health coverage, financing health care for millions of Americans through several programs.

- In 1965 the Medicare program for the elderly and disabled and Medicaid for the poor were established, followed in 1997 by the Children's Health Insurance Program (CHIP).

- And the federal and state governments have long sponsored health coverage for millions of government employees and members of the military and their families.

Government health coverage programs have helped drive the growth of health plans by increasingly turning to them as alternatives to traditional indemnity insurance. As of 2021 over 26 million Medicare beneficiaries are enrolled in a Medicare Advantage plan,[3] and over 70 percent of Medicaid enrollees in the majority of states receive some or all of their health care through managed care.[4]

Current Trends in Health Plans

Current Trends

Now let's turn to current trends. The most important is the steady rise in health care costs.

This has made it necessary for health insurance premiums to be increased, and that in turn has made it harder for employers and consumers to afford coverage. Health plans have responded to these problems with a number of solutions.

Rising Health Care Costs

Spending on health care in the United States continues to rise. While the rate of increase is not as high as it was a decade ago, it is still far above general inflation. And some studies suggest that costs are likely to begin rising more rapidly.[5]

What drives this increase? Let's look at some key factors.

Technological and Pharmacological Advances

New tests and treatments involving technology are constantly being developed, and new drugs are being invented.

- These advances have enabled doctors to prevent, cure, or manage a variety of medical conditions, allowing many people who just a few years ago might have died or lived with pain or severe limitations to live normal lives.

- But in many cases, they are extremely expensive, and this has been a major component of cost increases.

Demographic Changes

The percentage of the elderly in the U.S. population continues to rise, and this increase is accelerating with the aging of the large Baby Boom generation, a bulge in the population whose members have begun to reach age 65.

In general, older people need more medical care than younger people. Many have chronic diseases that require ongoing treatment, medication, and therapy, and they often need nursing home care or home health care. And a very substantial portion of health care spending goes to people in their last few months of life, when long hospital stays (often in intensive care), multiple operations, and the use of technology are common.

Overutilization and Incentives

Another major cause of high health care spending is unnecessary medical services. Many physicians, hospitals, and other health care providers are still compensated under the fee-for-service approach. This means that the more services they deliver, the more they get paid—in other words, in most situations they have a strong financial incentive to provide additional services, even when it is doubtful that these services are needed or useful.

This problem is exacerbated by the fear of malpractice suits, which drives providers to order unnecessary tests and treatments just to make sure no one can accuse them of not doing everything conceivably possible. This is known as **defensive medicine**.

Other Trends

Commentators have pointed out a few other trends that contribute to higher health care spending.

- More Americans are overweight and physically inactive than in the past, leading to diseases such as diabetes and heart disease and to overall poor health.

- Some believe that widespread advertising of prescription drugs is creating an inflated demand for some products.

Higher Premiums and the Lack of Coverage

As mentioned earlier, to cover greater health care costs health plans are forced to raise premiums—otherwise they would go out of business. This has made health coverage less affordable, both for employers and individuals. Some small businesses have had to stop sponsoring coverage while larger businesses have shifted a greater share of the premium to employees.

As a result, many people of modest means find it difficult to afford health coverage. The Affordable Care Act (ACA) sought to alleviate this situation by providing subsidies to those of modest means and by expanding Medicaid.

But still, there are those who cannot afford coverage or voluntarily remain uninsured. These people often wait until a medical condition becomes severe and then seek care in a hospital emergency room, and they do not receive ongoing treatment or screening for diseases. This drives health care costs even higher.

The Response of Health Plans: Provider Compensation

Health plans have sought to address the problems of higher premiums and reduced access to coverage in various ways.

Provider compensation. Managed care generally seeks to replace fee-for-service compensation, which as we have seen gives health care providers incentives to deliver more services than may be necessary. Health plans use other compensation methods under which providers have incentives to avoid excessive services—such as monthly capitation payments or global payments for certain treatments (such as a joint replacement).[6]

Health plans are also able to negotiate lower payments to providers in exchange for supplying them with a large volume of patients.

In this course we will study in detail health plan compensation of providers.

Management Techniques

Health plans use a number of approaches to ensure that plan members are cared for in the most effective and cost-efficient way.

- Health plans emphasize **prevention** of illnesses (much less costly than treatment).
- **Utilization management** seeks to make sure that the services patients receive are appropriate to their needs.
- **Case management** coordinates care to avoid overlapping services from different providers.
- **Disease management** helps patients with chronic conditions maintain their health and avoid serious episodes.

Consumer-Directed Health Plans

CDHPs, described previously, address high costs in two ways.

- Because they have high deductibles, insurers pay less in benefits and so can charge a lower premium, making them affordable to more people.
- And because individuals pay for their own care until they satisfy the annual deductible (which is typically several thousand dollars), they have an incentive to use health care services wisely, not seeking care when it is not needed and choosing competitively priced providers and products.

Technology

A high priority of health plans is to reduce administrative costs in order to hold down premiums.

One of the best ways of doing so is using technology to perform such functions as processing and paying claims, billing, enrolling new members, generating member identification cards, and maintaining information. Handling these operations electronically rather than manually reduces staffing requirements and improves quality and customer service by increasing accuracy and shortening processing time.

Health plans are now expanding their use of automation into areas beyond core functions—for example, the widespread use of electronic medical records and artificial intelligence to assist in customer service.

Quality

Quality

So far, we have talked mostly about costs. But another important element in the evolution of health plans is quality.

In the past quality was often narrowly measured in terms of the scope of services provided for a certain cost. Today quality is evaluated more broadly and includes such components as desired outcomes, preventive care, access to physicians (both primary and specialty care), patient satisfaction, and care for chronic illnesses.

The Role of Employers

Historically, employer-sponsored health coverage was traditional indemnity insurance. There were no networks, and employees were generally free to go to any health care provider they chose, so it was up to them to make judgments and decisions about provider quality. But as premiums rose, employers took a more active role in evaluating and selecting health plans for their employees, and in doing so they considered not only costs and services covered but a number of quality measures.

Some employers have joined together to form purchasing coalitions to bargain more effectively for the lowest-cost and highest-quality health care. A recent example of employer concerns and reactions to rising health care costs and the quest for quality was the banding together of Amazon, Berkshire Hathaway, and J.P. Morgan Chase to provide coverage to their employees through a not-for-profit entity.[7] While this venture lasted just three years, it demonstrated the seriousness of employers regarding health care costs and their impact on bottom-line results. [8]

The Role of Accreditation

Health plans have responded to the demand for quality by establishing quality management programs. They have also sought to demonstrate the quality of their operations to consumers, employers, and government agencies by obtaining accreditation from independent agencies.

Accrediting Organizations

Two of the best-known accrediting bodies are NCQA and URAC.

- **NCQA (the National Committee for Quality Assurance)** has been accrediting health plans since 1991. Its mission is "to improve the quality of health care… through measurement, transparency, and accountability."[9] NCQA focuses on measuring results and sharing the information with consumers and the market. NCQA has developed a variety of quality measurement tools, including the Healthcare Effectiveness Data and Information Set (HEDIS). The large majority of health plans use HEDIS to measure performance on important aspects of health care and service.

- **URAC** was originally formed to evaluate utilization review processes, but it has expanded into evaluating health plans and other health care entities. The stated mission of URAC is "to promote continuous improvements in the quality and efficiency of health care management through processes of accreditation and education."[10]

Quality management and accreditation (including NCQA and URAC) are discussed in more detail later in the course.

Summary

Summary

A health plan is an organization that integrates the delivery and financing of health care and seeks to manage health care costs, access, and quality. Since their emergence a century ago, health plans have evolved in response to consumer and employer demand, legislation and regulation, and the role of government as a purchaser of health coverage.

Health plans have worked to hold down health care costs and premiums, through provider compensation methods, health care management, plan design, and technology. Plans have also sought to improve the quality of the care received by plan members.

Notes

[1] 21st Century Cures Act, https://www.gpo.gov/fdsys/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf

[2] Health Reimbursement Arrangements and Other Account-Based Group Health Plans (Final Rule), Internal Revenue Service, 26 CFR Parts 1 and 54; Department of Labor, 29 CFR Parts 2510 and 2550; and Department of Health and Human Services, 45 CFR Parts 144, 146, 147, and 155, Federal Register, Vol.84, No.119,, 2888, June 20, 2019, available at https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans

[3] Centers for Medicare and Medicaid Services, "Monthly Contract and Enrollment Summary Report" https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report.html ; Meredith Freed, Jeanie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage in 2021: Enrollment Update and Key Trends Data Spotlight—Plan Enrollment Patterns and Trends."Kaiser Family Foundation Issue Brief, June 21, 202, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/

[4] Kaiser Family Foundation, "Share of Medicaid Population Covered under Different Delivery Systems," July 1, 2017, *https://www.kff.org/medicaid/state-indicator/share-of-medicaid-population-covered-under-different-delivery-systems/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D* See also, Jeff C. Goldsmith, David Mosley, Anne Jacobs, "Medicaid Managed Care: Lots of Unanswered Questions (Part 1), Health Affairs Blog, May 3, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180430.387981/full/

[5] PWC Health Research Institute, "Medical Cost Trend: Behind the Numbers 2018," June 2017, https://www.pwc.com/co/es/salud/publicaciones/hri-behind-the-numbers-2018.pdf ; Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner, "Is This Time Different? The Slowdown in Health Care Spending," *Brookings Papers on Economic Activities*, 2013, pp. 261-302, https://www.brookings.edu/bpea-articles/is-this-time-different-the-slowdown-in-health-care-spending/

[6] National Conference of State Legislatures, "Global Payments to Health Providers," NCSL Briefs for State Legislators, May 2010 http://www.ncsl.org/research/health/global-payments-to-health-providers.aspx

[7] Cara Lombardo, Laura Stevens, and Nicole Friedman, "Amazon, Berkshire Hathaway, JP Morgan Join Forces to

Pare Health-Care Costs," *The Wall Street Journal,* Jan. 30, 2018, https://www.wsj.com/articles/amazon-berkshire-hathaway-jpmorgan-to-partner-on-health-care-1517315659

[8] John Tozzi and Matt Day, "Amazon-Berkshire-JP Morgan Health Venture to Shut Next Month," Bloomberg, January 4, 2021, https://www.bloomberg.com/news/articles/2021-01-04/amazon-berkshire-jpmorgan-health-venture-to-shut-next-month

[9] National Committee for Quality Assurance, www.ncqa.org.

[10] URAC, www.urac.org.

2 Basic Concepts of Health Insurance

Indemnity Insurance

Until the last few decades, most health coverage in the United States was indemnity insurance. Before we begin to learn about today's health plans, it is important to understand some basic concepts of this traditional coverage.

Why? Some health plans still retain certain characteristics of indemnity insurance, and many health plan designs and features were developed to address problems in indemnity insurance.

Learning Objectives

After completing this module, you should be able to:

- define insurance and indemnity health insurance.
- define risk, underwriting, and pricing.
- explain fee-for-service compensation and deductibles, coinsurance, and copayments.
- identify the main cost control methods used by indemnity health insurance.

Insurance

What Is Indemnity Insurance?

Insurance is a way of protecting against the risk of financial loss.

- An individual or business enters into a contract with an insurance company by purchasing an insurance policy. The person or business pays a relatively small, fixed amount (a premium) to the insurer at regular intervals (such as monthly or yearly).
- In exchange, if the person or business incurs a financial loss covered by the insurance policy, the insurer makes a payment (a benefit) or payments to cover or help cover this loss. (The insurer is said to "indemnify" the insured against the loss, hence **indemnity insurance**.)

The Purpose of Insurance

Insurance enables people to protect themselves against the possibility of losing a large, unpredictable amount of money by paying much smaller, set amounts over time. For instance, a homeowner can pay annual fire insurance premiums of a few hundred dollars so that if his/her home burns down he/she will not have to pay hundreds of thousands of dollars to replace it.

In **indemnity health insurance**, if a person covered by a policy (an insured) incurs medical expenses covered by the policy, the insurer pays benefits to pay those expenses or reimburse for them. By paying monthly premiums, the insured protects themselves against the risk of having to pay thousands, or tens of thousands, of dollars for treatment of a serious illness out of her own pocket.

Individual and Group Insurance

Insurance can take the form of individual or group coverage.

- In **individual insurance** a private person buys a policy from an insurer. He/she is the policyholder (the party to the insurance contract), he/she pays the premium, and he/she (and in some cases his/her dependents) are insured.

- In **group insurance** a business buys a policy that covers its employees, or an association or union buys a policy for its members. The policyholder is the business, association, or union; the employees or members and often their dependents are insured; and while employees or members may pay all or part of the premiums, they do so through the policyholder.

Risk and Underwriting

Risk

In insurance, **risk** is the possibility of a covered financial loss. In health insurance, it is the possibility (or probability) that a person will incur a health care expense covered by the policy.

While it is usually impossible to predict if and when a particular individual will need health care and how much that care will cost, it is possible to project with reasonable accuracy how much care will be needed by a sizable group of people over a certain period. Heath insurance works by bringing together such a group and collecting enough from them in premiums to pay for the care of those group members who need it.

Loss Rate

To charge enough in premiums to cover benefits (and other costs), an insurer must be able to predict the **loss rate** for a population of insureds—how much the insurer will pay in benefits.

Insurers are able to project loss rates by looking at past populations of insureds with similar characteristics (age, gender, occupation, location, etc.), the illnesses and injuries they suffered, and the amount of medical expenses they incurred.

Underwriting and Pricing

Underwriting and **pricing (rating)** are the processes by which an insurer decides whether to offer a policy to an individual or group, and if so, on what terms and at what premium rate.

The insurer seeks to ascertain the risk presented by an applicant, so that it can avoid unacceptable risks and charge a premium rate sufficient to cover the likely loss rate.

Individual Underwriting Pre-ACA

Before the **Affordable Care Act** (2010), an underwriter working for a health insurer might evaluate an individual's application for coverage and seek to find out whether he/she had any health conditions or medical history that made him/her much more likely than average to need medical care.

- If a person was very likely to need extensive care in the near future, the insurer might deem them uninsurable and decline to issue a policy.

- If he/she presented only a somewhat high risk, the insurer might issue a policy at a higher-than-average premium or exclude coverage for a preexisting condition.

Individual Underwriting Under the ACA

For broad health coverage for individual buyers, the ACA prohibits such individual medical underwriting and mandates **guaranteed issue**. This means that an insurer may not, based on an individual's health or medical history, decline to offer coverage, or exclude a preexisting condition, or charge a higher premium. (An insurer may charge a higher premium based on age, tobacco use, family size, and locality.)

However, while individual medical underwriting is prohibited for broad health coverage, it is still used for other health-related insurance products, such as disability income insurance, long-term care insurance, and (in some circumstances) Medicare supplement insurance.

Group Underwriting

In group insurance, the underwriter does not look at individuals; instead, he/she seeks to determine if the applicant group (such as eligible employees) has any characteristics that make it likely to have a higher-than-average loss rate.

For large groups the underwriter may look at the group's past health insurance claims as an indication of its future loss rate. If the group's loss rate is likely to be high, the insurer must charge a higher-than-average premium rate.

Adverse Selection

Underwriters must be alert to the possibility of **adverse selection** (also called **anti-selection**). Adverse selection can occur when people have the option of enrolling in health insurance or not. This happens in the individual market and in group insurance where employees pay all or part of the premium and therefore have the right not to participate.

In such cases people who are more likely than average to become ill, because they are older or in poor health, are more likely to choose coverage. If this occurs, the covered group will have a higher-than-average loss rate, and if premiums are based on average loss rates, they may be insufficient to cover benefits.

Factors in Group Health Insurance Underwriting

Factors in Group Health Insurance Underwriting

- **Age.** Older people generally incur more medical expenses than younger people, so an older-than-average employee group will have a higher-than-average loss rate.

- **Sex.** Females incur more medical expenses than males, so an employee group that is majority female will have a higher-than-average loss rate.

- **Occupation/industry.** Some occupations and industries involve dangerous activities or unhealthy conditions, and people engaged in them are more likely to suffer injuries or become ill. The loss rate for such employee groups will be high.
- **Location.** Medical practices and prices vary from region to region, and costs are generally higher in cities than in rural areas. This may affect the loss rate of a group.
- **Group size.** Larger groups spread risk over more people. As a result, larger groups tend to have a loss rate close to the average, while smaller groups are more likely to diverge from the average.
- **Participation.** If only a small percentage of eligible employees choose to enroll in a group plan, the risk of adverse selection is high. That is, the insured group will likely include a disproportionate number of people who need health care.

Basic Features of Indemnity Health Insurance

Provider Choice

In traditional indemnity health insurance, when an insured needs health care, they can go to any physician, specialist, hospital, or other health care provider they choose. They do not have to use a provider affiliated with a network, nor will they pay more if they use a non-network provider, as is the case in some health plans.

Benefit Payment

Under an indemnity policy, an insured receives care from a provider, the provider charges them for the services rendered, they submit to their insurer a **claim** (a request for payment based on the terms of the policy), and the insurer reimburses them.

Or more commonly, the insured assigns benefits to the provider—under **assignment of benefits**, the provider bills the insurer directly, and the insurer reimburses the provider.

Provider Compensation

Typically, in indemnity insurance, the provider bills the insurer their usual fee for the service they performed, and the insurer pays this amount. This system is known as **fee-for-service (FFS)**.

There are limits, however—typically, an insurer will not pay a fee considerably higher than the usual and customary charge for the service in the locality.

Cost Sharing

While indemnity insurers generally pay providers' fees, this does not mean that insurers cover all health care costs and insureds pay nothing. Indemnity health insurance policies generally have **cost sharing**— insureds must pay a portion of the expenses they incur.

Deductible and Coinsurance

In indemnity insurance cost sharing usually takes the form of a deductible and coinsurance.

- **Deductible.** The insured must pay a specified dollar amount of expenses covered by the policy before the insurer begins paying benefits. For instance, if a policy has a $1,000 annual deductible, each year the insured must pay for the first $1,000 of covered medical expenses. Once this is done (that is, the deductible is satisfied), the insurer pays benefits for any additional covered expenses for the remainder of the year.

- **Coinsurance.** After the deductible is satisfied, the insurer pays a percentage of covered medical expenses, and the insured pays a percentage. For instance, the insured might pay 20 percent coinsurance and the insurer the remaining 80 percent.

Example

Example: *Mark is covered by an indemnity health insurance policy. It has a $1,000 annual deductible and 20 percent coinsurance. At the beginning of the year, Mark is hospitalized and incurs $5,000 in medical expenses covered by his policy. What amount of these expenses will Mark pay? What amount will the insurer pay?*

Mark pays the first $1,000 (the deductible). Of the remaining $4,000, he pays 20 percent coinsurance, or $800, for a total of $1,800 dollars. The insurer pays the other $3,200.

Copayments

There is another form of cost sharing, not typical of indemnity insurance but common in health plans—**copayments**. A copayment is a flat dollar amount a plan member pays for a certain service, not a percentage of the cost of that service.

Example: *Jake is a member of a health plan. Whenever he sees his primary care physician, he makes a $20 copayment. The amount is always $20 regardless of the actual cost of the services the physician provides.*

The Purpose of Cost Sharing

The purpose of cost sharing is to hold down the cost of health coverage by reducing the amount the insurer pays in benefits, and to give insureds an incentive not to use health care services unnecessarily.

To return to the example of Mark, if he paid no cost sharing, he would have no reason not to go to the doctor for every minor complaint and to request as many tests and services as the doctor would provide. But if he has to pay part of the cost of any health care services, he is likely to request care only when he really needs it.

Cost Control

Cost Control in Indemnity Health Insurance

As health care expenditures and premiums rose, indemnity health insurers took a number of steps to hold down increases.

Some of these were successful and have been adopted by health plans, and others laid the groundwork for approaches used today.

Coordination of Benefits

A **coordination of benefits (COB)** provision of a health insurance policy is designed to prevent duplication of benefits when a person is covered by two policies (such as a child whose parents both have employer-sponsored coverage that includes dependents).

Under a COB provision, one policy is considered primary and the other is secondary. The primary policy pays all the benefits it normally would, and if there are any expenses not covered by the primary policy but covered by the secondary policy, the secondary policy pays additional benefits.

In this way, no benefits in excess of the actual expenses incurred are paid.

Example

> ***Example:*** *Amelia is covered by both her father's and her mother's employer-sponsored group health insurance policy. Amelia receives health care services costing $1,000, all of which are covered by both policies. Her father's policy has 30 percent coinsurance, so it pays $700. Her mother's policy has 20 percent coinsurance, so it pays $800. But both policies have COB provisions, and the father's policy is the primary policy. So the father's policy pays $700 (the normal benefit), and the mother's policy pays $100 (the difference between the normal benefit and what has already been paid by the other policy).*

Increased Cost-Sharing

Increasing deductibles and/or coinsurance has two affects.

- It shifts health care costs from the insurer to the insureds, and because the insurer is paying less in benefits, it can charge a lower premium.

- Insureds' incentives are increased to help mitigate the use of unnecessary health care services. This reduces health care expenditures, making it possible to hold down premiums.

Example

> ***Example:*** *Karen is covered by a group indemnity health insurance policy sponsored by her employer. The policy has a $1,000 annual deductible and 20 percent coinsurance. The premiums Karen and her employer pay have been increasing significantly every year. In an effort to hold down these increases, the insurer proposes increasing the deductible to $2,000 and coinsurance to 25 percent. Since the insurer will pay less in benefits, they will be able to charge less. So Karen and her employer will pay a lower premium, but Karen will pay more out of her own pocket for health care. And because she pays more, she has a greater incentive to seek care only when she really needs it.*

Increased cost sharing can be seen as a precursor to consumer-directed health plans, mentioned in the last module and discussed in more detail later in the course.

Cost Containment

Cost containment measures are designed to lower health care expenditures (thereby holding down health insurance benefits and premiums) by ensuring that the medical services provided to insureds are necessary, appropriate, and cost-effective.

For instance, before nonemergency surgery is performed, a second opinion from another physician might be sought to make sure that the surgery is necessary and is the most medically effective and cost-effective way to treat the condition. Steps are also taken to see that the most appropriate and cost-effective levels of care and care settings are used—for instance, it may be just as medically effective and safe and much less expensive to perform a certain procedure on an outpatient basis rather than admitting the patient to a hospital.

Many other cost-containment strategies, such as utilization management, medical management, and case management, are discussed later in this course.

Preventive Care

In the past many indemnity health insurance policies did not cover some **preventive care** services, such as annual checkups, immunizations, and screenings for medical conditions.

But it is relatively easy and inexpensive to prevent many conditions or cure them if they are detected early but difficult and expensive to treat them in later stages.

Insurers began to realize that it is more cost-effective in the long run to pay for preventive care services and encourage insureds to use them. And the ACA now requires insurers to cover many preventive care services without cost sharing.

Wellness

Insurers also began to take note of the correlation between behaviors such as smoking, lack of exercise, and overeating and certain medical conditions. In response, they began to establish **wellness programs**, which help pay for smoking cessation, fitness, weight-loss, and similar programs.

As with preventive care, wellness programs are cost-effective in the long term. For instance, it costs much less to help an insured pay for a weight-loss program than to treat diabetes later.

The Impact

These measures by indemnity insurers have had a positive impact, but they have not proved sufficient.

Consequently, other models, such as HMOs, PPOs, and POS products, have been developed. These health plans integrate the financing and delivery of health care and monitor and control costs and quality in different ways—as we will see in this course.

Summary

Summary

Historically, most health coverage in the United States was indemnity insurance. Health plans retain some characteristics of this traditional coverage, and some plan features were designed to address

problems with it. So to understand health plans, it is helpful to have a basic understanding of indemnity insurance.

In traditional indemnity health insurance, insureds could go to any provider they chose—they did not have to use network providers or pay more for out-of-network care. Providers were paid on a fee-for-service basis. Insureds had to satisfy a deductible and pay a percentage of costs (coinsurance).

Summary (Continued)

Indemnity health insurers sought to hold down costs through coordination of benefits provisions (to prevent duplication of benefits), increased cost sharing, cost-containment measures (to ensure that the health care services provided were necessary and appropriate), and preventive care.

These approaches had some positive impact, but health plans have gone further in promoting the quality and cost-effectiveness of the health care received by their members.

3 Health Plan Benefits and Networks

Learning Objectives

After completing this lesson, you will be able to:

- give examples of health plan types and health plan products
- describe health plan benefits
- define “copayment,” “coinsurance,” and “deductible”
- discuss access to care in health plans, including the role of networks and primary care
- describe utilization management and quality management

In this lesson, we will first review and expand on the definition of “health plan” and discuss some basic concepts and characteristics of health plans. Additionally, we will look at health plan products, benefits, and cost-sharing; examine how health plan members access care, including through organized systems of care (networks); and briefly discuss utilization management and quality management.

Health Plans

Health Plan

The term **health plan** has many meanings. As previously defined, a health plan is the integration of financing and delivery of healthcare within a system. It seeks to manage the cost, access, and quality of care.

For this reason, health plans may also be called managed care plans or managed care organizations. The term “health plan” may be used to refer to a single organization or to a company that offers several types of health insurance or health plan products. In this lesson, we will use the term “health plan” to refer to any entity that utilizes certain concepts or techniques to manage the cost, access, and quality of healthcare.

Health Plans and Health Plan Products

Just as it is difficult to define a health plan, it is an equally complex task to describe and distinguish among the different types of health plans and health plan products.

In some cases, the same term may be used to describe both a type of health plan and a type of health plan product.

Examples: Health maintenance organizations (HMOs), preferred provider organizations (PPOs), and physician-hospital organizations (PHOs).

More information on PHOs:

Physician-hospital organizations (PHOs) are organizations that bring together hospitals and their attending medical staff. PHOs are often developed for the purpose of contracting with managed care health insurance plans. A PHO may be open to any member of staff who applies or it may be closed to staff members who for example, represent an already overrepresented specialty. [i]

Health Plan Products

In an effort to meet changing customer demand for customization and flexibility of product options, health plans are offering more and different health plan product types and models.

In general, there are some basic characteristics that distinguish the different types of products from one another. But product types are becoming less clearly distinguishable from one another, and there few rigid and absolute distinctions among different types. And it is likely that these distinctions will blur even further as the health plan industry continues to evolve.

Types of Health Plan Products (Examples):

- **Health maintenance organizations (HMOs)**—plans that typically utilize physicians as gatekeepers.
- **Preferred provider organizations (PPOs)**—plans that usually contract at discount prices with physicians.
- **Point-of-service (POS) products**—plans in which members do not have to select how to receive services until they use them.
- **Consumer-directed health plans (CDHPs)**—plans that combine a health savings account with a high-deductible health insurance plan – sometimes simply referred to as high-deductible health plans. [ii] At other times they are referred to as account-based plans.

Service & Population Specific Health Plan Products

There are also specialty health plan products for specific types of services and populations.

Examples include:

- dental HMOs and PPOs,
- vision care HMOs and PPOs,
- Medicare HMOs and PPOs, and
- Medicaid plans.

Managed Care Techniques

Health plan products vary in their use of managed care techniques, with a range from highly managed to minimally managed products.

The cost-containment techniques described earlier are examples of some ways that health plans manage costs.

Other managed care techniques include benefit design and cost-sharing structures, network structure, and various medical management practices (such as prior authorization, second opinions, and case management programs).

More information on managed care continuum:

The Use of Managed Care Techniques and Concepts				
Less				***More***
Traditional indemnity health plans	Traditional with cost-containment features	PPO	POS	HMO

The Health Plan Continuum

All health plan products can be positioned between the two ends of the continuum. The farther to the right on the continuum a health plan is (for instance, an HMO), the more managed care techniques and concepts are practiced by the plan. As you learn more about the different types of plan products, you will begin to understand where each type of plan fits on the continuum.

Regardless of where a plan product falls on the managed care continuum, all health plans have in common the ultimate goal of accessible, cost-effective, and quality healthcare.

The Key Players

There are key participants in health plans. These are organizations and individuals who are involved in the delivery, financing, and consumption of healthcare.

The roles of these participants evolve as health plans mature and new types of health plan products are introduced. The key players in health plans include:

- **Providers**—individuals and entities that provide healthcare services, such as physicians, nurses, hospitals, and laboratories.
- **Payors**—organizations or individuals that finance or reimburse the cost of healthcare services, such as insurance companies, health plans, and the federal government.

- **Purchasers**—organizations or individuals that pay the premiums for the healthcare plan, such as employers and individual insureds.

- **Members**—individuals who are enrolled in a health plan and for whom the health plan provides healthcare services.

Overlapping Roles

In health plans, services are delivered through integrated systems of providers and the plans, with all of the key players working together. As we mentioned previously, the roles of these players are changing—roles have begun to overlap, and there are fewer distinctions between the roles of key players.

Example: Risk bearing (assuming the financial risks associated with the costs of care provided to members) has generally been associated with the payors, such as Medicare and Medicaid and insurance companies. But in coordinated healthcare delivery systems, providers can also share the role of "risk bearers." The evolution of roles will certainly continue as health plans and products evolve.

Health Plan Benefits

Health plans typically provide a comprehensive benefits package. Health plan benefits (or the services and products that the health plan provides) are generally more extensive than those covered by indemnity insurance. Some typical benefits provided by health plans include:

- hospitalization
- physician services
- many outpatient services, including mental healthcare
- emergency care inside and outside the service area
- prenatal and well childcare
- immunizations
- periodic health evaluations and examinations
- diagnostic services and lab test.
- inpatient and short-term rehabilitation services and physical, occupational, and speech therapy

Typical Health Plan Services and Terms

Some services and terms typically found in plan benefits are:

- Primary Care
- Specialty care (secondary care)
- Specialist

- Referral
- Outpatient services
- Ancillary Services

Primary Care

Primary care—general medical care, with a focus on preventive care and the diagnosis and treatment of routine injuries and illnesses, which is provided directly to a patient without referral from another physician.[iii]

Specialty care (**secondary care**)—treatment by specialists to whom a patient has been referred by primary care facilities.[iv]

Specialist

Specialist—a healthcare professional (usually a physician but may also be a dentist or other practitioner) who voluntarily limits his/her practice to a certain branch of medicine (orthopedics). A specialty may be based on specific services or procedures (such as anesthesia), specific body systems (neurology), certain types of diseases (oncology), or an age group (pediatrics or gerontology).[v]

Referral

Referral—a recommendation by a physician and/or a health plan for a member to be evaluated and/or treated by a different physician or medical professional, who may be a primary care physician or a specialist.[vi]

Outpatient Services

Outpatient services—services provided by a hospital or other healthcare facility without the patient staying overnight.[vii]

Learn about ambulatory surgical centers:

Some medical procedures are too complex to be done in a physician's office but simple enough that patients do not usually require hospital care prior to or after undergoing them. Ambulatory surgical centers (ASCs) are designed for these types of procedures. These centers aim to provide a safe environment for surgery and basic monitoring during the initial post-operation hours. Ambulatory surgical centers, also referred to as outpatient or same day surgery centers, are often a less expensive option compared to hospitalization. Examples of the types of surgeries and procedures undertaken in these facilities include:

- cataract surgeries,

- esophagogastroduodenoscopies,
- colonoscopies, and
- spine epidural injections.[viii] [ix] [x]

Ancillary Services

Ancillary services—outpatient or auxiliary services that support the diagnosis and treatment of a patient's condition; supplemental services needed along with other care. Included are laboratory work, pharmacy services, radiology, physical therapy, medical supplies, and other items.[xi]

Preventive Care

Health plans focus on improving the health of their members and typically place greater emphasis on preventive care than do indemnity plans.

Examples: physical examinations, immunizations, well childcare, and routine mammograms.

Plans use benefit design to encourage members to utilize preventive care services and to seek care earlier.

Example: Typically in health plans, members pay nothing or very little for preventive services, thereby removing financial barriers to their use.[xii] [xiii]

Mandated Benefits

State and federal laws – in some cases both – require that certain services be included in health plan benefits. These are known as **mandated benefits**.

Before 1996 only state legislatures had established health insurance mandates, and these mandates applied only to traditional health insurance benefits within the state. But, that year, Congress passed the first-ever federal benefit mandates, requiring health plans and employers to cover a minimum maternity stay of 48 hours and to cover mental health services at the same level as physical healthcare services.

Other federal benefit mandates that have been enacted include essential health benefits, COBRA continuation coverage, and reconstructive surgery after mastectomy.

Essential Health Benefits

The federal government set down a series of mandates called *essential health benefits (EHB)* as part of the Affordable Care Act.

These EHBs are ten in number and they are applicable to coverage sold in the individual and small group markets.[xiv] Throughout changes in administrations, CMS has sought to provide states greater flexibility in setting their EHB-benchmark plans.[xv]

Learn about the 3 types of mandated health insurance benefit laws.

Mandated health insurance laws passed at either the federal or state level usually fall into one of three categories:

- Health care services or treatments that must be covered, such as substance abuse treatment, maternity services, prescription drugs, and smoking cessation.
- Healthcare providers other than physicians, such as acupuncturists, chiropractors, nurse midwives, therapists and social workers.
- Dependents and other related individuals, such as adopted children, dependent students, grandchildren, and domestic partners.[xvi]

It is important to understand that if a benefit is defined as a mandated benefit, it must be included in the benefits of the specified insured products (such as individual coverage) offered by managed care organizations and health insurance companies.

Cost Sharing

We introduced deductibles, coinsurance, and copayments in the last lesson. Let's take another look.

Copayment

A **copayment** is a specific dollar amount that a member must pay to the provider out of his/her own pocket for a specified service at the time that the service is rendered. The amount is the same regardless of the actual cost of care provided.

For instance, if a plan has a $20 copayment for a physician office visit, the member pays this amount whether the doctor provides only a few services or many during the visit.

Copayment amounts generally vary by type of service. For example, preventive services may be fully covered by the plan with no copayment, while other services typically require copayments. In addition, copayments can vary depending on whether a provider is considered in-network or out-of-network. In-network copayments are usually less than out-of-network copayments.[xvii]

Coinsurance

The terms "copayment" and "**coinsurance"** are sometimes confused, but they have distinct meanings. While a copayment is normally a flat dollar amount (such as $35 per specialist visit), coinsurance is typically a percentage of the total cost of the service or product provided (such as

10 percent of the cost of a $700 test). Thus, coinsurance is based on the total cost of the service while a copayment is not.[xviii]

Deductibles

A **deductible** is a fixed dollar amount that an insured or member must pay for his/her healthcare, within some defined period, before the insurer or plan starts to pay benefits.

For instance, an insured might have to pay the first $750 of his/her healthcare expenses each year before the plan begins paying benefits. There may be separate deductibles for specific services, and deductibles may vary depending on whether services are provided by a network or a non-network provider.[xix]

While health plans may have deductibles, copayments, and/or coinsurance, cost-sharing requirements in health plans generally result in less out-of-pocket expense for the member than in most traditional indemnity plans.

Access to Care

Access to Care

Now that we have described the types of benefits found frequently in health plans, let's learn how plan members access these benefits. Previously we defined "access" as an individual's ability to obtain healthcare. The lack of access to care by many people in the United States was one of the main drivers behind the passage of the Affordable Care Act (ACA) and expanding it was one of its key objectives.[xx]

Networks

Health plans use networks to address some traditional and some new access issues. In health plans, healthcare is provided to members through networks of physicians, hospitals, and other providers. In this section we will introduce networks, discuss the use of primary care as an entry point to manage healthcare, look at the role of the physician in primary care, discuss issues of provider choice, and review how networks enhance access to care.

Delivery System or Provider Network

The physicians, hospitals, and other providers that a health plan has contracted with to deliver medical services to its members are often referred to as the plan's **delivery system** or **provider network**. For most plans the network is an important part of plan design. Some plans or products require members to receive care only from providers in the network. With other plans or products, members may receive services from non-network providers, but when they do their out-of-pocket expenses are higher.[xxi]

Network Formation

A health plan's network is formed by the plan entering into contractual arrangements with specified providers. These contracted providers agree to furnish services to specified persons (members or enrollees) in exchange for specified payments.

The contract between the plan and the provider also includes rules and obligations, including medical management, billing, etc. There are many variations to the contract, as different arrangements are needed for different types of health plans, products, and networks.[xxii]

What a Network Must Include

One of the most important goals of a health plan is ensuring that members have convenient access to services. To provide good access, health plans must ensure that their network includes:

- the right *number* of providers
- the right *types* of providers
- providers in the right *locations*

Number of Providers Needed

The number of providers needed is sometimes based on ratios of physicians to members. The types of providers in a network are dependent on the type of plan or benefits offered. Finally, providers must be within reasonable proximity to members' homes and/or workplaces. For added convenience and access, plans sometimes seek to combine a comprehensive set of services (such as medical, laboratory, and pharmacy) in one location.

A health plan must validate that providers in its network meet standards for their particular profession. To accomplish this, health plans use various criteria, standards, and processes. These processes and other activities related to provider selection are discussed in detail in the lesson entitled *Network Structure and Management*.

Primary Care

In health plans the role of primary care is very important. In its most general sense, **primary care** refers to general medical care and care that is provided directly to a patient without a referral from another physician. Primary care generally focuses on the prevention and treatment of routine injuries and illnesses.

Primary Care Providers (PCPs)

Primary care providers (PCPs) are typically family or general practitioners, internists, obstetricians/gynecologists, and pediatricians. Some plans allow for medical professionals such as nurses, nurse practitioners, or physician's assistants.

Primary care providers are also referred to as personal care physicians or personal care providers.

The Role of the PCP

In addition to providing primary care services, in many health plans the PCP serves as the member's point of entry into the healthcare system, his/her first point of contact.

The PCP also coordinates the healthcare services of his/her members, including determining when specialty care is needed and referring the member to a specialist provider.

Other PCP roles may include managing and directing the member's healthcare. PCP roles and responsibilities may be defined in the contract between the PCP and the health plan. The role of the PCP may vary depending on the health plan and product type.[xxiii xxiv]

Example: *Grace is a member of a PPO. She has chosen Dr. Cherie Mansetti, an internist, as her primary care physician. Grace sees Dr. Mansetti for digestion difficulties, which the doctor diagnoses as a medical condition involving her gallbladder. Dr. Mansetti refers Grace to one of the plan's specialists, Dr. McCarty, for surgery. Dr. McCarty operates on her at a hospital in the plan's network.*

Provider Choice

A choice of providers is very important when individuals select a health plan and in member satisfaction with their plan.

For this reason, plans strive to make their networks attractive and comprehensive.

In addition, many health plans offer products that allow for more open access and fewer restrictions. PPOs and POS products are examples of products with more open access to providers.

Managing Member Access to Healthcare Services

Traditionally health plans have managed member access to healthcare services by either requiring members to use network providers or by providing financial incentives for them to do so. The following are examples of how this is accomplished in some plans:

- Members are encouraged to use network doctors and providers by a benefit design that includes lower out-of-pocket costs for in-network care than for out-of-network care.

- Provider contracts are structured to include favorable financing and delivery provisions.

Enhancing Accessibility of Care

By their very design health plans enhance the accessibility of healthcare in ways that are not achievable under indemnity coverage.

For instance, a plan's cost structure may lower members out-of-pocket cost, and there is typically an emphasis on prevention and wellness.

Cost Structure

Traditional indemnity plans typically have high out-of-pocket costs, including significant deductibles and coinsurance, and this may create barriers to access to care. Health plans' out-of-pocket costs are typically lower, so that care is more accessible. In some markets, health plans through their market power have in fact been a factor in lowering costs. [xxv]

Primary Care, Prevention, and Wellness

Managed care health plans emphasize primary care, prevention, and wellness. Members are encouraged by benefit design to seek preventive healthcare such as mammograms, physical examinations, and screenings (for instance, for high cholesterol).

Health plan primary care focuses on early detection and treatment, preventing illnesses or complications. Health plan benefit designs generally include incentives (such as lower copayments) for members to use PCP services. Some health plans give premium discounts or include benefit coverage for wellness programs, initiatives, and/or wellness results.

Utilization and Quality Management

Slide-Utilization and Quality Management

Two additional concepts critical to healthcare management are utilization management and quality management. Both will be covered in detail in later lessons, but you need some basic information about them before you begin your study of health plan types.

Utilization Management

Utilization management (UM) is managing the use of healthcare services so that patients receive necessary, appropriate, and high-quality care in a cost-effective way. UM includes a number of techniques:

- **Demand management**—strategies designed to reduce the overall demand for and use of unnecessary healthcare services by providing plan members with the information they need to make informed healthcare decisions.

- **Utilization review**—an evaluation of the medical necessity, appropriateness, and efficiency of healthcare services and treatments for a given patient.

- **Case management**—an approach that identifies plan members with special healthcare needs, develops a strategy to meet those needs, and coordinates and monitors the delivery of necessary services.

- **Disease management**—the coordination of diagnostic, preventive, and therapeutic measures to manage certain chronic conditions (such as diabetes and hypertension).

These techniques can be applied to all components of a plan's healthcare delivery system, including primary care, specialist referrals, hospitalizations, drug use, and others. They may be conducted by the plan itself or by a third-party organization specializing in UM.

Quality Management

Quality management (QM) is an organization-wide, ongoing process of measuring and improving the quality of the healthcare and services a health plan provides to its members. Most health plan QM programs have the following features:

- **Oversight.** Most health plans assign overall responsibility for QM to a senior executive, who typically heads a QM oversight committee.

- **Credentialing.** Health plans evaluate the credentials of providers before permitting them to join their networks.

- **Measuring and improving care.** Plans measure the quality of the care provided by their providers and seek to improve it in various ways, including outcomes studies, provider profiling, clinical practice guidelines, benchmarking, peer review, and member surveys.

- **Members' rights and complaint resolution procedures.** Most health plans have a written policy stipulating members' rights and responsibilities and a formal system for addressing complaints.

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4 Provider Compensation: Fee-for-Service to Value- Based Care

Learning Objectives

After completing this lesson, you will be able to:

- describe fee-for-service compensation
- discuss the drawbacks presented by fee-for-service (FFS) compensation of healthcare providers
- describe compensation programs other than fee-for-service (FFS) used by health plans to compensate providers
- explain why value-based compensation programs are being adopted throughout the healthcare system;
- compare compensation arrangements in terms of the risk assumed by providers
- understand the impact of MACRA on provider compensation in the Medicare program

Fee for Service

As we learned in earlier lessons, traditional indemnity health insurance healthcare providers are generally compensated by **fee-for-service (FFS)**.

FFS is when a provider performs a service for an insured, the provider bills the insurer her normal fee for that service, and the insurer pays. [i]

Health plans continue to use the fee-for-service approach in some cases, but they have also developed a number of other compensation methods, which we will discuss in this lesson. [ii]

Incentives and Risk

As we have mentioned briefly before, the fee-for-service approach creates a problem.

The more healthcare services a provider delivers, and the more expensive the services, the more the provider is paid. Consequently, providers have a strong financial incentive to deliver more care, and they have few incentives to avoid unnecessary services.

Combined with the need many physicians feel to perform unnecessary tests and treatments to make sure they cannot be accused of not doing everything conceivably possible (defensive medicine), this creates strong pressure for the overutilization of healthcare and drives up costs.

FFS gives physicians no financial incentives to focus on preventive care or promote wellness, since it is only when people get sick that they are paid.

More on the pros and cons of fee-for-service:

Pro	**Con**
Encourages the delivery of care	Offers minimum incentive to deliver efficient care or prevent unnecessary care
Relatively flexible and can be employed regardless of organizational size or structure	Often limited to face-to-face visits and acts as a barrier to care coordination
Supports accountability for patient care but is often limited to the scope of service provided by a particular provider at any point in time	Patients must deal with the logistics of face-to-face visits involved in this model. *(Note, the increased acceptance and availability of telehealth services makes this less of a barrier moving forward).* [i]

Risk Sharing and Financial Risk

In response to this situation, other provider compensation methods have been developed and are used by health plans. These methods give providers incentives to deliver care in a cost- effective way, avoid unnecessary services, and promote prevention and wellness.

One of the main ways they do this is **risk-sharing**. In the context of health plans, **financial risk** is the possibility that plan members will need more healthcare than projected, resulting in a financial loss.

Premiums

A health plan collects premiums from members and purchasers such as employers.

Premium amounts are set to cover the level of healthcare services that the plan's members are expected to need. If members need more services than projected, the premiums collected may not be sufficient to cover costs, and the plan suffers a financial loss.

Under FFS compensation, healthcare providers do not share this risk—if insureds need more services, the providers deliver them and bill the insurer for them, and the insurer pays the additional cost. But under other forms of compensation, providers do share risk, and this gives them an incentive to hold down costs, as we will see in this lesson.

Why Do Providers Accept Other Forms of Compensation and the Risk They Entail?

Health plans contain a volume of patients that providers can bring on.

To become a participating provider with a health plan, a provider may have to accept a compensation arrangement that pays somewhat less for services that he/she normally charges

and that requires him/her to assume a certain amount of risk.

However, doing so gives them access to a larger population of patients. Participation is then financially advantageous for providers.

Capitation

How Capitation Works

Capitation is a provider compensation method that is very different from fee-for-service.

Under FFS a provider is paid based on the number of services he/she provides and the cost of those services. Under capitation the provider is paid based on the number of people he/she cares for (he/she is paid "per capita," meaning "per person"), regardless of how many services he/she provides to them or what those services cost.

Capitation Rate

A health plan pays a provider a set amount (a **capitation rate**) for each plan member under his/her care for each time period.

In exchange, the provider must deliver whatever healthcare services are needed by those members during that period. Whether the provider delivers many services or few or none, he/she receives the same amount.

Per Member Per Month (PMPM)

Most commonly, a capitated provider is paid on a **per member per month (PMPM)** basis.

Example: A plan may pay a primary care provider (PCP) a certain dollar amount per month for each plan member assigned to her. In return for that PMPM payment, the PCP must provide whatever primary care those members need. [iii] [iv]

FFS and Capitation: Risk and Incentives

Under FFS, as we have seen, a provider assumes no risk. If insureds need more services than expected, he/she delivers them and is paid for them.

Under capitation, on the other hand, providers do bear risk. If members need few or no services, a provider will have to do little for her capitation payment, but if they need a lot of care, he/she will have to deliver many services and will not be paid any more.

FFS and Capitation: Risk and Incentives (Continued)

This risk-sharing gives capitated providers a strong incentive to avoid unnecessary services and control costs.

However, one of the criticisms of capitation is that there could be a tendency to withhold care.

The counterargument is that capitation promotes healthcare quality because physicians also

have a strong incentive to promote prevention and wellness—it is in the doctors' interest for the members assigned to them to stay healthy so that they do not need services and for sick patients to get well soon and avoid complications and more expensive treatments. [v] [vi]

Capitation Considerations

In addition to PCPs, other physicians including specialists may be compensated by capitation. So may groups of physicians (including multi-specialty groups) as well as hospitals.

When an organization such as a group practice is paid by capitation to provide care for a plan's members, capitation may cover primary care only, or primary and specialty care but not ancillary services, or all services.

Service Categories

In designing capitation arrangements for PCPs, a plan must decide what services will be considered primary care and therefore covered by the capitation payment and stipulate these services in the provider contract.

Likewise, if a hospital is paid by capitation, the contract must clearly set forth what services are included.

Hospitals Accepting Capitation

A hospital that accepts capitation for providing the care needed by a health plan's members assumes a considerable amount of risk—if members need more hospital care than expected, the hospital will be responsible for providing it without additional compensation from the plan.

Consequently, such a hospital must have a strong program to manage utilization, and it may purchase stop-loss insurance, which covers costs if expenditures go above a certain level.

As we have seen, some health plans (such as PPOs and POS plans) allow members to receive care from non-network providers. This can create a situation in which a plan is paying a provider a capitation payment to provide the care needed by a member, but in fact the member is receiving services from a non-network provider instead. Various adjustments may be made to account for out-of-network care.

Trends in Capitation

In the early decades of managed care, when most health plans were HMOs, capitation was a very common form of compensation. But as we have seen, as PPOs and other plan types became more popular, there was a trend away from pure capitation.

However, as healthcare costs continue to rise and policymakers and health plans seek ways to control them, capitation is getting another look, and many proposals for reform of provider compensation include elements of capitation, often blended with other approaches. Capitation may play a greater role in the future. [vii] [viii]

Other Compensation Arrangements

Other Compensation Arrangements

In addition to traditional fee-for-service and capitation, there are a number of other compensation arrangements between health plans and providers.

Fee Schedule

A health plan may pay providers on a fee-for-service basis but limit the amounts paid by means of a **fee schedule**.

This is a list of healthcare services and procedures with the maximum amount that the plan will pay for each service. This approach is also referred to as **fee maximums**, **capped fees,** or **fee allowances**. [ix] [x]

Balance Billing

Providers serving a plan's members agree to charge the plan no more than the maximum listed in the fee schedule and to accept that amount as payment in full. This means that providers may not engage in **balance billing** of members.

Example: If a doctor normally charges $100 for a service, but a plan's fee schedule allows only $85, the doctor must accept the $85 as payment in full and may not charge the member the remaining $15. Thus, although this is a form of fee-for-service, the provider accepts some degree of risk—while the allowable fee will normally cover the cost of providing a service, if it does not, the provider must bear the cost. [xi] [xii]

Usual, Customary, and Reasonable (UCR) Fees

A fee schedule is typically based on **usual, customary, and reasonable (UCR) fees**.

A UCR fee for a service is the amount commonly charged for the service by physicians in the region, and health plans may determine UCR fees by collecting data on physician charges. [xiii] [xiv]

Discounted Fee-for-Service

Another common compensation arrangement is **discounted fee-for-service**.

The plan pays the provider the UCR fee for a service minus a negotiated percentage discount. As with a fee schedule, the provider agrees to accept this amount as payment in full and accept a certain degree of risk. [xv] [xvi]

Relative Value Scale (RVS)

Some plans use a **relative value scale (RVS)**. The plan gives a numerical value to each medical procedure or service. This value is multiplied by a dollar amount negotiated by the plan and providers, yielding a payment amount.

Example A plan rates the value of a particular service as 5 and another service as 7. It multiplies

these values by $11 dollars (the dollar multiplier agreed to by the plan and providers) and pays $55 for the first service and $77 for the second.

Resource Based Relative Value Scale (RBRVS)

Simple RVS systems tend to give a high value to medical procedures (such as surgery) and a relatively low value to other activities such as seeing patients in office visits or researching patients' conditions.

To address this problem, the **Resource-Based Relative Value Scale (RBRVS)** was developed. RBRVS seeks to take into account all the resources that physicians use in providing care to patients, including not only physical and procedural resources, but educational, mental, and financial resources as well. [xvii] [xviii]

Salary

In some HMOs, as we will explore in future lessons, some physicians are employees and are paid a salary. A salaried doctor generally assumes no risk—he is paid the same regardless the amount of care members' needs.

However, some HMOs use withholds or other arrangements to share risk with employee-physicians, and many offer incentive payments to doctors who meet cost-effectiveness or quality goals.

Diagnosis-Related Groups (DRGs)

The federal Medicare program developed the **Diagnosis-Related Group (DRG)** system for compensating hospitals, and some health plans.

When a member is hospitalized, his/her case is classified as one of about 500 DRGs based on his/her diagnosis, age and gender, the procedures to be performed, and any complications or other medical conditions.

Hospitals and the DRG Rate

Cases in the same DRG generally require about the same amount of hospital resources, and a fixed payment amount is set for each DRG based on average costs.

The hospital is paid the DRG rate for the hospitalization, regardless of how long the stay actually lasts or how much it costs the hospital. This means that the hospital assumes risk—it must bear the cost if expenditures exceed the DRG rate. [xix]

Per Diems

A health plan may pay a hospital a fixed **per diem** amount for each day a plan member is in the hospital, regardless of the services used. The amount may be higher for some types of care (such as intensive care or cardiac care), and sometimes a higher amount is paid for the first day, as this is often the most costly for the hospital.

The per diem amount is negotiated by the plan and the hospital. The more patients a plan

provides to a hospital, the lower the per diem rate the hospital is likely to agree to. As with a DRG rate, the hospital assumes risk and bears the cost if expenses are greater than the per diem amount. [xx]

Other Compensation Provisions

To further share risk and give providers incentives to provide cost-effective, high-quality care, some other provisions can be used in conjunction with the compensation arrangements as previously discussed

Withholds

A **withhold** may be used with some compensation arrangements.

Example: A health plan pays PCPs by capitation, but each month it does not pay a certain percentage of the capitation payment. At the end of the year, if the number of referrals by PCPs to specialists has been as projected, the withheld money is paid to the PCPs. But if there have been many referrals, the plan uses all or part of the withheld funds to cover the cost, and the PCPs do not receive it. A withhold may also be used for salaried physicians.

What is the Purpose of Such a Withhold?

Since capitated providers receive the same payment regardless of the amount of services they deliver, some may be tempted to reduce their workload by referring patients they could treat themselves to a specialist.

A withhold gives them an incentive to avoid this. It also gives them an incentive to focus on preventive care and wellness so that their patients do not develop the need for specialty care.

Risk Pools

Risk pools are another way of giving providers an incentive to deliver care themselves and to promote prevention and wellness so that the need for non-primary care does not develop.

Example: A plan pays monthly capitation payments to PCPs, and it also pays monthly capitation payments into three pools, one for specialty care, one for hospital care, and one for ancillary services. The money in the pools is used to cover the costs of these services, but if members do not use many services and there is money left over, some of it is distributed to the PCPs. On the other hand, if members need many services and the money in the pools is insufficient, physicians may have to make up part of the shortfall.

Multiple Compensation Methods

Health plans typically use different compensation arrangements for different types of providers.

Example: A plan might use capitation for PCPs, discounted fee-for-service for specialty physicians, and per diem payments for hospitals.

Value-Based Payment Models

Pay for Performance (P4P) Programs

Many health plans have **pay for performance (P4P) programs**. Targets are set for measures of physician performance, which may be in the areas of quality of care, patient satisfaction, utilization, or cost-effectiveness.

If a doctor meets these targets, he/she is rewarded, typically by means of a percentage increase in compensation or a bonus. Some plans share with physicians meeting the targets the savings realized through cost-effectiveness efforts.

Most P4P programs give physicians report cards showing how they are doing in relation to the targets and what they can do to meet them. Targets may be based on nationally developed and recognized measurements or may be developed by the plan itself.

Examples of P4P measures:

A P4P program might award a bonus to a provider whose diabetic patients experience reductions in their hemoglobin A1C measures.

A P4P program might reward improvement in a performance measure over time such as year-to-year reductions in in the rate of avoidable hospital readmissions.

P4P Programs (Continued)

P4P may also impose financial penalties on providers who fail to achieve specified goals. For example, a program might not pay for the treatment of a patient who contracts a bed sore during a hospitalization where it is considered preventable. [xxi]

P4P programs continue to evolve with many details are still being worked out, such as identifying and obtaining the most relevant data and setting incentives payments at the right level to influence physician behavior. [xxii]

Shared Savings

The **shared savings** model can be most succinctly described as a model that pays providers for a portion of any savings achieved in relation to an anticipated cost level for the care of a specified group of patients. Shared savings agreements between providers and payors can and do have many variations, but they can be broadly grouped based on the kinds of risks assumed by providers – upside and downside risk.

Upside Risk

In **upside risk**, providers share in any savings achieved. That is, if the actual cost of providing care to the designated population is less than the budgeted benchmark level, the providers receive a share of the savings in the form of additional payments.

Example of upside risk:

Physician Practice A enters into a shared savings agreement with a private-sector health plan for a targeted population of plan members. Under the terms of this agreement, if the practice provides care to the population at a cost of less than $5.2 million, the practice will receive 3 percent of the savings (upside risk). For instance, if costs are $4.9 million, $300,000 below the benchmark, the practice will receive 3 percent of this amount ($9,000). However, if the costs of care exceed $5.2 million, the practice pays no penalty. It simply does not receive the extra payment.

Downside Risk

In **downside risk**, if actual costs exceed the benchmark, providers pay a financial penalty. The two most common types of shared savings agreements are upside risk only and both upside and downside risk. [xxiii]

Example of upside and downside risk:

Physician Practice B also enters into a shared savings program with a health plan. If care is provided at less than a $5.2 million benchmark cost level, the practice will receive 3 percent of the savings (upside risk). If however, the costs of care exceeds $5.2 million, the practice will pay a financial penalty which could amount to all or a portion of the extra costs incurred (downside risk).

Phasing-In Downside Risk

Private health plans have recognized that some providers have taken steps that enable them to participate in shared savings programs involving upside risk but perhaps need additional time and support before they can fully assume the potential financial burdens associated with downside risk.

In these situations, a phased-in approach to downside risk assumption may be appropriate.

Example An agreement may include a threshold of losses that the health plan is willing to accept before triggering any financial responsibility by the provider. Other approaches might include fairly frequent calculations of risk, giving the provider feedback about how well risk is being managed. [xxiv]

Bundled Payment

Bundled payment is a model that provides a single payment to a provider (or group of providers) for all the healthcare services associated with a defined episode of care. [xxv]

This is sometimes referred to as episode-based payment or episode payment model. A bundled payment may be made for a wide variety of healthcare needs, including care related to chronic care conditions, such as diabetes or to certain clinical procedures, such as joint replacements.

Private health plans were early proponents of the bundled payment approach. [xxvi]

The model has also been widely adopted by the public-sector [xxvii]

Bundled Payment Model Design

The bundled payment model can also include in its design:

- Risk stratification and complication allowances,
- Payment amounts based on the cost of adhering to clinical standards of care (rather than based on historical experience), and
- Various performance incentives.

Advantage and Disadvantage of the Bundled Payment Model

Where groups of providers provide care, the bundled payment model encourage doctors, hospitals, and others to work together to coordinate their services and avoid overlap and waste.

They also promote longer-term accountability—if providers must pay for any care needed for 90 days after the patient leaves the hospital, there will be strong incentives to avoid complications that might require additional care or even readmission.

The main challenges to this approach are getting hospital, physicians, and other providers to work together and to equitably distribute the payment among them. [xxviii]

Global Payment

Under the global payment model, providers prospectively receive fixed payments that cover all or most of the care that their patients may require over a contract period.

The global payment model is thus a capitation system (discussed previously) that is both similar and different from the managed care model of an earlier era (one of whose hallmarks was gatekeepers to specialty care).

The global payment model is sometimes referred to by other names, including population-based payments. As with the shared savings model, private health plans offer providers the opportunity to enter into a variety of global payment agreements offering different levels of risk assumption. [xxix]

Compare the global payment model to earlier forms of managed care:

Similarity: Providers receive fixed payments (typically upfront) for the care of patients.

Differences:

- Under the global payment model, providers receive quality bonuses to discourage under-treatment and to maintain and improve access to services.
- Data management systems are far more sophisticated today than in prior years. They are better suited to care management and the challenges associated with the global payment model.

Different Levels of Risk Assumption

As with the shared savings model, private health plans offer providers the opportunity to enter into a variety of global payment agreements offering different levels of risk assumption. These can be broadly grouped into two subsets:

- Full risk
- Shared risk

Full Risk

Full risk – Under the full risk model, the provider retains any savings realized when the total cost of caring for a population group falls below the global payment amount, but the provider is also responsible for paying any cost of providing necessary care for the group above the global payment.

Shared Risk

Shared risk – Under the shared risk model, the provider and payor (private health plan) share any retained savings, and they take joint responsibility for paying any cost overruns above the global payment.

The Risk-Sharing Continuum – Fee For Service

The provider compensation arrangements discussed can be viewed as falling on a continuum based on the degree of financial risk borne by providers—that is, the extent to which, if the care needs of plan members are greater than expected providers must bear the cost.

At one end of the spectrum is traditional fee-for-service, under which providers bear no risk. If plan members need more services, providers deliver them and charge the plan for them. The plan must cover all costs with the premiums it receives, and if costs exceed premiums, the plan suffers a loss.

The Risk Sharing Continuum – Full Risk Global Payment Model

At the other end of the spectrum one might place the full-risk global payment model under

which providers bear most of the risk. They receive the same payment whether the members they are responsible for require no care, a few services, or many services. If members need much more care than expected, providers must deliver it without any extra compensation. Meanwhile, the plan bears relatively little risk, as its costs are fixed.

Between these two extremes are the other arrangements we have discussed.

Medicare: Primer

Medicare

Medicare is a federal program established in 1965 that provides benefits for hospital care, medical services, and other healthcare expenses. It is available to persons 65 or older and people under 65 suffering from severe disabilities. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS).

Medicare Part A and B

Medicare has four primary components referred to as Parts A, B, C, and D. The coverage provided by these various parts can be briefly described as follows:

- Medicare Part A coverage includes inpatient hospital care, skilled nursing care following hospitalization, some home health care following hospitalization, and hospice care for the terminally ill.

- Medicare Part B coverage includes physician and surgeon services, services provided by some other healthcare practitioners, outpatient medical and surgical services, laboratory services, therapy, and durable medical equipment, along with a wide array of other services and supplies.

Medicare Part A and B (Continued)

Medicare Parts A and B are sometimes referred to as Original Medicare. Physicians and other healthcare professionals servicing Medicare enrollees have traditionally been paid on a variation of fee-for-service – a system that many commentators believe encourages quantity versus quality of care.

Congressional action gradually moves physicians (and other healthcare providers) providing services under the Original Medicare program to a value-based compensation system.

Medicare Part C and D

- Medicare Part C is an alternative to Original Medicare referred to as Medicare Advantage (MA). Those entitled to Medicare have the option (in most areas of the country) of enrolling in a MA plan. These are private sector health plans that rely on care management principles that place strong emphasis on such factors as disease prevention, early detection, and chronic disease management.

- Medicare Part D is an optional program in which those entitled to Medicare may

enroll. It provides for prescription drug coverage.

History of MACRA and Medicare Compensation

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on a bipartisan basis on April 16, 2015.

The legislation overhauled the way Medicare pays for healthcare provider services. MACRA ended the Sustainable Growth Rate formula (SGR).[xxx]

This formula was established in 1997 to control the cost of Medicare payments to physicians by basically limiting the amount of reimbursements paid on a fee-for-service model. Unfortunately, SGR did not work and each year (for many years) Congress passed temporary "doc fixes" to avert cuts in the Medicare payments to providers. For example, no fix in 2015 would have meant a 21 percent cut. [xxxi]

MACRA and Medicare Compensation

MACRA also seeks to move Medicare from a fee-for-service payment system to a value-based payment system called the Quality Payment Program (QPP). This program aims to reform Medicare Part B program (which covers doctor visits) payments for the many of clinicians serving Medicare enrollees. Providers can choose from two tracks how they want to participate in QPP:

- the Merit-based Incentive Payment System (MIPs)
- the Advanced Alternative Payment Models (APMs)

MIPs Versus APMs

Providers can decide in which track to participate based on their practice size, specialty, location, or patient population. Those who choose MIPs have the opportunity to earn a performance-based payment adjustment (extra compensation).

Those who choose APMs have the opportunity to earn a Medicare incentive payment (higher than the MIPs adjustment) for participating in an innovative payment model. While those who participate in APMs have the opportunity for higher rewards they also assume greater penalties for poor performance. [xxxii]

Who Can Enroll in QPP

Small practices and newly enrolled Medicare providers are excluded from the program. The Bipartisan Budget Act of 2018, extended the transition time for the adoption of MIPs (from 2019 to 2022) thus providing clinicians serving the Medicare population a more gradual pathway to the value-based compensation system. [xxxiii]

COVID-19 Impact

The COVID-19 pandemic impacted many provider practices. This resulted in CMS taking a closer look at the quality measures it asks providers to report with more emphasis on patient outcomes. Furthermore, the aftermath of the pandemic and its reappearing variants can be reasonably expected to result in some changes and delays in implementation of Quality Payment Program.

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5 The Health Maintenance Organization (HMO)

Learning Objectives

After completing this lesson, you will be able to:

- summarize the key elements of HMO membership and benefits,
- describe HMO network arrangements,
- explain how HMOs are paid and pay their providers, and
- discuss utilization management and quality management in HMOs.

Health Maintenance Organization (HMO)

A **health maintenance organization (HMO)** is a health plan that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee. In other words, an HMO arranges for the delivery of medical care and provides, or shares in providing, the financing of that medical care. An HMO may be owned or sponsored by many different types of organizations and may be for-profit or not-for-profit.

HMO's (Continued)

Historically, HMOs were called prepaid group practices, although they were formed as corporations. The laws of most states require an HMO to be organized as a corporation rather than a partnership or other legal entity. Most HMOs must be licensed in the states in which they are incorporated, and they must comply with statutory requirements for HMOs in each state in which they do business.

Background

HMO Act of 1973

Although predecessors to HMOs have been in existence for over 70 years, HMOs became popular during the 1970s as a result of federal legislation. [i]

The **HMO Act of 1973** removed many of the market barriers that constrained the development of HMOs. [ii] [iii] [iv]

Federal Qualifications

The Act and its amendments also established requirements that an HMO could voluntarily meet to become **federally qualified**. Federal qualification preempted the application of certain state laws to HMOs. To be federally qualified, an HMO could not exclude preexisting conditions and had to offer the following:

- healthcare delivery in a geographic service area,

- both basic and supplemental healthcare services, and

- voluntary membership to an enrolled population.

HMO Act of 1973 (Continued)

The Act also required dual choice in employer-sponsored health plans, which we discussed previously. Many HMOs pursued federal qualification because it gave them access to employers in their markets. Federal financial assistance, in the form of grants and loans, was made available from 1973 until 1981.

In 1995, federal law eliminated the dual choice requirement, and because of this change and the discontinuation of federal grants, HMOs now have fewer incentives to become federally qualified. However, federal qualification is still important for Medicare and large employer contracts.

HMO Regulations

HMOs are heavily regulated at both the federal and state levels to ensure solvency and member access to quality medical care. An HMO may have to have a license as an HMO or insurance company (called a certificate of authority or COA) in each state in which it conducts business. Most HMOs are subject to state enabling statutes and the requirements of various state health departments or state departments of insurance.

Characteristics of HMOs

The following are key characteristics of HMO operation, organization, and provision of healthcare and insurance coverage:

- tight relationships with providers,

- an emphasis on the role of primary care providers (PCPs),

- the utilization of a referral management process,

- an emphasis on prevention and wellness, and

- an integration of insurance and the provision of healthcare services. [v] [vi]

What Do These Characteristics Enable for an HMO?

These characteristics enable an HMO to provide access to quality, affordable care through a coordinated system. One measure of an HMO's quality is its accreditation by independent accrediting agencies such as NCQA (the National Committee for Quality Assurance). Employers and other purchasers and payors of healthcare benefits normally consult these agencies as part of their health plan selection process.

What Do Employers Consider In Evaluating and Selecting HMOs?

Access to care, cost, and member satisfaction are almost always important. Most employers also take into account the financial strength of an HMO, the reputation of its networks, and the ease of doing business with it. Many also consider such things as care outcomes, the focus on prevention and wellness, NCQA accreditation, historic cost trends, the ability to approve health status, physician turnover, physician credentialing, and Healthcare Effectiveness Data and Information Set (HEDIS) reports. [vii]

Membership and Enrollment

Ways to Enroll in an HMO

Most commonly a person becomes a member of an HMO by enrolling in an employer-sponsored group plan. Under such a plan, a member has no contractual relationship with the HMO; the contract is between the HMO and the employer. But individuals may also join an HMO on their own, and this is a growing market for HMOs. These persons contract directly with the HMO and receive benefits on an individual basis. Members of an HMO include both subscribers (who are eligible to enroll directly) and their dependents (whose eligibility is contingent on that of the subscriber).

What Groups do HMOs Serve?

Traditionally HMOs were marketed to employer groups with more than 100 employees. But today HMOs serve large groups, small groups, and individuals. Members range from the very young to the very old, and from the very healthy to the chronically ill. Many Medicare and Medicaid beneficiaries join HMOs.

Employer-Sponsored HMOs

Employers sponsoring HMOs usually have an annual open enrollment period, usually 30 days, during which employees select their healthcare coverage. During this period the HMO automatically accepts those employees who wish to enroll or to switch to the HMO from another plan offered by the employer. Employers and HMOs also allow new employees to enroll during an initial enrollment period.

Federally-qualified and Some State- Licensed HMOs

Federally qualified HMOs and some state-licensed HMOs must cover preexisting conditions for all eligible employees and dependents who enroll during their initial enrollment period. However, under the Affordable Care Act (ACA), most health plans (not just some HMOs) have to cover preexisting conditions (effective 2014).

Medicare also represents a growing marketplace for HMO-type plans.

Example

For example, seniors eligible for Medicare may choose to enroll in Medicare Advantage HMO plans which are discussed in further detail later in this course. [viii]

Learn about the divergence between workers and seniors in choosing HMO plans:

Workforce: PPOs continued to be the most common plan type chosen by workers in recent years with 44 percent of covered workers choosing them in 2019 while 19 percent choose to enroll in HMOs.

Seniors: in contrast to workers, nearly two-thirds (62 percent of all Medicare Advantage enrollees choose HMOs.

Sources: Kaiser Family Foundation, Employer Health Benefits, 2019 Summary of Findings, available at https://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019

https://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2019

Kaiser Family Foundation, Medicare Advantage Fact Sheet, June 6, 2019, available at https://files.kff.org/attachment/Fact-Sheet-Medicare-Advantage

Benefits

What do HMOs provide?

HMOs provide comprehensive medical benefits. By law federally qualified HMOs must provide a stipulated minimum set of benefits, and some states require HMOs to offer certain benefits to meet licensing requirements. In addition to medical coverage, most HMOs cover special services and products such as vision care, dental care, mental healthcare, and prescription drugs. HMOs typically offer lower member cost-sharing than other plan types.

HMOs and Preventive Care

HMOs historically have focused on preventive care and wellness. While they also rely on disease management and other approaches to controlling costs, they recognize that prevention is the best method of healthcare cost containment.

The preventive care programs of HMOs are typically extensive. Routine physical examinations, 24-hour telephone access to a nurse, prenatal care, well-baby care, and childhood immunizations are common preventive care services offered. And because HMOs strongly emphasize prevention, these services are often covered in full, although a small copayment for an office visit may be charged depending upon the particular service and whether it is mandated free of charge under the Affordable Care Act (ACA). HMOs may also provide members with medical information through seminars, newsletters, and self-help medical booklets.

HMOs and Wellness Programs

HMOs often give their members access to wellness programs, such as for smoking cessation, weight management, and stress management. Some HMOs contract with local health clubs to make exercise facilities and equipment available and affordable to members.

By offering a comprehensive set of benefits, an HMO promotes comprehensive care. And by coordinating care across various areas, an HMO ensures that its members receive quality, cost-effective, and appropriate medical care on a timely basis. An HMO also provides convenient, usually local, access to preventive care without significant financial cost.

Example of benefits offered by an HMO plan offered through a large university:

Health Maintenance Organizations (HMO)

An HMO is a Managed Care Plan that provides its members with comprehensive medical care services on a prepaid basis. HMOs require that you choose a Primary Care Physician (PCP) and provider location from those participating in the HMO provider network. The PCP manages your health care treatment by requiring referrals for specialized services. All HMOs have a uniform basic benefit plan; however, some may offer additional benefits or may not include coverage for certain providers, such as chiropractors. Consult the specific HMO for details. All HMOs have unlimited policy maximums.

Prescription drug deductibles and copayments you pay apply to your out-of-pocket maximum; therefore, when you reach your out-of-pocket maximum, eligible medical, behavioral health and prescription drug charges will be covered at 100 percent for the remainder of the plan year.

Points to consider in making this choice:

- The doctor you choose becomes your PCP and all medical care, including routine care, hospitalization, and referral to other health professionals, must be coordinated under the direction of your PCP.
- Preventive and well-care services, such as routine physicals and pediatric care, are provided at no additional cost.
- Co-payments apply to doctor's office visits, prescriptions, hospital admissions, emergency room visits and some other services.
- You generally do not need to submit claim forms, except in cases when emergency care takes place outside of your coverage area. [ix]

Networks

HMOs and Negotiated Contracts

HMOs deliver comprehensive medical care to their members by entering into negotiated contracts with providers to form a network. Alternatively, an HMO may own the facilities and employ the physicians in its network. The network providers, including physicians, hospitals, and ancillary service providers, deliver medical care to HMO members in exchange for negotiated compensation.

Delivery of Healthcare

Unlike the financing of healthcare, which may be conducted on a national or regional basis, the delivery of healthcare is primarily local. Providing members with convenient, local access to an HMO's provider network is therefore critical to the relationship between the HMO and employers and other purchasers or payors. Some HMOs operate in only one geographic region, but others are national organizations that own or sponsor separate HMOs in different regions.

Building and Maintaining a Provider Network

In building and maintaining a provider network, an HMO considers the following:

- **Access**—How many and what types of providers are needed? In what locations within the service area?
- **Credentialing**—What credentials should be required and verified? How often should recredentialing and peer reviews be conducted?
- **Contractual relationships**—Should the HMO own facilities or contract for their use? Should it employ providers or contract for their services? How should providers be compensated (for example, salary, capitation, discounted fee-for-service)?

Why Contract With Specific Providers?

By contracting with specific providers to deliver care, an HMO seeks to increase quality control over medical care and decrease costs. Let us now examine the relationships between an HMO and the three key provider groups:

- Physicians
- Hospitals
- Ancillary Service Providers

Physicians

The relationship between an HMO and its participating physicians is a contractual one, either direct employment or an independent contractor arrangement. As noted earlier, to establish a network that provides members with adequate access to medical care, an HMO must contract with sufficient numbers and types of physicians.

Determining Number of Physicians and Specialties

An HMO determines the number of primary care and specialty care physicians needed in its network in part by considering the size and location of the geographic service area, criteria for network adequacy, the medical needs of its members, and employer or other purchaser requirements, including provider education, board certification, and work history.

Before an HMO contracts with a physician, the HMO first verifies his or her credentials. After becoming part of the network, the physician is subject to recredentialing and ongoing peer review. Credentialing, recredentialing, and peer review enable an HMO to establish and maintain quality standards of clinical competence, professional conduct, and practice management.

The Role of Primary Care Providers

Most HMOs require their members to select a primary care provider (PCP) from the HMO's network. Recall that a PCP is usually an internal medicine or family medicine practitioner for adults and a pediatrician for children. Some HMOs also utilize nurse practitioners or physician assistants in the primary care function.

In addition to providing primary care services, in HMOs the PCP serves as the member's point of entry into the healthcare system. Usually to see a specialist an HMO member must obtain a referral from her PCP. But some HMOs allow members with specified conditions to contact certain specialists such as obstetricians directly instead of going through the PCP first.

Out-of-Network Services

Traditionally, an HMO did not cover medical care obtained outside its provider network. [x] [xi]

However, in response to member requests for greater provider choice and timely access to quality medical care, many HMOs now offer options, such as a point-of-service (POS) product, in which members may choose out-of-network providers, usually at a higher cost to the member. Some of these HMOs require members to obtain a referral and/or prior authorization to obtain coverage for out-of-network services.

Hospitals

HMOs negotiate contracts with hospitals and other inpatient facilities to provide medical services to their members. Again, the issues of access, credentialing, and contractual arrangement previously mentioned come into play.

Accreditation by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations or (JCAHO) and verification of the existence of a state license are typically minimum requirements for a hospital to participate in an HMO network. Other factors that an HMO considers in contracting with hospitals include the level and cost of hospital services, the quality of the physicians on the hospital's medical staff, the type of specialty facilities and services offered by the hospital, and member access within a geographic area.

Ancillary Service Providers

An HMO also contracts with ancillary service providers. Ancillary services are auxiliary or supplemental services that support the diagnosis and treatment of a patient's condition. They include laboratory, radiology, and other diagnostic services; home health care; and physical and occupational therapy. An HMO contracts with the appropriate number and types of ancillary service providers so that its provider network includes the healthcare services that are commonly needed by plan members.

An HMO may provide some ancillary services, such as laboratory services, in the facility where its PCPs see plan members. Other ancillary services are provided at separate facilities. Ancillary service providers must provide adequate access to their services and participate in an HMO's quality management program.

Ancillary Service Providers (Continued)

In a typical HMO, a PCP refers a member to ancillary providers for all services covered by the plan. And for certain ancillary services, such as physical or occupational therapy, an HMO may require a member to obtain prior approval from her PCP to continue the therapy beyond a specified number of treatments.

Some HMOs use a specialty care provider for mental health and chemical dependency services. These specialists may be psychologists and social workers who complete initial assessments and conduct referrals to specified facilities.

Financing

Now let's look at how an HMO finances healthcare. We will examine first how an HMO is paid for providing healthcare by its members, sponsoring employers, and other payors (prepaid care), and then how the HMO pays its providers for delivering that care (provider compensation).

Prepaid Care

An HMO usually has a **prepaid care** arrangement. Typically, a monthly premium of a fixed amount is paid in advance of delivery of care. This premium may be paid by members, sponsoring employers, other payors such as the government, or a combination. The premium generally covers most healthcare services that a member might need, no matter how many services the member uses or how often.

Although HMOs typically do not have deductibles or coinsurance, they usually have small copayments for some services. For instance, an HMO may require its members to pay a $20 copayment for each doctor's office visit or prescription, a $35 copayment for an office visit with a specialist or $50 for an emergency room visit.

Provider Compensation

An HMO negotiates compensation arrangements with its providers, and there are a variety of reimbursement methods. Compensation arrangements are one of the features that distinguish the various HMO models from one another. Let's look at the compensation arrangements typically used with physicians, hospitals, and ancillary service providers.

Physicians

Typical compensation arrangements for physicians include capitation, several forms of fee-for-service (FFS), and salary. Capitation is widely used for primary care providers. To gain the active involvement of PCPs in risk-sharing and utilization management, many HMOs use withholds or risk pools for nonprimary care. An HMO may have a risk pool for each broad category of care

(such as specialty care, inpatient care, and others), with the risk-sharing and reward-sharing arrangements usually differing among these pools.

Physician Contract Negotiations

In some HMOs physicians are employees and are paid a salary. Salaried physicians expect to earn an income, including benefits, equivalent to that available in the local market. Benefits that may be considered in physician contract negotiations include: salary, short-term sick leave, vacation leave, profit-sharing plans, retirement plans, professional dues and membership fees, reimbursed business-related expenses, disability income insurance, malpractice insurance, and life and health insurance. Nonfinancial benefits available to salaried physicians include access to patients and may include time off for research or volunteer work, compensatory time, and limitations on on-call time or total weekly or monthly work hours.

Hospitals

HMOs reimburse hospitals in several ways, including FFS, discounted FFS, Diagnosis-Related Groups (DRGs), per diem rates, and capitation. Often included in the compensation agreement between an HMO and a hospital are financial incentives such as service bonuses, quality bonuses, and risk pools. Sometimes HMOs use financial disincentives when providers exceed utilization goals.

Stop-Loss Provision

Hospitals that are reimbursed under capitation or DRGs (as well as physicians who are capitated) may negotiate a **stop-loss provision** in their HMO contracts. This specifies that, once a provider's total costs have reached a certain level, additional costs will be reimbursed under a different payment method, such as discounted FFS.

Factors that determine an HMO's compensation arrangements with hospitals include state laws and regulations, market competition, hospital ownership of the HMO, and the level of predictability, supported by valid data, associated with hospital utilization.

Ancillary Service Providers

Compensation arrangements for ancillary service providers include capitation and discounted FFS. For discrete services such as diagnostic testing, capitation may be best; for more open-ended services, such as home health care and hospice care, a combination of capitation and discounted FFS fees may be more appropriate.

Capitation enables an HMO to share risk with providers and to manage costs. In exchange for accepting capitation, ancillary service providers receive a large referral base and a stable income flow.

Utilization and Quality Management

Utilization Management

An HMO manages physician utilization through capitation, risk pools, and physician practice guidelines. These techniques shift part of the utilization management function to providers.

To manage member utilization of healthcare services, HMOs use referral management (monitoring specialist referrals), copayments, and alternatives to emergency care, such as nurse advice lines and subacute clinics.

Utilization Management in a Hospital Setting

For utilization management in a hospital setting, HMOs employ precertification for inpatient hospitalization, concurrent and retrospective reviews of admissions, inpatient utilization review, discharge planning and readmission prevention (including post-hospitalization follow-up), and case management.

A key to ensuring efficient and appropriate utilization and quality care is information-sharing among PCPs and other providers within an HMO.

Federal Regulations and Utilization Standards

Federal regulations may require HMOs to adhere to certain utilization standards. For example, an HMO that enrolls Medicare or Medicaid beneficiaries must comply with the utilization management requirements set forth by the federal Centers for Medicare and Medicaid Services (CMS). Accreditation organizations and state enabling statutes may also require an HMO to provide evidence of its utilization management program.

Accountable Care Organizations

Under ACA there is another potential role for HMO-like organizations in the Medicare program. **Accountable care organizations (ACOs)** that voluntarily meet quality thresholds will share in the cost savings they achieve for Medicare. ACOs are similar to HMOs because they focus on narrow provider networks to incentivize quality outcomes. To qualify as an ACO, organizations must meet accountability standards related to overall care of Medicare beneficiaries, define evidence-based medicine, have adequate PCP participation, and report on their quality and cost outcomes. ACOs are discussed in further detail in our next lesson.

Quality Management

HMOs use many quality management techniques. These include credentialing, recredentialing, and peer review for PCPs and specialists; accreditation standards for hospitals and ancillary services providers; and accreditation standards for the HMO itself.

Because HMOs were among the first managed care health plans, they are subject to strict regulation in regard to quality standards at both the state and federal levels. State enabling statutes require HMOs to submit evidence of a quality assurance program as part of the state licensing process. HMOs that enroll Medicare and Medicaid beneficiaries must comply with CMS quality assurance requirements (and Medicaid requirements vary by state.)

Employers also review an HMO's accreditation status and its HEDIS measures to evaluate plan quality. Upcoming lessons discuss utilization management and quality management in greater depth.

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6 Types of HMOs and ACO Basics

Learning Objectives

After completing this lesson, you will be able to:

- differentiate between closed and open panels and closed and open access
- describe the structure of the four main HMO models
- compare provider compensation under the four main HMO models
- give some advantages and disadvantages of each of the four main HMO models
- explain the basics of both private and public accountable care organizations (ACOs)

Learning Objectives (Continued)

This lesson describes the most common ways of structuring an HMO.

First, we discuss the difference between closed and open provider panels and closed and open access to providers.

Then we examine the four main HMO models: the independent practice association (IPA) model HMO, the staff model HMO, the group model HMO, and the network model HMO. We look at how they are structured, how they compensate providers, and their advantages and disadvantages.

We then turn our attention to accountable care organizations, explaining what they are, their role in both the public and private sectors, and the impact of the Affordable Care Act (ACA) on their development.

Concepts and Terms

Closed and Open Panels

The term “panel” is used to refer collectively to the physicians who serve a health plan’s members. An HMO’s panel may be either:

- closed
- open

Close Panel HMO

In a **closed-panel HMO**, the physicians providing care to members are either employees of the HMO or members of a group of physicians that contracts with it. Other physicians are not allowed to join the HMO's network.

In a closed-panel plan, HMO physicians most commonly see only members of the HMO; in an open-panel plan, they typically see other patients as well. In the past most HMOs had closed panels, but this is no longer true.

Open Panel HMO

In an **open-panel HMO**, any physician who meets the HMO's standards is eligible to join the HMO's network by contracting independently with it.

It should be understood that while a physician who meets the criteria of an open-panel HMO is eligible to join it, the HMO has no obligation to contract with anyone. An open-panel plan may stop accepting new doctors if it already has enough to meet its members' needs, and it may start accepting them again if a need develops.

As previously mentioned, in a closed-panel plan, HMO physicians most commonly see only members of the HMO; in an open-panel plan, they typically see other patients as well. In the past most HMOs had closed panels, but this is no longer true.

Closed and Open Access

The terms "closed access" and "open access" are sometimes used along with closed and open panel, but they do not mean the same thing.

"Closed or open panel" refers to whether a physician can join an HMO's panel (network), whether members can access non-network care and whether they can access specialty care without a PCP referral.

Closed Access

Closed access means that, to receive benefits, an HMO member must obtain care from network providers, not out-of-network providers. Also, to receive care from a specialist, even in-network, a member must obtain a referral from her primary care physician (PCP).

Open Access

Open access (also called **direct access** or **self-referral**) means that a member may go to a specialist, either in-network or out-of-network, without a referral from her PCP (that is, she can self-refer). She will receive benefits, although benefits for non-network care may be lower than for network care.[i]

Closed Versus Open Access

Traditionally, closed access was one of the main features that distinguished an HMO from other health plan types. However, open access has become more common.

Many consumers do not like having to go to their PCP (and paying a copayment for the office visit) in order to see, for instance, a dermatologist or allergist, and many HMOs have discontinued this requirement in an effort to meet consumer preferences and remain competitive.

Although the PCP referral system was designed to help contain costs by managing utilization of specialty care, it is unclear if it achieves that goal. In some cases, a referral requirement may even lead to a delay in treatment and higher costs.

Provider Compensation

Earlier in our studies we learned about some of the ways health plans compensate providers. Let's review three of the most common:

- Fee-for-service (FFS)
- Discounted fee-for-service
- Capitation

Fee-for-service (FFS)

Fee-for-service (FFS). A health plan pays a healthcare provider a fee for each service rendered to plan members, and the amount paid is the provider's normal fee for that service.

Example: A doctor examines a plan member and has some tests done; she bills the plan her normal charges for these services, and the plan pays these amounts. Under FFS the more services a provider delivers, the more she earns. The risk is borne by the health plan—if members use more services than expected, the plan pays the cost. [ii]

Discounted fee for service

Discounted fee-for-service. A plan pays a provider a fee for each service rendered to plan members, but the amount is based on a discount off the normal charge. A set percentage may be subtracted from the provider's regular fee or from the usual and customary fee for the service in the locality, or the amount paid may depend on a fee schedule (a listing of amounts to be paid for different services).

Although the provider earns less than under regular FFS, as in regular FFS the more services she delivers, the more she earns. A provider is willing to accept discounted payment because affiliation with the plan brings her more patients, so that although she receives less per service, she may have greater total earnings. As under regular FFS, the risk is borne by the plan.[iii]

Capitation

Capitation. A healthcare provider is responsible for providing the healthcare services needed by certain members of a health plan; in return, for each time period the plan pays the provider a fixed amount per capita (per plan member served).

Example: A doctor agrees to provide primary care to members of an HMO, and the HMO pays the doctor a set dollar amount per member per month. Under capitation, the provider is paid the same amount regardless of the number or costs of the services she provides to plan members. The provider assumes risk—if members need many services and the cost of caring for them is higher than expected, the provider must bear the cost.[iv]

HMO Models

Four Main HMO Models

There are models (basic types) of HMOs, distinguished largely by the contractual relationship between the HMO and its providers, including reimbursement arrangements. There are four main models:

- the independent practice association (IPA) HMO
- the staff model HMO
- the group model HMO
- the network model HMO

Mixed Model HMO

A **mixed model HMO**, which combines characteristics of two or more of the four main models. Most early HMOs were staff model or group model, but the current trend is toward the mixed model.

Example: An HMO might use a staff model for primary care and a network model for specialty care.

Mixed model HMOs have evolved in response to employer and consumer demand for a flexible delivery system that combines the best features of different models. As HMOs adopt various features from different models, distinctions among models become blurred, and it can be hard to classify a particular plan as belonging to one model or another.

Independent Practice Association

A common HMO model today is the IPA model. An **independent practice association** (or individual practice association) is an association of physicians in independent practice.

It is established primarily to give its members a vehicle for negotiating contracts with health plans. IPAs often include a variety of providers, including individual primary care physicians, individual specialist physicians, group practices, and multi-specialty group practices (for instance, including internists, family practitioners, pediatricians, orthopedists, and others).

IPA Model HMO

In an **IPA model HMO**, each participating physician contracts with the IPA, and the IPA contracts with the HMO. The HMO pays the IPA, and the IPA pays its members.

The IPA agrees to provide healthcare services to HMO members, and the IPA's physicians become part of the HMO's network, agreeing to adhere to the terms of the IPA-HMO contract. IPA physicians remain independent practitioners who manage their own offices and medical records; they usually see other patients besides HMO members and may contract with other health plans. An HMO may contract with more than one IPA, and an IPA may contract with more than one health plan. [v]

Establishment of an IPA Model HMO

An IPA model HMO may be established in different ways.

- Sometimes physicians in an area form an IPA, which contracts with one or more HMOs or other health plans.
- Sometimes the HMO and community physicians work together to create an IPA and recruit other physicians. In this case, the HMO and IPA typically have an exclusive contract—that is, the IPA cannot contract with other HMOs or health plans.
- Sometimes a hospital establishes an IPA, which contracts with an HMO.

Some IPAs have an open panel—all physicians who meet the IPA's standards are eligible to join. But some have a closed panel—for instance, physicians may not join a hospital-based IPA unless they are affiliated with the hospital.

IPA: Compensation

In an IPA model HMO, compensation is normally by fee-for-service or capitation; most commonly plans use capitation for PCPs and discounted FFS or the Resource-Based Relative Value Scale (RBRVS) for specialists.

HMO members make copayments to physicians for office visits, but they account for only a small portion of physician compensation.

IPA: Sharing Financial Risk and Utilization Management

An IPA may use techniques such as withholds to share financial risk with member physicians and give them financial incentives to manage utilization.

A withhold is a percentage of provider compensation that is retained by a health plan during a year. If care costs are higher than expected, this money is used to cover them; if they are not and funds remain, the money is distributed to providers at the end of the year.

An IPA may also establish compensation systems that depend on quality and preventive care measures.

IPA: Advantages

The open-panel IPA model appeals to HMOs and their members because members can usually choose from a large number of physicians practicing in their own offices throughout the HMO's service area.

This has given this model a competitive edge over staff model and group model HMOs. Additionally, the IPA model is in some ways cost-effective. Since physicians have their own offices, the HMO does not have the expenses of facilities. Compensation by capitation and withholds gives physicians incentives to manage utilization and costs.

Many physicians appreciate that the IPA model HMO allows them to see members of other health plans and contract with multiple plans, giving them access to large numbers of patients and a variety of income sources.[vi]

IPA: Disadvantages

On the other hand, because there are many independent physician offices, an IPA model HMO cannot realize the economies of scale of staff and group model HMOs. This can be difficult to achieve consistency in care management and quality management.

Direct Contract Model

A less common variation of the IPA model is the **direct contract model HMO** (or direct model HMO). In this model the HMO contracts directly with individual physicians; there is no IPA or other legal entity that represents and negotiates contracts for groups of physicians.

The HMO has full responsibility for functions that an IPA might participate in—the HMO must recruit physicians and handle care management and quality management.

A direct contract model HMO usually includes PCPs and a wide range of specialists. It has an open panel and nonexclusive contracts (physicians may see other patients and contract with other health plans). It typically compensates PCPs through capitation and specialists through discounted FFS.

Staff Model HMO: Employees

In a **staff model HMO**, the physicians who care for members are employees of the HMO, and usually the facilities in which they work are owned and operated by the HMO.

Generally, a staff model HMO employs all the PCPs and specialists required to meet members' needs, but some plans contract with some outside specialists, who provide services to members referred to them by the plan's PCPs. The HMO also owns or contracts with hospitals, pharmacies, and other entities to provide non-physician healthcare services.

Staff Model HMO: Closed Panel

A staff model HMO has a closed panel, since (with the possible exception of a few specialists) as previously mentioned, a physician cannot provide services to the HMO unless she is an employee of it.

Because physicians are employees, they may see only HMO members and may not contract with other health plans.

Ambulatory Care Facilities and Outpatient Care

In a staff model HMO, most physicians practice in centers owned and operated by the HMO, called **ambulatory care facilities (ACFs).**

An ACF provides **outpatient care**—medical treatment that does not require an overnight stay. In a single facility, members can access a wide range of physician services, including preventive care, acute care, and outpatient surgery.

There are also non-physician providers, nurses, laboratory and other diagnostic services and technicians, and professional support staff. ACFs offer members "one-stop shopping" for healthcare. A staff model HMO may have several ACFs in its service area.

Staff Model HMO: Compensation

Compensation in a staff model HMO is generally simple and straightforward—physicians are employees and are paid a salary.

All risk is borne by the HMO, and not by the physicians. If many or few services are provided, the physician still receives their salary, and if utilization of services is greater than expected, the HMO bears the cost.

Staff Model HMO: Advantages

The staff model offers several advantages. Care is centralized in ACFs, making possible economies of scale and facilitating the coordination of patients' care, the management and monitoring of utilization and quality standards, and the evaluation of physician performance.

Many consumers like being able to access a wide range of medical services in one place.

Staff Model HMO: Disadvantages

On the other hand, a staff model HMO is usually more time-consuming and expensive to establish because of the capital costs of building facilities, and it is also costly to maintain because of the large, fixed expense of physician salaries and building maintenance.

Adding medical services or expanding geographically is also capital intensive, thus limiting a staff model HMO's competitive ability in a changing market.

For consumers, a staff model HMO offers a relatively narrow choice of providers, and to address this, many staff model HMOs have added an IPA delivery system or a point-of-service option (discussed in the next lesson).

Group Model HMO

In a **group model HMO** (also called the group practice model), the HMO contracts with a multi-specialty group practice of physicians.

This group practice may be formed as a corporation, partnership, professional association, or other legal entity. The physicians in the group practice are employees of the group practice, and they may also have an ownership interest in it.

They generally share office space, support staff, medical records, and medical equipment at a common medical center or clinic. While a multi-specialty group practice includes PCPs and a variety of specialists, it may not have specialists in every area, in which case it may subcontract with outside specialists to provide some services to HMO members.

Group Model HMO: Types

A group model HMO may be either:

- captive
- independent

Captive Group Model HMO

In a **captive group model HMO**, the group practice serves only (or primarily) the HMO's members and may not contract with other health plans.

The panel is closed—a physician cannot join the HMO's network without being a member of the group practice. Typically, the HMO performs management and administrative functions for the group practice, and it may also own the facilities or equipment used by it.

Independent Group Model HMO

In an **independent group model HMO**, the group practice provides services both to the HMO's members and to other patients, and it may contract with other health plans. The HMO has an open panel—a physician can join without belonging to the group practice.

Group Model HMO: Compensation

A group model HMO usually compensates the group practice by capitation, and the group practice compensates its physicians (including any subcontracted specialists).

Physician compensation is by salaries and incentive payments, based on a physician's performance, area of expertise, and administrative work.

Physician compensation often includes incentives for care management. In this arrangement, the group practice bears the risk, and to the extent physicians have an ownership in the practice they share in profits and losses.

Group Model HMO: Advantages

Unlike a staff model HMO, a group model HMOs does not have to pay for facilities, since these are most often owned and maintained by the group practice. And it does not have the fixed expense of physician salaries, since it pays the group by capitation.

Group Model HMO: Disadvantages

On the other hand, a group model HMO may be limited by the location of the group practice, and in the case of a captive group with its closed panel, members' access to and choice of physicians may be limited. Also, a group model HMO has less control of care management and quality of care than a staff model HMO.

Network Model HMO

A **network model HMO** is like a group model HMO, except that the HMO contracts with more than one group practice. This allows the HMO to provide a wide range of physician services in a geographic area.

A network model HMOs may have either an open or closed panel.

Example: Suppose an HMO contracts with six or seven group practices. It might not allow physicians not belonging to these groups to join (closed panel), or it might accept into its network any physicians who meet certain criteria. Group practices can usually see non-HMO patients and contract with other health plans.

Network Model HMO: Compensation

As in the group model, in the network model the HMO compensates the group practice, and the group practice compensates its physicians. Network model HMOs are increasingly moving toward a mix of capitation and discounted fee-for-service in compensating group practices. To the extent a group is compensated by capitation, it bears risk.

Network Model HMO: Advantages

An advantage of network model HMOs, particularly open-panel plans, is that members have access to a broader range of physician services and locations than under the staff and group models. As with the group model, there are no facility costs and no fixed salary expense, but there is limited control of care management and quality of care.

Network Model HMO: Disadvantages

Disadvantages of the network model HMO include the lack of direct control and centralization of resources compared to the staff model.

Accountable Care Organizations

Accountable Care Organizations

Accountable care organizations (ACOs) build upon the foundations of care management and coordination introduced by HMOs.

Many health plans are engaging with this model either as part of ACOs or working closely with provider organizations who have established ACOs.

What Is an ACO?

The term accountable care organization was first coined in 2006 by Elliott Fisher and associates to describe a new payment and delivery model (in contrast to fee-for-service) to encourage groups of providers to focus on improving quality and avoiding unnecessary expenditures. [vii]

The federal government defines an ACO as:

> *A group of healthcare providers who give coordinated care and chronic disease management and thereby improve the quality of care patients get. The organization's payment is tied to achieving healthcare quality goals and outcomes that result in cost savings.* [viii]

Distinguishing ACO Factors

There are several factors that distinguish ACOs from other types of healthcare delivery systems.

These include:

- coordinated care across a spectrum of providers
- enhanced quality of care and patient experience
- substantial use of electronic medical records (EMRs) and other technology to facilitate care and communication among providers
- a shared savings approach

ACOs' Increased Awareness

There was increased awareness of the role that ACOs could play in the healthcare system following the passage of the Affordable Care Act (2010)- which included provisions to encourage their formation to provide services to Medicare beneficiaries.

ACOs however, can provide services to both the public and private sectors and much of the recent growth in ACOs can be fact to attributed to the efforts of health plans and other entities including hospitals and physician groups serving the private commercial sector. [ix]

We will begin our studies by looking at the role of health plans in the private sector before examining ACOs in the public sector and recent efforts by the Centers for Medicare and Medicaid (CMS) to reorganize the federal government approach to ACOs.

Formation and Participation in ACOs

What do health insurance plans hope to accomplish by encouraging the formation of ACOs and participating in them?

Three of their main objectives are:

- health awareness and member engagement– plan members will be become more aware of their health and how to take charge of it
- shared decision-making – providers, members, and (where appropriate) members' families will participate in decisions
- preventive healthcare – the use of preventive services will increase, leading to lower overall healthcare costs

Health Awareness and Member Engagement

Private health plans are taking an increasingly active role in making their members aware of their health and the consequences of certain choices. For example, need for diabetics to adhere to their medication and diet regimen and the severe adverse consequences for their health and quality of life that can result for failing to do so.

Private health plans have long realized the importance of member engagement in their health and the impact of that engagement on the dollars spent on their healthcare. Health plan efforts in this area take many forms, employing both electronic media as well as traditional print. [x]

Shared Decision-Making

Closely related to increased engagement by members in their health is shared decision-making.

Industry commentators have suggested that shared decision-making is one way of addressing the information gap that many patients confront when making medical decisions.

Although studies of shared-decision making have been limited, those that have been conducted indicate that patients who receive specific unbiased information about their treatment options as part of shared decision-making tend to opt for lower intensity services, resulting in expenditure of fewer healthcare dollars. [xi]

How Do ACOs Fit Into This Equation?

Commentators have pointed to the fact that the fee-for-service (FFS) model discourages shared decision-making because it fails to compensate providers for the time spent educating patients.

In contrast, ACOs provide an ideal environment for shared decision-making because their payment systems tend to tilt the balance of incentives away from the volume of services delivered by individual practitioners toward coordinated care delivered by teams. [xii]

Simply put, ACOs provide financial space for shared decision-making and the financial reward mechanisms to support it.

Preventive Healthcare

Preventive healthcare focuses on disease prevention and health maintenance rather than treatment of illness.

It includes early diagnosis of disease, identification of those at risk for developing specific diseases, or other health-related problems, and steps to avert the onset of diseases. Screening tests, check-ups, and immunization programs are common examples of preventive healthcare services.

The ACA and Preventive Services

The Affordable Care Act (ACA) emphasizes the role of preventive services and increased access to many of them at no or low cost to many individuals.

Long before the passage of the 2010 passage of the ACA, private health plans recognized the importance of evidence-based preventive care and provided coverage of it. Given their focus on quality of care and patient experience, it should come as no surprise that ACOs place strong emphasis on evidence-based preventive care.

ACOs offer a model that can not only detect disease early but actively engage members in the disease management process demonstrating the impact of lifestyle decisions on their health and healthcare costs. [xiii]

ACO Opportunities for Health Plans

Even prior to the implementation of the ACA, some health plans had already engaged with or have been part of private ACOs. Moving forward, as more plans gain experience with value- based care, its anticipated that more will be participating in ACOs both public and private.

The ACO model offers private health plans opportunities to leverage their expertise to both improve the quality of care and bend the cost curve. These opportunities include:

- the deployment of medical management techniques beyond preventive healthcare services
- the reduction of unnecessary spending and waste in the healthcare system
- increased member satisfaction with the healthcare experience
- increased administrative cooperation and clinical integration

Medical Management

Private health plans have considerable experience in medical management, having pioneered coverage that includes disease management and case management, which have been shown to both improve health and reduce healthcare outlays.

Example: Disease management coupled with value-based insurance coverage has been shown to increase adherence to medication regimens, improving health outcomes, reducing acute care interventions, and leading to savings. [xiv]

Medical Management (Continued)

Chronic diseases (such as heart disease and diabetes) are among the most common, costly and preventable health problems in the United States [xv]

While many individuals receive treatment for chronic conditions from primary care physicians, they also receive care from other clinicians (such as specialists) in other settings. This is where the integrated structure of the ACO offers a key advantage in facilitating the care coordination necessary to the fullest success of medical management programs.

Unnecessary Spending and Waste

Unfortunately, many healthcare expenditures do not improve health outcomes (unnecessary hospitalizations, unneeded or redundant tests, and cutting-edge drugs and devices). In fact, there are situations that sometimes involve fraud. [xvi]

Private health plans are well aware of these problems because they are often paying the bills associated with them. Private health plans have also been among the first to act to remedy and improve this situation.

***Example*:** Many health plans have instituted sophisticated electronic claims systems designed to flag potential abuses before payments have ben made.

ACOs offer health plans an additional tool to reduce unnecessary spending. Use of standardized approaches to care can cut waste while ensuring that an evidence-based approach is use in care provided to patients suffering from similar conditions. [xvii]

Member Satisfaction

In today's environment of annual surveys and online commentary, consumer satisfaction is important to all those providing services to the public, including private health insurance plans.

The industry takes the concerns of plan members seriously,

Example: Surveys of Medicare Supplement (Medigap) enrollees have shown satisfaction with their choice. These survey results are encouraging but private health plans strive to do more to increase member satisfaction and ACOs offer one vehicle for doing so.

More on Medicare Supplement insurance:

Medicare Supplement insurance is offered by private health. It is designed to fill-in the gaps in Medicare coverage such as overseas travel. Medicare Supplement insurance, also referred to as Medigap, is covered in further details in a later lesson in this course.

Patient- Centered Medical Home (PCMH)

The **patient-centered medical home (PCMH)** is often the bedrock of an ACO.

A PCMH is based on widely endorsed principles that include access to care, long-term relationships with healthcare providers, and both comprehensiveness and coordination of care. It is also grounded in evidence-based medicine and quality improvement. [xviii]

Properly established and managed, and with payment systems aligned to support care management, PCMHs can be a key factor in increasing member satisfaction by focusing on their overall healthcare experiences and their preferences for care.

Administrative Cooperation and Clinical Integration

Among the goals that private health plans seek to achieve through ACOs are increased administrative cooperation (including reduced processes) and greater clinical integration and cooperation among providers to improve the quality of care and contain costs.

More on clinical integration:

Clinical integration is defined as the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units to as to maximize the value of services delivered. Clinical integration includes both horizontal integration (the coordination of activities at the same stage of delivery of care) as well as vertical integration (the coordination of services at different stages). [xix]

Care Coordination

A way private health plans can foster care coordination is asking the various units participating in the formation of an ACO to rethink the care delivery processes of their respective organizations.

Example: In a situation where a private health plan, hospital, and large provider network sought to forge an ACO, it was found that inpatient processing was being performed by all three organizations duplicating effort. Streamlining this process and dividing responsibilities not only saved administrative steps and dollars but also improved members' experience. [xx]

Incentivization Goal of Evidence- Based Medicine

In any discussion of clinical integration, it is important to remember that providers' care decisions impact both health outcomes and costs. The goal is to incentivize the practice of evidence-based medicine.

This can begin by looking at the care provided to certain types of patients (such as those suffering from serious heart disease) and establishing mutually agreed on quality metrics, baseline cost projections, and use of bonus payments for meeting goals.

One potential path is setting up such programs for one or two targeted diseases and later expanding, applying the lessons learned more widely in the ACO system. [xxi]

The Role of Information Technology in ACOs

The American healthcare system is moving from a fee-for-service model that rewards quantity of services toward a value-based model that rewards quality of services, population health.

Population health management (PHM) is becoming increasingly important to private health plans and their partners in ACOs.

Public Health Management

A key objective of PHM is keeping a patient population as healthy as possible and thereby minimizing the need for expensive medical interventions such as hospitalizations and surgical procedures. This not only has the effect of lowering costs but focuses healthcare on far more than acute care.

While PHM does involve considerable effort on behalf of high-risk patients, PHM also recognizes and seeks to systematically address the preventive and chronic care needs of all patients.

PHM takes into account the change in individuals' healthcare needs over time and seeks to identify and modify the factors that make people sick or intensify their illnesses as they age. [xxii]

Information Technology and PHM

Information technology (IT) makes PHM possible. It enables private health plans and their ACO partners to bring together and manage the administrative and clinical tools needed to supply proactive preventive and chronic care to all patient-members, both during and between encounters with the healthcare system.

Among the IT tools employed in PHM are:

- electronic health record (EHR) databanks
- digitalized disease registries
- population health data management systems

How IT Can Increase Quality of Care

IT tools enable private health plans working with providers to give better care to their members while maintaining affordability.

The application of IT in ACOs can substantially increase the effectiveness of population health strategies by continually identifying, assessing, and stratifying members as to their care needs and matching them with appropriate provider care teams and resources.

By enabling ACOs to manage their patient-member populations more effectively, IT helps to drive better care outcomes and can also help reduce overall costs.

Public Sector ACOs

Medicare provides government-sponsored healthcare to millions of older Americans as well as to younger individuals who are severely disabled. The program, while widely supported, costs the federal government billions of dollars.

The program and its costs came under considerable discussion during the passage of the Affordable Care Act (ACA) as well as the role ACOs might play in providing those benefits moving forward with an eye both as to the quality of care provided as well as costs.

As a result, the ACA contains provisions calling for the creation of ACOs within Medicare.

Responsibility for implementing these provisions rests with the Centers for Medicare and Medicaid (CMS).

Multiple Initiatives to Establish ACOs

To achieve those goals, CMS launched multiple initiatives to help providers of various sizes establish ACOs including the:

- Medicare Shared Savings Program,
- Pioneer ACO Model Program, and
- Advanced Payment ACO Initiative.

For the purposes of this course, we will focus on the Medicare Shared Savings Program (MSSP) launched in 2013 and more recent changes to it. [xxiii]

Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP) allowed healthcare providers to join together in ACOs to integrate and coordinate services in return for a share of the savings realized by Medicare.

ACOs participating in the program were rewarded for lowering growth in Medicare costs while meeting quality performance standards. This was (and its successor continues to be) a voluntary program, for which healthcare organizations must file applications and receive CMS approval.

MSSP Participation Tracks

The MSSP offered different participation options (tracks) that allowed ACOs to assume various levels of risk:

Track	Financial Arrangement	Description
1	One-sided	Track 1 ACOs *do not* assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
1+	Two-sided	Track 1+ ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk but, may share in the greatest portion of savings if successful.

Recent MSSP Developments

In August of 2018, CMS issued a proposed rule to update the MSSP. Subsequently, this rule was finalized in December 2018.

The redesigned program is called *Pathways to Success.*

The goal of this initiative is to move more ACOs into two-sided participation agreements where downside risk for increased costs is assumed. This initiative began with a start date of July 1, 2019.

Pathways to Success

The *Pathways to Success* program builds upon the lessons learned from the Medicare Shared Savings program and seeks to provide a structured path for ACOs to take on increased levels of performance-based financial risk. ACO can begin participation on either a Basic Track or Enhanced Track based on their prior experience and ability to assume risk. Thus far, most begin on the Basic Track.

The Basic Track is subdivided into five levels. Additional levels of risk and reward through shared savings occur at each level. It is assumed that an ACO will normally enter the program for a five year period and automatically advance through the levels each year. Below is a chart showing these Basic Track levels:

Level	**Characteristics**
Basic A & B	Upside only (shared savings no downside risk) Savings 40% Downside 0%
Basic C &D	Two-side risk Upside 50% Downside 30% of losses with cap of 2-4% of Medicare FFS revenue
Basic E	Two-sided risk Upside 50% Downside 8% of FFS revnue
Enhanced	Two-sided risk Upside 75% Downside 15% of FFS revenue

Pathways to Success (Continued)

Basic Track levels A and B are upside risk only. In other words, participants can share up to 40 percent of any shared savings but are not accountable for any losses. These levels are designed for ACOs that would like to participate in value-based care but are not ready to shoulder financial risk.

Basic Tracks C and D assume that ACOs have learned from their experiences in earlier program participation years and now are ready to begin taking on some downside risk. These levels offer the opportunity for more shared savings – 50 percent versus the 40 percent offered in levels A and B. However, ACOs are required to be accountable for 30 percent of any downside losses with a risk cap of either 2 or 4 percent of their Medicare fee-for-service revenue.

Basic Track E – ACOs in this level assume further accountability for patient outcomes through further assumption of downside risk. Here ACOs are offered up to 50 percent of shared savings along with up to 30 percent of losses. However, at this level the risk cap is higher at 8 percent of Medicare fee-for-service revenue.

The Enhanced Track is deemed to be equivalent to Track 3 under the earlier Medicare Shared Savings model. The Enhanced Track provides ACOs with the opportunity to receive up to 75 percent of shared savings. At the same time, ACOs in the Enhanced Track are responsible for up to 40 percent of losses with the risk cap at 15 percent of Medicare fee-for-service revenue.

Medicare ACOs versus Medicare Advantage Plans

MA plans are offered by private health plans that provide benefits comparable to Original Medicare Parts A and B. A Medicare ACO is *not* a type of MA plan.

More about some differences between Medicare ACOs and MA plans:

Medicare ACOs and MA Plans differ in the following ways:

- Medicare beneficiaries cared for by an ACO are enrolled in Original Medicare, not an MA plan.
- Medicare ACO initiatives address how healthcare providers are compensated by Medicare. They do not affect the benefits received by Medicare enrollees. Enrollees in MA plans often enjoy some enhanced benefits such as vision care depending upon the plan in which they enroll.

Notes:

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7 PPOs and Other Health Plan Types

Learning Objective

After completing this lesson, you will be able to:

- define a preferred provider organization (PPO) and describe its main features, and
- define and describe an exclusive provider organization (EPO), a point-of-service (POS) product, and a managed indemnity plan.

PPOS, EPOs, POS, and Managed Indemnity Plans

In the last two lessons we studied HMOs, and now we will look at some other health plan designs—preferred provider organizations (PPOs), exclusive provider organizations (EPOs), point-of-service (POS) products, and managed indemnity plans. These plan types are not as tightly managed as traditional HMOs, but they also differ from traditional indemnity insurance in that they employ healthcare management concepts and techniques. They fall in the middle of the managed care continuum discussed earlier.

We will learn the main features that characterize each of these plan types and distinguish it from others. But it should be kept in mind that distinctions between types are not always clear-cut. In an effort to be responsive to consumer and purchaser needs and preferences and to remain competitive, health plans develop designs that in a variety of ways balance managing costs with giving members a choice of healthcare providers. As a result, a product of a certain type may take on the features characteristic of other types, blurring the difference between them.

Preferred Provider Organizations (PPOs)

What Is a PPO?

A **preferred provider organization (PPO)** is a healthcare benefits arrangement with these main characteristics:

- The health plan contracts with healthcare providers to deliver services to its members, and these providers agree to discounted compensation. That is, contracted providers charge the PPO less than their normal fees for services. Why are they willing to do this? Affiliation with a PPO generally brings a high volume of patients, so although a physician or hospital may receive less per service, more services are performed and billed.[i]
- Like an HMO, a PPO has a network, made up of its contracted providers. But unlike a traditional HMO, a PPO does not cover only care received from network providers— members can go to outside of the network and still receive benefits. However, members have strong incentives to use preferred (network) providers. The benefit package for in- network care is typically “richer” than for non-network care—that is, more procedures and services are covered. Also, members pay more in cost-sharing when they go out of

network—copayments or coinsurance is typically higher. And there may be a limit on a member's out-of-pocket costs for in-network care but no such limit for non-network care.

- Unlike traditional HMOs, most PPOs allow members to see a specialist without a referral from their primary care physician (PCP), adding to the flexibility of the PPO model.
- The contracted providers agree to comply with certain utilization review, care management, and quality management requirements.

PPO Membership Freedom

Thus, PPO members have the freedom to choose any provider, as in indemnity insurance, but other features (such as incentives to stay in the network, utilization review, and quality management) promote cost-effective, high-quality care. Consumers like this combination, and a majority of employees with health coverage are in PPOs (47 % of employees in 2020).[ii] There are approximately 450 PPOs in the United States. (This number has been declining for a number of years, but this is a result of consolidation, not decreasing enrollment.) [iii]

PPO Structure and Organization

As mentioned, a PPO involves a contract arrangement between healthcare providers (physicians, hospitals, and others) and purchasers, such as insurance companies and employers. One of the primary functions of a PPO is to negotiate contracts between providers and purchasers.

A PPO can be sponsored by a group of physicians and/or hospitals, a Blue Cross/Blue Shield plan, a third-party administrator (TPA), or an employer. But more than half are owned by insurance companies. Some of the largest insurers have developed their own PPO networks, while others lease provider networks or form cooperative ventures with independent PPOs.

Risk and Centralization

PPOs take many different forms, with a wide variety of structures. Two key ways in which they differ are risk and centralization.

- As we explained earlier in the course, a healthcare organization assumes risk if it is exposed to possible financial losses by having to spend more to provide healthcare than it is paid for providing that care. Some PPOs are risk-bearing entities, but most are not. In many cases, the risk is assumed by self-insured employers or other organizations.
- A PPO can be a decentralized network of preferred providers, established and maintained by the entity that insures the members, or even just leased by it. At the other end of the spectrum, a PPO can be a highly centralized organization, with not only its own network but an administrative structure that pays claims and performs other functions. Such a PPO may also assume risk.

PPO Healthcare Benefits

Like other health plans, PPOs provide comprehensive healthcare benefits. In addition to standard medical care, they typically cover many types of specialty care. Nearly all cover behavioral healthcare and most offer pharmacy benefits. A PPO network may include primary care providers, specialists, hospitals, diagnostic facilities, and other healthcare providers.

Provider Compensation

For physicians contracted with PPOs, the most common method of compensation is discounted fees—the PPO pays the physician a fee for the service they provide, but the amount is reduced from their normal charge. Fee amounts are commonly based on a fee schedule (also referred to as fee caps)—the physician receives their billed fee up to an amount set by a schedule. Over 90 percent of PPOs use a fee schedule (fee caps) and over 50 percent pay doctors based on a discount off the billed charge; just over 6 percent used capitation. (Some plans use more than one method.).[iv]

Hospital Compensation

For hospitals, PPOs use several payment methods. These methods include per-diem payments (a set amount for each day a member is hospitalized), discounted charges, rates based on classes of medical conditions called diagnosis-related groups (DRGs), and combination models.[v]

Other PPO Compensation Structures

Historically, most PPOs were structured so that providers did not assume any risk for providing care, and many of the compensation methods mentioned previously (such as discounted fees and charges) do not entail provider risk. But others, such as per-diem payments, capitation, and packaged price per episode of care (also, referred to as bundled payments) do. Some PPOs have included such risk-sharing arrangements in their provider contracts to promote more cost-effective care and greater provider involvement in managing utilization.[vi]

Utilization Management, Care Management, and Quality Management

A PPO generally requires contracted providers to follow utilization and care management procedures to achieve cost-effective, appropriate care. PPOs have adopted many utilization and care management techniques once common only to HMOs. Some PPOs, especially those owned by HMOs or insurance companies, have in-house utilization review staffs; others contract this to outside firms or delegate it to providers.

PPOs also employ many quality management techniques typical of HMOs. Nearly all PPOs routinely credential and re-credential contracted physicians, and increasingly PPOs are obtaining accreditation for their quality management programs from well known independent third-party organizations such as URAC.

Other Types of Health Plans

After PPOs became popular, health plans further refined and customized products to meet the needs and preferences of consumers and purchasers, and new plan designs were introduced.

Specialty PPOs

Specialty PPOs are structured and operate like regular PPOs, but they provide specialty healthcare services such as dental care, behavioral healthcare, prescription drugs, vision care, physical therapy, laboratory services, chiropractic care , and podiatry. (Specialty health plans are discussed later in this course.)

Exclusive Provider Organizations (EPOs)

An **exclusive provider organization (EPO)** is structured and operates like a PPO, but it is like a traditional HMO in one important way—out-of-network care is generally not covered. If a member receives services from a provider not in an EPO's network, she receives no benefits and must pay out for the services of her own pocket.

Many PPOs developed EPOs to help them compete directly with HMOs. In most states, EPOs are regulated as insurance companies under state insurance laws and are not subject to state and federal HMO legislation. But some states either prohibit EPOs or regulate them as HMOs.

Point-of-Service (POS) Products

A **point-of-service (POS) product** is a hybrid that combines features of PPOs, HMOs, and indemnity insurance. POS products are called by several names, and there are a number of variations, so defining this design and distinguishing among types can be complicated.

Basic Characteristics of a POS Product

- When members need healthcare, they choose at that time (at the point of service) whether to go to a network provider or one not in the network. Members going out-of- network normally pay higher cost-sharing, giving them an incentive to remain in network. In this way, POS plans are more flexible than traditional HMOs and similar to PPOs.

- POS plans are like HMOs in that they usually require members to select a primary care physician (PCP), who delivers routine care and serves as a gatekeeper, giving referrals to specialists.

- POS plans also resemble HMOs in their strong emphasis on preventive care and wellness (including such services as vaccinations and smoking cessation programs).[vii]

POS Offerings

POS products are offered by network-based health plans and by insurers. Often an HMO offers a POS option to its members; in this case, the HMO generally compensates PCPs by means of

capitation, and it may also withhold compensation pending PCPs meeting utilization or cost-saving goals. The HMO reimburses non-network providers on a fee-for-service basis.

POS Product Members

As mentioned, under a POS product members receiving out-of-network care pay more, typically higher cost-sharing. In some designs, the member must pay the difference between what the POS plan pays network providers for a service and what a non-network provider charges. HMO members with a POS option pay relatively small copayments for network care and 20 or 30 percent coinsurance for out-of-network care, and there is also generally a cap on non-network benefits. However, some plans provide greater benefits for non-network care if the member has obtained a referral for his PCP to see a non-network specialist.

POS Comparison

Some employers like POS products because they are a compromise between less restrictive designs like indemnity and PPOs and more tightly managed HMOs. In the past POS products had a major drawback—higher administrative costs, resulting from the need to administer benefits for both network and non-network providers. But this is less of a problem today because of the increased use of technology and enhanced managerial expertise. The percentage of employees covered by POS products was 8 percent in 2020,[viii] but the number has declined over the years. In 1999 for example, approximately 24 percent of employees were enrolled in POS plans.[ix]

Managed Indemnity Plans

Some indemnity health insurance plans have adopted certain managed care techniques and so are called **managed indemnity plans**. These plans are typically organized and administered like traditional indemnity insurance; there is no provider network, insureds use any provider they choose, and provider payment is by fee-for-service. But certain health plan cost-control measures, such as precertification and utilization review, are used. Wellness and preventive programs may also be available depending on the plan.

The Road to Consumer Choice

PPOs, POS products, and similar designs addressed the demand for greater flexibility in health plan products, but they still insulated consumers from the cost of care. The next step in the health plan industry's evolution was the consumer-directed health plan (CDHP), in which the consumer is directly involved in the cost of care. CDHPs (sometimes referred to as account-based plans) and the rise of consumer choice will be discussed in lessons 9 and 10.

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8 Health Plans for Specialty Services

Learning Objectives

After completing this lesson, you will be able to:

- explain how a health plan might carve out the delivery of specialty services
- distinguish between the three main types of dental plans
- articulate how a vision plan is complementary to a medical health plan
- describe basic strategies that managed behavioral health organizations (MBHOs) use to manage the delivery of behavioral healthcare services
- list some of the services offered by a pharmacy benefit management (PBM) plan

Essential Health Benefits

In the past, managed care plans focused on basic medical care—physician and hospital services. But today consumers want other health services, such as dental care, vision care, behavioral (mental) healthcare, and prescription drugs, to be included in their health plans, and employers have responded by offering benefits for these specialty services. And, as a result of the essential health benefits provisions of the Affordable Care Act (ACA), many of these benefits are now offered in many health plans.

List of the ACA essential health benefits:

Ambulatory patient services (outpatient)	Prescription drugs
Emergency services	Rehabilitative and habilitative services and devices
Hospitalization	Laboratory services
Pregnancy, maternity, and newborn care	Preventive and wellness services and chronic disease management
Mental health and substance use disorder services	Pediatric services including oral and vision care for children (but adult dental and vision are not essential health benefits)[i]

Specialty Services

Specialty services are healthcare services that are generally considered outside standard medical-surgical services because of the specialized knowledge required for service delivery and management. Specialty services often involve different types of providers and delivery systems

than standard medical services. Thus, a health plan may find it more cost-effective and efficient to contract with specialty organizations rather than providing these types of services in-house.

Contracted Specialty Services

Specialty services that a health plan chooses to contract out may include:

- dental care
- vision care
- behavioral healthcare
- prescription drugs
- chiropractic care
- other forms of complementary and alternative medicine such as acupuncture, naturopathy and massage therapy
- rehabilitation services
- chronic disease care
- home healthcare
- cardiac surgery
- oncology services
- certain diagnostic services, such as radiology and magnetic resonance imaging

More information on acupuncture, naturopathy, and massage therapy:

Acupuncture – is a technique in which practitioners stimulate specific points on the body – most often by inserting thin needles through the skin. It is one of the practices used in traditional Chinese medicine.[ii]

Naturopathy – also called naturopathic medicine – is a medical system that evolved from a combination of traditional practices and health care approaches popular in Europe during the 19th century. Naturopathic practitioners used many different approaches including dietary and lifestyle changes, herbs and other dietary supplements, exercise therapy, and stress reduction.[iii]

Massage therapy – is the scientific manipulation of the soft tissue of the body for the purpose of normalizing those tissues and consists of manual techniques that include applying fixed or movable pressure, holding, and/or causing movement of or to the body.[iv]

Arranging & Managing the Delivery of Specialty Services

Managed care approaches for many specialty services are still in a developmental stage. For others, health plans have found that the application of focused management techniques can yield cost savings and promote quality care. Employers and health plans have two options for arranging and managing the delivery of specialty services:

- Develop and maintain their own programs.
- Carve out the delivery and management of these services.

Carve-out

Various Carve-out Descriptions

The term **carve-out** carries several different meanings in the healthcare industry.

In a general sense, a carve-out refers to the separation of a medical service (or a group of services) from the basic set of benefits in some way. The separation may be either through a different compensation method for providers or through the use of a separate network or delivery system.

Example: A health plan might carve out its HIV/AIDS disease management services from its other medical services by contracting with an external company that specializes in the management of this program. The health plan, however, still retains accountability for the HIV/AIDS services under the medical plan. This type of carve-out is the one that is relevant to our discussion of specialty services.

Frequently Carved-Out Specialty Services

In this lesson, we will discuss the use of carve-outs as a means of delivering specialty services. We will then provide a more detailed discussion of four specialty services that are frequently carved out of the basic set of benefits:

- dental care
- vision care
- behavioral healthcare
- prescription drug benefits

For these specialty services, we will also look at what appears to be trending for each of these services over the next few years.

The History of Carve-outs

As costs in all areas of healthcare increased in the late 1970s and early 1980s, some health plans began exploring ways of applying managed care techniques to specialty services. These pioneering organizations found that within certain specialties, the application of focused management techniques seemed to yield cost savings.

The Role of Contracted Independent Organizations

Independent organizations, whose primary purpose was to deliver a particular specialty service, also began to apply managed care techniques to manage those services. In some instances, these independent organizations were able to deliver specialty services more affordably and more effectively than health plans. As a result, many health plans began to contract with these independent organizations to deliver such services.

Further discussion of why carve-outs emerged:

One analogy as to why carve-outs emerged and proved enduring is the concept of multi-tasking. In the not too distant past, multi-tasking was considered a way to get more work done within the same amount of time. Studies have shown however, that neither is more likely to be accomplished but the work that is done is frequently of lower quality. One can surmise that this is because workers are unable to concentrate on a single task or project at a particular time. Think of this in effect, as a "jack of all trades, master of none" situation.[v]

Characteristics of Carved-out Specialty Services

Health plans often carve out specialty services that have one or more of the following characteristics:

- an easily defined benefit,
- a defined patient population,
- high or rising costs, and/or
- inappropriate utilization.

Types of Carve-Out Arrangements

In a **comprehensive carve-out arrangement**, a health plan transfers to the carve-out organization the authority to conduct all the activities necessary to deliver and manage the specialty service. Such activities may include network management, quality management, utilization review, case management, and claims administration.

In a **partial carve-out arrangement**, the health plan retains the management of one or more of these selected activities.

Compensation for Carve-outs

Compensation for comprehensive carve-outs in mature health plan markets is typically on a capitation basis.

In this these situations, there is sufficient financial and utilization history to identify a fair fee per member per month to compensate the specialty organization for the expected services.

In less mature markets, in partial carve-outs, and for services that do not have well-defined patterns of utilization, compensation is often based on fee-for-service or a fee plus a percentage of savings, or an agreed fee for the service plus an amount for administrative costs.

Fragmentation of Services

Although many carve-out arrangements have produced favorable outcomes for members, providers, and health plans, there is some concern that healthcare may become too fragmented with numerous carve-out arrangements (particularly where members suffer from multiple chronic diseases).

In response, disease management organizations have consolidated in order to offer a broader range of services in some cases, managing several chronic diseases including diabetes, chronic obstructive pulmonary disease (COPD), asthma, cardiovascular and heart disease.[vi]

Example: Consider for example, the situation where ABC health plan carves out disease management for diabetes to one specialty organization, SO#1. Shortly thereafter, ABC health plan carves out management for heart disease to another specialty organization, SO#2. What happens if a health plan member suffers from both diseases? The result could be that the member becomes both confused and overwhelmed.

Effects of State Legislation

State legislation may affect the way health plans manage and deliver specialty services.

Example: Laws in some states mandate that HMOs arrange and manage the delivery of certain specialty services to retain their HMO licenses. Similarly, state consumer protection laws may seek to ensure that health plan members receive integrated, quality care.

States with such laws require a health plan to provide evidence of health improvements and/or integration.

Example: Reports may be required to demonstrate that services are not overly fragmented and/or effective. These concerns have prompted some HMOs and other health plans to roll previously carved-out services back into the basic bundle of services they deliver to their members.

Specialty HMOs

Some states provide for the formation of specialty health maintenance organizations for specialty services. A **specialty health maintenance organization (specialty HMO)** is an organization that uses an HMO model to provide healthcare services to a subset or single specialty of medical care.

Typical specialty HMOs include:

- dental HMOs
- vision HMOs
- behavioral health HMO

Although they are based on an HMO model, specialty HMOs may differ greatly in structure and operations from basic medical HMOs. In states which specify a broad range of services that must be provided by a licensed HMO, specialty HMOs are not an option. In those states, managed specialty service organizations do exist, but not in the legal form of a specialty HMO.

Dental Care

Managed Dental Care

The term **managed dental care** was once synonymous with dental HMOs, and later it was used to refer to other network-based plans as well. Today virtually any plan that includes some level of oversight of provider fees, utilization, quality of care, and other such matters could be considered managed dental care.[vii]

Growth of Managed Dental Care

Managed dental care has grown, as more employers have sponsored dental benefits and as those benefits have been increasingly provided by health plans. A large majority (92 percent) of very large employers (500 or more employees) offer dental coverage.[viii]

A majority of Americans have dental coverage either through a combination of private insurance and public programs.[ix] Fifty nine percent of Americans ages 19-64 have private dental coverage.[x]

A large majority of this coverage is managed care. In 2017, preferred provider organizations for example accounted for 82 percent of the total dental benefit market and there is little expectation that this will change in the foreseeable future.[xi]

Chart showing the dramatic growth in managed care experienced since the early years of the 2000s.

Dental Plan Enrollees by Plan Type [xii]

Plan Type	2006	2016	Change 2016 vs. 2006*
Indemnity	19%	6%	-13%
PPO	62%	81%	19%
HMO	8%	7%	-1%

Possible Reasons for Managed Dental Care Growth

- Increased willingness of dentists to affiliate with health plans

  The costs of maintaining a dental practice have risen steadily, and an oversupply of dentists in some areas has made it difficult for dentists to acquire or retain market share, making participation in health plans attractive.

- Managed plans are generally less costly to purchasers than traditional indemnity plans.

Main Type of Managed Dental Plans

The three main types of managed dental plans are:

- Dental Health Maintenance Organizations (DHMOs)
- Dental Preferred Provider Organizations (Dental PPOs)
- Dental Point-of-Service (Dental POS) options

Dental Health Maintenance Organizations

A **dental health maintenance organization (DHMO)** (also known as a capitated plan) has the following characteristics:

- Members must see a network dentist, except for emergencies and in some cases specialty services when network specialists are unavailable.
- Dentists are usually paid on a capitation basis, meaning that they assume the majority of financial risk for providing all necessary services in exchange for a guaranteed cash flow.
- Members pay a small portion of costs by making copayments based on a schedule. There are usually no annual deductibles, coinsurance, or yearly maximums. Copayments

are not charged for routine diagnostic and preventive services, which are fully covered by the dentist's capitation payment.

- Network dentists also agree to a variety of requirements and administrative oversight. These requirements often include maintaining an active license to practice, having a set minimum level of liability insurance, and cooperating with plan audits, quality assessments, utilization management and dispute resolution procedures.

DHMOs almost always have the smallest network, lowest cost, least amount of choice, and greatest restrictions when compared to the other types of dental plans.

Dentist Compensation in a DHMO

Dentists may be reluctant to join DHMOs because of the low reimbursement and financial risk. Plan administrators have taken measures to enlarge DHMO networks by providing supplemental payments to dentists for certain procedures, guaranteeing them a minimum income per member, or reducing their financial risk or increasing their compensation for covered services, and/or limiting the services covered.

For example, allowing dentists to charge reasonable and customary fees for some more extensive services.

The State of DHMOs

Today, DHMOs make up a small portion of the market, and this share has been declining. In fact, for many years industry experts have been predicting their demise.

But this has not happened, because DHMOs serve a need. They have a small but loyal following among individuals who are dentally needy and/or very price-sensitive and willing to trade freedom of choice and a large network for low cost.

Dental Preferred Provider Organizations

A **dental preferred provider organization (dental PPO)** has the following attributes:

- Members can see the dentist of their choice—they do not have to use a network dentist. However, they generally pay less if they stay in network. It is common for a PPO to have a lower deductible, lower coinsurance, and a higher annual maximum for in-network care. A plan may require a member who visits an out-of-network dentist to pay the difference between that dentist's fees and an in-network dentist's discounted fees.

- Dentist reimbursement is commonly based on a fee schedule (discounted fee-for-service). Network dentists also agree to other requirements and administrative oversight provisions, such as maintaining an active license to practice, having a minimum level of liability insurance, and cooperating with audits, quality assessment, utilization management, dispute resolution, and others.

- Members pay an annual deductible and coinsurance. The deductible is generally $50 to $75 for an individual and $75 to $150 for a family. The coinsurance percentage members

pay is typically 20 percent for basic services such as fillings and 50 percent for major services such as crowns. There is no deductible or coinsurance for diagnostic and preventive services. There is usually also an annual maximum benefit, generally $1,000 to $2,500.

Point-of-Service (POS) Option

Definitions of a **point-of-service (POS) option** vary. For our purposes, we define a POS program as any that involves a combination of networks, where members can choose any dentist (including out-of-network) and the benefit level and provider reimbursement vary accordingly.

POS Option (Continued)

The most distinguishing feature of POS plans is that members do not have to choose any particular dentist or network during annual open enrollment—they are free to switch at will, depending on their needs and preferences, with the benefit available being determined at the point of service.

Usually, a member who goes out of network incurs higher out-of-pocket costs. The most common POS program in dental benefits involves combinations of PPOs and DHMOs.[xiii] [xiv]

Vision Care

Vision Care

Vision care is a health benefit designed to reduce costs for routine preventive eye care (eye examinations), corrective lenses, eye frames, and contact lenses. As of 2019, 44 percent of small firms and 83 percent of large firms offer vision benefits to their employees.[xv]

Information as to the number of Americans adults using corrective lenses:

According to research by The Vision Council, there are 195.3 million vision correction users in the United States.[xvi]

What Need Do Vision Benefits Address?

Vision care is not covered under most health insurance plans, so unless a person is covered by a vision benefit plan, they must cover all such expenses out-of-pocket. While this can amount to just a few hundred dollars for a single person, if several members of a family wear glasses, total expenditures can be substantial and benefits can prove very valuable.

Information on the Affordable Care Act and vision benefits:

Like dental benefits, the Affordable Care Act (ACA) essential health benefits include pediatric vision care but do not include vision coverage for adults.[xvii]

Types of Plans

Vision care benefit plans can be distinguished in three main ways:

- **Group vs. Individual** – Most vision care insurance is in the form of employer-sponsored group plans. Such plans are usually a voluntary benefit (that is, one that employees have the option of enrolling and paying for), and they may be offered as part of a menu of benefits from which employees choose. Individual policies, while less common, are offered by several insurers.

- **Integrated vs. Nonintegrated** – Like dental benefits, vision benefits may be integrated or nonintegrated. That is, vision benefits may be provided by a health insurance plan along with medical benefits, or more commonly, they are provided under a separate insurance coverage.

- **Indemnity Insurance vs. Managed Care** – Vision benefits plans are primarily traditional indemnity insurance but there some manage care plans (HMOs and PPOs) in the market.

Other Vision Plans

In addition to indemnity and managed care plans, there are also discount vision care plans.

These plans do not pay benefits, they simply arrange for discounts. Optometrists who join such a plan agree to provide products and services to plan members at a discount in return for the volume of customers that participation in the plan brings. Consumers pay fees to belong to the plan to be eligible for these discounts.

Information on use of tax-favored funds for vision care expenses:

Funds from flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) can be used to pay for vision care expenses not covered by insurance.

Vision Plan Benefits

A vision care plan generally pays benefits for the following:

- eye examinations (including dilation)

- eyeglass lenses

- eyeglass frames

- contact lenses

Some plans also pay benefits or provide discounts for laser vision correction (laser corrective surgery).

What's Not Covered

While vision plans pay benefits for eye exams, which may detect eye diseases, they do not cover the treatment of such diseases or any other medical treatment. Such care is generally covered under a health insurance plan.

Vision plans cover products necessary for good eyesight but not usually those with a largely cosmetic purpose (e.g. tinted contact lenses).

Likewise, plans typically cover only basic frames and insureds who want more expensive frames must pay the difference. Plans also rely on the use of networks. If an insured does not use an in-network provider, they may not be eligible for reimbursement.

Benefit Schedule

Under indemnity policies, the amount of benefits paid is set by a benefit schedule – that is, there is a specified dollar amount for each covered service and product, and the insurer reimburses the insured for the actual amount paid up to the scheduled allowance. (Note, such indemnity policies typically have no deductible or coinsurance).

A typical benefit schedule might be as follows:

- $50 for routine vision exam
- $50 for single vision lenses, $75 for bifocals, $100 for trifocals, and $150 for lenticular lenses
- $100 for frames
- $100 for contact lenses

Example of an indemnity vision plan:

Mildred visits her optometrist for an eye exam and learns she needs new glasses with single-vision lenses. The exam costs $75, the lenses $150, and the frames $200 for a total cost of $425. Mildred has vision coverage through an indemnity plan with the schedule of benefits listed above. It reimburses her as follows:

- $50 for the exam
- $50 for the single-vision lenses
- $100 for the frames

$200 total (or about half)

Benefit Schedule Limits

In managed care vision plans, there are no deductibles or coinsurance for most services and products. Members do make relatively small copayments. A benefit schedule may be used for some services and products.

A PPO may also use a benefit schedule for out-of-network care. (An HMO pays no benefits for non-network care.)

Frequency limitations are typical of vision care benefits. Some typical limits:

- One eye exam every 12 months
- One set of eyeglasses or contact lenses every 24 months
- One set of frames every 12 or 24 months

Behavioral Healthcare

The treatment of mental disorders and substance abuse is known as **behavioral healthcare**. Such problems are widespread in the U.S. population—in a given year about one quarter of adults are diagnosable for one or more disorders, and about 6 percent suffer from a seriously debilitating mental illness. And the incidence among young people is even higher—nearly half of teenagers have had some sort of mental disorder or substance abuse problem during their lives, and about one in five have had a serious mental illness. Because of the high frequency of these conditions, their treatment is a major component of the healthcare system. Some mental health experts estimate that roughly 18 percent of Americans suffer from mental health issues.[xviii] This figure may in fact, be far higher due to the impact of the COVID-19 pandemic.

Impact of the COVID-19 pandemic on mental health.

According to a CEC report, the COVID-19 pandemic has been associated with mental health challenges related to morbidity and mortality. Mitigation activities including social distancing and stay-at-home orders also adding to anxieties. Symptoms of anxiety and depression increased considerably in the United States during April-June of 2020 compared to the same period in 2019. In fact, during late June 2020 forty percent (40%) of US adults reported struggling with mental health or substance use issues. Source: Mark E. Czeisler, et al, "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020, , Vol. 69, No. 32, August 14, 2020 available at https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932-H.pdf

Controlling Behavioral Healthcare Costs—Initial Strategies

Decades ago, behavioral healthcare represented a very small percentage of healthcare spending. But beginning in the early 1980s, the demand for services rose.

This was caused by increases in people's awareness of mental health and substance abuse problems, in the social acceptability of treatment, in the availability of behavioral health services, and perhaps also in the stress on individuals and families.

Initial Strategies to Reduce Costs

As a result of this rising demand, behavioral healthcare costs to health plans and sponsoring employers soared.

To control costs and limit their financial liability, plans sought to reduce the utilization of inappropriate or unnecessary services. But existing utilization management strategies were not designed for the complexities of behavioral healthcare and were not effective.

Plans turned to:

- special cost-sharing
- benefit limits
- exclusions for behavioral healthcare

Initial Strategies to Reduce Costs (Continued)

Additionally, plans also started to:

- charge higher deductibles or coinsurance for behavioral care than for medical care
- limit the number of outpatient visits and inpatient care days covered each year and placed annual and lifetime dollar caps on behavioral care benefits
- exclude or limit coverage of certain illnesses (such as chronic illnesses, organic psychoses, and personality disorders); services (inpatient psychiatric services, long-term outpatient treatment, and marital counseling); and populations (geriatric patients, patients with developmental disabilities, substance abusers).

Ultimately, these strategies did little to reduce costs; in some cases, they limited access to necessary and appropriate care.

They also led to mental health parity legislation, which restricts a plan's ability to impose special cost-sharing and limitations on behavioral healthcare, as discussed later.[xix]

Second Generation Strategies

A **managed behavioral health organization (MBHO)** provides behavioral healthcare services and implements health plan techniques.

MBHOs emerged in the 1980s, and health plans and employers turned to them for access to care and cost management. MBHOs' specialized knowledge and experience in behavioral healthcare enable them to determine which services were necessary and appropriate for particular patients and to deliver the types of services that led to better outcomes.[xx]

MBHO's Four Basic Strategies to Manage the Delivery of Services

MBHOs use four basic strategies to manage the delivery of services:

- alternative treatment levels
- alternative treatment settings
- alternative treatment methods
- crisis intervention

MBHOs have also developed mechanisms to help match these services with patients' needs.

Alternative Treatment Levels

People with behavioral disorders have a wide range of care needs. There are a large number of disorders, and the severity of a particular disorder can vary dramatically among different patients and in the same patient over time. Many patients suffer multiple disorders. To meet these varied needs, MBHOs cover multiple levels of care.

Acute Care

Acute care is for those who need continuous, intensive, individualized care, often in conjunction with medical care. This is the most secure and restrictive level of care.

Post-acute Care

Post-acute care is for those who need continuous monitoring in a safe, structured environment but not acute care.

Partial Hospitalization

Partial hospitalization is for those who need substantial care and supervision but not 24-hour monitoring. Patients in partial hospitalization programs typically spend part of the day or week in a facility and part outside working or attending school. Many programs are designed to treat substance abuse.

Intensive Outpatient Care

Intensive outpatient care is for those who need extensive individual or group therapy but not continuous care and supervision in a confined setting. Such patients may attend therapy sessions for several hours per day, several days per week.

Outpatient Care

Outpatient care is for those who need less frequent therapy (once or twice a week or once a month) and shorter sessions (typically one hour or less) compared to intensive outpatient care. Outpatient care is the least intensive and restrictive level of care.

The level of care a patient receives typically depends on the risk to himself, others, and property; his ability to function effectively at home or in the community; and his medical needs.

Alternative Treatment Settings

Behavioral healthcare can be delivered effectively in a variety of settings.

- Acute care is typically provided in psychiatric hospitals, psychiatric units of general hospitals, or hospital observation units.

These facilities are equipped to address the needs of patients who pose a significant risk to themselves or others, are unable to function without assistance or supervision, or have suffered acute episodes such as drug overdoses.

- Post-acute care is most often provided in subacute care facilities.

Partial hospitalization programs are typically in psychiatric hospitals, rehabilitation hospitals, or halfway houses. Outpatient care takes place in the offices of therapists and mental health clinics.

Alternative Treatment Methods

Behavioral healthcare involves a variety of approaches. These include drug therapy, psychotherapy, and counseling, sometimes in combination.

Psychotherapy may be brief and goal-oriented or last a long time, and it may be administered individually or to groups. Methods used with children and adolescents often differ from those for adults.

There is also a variety of care providers. In some cases, services are provided by:

- psychologists
- psychiatric nurses
- licensed clinical social workers (LCSWs)
- marriage, family, and child counselors (MFCCs)

In other cases, care is provided by psychiatrists, who can prescribe medications as well as conduct psychotherapy and counseling.

Crisis Intervention

One of the key elements of behavioral healthcare is **crisis intervention**—the intensive treatment of acute episodes of a mental disorder.

The purpose is to keep the patient safe and to stabilize his condition so that he can begin psychotherapy or other treatment. Appropriate treatment in the acute phase of a behavioral health disorder helps reduce the likelihood of recurrent acute episodes.

Directing Patients to Appropriate Care

Assessing members' behavioral healthcare needs and providing quality services to meet those needs are important aspects of managed behavioral care.

Directing members to the most appropriate services in order to manage costs and utilization is also important.

Gatekeeper or Referral Process

In many health plans and MBHOs, members can access behavioral healthcare services directly, but in others, they must go through a gatekeeper or referral process.

Three common approaches are:

- primary care providers (PCPs)
- centralized referral systems
- employee assistance programs

PCPs as Gatekeepers

In the past some plans required members to access behavioral healthcare services through a primary care provider.

The PCP assessed a member's needs, gave the member a referral to a behavioral healthcare specialist, and sometimes authorized payment for services. But this has become much less common.

Although incorporating behavioral healthcare into primary care promotes coordination and continuity of care and supports utilization management, PCPs often lack the knowledge and experience needed to diagnose behavioral problems and determine whether services are needed and if so what kind.

Centralized Referral Systems

Some health plans and MBHOs have a centralized behavioral healthcare referral system. Members call and talk to a mental health/substance abuse case manager, who conducts an initial assessment and refers the member to the appropriate provider for treatment or a more detailed evaluation.

Today, such systems are much more common than PCP gatekeepers, as they offer quicker access to care and often a more accurate diagnosis, more effective treatment, and more efficient use of resources (although they may decrease coordination and continuity of care).

Employee Assistance Programs

Established by employers or MBHOs, another way people can be directed to appropriate behavioral healthcare services is through **employee assistance programs (EAPs)**.

EAPs are frequently the first point of contact for employees and family members in need of information or assistance regarding behavioral problems. EAP professionals generally encounter behavioral problems early and can direct plan members to providers and services before a problem turns into a crisis.

But unlike PCPs or case managers, EAP professionals may not have the background necessary to diagnose behavioral disorders and may lack experience with managed behavioral health programs.

Other Strategies

MBHOs and health plans manage quality and cost in other ways as well.

- They develop clinical practice guidelines—recommendations for providers on the best treatment approaches—which improve patient outcomes and reduce the use of inappropriate services.

- They direct members to effective outpatient services instead of unnecessary and more costly inpatient care.

- They negotiate with providers for reduced fees and greater acceptance of practice guidelines in exchange for increased patient volume.

- More recently, they have focused on the development of alternative treatment options, the incorporation of community-based resources into the healthcare system, case management, and the better integration of behavioral care and primary care.

The Trend in Recent Years

In recent years, there has been an increased focus on long-term outcomes.

For instance, it has been found that in some cases higher-cost drugs result in lower overall costs because of fewer office visits and hospitalizations and greater patient acceptance and compliance.

Example: In some cases (especially in substance abuse) increasing coverage for follow-up treatment can reduce relapses, resulting in lower long-term costs.

Mental Health Parity

An important issue in behavioral healthcare is **mental health parity**—equivalent coverage of behavioral healthcare and medical care.

As we have seen, to limit their liability in the face of rapidly rising costs, some health plans provided more limited benefits for behavioral care than for medical care, and many mental health advocates contended that this was unfair.

In response, Congress enacted the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to apply to group health plans and group health insurance coverage. MHPAEA was amended in 2010 by the Affordable Care Act (ACA) to also apply to individual health insurance coverage.

MHPA and MHPAEA

Neither MHPA nor MHPAEA requires health plans to cover behavioral healthcare, but if a group plan with more than 50 members does cover it, the plan must comply with certain parity rules.

MHPA requires that lifetime and annual dollar caps on benefits for behavioral care not be lower than for medical care. MHPAEA continues this requirement and adds the following:[xxi]

- Cost-sharing and out-of-pocket limits for behavioral care cannot be greater than for medical care.
- Limitations on behavioral coverage (such as on the number of visits or the frequency or duration of treatment) can be no more restrictive than for medical care. Nonquantitative limitations, such as medical management and preauthorization, also cannot be more restrictive.
- If a health plan pays benefits for out-of-network medical care it must do so for behavioral care as well.
- MHPAEA extends these rules (including those of MHPA on lifetime and annual caps) to substance abuse treatment (which was not covered by MHPA).

MHPA and MHPAEA (Continued)

It should be emphasized that MHPA and MHPAEA do *not* require a health plan to provide behavioral healthcare benefits, but if a plan does so it must comply with the previously stated rules.

Both laws do not apply to group plans with 50 or fewer members. They do apply both to insurers and to employers with self-insured (self-funded) plans (with some exemptions). It should be noted that some states have mental health parity laws that go beyond this federal legislation.

Progress for Mental Health Parity

MHPA and MHPAEA laid the foundation for additional progress for mental health parity. The ACA moves the parity needle further. It mandates coverage at parity for mental health and substance use disorders as one of the ten essential health benefits. In addition, the ACA helped to expand such coverage through its Medicaid provisions.[xxii] [xxiii] [xxiv]

Pharmacy Benefit Plans

Pharmacy Benefit Plans

Prescription drugs account for a substantial portion of all U.S. healthcare spending—in 2019 prescription drug spending amounted to over $369 billion dollars representing 10 percent of all healthcare expenditures.[xxv]

Drug costs have generally risen at an even faster rate than overall medical costs.[xxvi]This rise has prompted employers and health plans to focus on managing the costs and utilization of pharmaceuticals.[xxvii]

But drugs also play a role in the quality of healthcare. For example, a significant portion of hospital admissions of people 65 and older result from the inappropriate use of prescription drugs. This often occurs because several healthcare providers are treating the same patient and prescribing drugs for her without knowledge of her other prescriptions, leading to harmful drug interactions. This problem can be addressed by tracking and coordinating members' drug use.

The Pharmacy Benefit Management (PBM) Plan

In response to rising costs and quality of care issues, pharmacy benefit management plans emerged. A **pharmacy benefit management (PBM)** plan (also known as a prescription benefit management plan) is a specialty health plan designed to contain the costs of prescription drugs while promoting more efficient and safer use of them.

The great majority of health plans contract with PBMs. PBMs use various managed care cost-control techniques, and they promote quality in a number of ways.

For instance, a PBM may screen for drug interactions, using integrated data systems that provide a link among the provider, the health plan, and the pharmacy network. A PBM may promote quality in prescribing among providers through utilization management methods, feedback or consulting and reporting.

Clinical Services Offered by PBMs

Pharmacy benefit management plans typically interact with physicians and pharmacists in performing four types of clinical services:

- physician profiling
- drug utilization review
- formulary management

- prior authorization

These services are not unique to PBMs; they may also be performed by health plans, hospitals, retail pharmacies, or other specialty organizations.

Physician Profiling

Physician profiling consists of compiling data on physicians' prescribing patterns and comparing the actual prescribing patterns of individual doctors for select drug categories to those of most doctors.

Peer comparison is typically based on medical specialty and region. The PBM then seeks to educate doctors whose patterns differ from the norm, reviewing with them the appropriateness and cost of their prescribing patterns through reports, educational mailings, telephone calls, and face-to-face visits.

Drug Utilization Review

Drug utilization review (DUR) is a program that evaluates whether drugs are being used safely, effectively, and appropriately.

DUR is an important component of quality management programs because it promotes patient safety by identifying potential and actual problems related to the ordering, dispensing, administration, and use of drugs.

Drug utilization review programs identify problems with:

- inappropriate dosage
- overuse identified from early refills
- underuse identified through late refills
- the length of time a medication is taken
- duplication
- side effects
- drug interactions

Patient-specific DUR

PBMs monitor an individual patient's drug problems through prospective (before drug therapy), concurrent (during drug therapy), or retrospective (after dispensing or post-drug therapy) review. Patient-specific DUR is typically used to identify the following potential problems:

- drug-disease conflicts,
- drug-drug interactions,
- chronic overutilization,
- underutilization (noncompliance),
- drug-gender and drug-age conflicts, and

- drug-pregnancy contraindications.

Computerized systems at the point of dispensing play an important role in reducing the incidence of these problems. Following up with physician and patient education programs is an integral component of DUR.

Formulary Management

A **formulary** is a listing of drugs, classified by therapeutic category or disease class, that are considered preferred therapy for a given managed population and that are to be used by a health plan's providers in prescribing medications. The formulary is usually developed by an independent panel comprised of physicians, pharmacists, and other clinical experts.

Closed and Open Formulary

Formularies can be either closed or open. In a **closed formulary,** only those drugs on the preferred list are covered by the health plan. In an **open formulary,** drugs not on the preferred list are covered, but the plan member usually pays more in cost-sharing for them.

Copayment Structures

Copayment amounts are often based in part on formularies. Two common approaches are two-tier and three-tier copayment structures.

A two-tier structure requires that a member pay one copayment amount for a generic drug and a higher copayment amount for a brand-name drug.

A three-tier structure requires a member to pay one copayment amount for a generic drug, a higher amount for a brand-name drug included on the health plan's formulary, and an even higher amount for a nonformulary drug. With the advent of high-cost specialty drugs, a formulary may have a four or five-tier structure adding formulary and non-formulary levels for specialty drugs.[xxviii]

Rebate

Formularies are often a key program that a PBM or health plan uses to negotiate for rebates from drug manufacturers. A **rebate** is a reduction in the price of a particular pharmaceutical obtained from the manufacturer.

Most PBMs enter into discount rebate agreements with pharmaceutical manufacturers, under which the PBM receives a rebate on the price of a drug and in exchange the manufacturer has fewer restrictions on getting its drug into the PBM's formulary than companies without such an agreement.

However, the PBM's formulary panel must be careful to ensure the quality of the pharmaceuticals that it endorses by including in the formulary the safest, most medically effective, and cost-effective drugs. Rebates are then shared with a PBM's clients (although there has been controversy about the extent to which they are shared).[xxix xxx]

Generic and Therapeutic Substitution

Most PBMs use their formulary to perform generic and therapeutic substitution. **Generic substitution** is the dispensing of a generic equivalent; **therapeutic substitution** is the dispensing of a different chemical entity within the same drug class.

Generic substitution can be performed without physician approval in most cases, but therapeutic substitution always requires physician approval. Many PBMs use benefit design (such as copayment differentials) to encourage both therapeutic and generic substitution.

Prior Authorization

Prior authorization, sometimes known as a medical necessity review, is a program that requires physicians to obtain verification of medical necessity before a drug is dispensed. Many PBMs have established protocols for physicians to receive prior authorization over the telephone, using a semi-automated system.

In some of these programs, the physician is prompted through a series of interactive menus requesting clinical and patient information. At the end of the telephone menus, the physician is either given a prior authorization number or connected to a pharmacist, who asks further questions. PBMs may also allow physicians to submit requests via an online physician portal.

Other Services Offered by PBMs

Other Services Offered by PBMs

PBMs also offer a number of services to members, providers, and health plans that can control costs and improve convenience.

Mail-Order Pharmacies

In a **mail-order pharmacy program** drugs are ordered and delivered through the mail to members at a reduced cost. The primary focus of such mail-order services is for individuals needing repeated medications for chronic conditions.

Some PBMs operate their own mail-order pharmacy services, while others contract with outside vendors. PBMs that operate their own program generally negotiate a high-volume purchase contract with each drug manufacturer and pass the cost savings on to their clients. PBMs that contract this operation out usually negotiate a discounted rate with the vendor based on the size of the pharmacy network.

This discounted rate is applied to all drugs that are covered under the PBM's mail-order contract with the vendor.

Pharmaceutical Card Services

PBMs may also use **pharmaceutical card services** to facilitate the processing and tracking of pharmaceutical claims. Pharmaceutical cards, also known as drug cards or prescription cards, are identification cards issued by the PBM to plan members.

Use of Pharmaceutical Cards

A member must present her card to a participating pharmacist to receive PBM benefits. The card identifies the plan a person belongs to and other information the pharmacist needs, such as the copayment amount. Some PBMs do not issue separate pharmaceutical cards but use the health plan member identification card as a pharmaceutical card.

Pharmaceutical Card Program

A pharmaceutical card program allows a PBM to process a claim electronically when a prescription is filled by a pharmacist. It also enables the PBM to transmit information to the pharmacist about ingredient duplicates, therapeutic duplicates, severe drug interactions, early refills, age precautions, benefit restrictions, etc.

PBM Contractual Arrangements

PBM Contractual Arrangements

PBMs typically operate under one of three contractual arrangements: fee-for-service, risk sharing, and capitation.

Fee-for-Service

Under fee-for-service arrangements, the PBM creates a retail pharmacy network that offers discounts on prescription drugs and can perform online claims processing.

For each prescription filled for members of a health plan, the plan pays the PBM a claims administration fee while the plan pays for the drugs. The health plan generally saves money compared to unmanaged drug benefits because of quantity discounts and rebates.

Risk Sharing

A risk-sharing contract may be used when an employer contracts with a PBM to manage pharmacy benefits. The PBM and the employer agree on a target cost per employee per month. If the actual cost per employee per month is greater than the target, the PBM pays part of the cost overrun, and if the actual cost is less than the target, the PBM shares in the savings.

The PBM bases the target cost per employee per month on a combination of factors: price discounts (a percent reduction in the average wholesale price), rebates for formulary products, and savings from clinical services. The target cost per employee per month may be disease-specific or related to therapeutic drug class.

Capitation

Under a capitation contract, a PBM agrees to provide all pharmaceutical services in exchange for a fixed dollar amount per employee per month. Capitation contracts are increasing in popularity, but not quickly. One reason for this slow growth may be that PBMs have not yet determined how to accurately project or account for future pharmaceutical expenditures.

Many employers are hesitant to put in place strong utilization control measures (such as prior authorization and closed formularies), particularly when they may affect a negotiated benefit of a trade union.

Health Plan Ownership of PBMs

In recent years, there has been a trend for health plans to merge with, purchase, and/or develop their own PBMs. One reason for this is the belief that this creates synergies that can effectively offer health plan members better care while lowering costs.

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9 Account-Based Plans: Part I

Introduction to Account-Based Plans

Account-based plans include earmarked funds individuals can use to pay for certain health care expenses for themselves and their covered dependents.

These plans include:

- Flexible spending accounts (FSAs),
- Health savings accounts (HSAs), and
- Health reimbursement accounts (HRAs).

In this module, we will explore flexible spending accounts (FSAs) and health savings accounts (HSAs). In our next module, we will explore various types of health reimbursement accounts (HRAs), sometimes referred to as health reimbursement arrangements.

Learning Objectives

After completing this module, you should be able to:

- Describe flexible spending accounts (FSAs),
- List at least two tax benefits offered by FSAs,
- Explain how health savings accounts interact with high-deductible health plans,
- List three tax benefits offered by HSAs, and
- Give the reasons for the emergence of consumer-directed health plans (CDHP) and discuss the arguments for and against them.

FSAs: An Overview

Flexible spending accounts have their genesis in the 1970s with the introduction and sanctioning of cafeteria plans by the Internal Revenue Service under Section 125. This section permits employers to establish plans allowing employees to set-aside dollars for future health care costs on a tax-favorable basis.[i]

FSA Mechanics

An employer sponsors a flexible spending account plan and employees choose whether to participate.

Employees contribute funds through payroll deduction to fund their accounts. In some cases, employers contribute to their employees' accounts. Money contributed by either employer or employee is not counted as taxable income for the employee.

Employees can use funds from their health care FSAs to pay uninsured health care expenses such as copays, deductibles, and out-of-pocket costs for prescription drugs. On the other hand, costs incurred for face lifts, hair transplants and other types of cosmetic surgery to simply improve looks are not reimbursable. As a general rule, the Internal Revenue Service (IRS) determines which expenses can be reimbursed by an FSA. [ii] However, Congress through the Cares Act of March 2020, expanded the list of eligible expenses for FSAs by removing the need for prescriptions for many over-the-counter drugs such

as allergy and sinus medications. As well as adding feminine hygiene products.[iii] We will take a closer look at this expanded list when we discuss HSAs later in this module.

Examples of eligible and ineligible expenses:

Eligible	I**neligible**
Dental expenses: exams, cleanings, x-rays, braces	Teeth bleaching or whitening
Vision expenses: prescription eyeglasses, contact lens, eye examinations	Sunglasses (over the counter)
Professional services: physical therapy, occupational therapy	Concierge medical fees (billed for future services – no service rendered)
Weight loss surgery	Weight loss foods
Vitamins-prenatal	Vitamins for general health
Personal protective equipment: masks, and hand sanitizer for the primary purpose of preventing the spread of COVID-19	Surface wipes (less than 60% alcohol base)

Thus far, we have described healthcare FSAs. There are also dependent care FSAs, used mostly to pay for childcare expenses which we will discuss briefly later in this module.

<u>Types of Healthcare FSAs</u>

There are **general-purpose FSAs**, from which participants can draw funds to cover a wide range of health care expenses, including dental and vision care as well as unreimbursed costs for prescription drugs.

There are also **limited-purpose FSAs (LP-FSAs)** which can be used only for dental and vision care.

In this section, we will focus on general-purpose FSAs; later in this module we will discuss LP-FSAs, after we learn about HSAs,

<u>Funding the FSA</u>

Before the start of the plan year, employees specify the total amount they want deducted from their wages for the plan year and contributed to their FSA. The total amount is then divided by the number of pay periods within the year. Equal amounts are then withheld from each paycheck throughout the year. A key benefit from the employee viewpoint is that the full annual amount elected is available to them from the start of the plan year.

Example: Lindsay chooses to contribute $1,200 annually to her FSA, she is paid on a semi-monthly basis (24 paychecks per year) and the plan year is a calendar year – January through December. Since there are 24 pay periods, $50 is deducted each paycheck. At the very beginning of the year, Lindsey incurs $500 in medical expenses. Even though she has contributed only $50 to her FSA, Lindsey is reimbursed $500. This is referred to as the uniform coverage rule.[iv]

Funding Cap

The Affordable Care Act (ACA) limited the amount that individuals may contribute to FSAs to $2,500 indexed for inflation. In 2021 this amount had gradually increased to $2,750.

Year	2019	2020	2021	2022
Amount	$2,700	$2,750	$2,750	$2,850 [v]

If an individual is married, his or her spouse can also put up to the annual maximum amount into an FSA sponsored by their employer.

Example: Lindsey and Dale are married and both work for organizations sponsoring FSAs. In 2021, both could contribute $2,750 into their own FSAs.

FSA Tax Benefits for Employees

An employee contributes to an FSA by means of pretax salary reductions. In other words, the amount is not subject to federal income tax, nor is it subject to Social Security or Medicare taxes. This reduces the employee's tax liability and results in an increased take-home paycheck.

More information on Social Security and Medicare employment taxes:

Employers and employees both pay into the Social Security and Medicare programs at a combined rate of 7.65%. The Social Security portion (OASDI) is 6.20% on earning up to a taxable maximum amount determined each year. The Medicare portion (HI) is 1.45% on all earnings.

Tax Rate	2020	2021
Employee	7.65%	7.65%
Employer	7.65%	7.65%
Self-Employed	15.30%	15.30%

Also, as of January 2013, as part of Affordable Care Act financing, individuals with earned income of more than $200,000 ($250,000 for married couples filing jointly) pay an additional 0.9 percent in Medicare taxes. [vi]

Example: Julius earns $80,000 a year. If he contributes $2,500 to a general-purpose healthcare FSA, his taxable income will be reduced to $77,500. Assuming a tax rate of 20 percent, he will pay $500 less in federal income taxes. He will also pay $191 less in Social Security and Medicare employment taxes as follows:

Description	**Without FSA**	**With FSA**	**Savings**
Salary	$80,000	$80,000	
FSA Contribution	-0-	(2,5000)	
Taxable Income	$80,000	$77,500	
Federal Tax	$16,000	$15,500	$500
Employment Taxes	$6,120	$5,929	$191
Total Savings			$691

Healthcare and Dependent Care FSAs: Added Savings

When an employee opts to participate in both a healthcare FSA and dependent care FSA further tax savings are realized. Taking our example above, assume Julius contributes $5,000 for dependent care into an FSA, additional savings are realized as follows:

Description	**Without FSA**	**With FSA**	**Savings**
Salary	$80,000	$80,000	
Healthcare FSA	-0-	(2,5000)	
Dependent Care FSA	-0-	(5,000)	
Taxable Income	$80,000	$72,500	
Federal Tax	$16,000	$14,500	$1,500
Employment Taxes	$6,120	$5,546	$ 574
Total Savings			$2,074

FSA Tax Benefits for Employers

For employers who choose to contribute to FSAs on behalf of their employees, those contributions are tax deductible. As an added benefit for employees, those contributions are not taxable.

As we have previously mentioned, many employers choose not to contribute to employee FSAs. These employers still enjoy tax benefits. The dollars on which they pay Social Security and Medicare employment taxes are reduced.

Example: ABC Company has several workers each earning $80,000 and each contribute $2,500 to their healthcare FSAs. ABC realizes savings as follows:

Description	**Without FSA**	**With FSA**	**Savings**
Salaries	$240,000	$240,000	
FSA Contribution	-0-	(7,5000)	
Employment Wages	$240,000	$232,500	
Employment Taxes	$18,360	$17,786	$574

FSA Drawbacks

While many employers offer FSAs, a substantial number of employees choose not to participate for a variety of reasons. These reasons include:

- the “use it or lose it” rule, and
- lack of FSA portability.

Other reasons include the relative attractiveness of other tax-favored vehicles such as health savings accounts (HSAs) to some workers.

"Use It or Lose It" Rule

As a general rule balances in any FSA may not be rolled over from year to year. If an employee does not have many uninsured health care expenses any remaining dollars are forfeited.

Example: Marie elects to contribute $2,000 to an FSA at the beginning of the plan year. Marie and her covered dependents turn out to have fewer than expected medial needs during the plan year. At the end of the plan year $400 remains in Marie's FSA. This amount is forfeited unless her employer has opted one of the two alternative mitigation strategies discussed below.

Mitigation Strategies: Overview

Employers can include one of two mitigation strategies to the "use it or lose it" rule in their FSA plan document(s). These strategies are:

- adoption of a grace period, or
- a limited carryover allowance of unused funds. [vii]

Grace Period

An employer may design an FSA to allow funds for one year to be used for expenses incurred in the first two-and-a-half months of the following year.

Example: Millicent participates in an FSA sponsored by her employer, ABC Corporation. In Year 1, she contributes $2,000 to the FSA. Millicent however spends only $1,700 by December 31 – the end of the plan year. Under the design of ABC's plan, she has until March 15 of Year 2 to spend the remaining $300.

Carryover of Unused Funds

An FSA plan may allow for a carryover of unused funds of up to $570 (as of 2022) from one year to the next. The rollover does not affect the maximum allowed contribution for the following year.

Example: Juan participates in XYZ's FSA. In Year 1, he contributes $1,500 to the FSA but spends only $1,000 by December 31. The remaining $500 can be rolled over into Year 2. In addition, should he choose, Juan can contribute the maximum allowable amount to his FSA in Year 2.

These mitigation strategies are alternatives. An employer's FSA plan cannot offer both. In other words, the employer must choose either to offer a grace period or allow for a carryover of funds.

Lack of FSA Portability

Employees who change jobs or retire cannot take FSAs with them, and employers are not allowed to pay unused FSA balances to employees when they leave.

There is an exception for employees continuing their health coverage under COBRA. These employees can still access funds from their FSAs.

Brief explanation of COBRA:

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives many workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102% of the cost to the plan. [viii]

FSA Drawback(s) to Employers

Employers also face some financial risks in establishing healthcare FSAs. Situations can arise where an employee experiences heavy medical expenses at the beginning of a plan year, draws down FSA funds to cover those expenses, and subsequently leaves the firm. In these situations, the employer is out-of-pocket the difference between the amount advanced early in the year and the amount which the employee has not yet contributed to his or her FSA at the time of leaving employment.

One Final Caution: Medicare Benefit Reduction

There is one final caution to employees who participate in salary reduction account-based programs, such as FSAs. Social Security benefits at retirement are based on an employee's earning history. Contributions which reduce an employee's salary can result in lower Social Security benefits at time of retirement. Most commentators however believe that the immediate tax savings offered by account-based programs overweigh the potential for lower retirement benefits in the future.

Health Savings Accounts

Health Savings Accounts (HSAs): Introduction

Health savings accounts (HSAs) have similarities to FSAs.

- An individual can contribute to an HSA through a cafeteria plan, and the money is not considered taxable income to the individual. (Alternatively, as we will discuss later, an individual can contribute directly to an HSA and deduct those dollars from their income).
- Money can be withdrawn to cover uninsured health care expenses on a tax-favored basis.
- And, as we will also discuss later, employers can also contribute to HSAs on behalf of their employees.

Advantages of HSAs to Individuals

An HSA offers individuals some advantages compared to an FSA:

- An HSA can be set-up by an individual without employer involvement.
- An HSA is fully portable. Even if an HSA is sponsored by an employer, the employee can take it with them if they leave.
- Unused HSA funds can be carried over from year to year and unlike FSAs there is no government mandated rollover cap.

- The investments earnings on assets in an HSA are not taxed allowing funds to compound in value.
- Money from an HSA can be used for non-health care related expenses. Here it is important to note that only withdrawals for health care related expenses are tax free.

Who Is Eligible to Participate?

To participate in an HSA, an individual must:

- Be covered by a qualified high-deductible health plan **(HDHP).**
- Not have broad health coverage that is not an HDHP. Some limited coverages are permitted (to be discussed shortly).
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return. [ix]

What limited coverages are permissible with an HSA:

Products that offer limited benefits such as accident insurance, dental or vision benefits, workers' compensation, disability income insurance, or long-term care insurance are permitted.

What qualifies as a HDHP?

A qualified HDHP must have:

- An annual deductible of a set minimum for both self-only and family coverage that is adjusted annually by the Internal Revenue Service (IRS).
- An annual limit on out-of-pocket expenses (deductibles, coinsurance, and copayments) for self-only and family coverage that is also adjusted annually by the IRS.

These amounts for 2020, 2021, and 2022 are listed below:

Minimum and Maximum HDHP Amounts

Year	**2020**	**2021**	**2022**
Self-Only Minimum Deductible	$1,400	$1,400	$1,400
Self-Only Maximum Out-of-Pocket	$6,900	$7,000	$7,050
Family Minimum Deductible	$2,800	$2,800	$2,800
Family Maximum Out-of-Pocket	$13,800	$14,000	$14,100

Application of the HDHP Deductible

The HDHP deductible and out-of-pocket limits must apply to all benefits covered by the plan, including prescription drugs with two exceptions:

1. A qualified HDHP may cover preventive care without a deductible or with a lower deductible. Preventive care includes a broad range of services: immunizations, screenings, periodic diagnostic tests, programs to lose weight and to quit smoking, routine prenatal and well-

childcare, as well as others. Also included are medications to prevent a disease from developing or recurring (such as cholesterol-lowering drugs).

2. If an HDHP has a provider network, the deductible and out-of-pocket limit do not apply to services provided outside the network.

HSA Contributions

Tax-favored contributions may be made to an HSA by an employee, an employer, a self-employed individual, or a family member on behalf of an eligible individual.

There are annual contribution limits for self-only and family coverages. Individuals aged 55 or older can make additional "catch-up" contributions of up to $1,000 per year.

Maximum Contribution Levels [x]

Year	2020	2021	2022
Self-Only	$3,550	$3,600	$3,650
Family	$7,100	$7,200	$7,300
Catch-Up	$1,000	$1,000	$1,000

HSA Contribution Deadline

The deadline for making contributions to an HSA is the Federal income tax filing date. This date normally falls on April 15th. This deadline was extended for 2020 1040 tax returns to May 17, 2021, due to the COVID-19 pandemic.[xi] While the deadline for making HSA contributions is expected to resume to normal 1040 filing and contribution deadlines, a precedent has been set in the event of future pandemic and similar disruptive events.

HSA Distributions

Individuals can withdraw HSA funds tax free to pay for qualified medical expenses. As you may recall, these are defined by the IRS to include doctor office visits, hospital care, dental care, vision care, prescription drug costs, and many other health care services and products.[xii]

As you may recall, for many years following the passage of the Affordable Care Act (ACA), over the counter (OTC) medications did not qualify unless prescribed by a doctor. This is no longer the case due to 2020 passage of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. [xiii]

List of some of the OTC products made eligible by the CARES Act.

Cold and flu medications	Allergy and sinus medications
Tampons, pads, and liners	Acid controllers
Pain relief and anti-inflammatory medications	Acne medications
Digestive aids and laxatives	Baby rash ointments

Triple Tax Benefits Offered by HSAs

Let us take a moment to recap the triple tax benefits offered by HSAs to participants:

- Tax deductible contributions,
- Tax-free growth of earnings within the HSA, and
- Tax-free withdrawals for medical expenses. [xiv]

Example: Mel establishes an HSA. In Year 1, Mel contributes $2,000 to his HSA. These dollars are tax deductible. Mel continues to contribute $2,000 annually to her HSA for an additional 4 years. At that point, Mel has contributed a total of $10,000 which she has allowed to grow within the HSA. Earnings on these funds have not been taxed and have further contributed to the growth of the HSA. In Year 6, Mel suffers from some health setbacks and withdraws funds to meet medical expenses. These funds are withdrawn tax free.

HSAs & Premiums

In general, individuals cannot use HSA funds to pay for health insurance premiums on a tax-free basis. However, they may use them on a tax-favored basis for:

- COBRA contribution coverage
- Tax-qualified long-term care insurance
- Medicare premiums for Parts A, B, C (Medicare Advantage), and Part D.
- Health coverage while receiving unemployment compensation.

Non-Health Care Expenses

Unlike an FSA, an individual may withdraw money from an HSA for items other than qualified medical expenses or allowed premiums.

However, such withdrawals are subject to federal income tax plus a 20 percent excise

tax.There are exceptions to the imposition of the excise penalty:

- If the individual is 65 or older, or
- if the withdrawal is made after the death or disability of the individual.

In these situations, regular income tax applies to the withdrawn funds but not the excise tax penalty. [xv]

Health Savings Accounts Additional Planning Considerations for Individuals

Planning Considerations

In this section we look at two addition planning opportunities offered to individuals by HSAs:

- HSAs combined with Limited-Purpose FSAs (LPFSA).
- HSA last-month contribution rules.

HSAs and Limited-Purpose FSAs

A person with an HSA cannot participate in a general-purpose FSA. They can however have a limited-purpose FSA (LP-FSA). As we have discussed previously, a LP-FSA works like a regular FSA but can only be used for dental and vision care.

Why Use an LP-FSA and HSA?

HSA funds can be used to cover dental and vision costs, so why would someone with an HSA choose to also participate in a separate LP-FSA? Here are three reasons:

1. An individual may want to further reduce their taxable income by contributing to an LP-FSA in addition to an HSA.
2. An individual may anticipate high medical costs that will deplete their HSA balance.
3. An individual may prefer to let their HSA funds accumulate tax free for future healthcare costs during work or after retirement.

Example: Diedre is enrolled in an HDHP and HSA at her place of employment. Her plan does not offer dental or vision coverage. Her employer does offer an LP-FSA in which she participates. Diedre can use funds set-aside in her LP-FSA to cover her dental and vision expenses rather than drawing funds from her HSA.

HSA Last-Month Rule

There are individuals who do not participate in an HSA for a full plan year, perhaps because they were hired mid-year. This can result in a reduction of that amount that they can contribute. One tool to mitigate this result is the so-called last-month rule.

Under the last-month rule, if a person is an eligible individual on the first day of the last month of their tax year (December 1 for most taxpayers), they are considered an eligible individual for the entire year. This allows them to contribute the full allowable amount for either self-only or family coverage to their HSA.[xvi]

Testing Period for Last-Month Rule

If contributions were made to an individual's HSA based on the last-month rule, they must remain an eligible individual during a testing period for the next twelve months.

In other words, if an individual becomes eligible under an HDHP by December 1, 2020, they must remain covered by the HDHP until December 31, 2021 – the last day of the 12th month. If an individual changes or loses HDHP coverage before then, and is no longer eligible to participate in an HSA, additional taxes and penalties are due. The penalty does not apply in cases of death or becoming disabled.

Failing the Testing Period: Income Tax + Penalty

Once again, if an individual fails to remain an eligible individual for an HSA during the testing period, for reasons other than death or becoming disabled, they must include in income the total contributions made to their HSA that would not have been made except for the last-month rule. This amount is also subject to an additional 10 percent tax. These amounts are calculated using IRS form 8889 and its worksheet instructions.

Example:

Rodney, a middle-aged man, becomes an eligible individual for an HSA just prior to December 1, 2020. He has family HDHP coverage on that date. Under the last-month rule Rodney contributes the $7,100 (the maximum contribution allowed in 2020 for those with family coverage).

Rodney fails to be an eligible individual in June 2021. Thus, he fails the testing period and must include in his 2021 income the contributions made in 2020 that would not have been made except for the last-month rule.

January	-0-	
February	-0-	
March	-0-	
April	-0-	
May	-0-	
June	-0-	
July	-0-	
August	-0-	
September	-0-	
October	-0-	
November	-0-	
December	$7,100	
Total for all months	$7,100	
Limitation divide total by 12		$591.67

Rodney must include $6, 508.33 ($7,100 – $591.67) of gross income on his 2021 income tax return. In addition, a 20 percent penalty tax applies to the $6,508.33.

Employer Contributions

Employer Contributions: Overview

Thus far, we have discussed HSAs from the viewpoint of individuals and employees. In this section we will examine HSAs from the viewpoint of employers.

Many employers make contributions on behalf of employees to their HSAs. These contributions are deducted by an employer on their business income tax return for the year in which the contributions are made. If the contribution is allocated to the prior year of an employee's HSA, the employer still deducts it in the year in which the contribution is made.

And it should be noted that an employee is not taxed on these dollars but also cannot deduct those dollars on their individual income tax return.

Employer Contributions Pre-Tax

If employers allow employees to make pre-tax payroll deductions, both employer and employee contributions are made through a *cafeteria plan* (sometimes referred to as a Section 125 plan). In these situations, employers must draft a cafeteria plan document that covers the HSA program.

Nondiscrimination Testing

Cafeteria plans are subject to *nondiscrimination testing*. to ensure that a plan does not disproportionately favor highly compensated employees. In the case of HSAs, employer contributions and employee pre-tax payroll deductions are lumped together for purposes of this testing.

If a plan is found to be discriminatory, one solution is to have highly-compensation employees reduce their pre-tax contributions and opt instead to make contributions directly to their HSAs and then deduct the non-pre-tax contributions from their taxable income

(*A full discussion of non-discrimination testing is beyond the scope of this module).*

Comparable Contribution Requirement

Some employers prefer not to set-up cafeteria plans that cover HSAs and make contributions directly to employee HSAs. Employers who decide on this route to make HSA contributions must make *comparable contributions* to all comparable participating employees' HSAs. Employer contributions are comparable if they are either:

- The same amount, or
- the same percentage of the annual deductible limit under the HSHP covering the employees,

Comparable participating employees:

- Are covered by the employer's HDHP and are eligible to establish an HSA,
- Have the same category of coverage (either self-only or family coverage), and
- Have the same category of employment (part-time, full-time, and former status).

Employer Contribution Risks

Employees are immediately vested in employer contributions to their HSAs. This creates the risk that some employees will terminate their employment and leave with recently deposited funds by their employer. This presents the most risk if the entire employer contribution occurs in one upfront lump-sum deposit.

Such a scenario defeats at least in part, employer objectives in seeking to maintain a healthy and stable workforce. Ways suggested to mitigate this outcome include:

- Flat contributions per payroll period over the entire year,
- A partial upfront lump-sum at the beginning of the year followed by flat contributions per payroll period, and
- Periodic lump-sum deposits split into semi-annual or quarterly amounts.

The Rise of Consumer Directed Plans – HDHP and HSAs

Historical Background

In the 1990s many consumers became disenchanted with the limited choices and access they had under traditional managed care plans. In response, insurers offered less restrictive plan models such as preferred providers organizations (PPOs) and point-of-service (POS).

These newer plans came with a major drawback, such plans had less control over enrollee utilization and spending. As a result, health care utilization and spending increased, and so did health insurance premiums.[xvii]

Employers and others then began looking for an approach that would allow insureds more choice than traditional managed care plans but would also give them incentives to hold down their health care spending. And consumers and employers alike wanted more affordable premiums.

The Consumer-Directed Health Plan Solution

To meet this need, for lower premiums what was then termed the consumer-directed health plan (CDHP) model was developed. The CDHP model consists of two components which we have previously seen and discussed:

- A high deductible health plan (HDHP), which does not pay for the first few thousand dollars of healthcare expenses (the deductible) but usually covers most if not all costs above this amount.
- A tax-advantaged personal healthcare account, which can be used to pay for healthcare expenses before the deductible is met - HSAs

Creation and Growth of HSAs

Health savings accounts (HSAs) were authorized in 2003 and designed to allow substantial consumer direction and discretion as to the use of funds for healthcare purposes. Since their legislative establishment, HSAs have enjoyed substantial growth.[xviii]

In 2005, there were 1,031,000 million people enrolled in HSA-HDHPs. By 2017, there were an estimated 21,824,627 enrolled in HSA-HDHPs.[xix]

And recent research has shown that HSA assets reached over $92 billion dollars through the first half of 2021. [xx]

Criticism of Consumer Directed Model Regarding Health Equity

As we have seen, HSAs allow for immediate use of funds to meet healthcare outlays, provisions which allow balances to rollover from year to year, individual ownership, and portability. They also allow for tax-free growth of funds within the account. For those with sufficient resources to fund them and allow funds to grow, HSAs offer substantial benefits and consumer discretion for the use of those funds.

For participants in HDHP plans however, without sufficient assets to contribute to HSA account questions regarding health equity, individuals often struggle to meet the economic hurdles faced by high deductibles in accessing healthcare. Cost-related access barriers have been found to exist not only in areas of medication and treatment for breast cancer, diabetes, lung disease but also in medication adherence needed to treat chronic disease. [xxi]

In recent years there have been Congressional initiatives to expand the use of HSAs by removing the need to be enrolled in a high-deductible heath plan (HDHP) as well as allowing the funds to be used to pay health insurance premiums. Such legislation would help to promote health equity however, whether these initiatives are eventually enacted remains an open question. [xxii]

Slide - Initiatives to Loosen CDHP Rules

In recent years there have been Congressional initiatives to expand the use of HSAs by removing the need to be enrolled in a high-deductible heath plan (HDHP) as well as allowing the funds to be used to pay health insurance premiums. Such legislation would help to promote health equity however, whether these initiatives are eventually enacted remains an open question. [i]

Notes:

[i] Healthcare.gov, "Using a Flexible Spending Account," Fact Sheet, available at https://www.healthcare.gov/have-job-based-coverage/flexible-spending-accounts/; See also, 26 US Code Section 125 – Cafeteria Plans, available at https://www.law.cornell.edu/uscode/text/26/125

[ii] 26 US Code Section 213 – Medical, dental, etc., expenses, available at https://www.law.cornell.edu/uscode/text/26/213; See also, Internal Revenue Service Publication 502, Medical and Dental Expenses, 2020 Returns, available at https://www.irs.gov/publications/p502

[iii] CARES Act, Public Law 116-136, enacted March 27, 2020, available at https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf

[iv] Michelle Turner, MBA, CEBS, "Healthcare FSAs Uniform Coverage Rule – an Employer's Risk," The Compliance Rundown, May 6, 2019, available at https://thecompliancerundown.com/2019/05/06/healthcare-fsas-uniform-coverage-rule-an-employers-risk/

[v] Rev. Proc. 2021-45, available at https://www.irs.gov/pub/irs-drop/rp-21-45.pdf

[vi] Social Security, Contribution and Benefit Base, Fact Sheet, available at https://www.ssa.gov/oact/cola/cbb.html

[vii] IRS Notice 2013-71, Modification of Use-or-Loose" Rule for Health Flexible Spending Arrangements (FSAs) and Clarification Regarding 2013-2014 Non-Calendar Year Salary Reduction Elections under Section 125 Cafeteria Plans, available at https://www.irs.gov/pub/irs-drop/n-13-71.pdf

[viii] US Department of Labor, Continuation of Health Coverage, Fact Sheet, available at https://www.dol.gov/general/topic/health-plans/cobra

[ix] 26 US Code Section 223 (c) (1) – Eligible Individual, available at https://www.law.cornell.edu/uscode/text/26/223 ; See also, IRS Notice 2013-57, available at https://www.irs.gov/pub/irs-drop/n-13-57.pdf

[x] 26 US Code Section 223 (b) (2) (A). 223 (b) (2) (B). and 223 (b) (3) (A) – Additional contribution amount, available at https://www.law.cornell.edu/uscode/text/26/223 ; See also. Rev/ Proc. 2021-25, available at https://www.irs.gov/pub/irs-drop/rp-21-25.pdf

[xi] IRS Notice 2021-21 – Relief for Form 1040 Filers Affected by Ongoing Corona Virus Disease 2019 Pandemic, available at https://www.irs.gov/pub/irs-drop/n-21-21.pdf

[xii] 26 US Code Section 213 – Medical, dental, etc., expenses, available at https://www.law.cornell.edu/uscode/text/26/213

[xiii] CARES Act, Public Law 116-136, enacted March 27, 2020, available at https://www.congress.gov/116/plaws/publ136/PLAW-116publ136.pdf

[xiv] 26 US Code Section 223 (a) – Deduction allowed, 223 (e) – Tax treatment of accounts, and 223(f) – Tax treatment of distributions, available at https://www.law.cornell.edu/uscode/text/26/223

[xv] 26 US Code Section 223 (f) (4) (A) – Additional tax on distributions not used for qualified medical expenses and

223 (f) (4) (B) – Exception for disability or death, available at https://www.law.cornell.edu/uscode/text/26/223

[xvi] 26 US Code Section 223 (b) (8) (A) – increase in limit for individuals becoming eligible individuals after the beginning of the year, available at https://www.law.cornell.edu/uscode/text/26/223

[xvii] Aaron C. Catlin and Cathy A. Cowan, History of Health Spending in the United States, 1960-2013, p.10, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/HistoricalNHEPaper.pdf

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10 Account-Based Plans: Part II

Introduction

This is the second module focused on account-based plans. In this module we will study various health reimbursement accounts (HRAs) including:

- Qualified small employer HRAs (QSEHRAs),
- Individual coverage HRAs (ICHRAs), and
- Excepted benefits HRAs (EBHRAs).

Learning Objectives

After completing this module, you should be able to:

- define what is a heath reimbursement account (HRA).
- describe QSEHRAs, ICHRAs, and EBHRAs.
- list at least two differences between QSEHRAs and ICHRAs.
- describe the affordability rules and their impact on participants in both QSEHRAs and ICHRAs.
- explain the availability of the premium tax credit (PTC) to participants in both QSEHRAs and ICHRAs; and
- provide at least one reason why an employer might wish to offer EBHRAs.

What Is an HRA?

Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the HRA. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements. [i]

HRA Basics

Here are some other HRA operational basics to consider:

- Funding – HRAs are funded entirely through employer contributions. The employer determines contribution amounts, when they will be made, and at what frequency.
- Eligibility – The employer through the HRA plan document determines eligibility requirements.
- Expenses Eligible for Reimbursement – The employer may limit the expense types that can be reimbursed through the HRA. Generally, these are defined through reference to allowable medical expenses under the Internal Revenue Code and may include copays, coinsurance, deductibles, and both dental and vision expenses. [ii]
- Availability of Funds – While some plans limit the availability of funds to a particular plan year, other plans allow for unspent funds to rollover from year-to-year.

Types of HRAs

There are various types of HRAs. The more traditional types of HRAs include:

- Flat Dollar HRAs – These cover first dollar medical expenses or provide a source of funds after a specific deductible has been met.
- Copayment Replacement HRAs – These provide a partial flat dollar amount to cover copayments.
- Post-Deductible HRAs – These HRAs work in conjunction with qualified high-deductible health plans (HDHPs). The HRA begins after the minimum statutory deductible has been met.

Newer types of HRAs, the subject of this module, include:

- Qualified small employer HRAs (QSEHRAs),
- Individual coverage HRAs (ICHRAs), and
- Excepted benefit HRAs (EBHRAs).

HRA Background

HRAs were available as a planning tool for many years and were widely used prior to the passage of the Affordable Care Act (ACA) in 2010 – particularly, by businesses who preferred a defined contribution (fixed amount) approach to healthcare costs.

Under long-standing tax law, employer-sponsored health benefits were, and remain, generally excluded from an employee's income for federal and state tax purposes. These rules allowed employers to contribute funds on a tax-favored basis to HRAs for their employees. These funds could then be used by an employee to pay for medical expenses not otherwise covered by insurance. [iii]

Impact of ACA Provisions on HRAs

HRAs, like other types of employer-sponsored health benefits, are considered a group health benefit under federal law. The ACA placed market reform requirements on all group health plans that include coverage of preventive benefits without cost-sharing and the abolishment of annual and lifetime dollar limits on core health benefits. HRAs are typically unable to meet these standards since for example, they inherently include an annual dollar limit on the amount to be reimbursed and noncompliance with these rules can result in heavy penalties. As a result, the use of HRAs diminished. Many workers at smaller firms, that previously offered HRAs, faced the prospect of providing for their health coverage on their own.

Legislative Solution

The 21st Century Cures Act (Cures Act) sought to solve the problems created by the ACA for small businesses. Its provisions included an amendment of the Internal Revenue Code to allow for the creation of qualified small employer HRAs (QSEHRAs) for plan years beginning on or after January 1, 2017. [iv] Further guidance was provided by the Internal Revenue Service. [v]

How Do QSEHRAs Work?

QSEHRAs work basically like HRAs, but they are not defined as group health plans and not subject to ACA reforms and associated penalties.

QSEHRAs are however, available only to small employers and to employees enrolled in health insurance plans that offer minimum essential coverage as defined by the ACA.

QSEHRA Requirements

The Cures Act provides that for an HRA to qualify as a QSEHRA it must meet the following four requirements:

1. It must be funded solely by an ***eligible employer***, and no salary reduction contributions may be made.
2. The arrangement provides that an ***eligible employee*** must provide ***proof of coverage***, for the payment or reimbursement of the medical expenses incurred by the employee and his or her family members in accordance with the terms of the arrangement.
3. The amount of payments and reimbursements must be no more than the ***statutory maximum.***
4. The arrangement must be provided on the ***same terms to*** all eligible employees.

In addition, there are notice requirements that must be satisfied.

Who Is an Eligible Employer?

To take advantage of the QSEHRA provisions, an employer must have fewer than 50 full-time equivalent employees. It also may not offer a group health insurance plan.

Furthermore, the dollars must come solely from the employer and cannot accept funds through Section 125 pre-tax employee salary reduction contributions. Thus, it cannot be funded using employee dollars like flexible spending accounts (FSAs).

Why fewer than 50 full-time equivalent employees?

This has been a traditional breakpoint between companies that are considered small in the health insurance marketplace and those who are considered large group. This breakpoint was recognized in the drafting of the ACA. Companies with less than 50 employees are exempt from many of the ACA's rules, including the so-called employer mandate to provide affordable health coverage to employees. Many of these small companies also did not offer traditional group health coverage to their employees because of the costs and compliance issues entailed.

The legislators who drafted the 21st Century Cures Act had this historical background to draw upon in considering what companies should be able to use QSEHRAs.

Who Is an Eligible Employee?

Under the QSEHRA rules, an "eligible employee" is any employee of an eligible employer except that some categories of employees may be excluded. A QSEHRA may exclude employees:

- who have not completed 90 days of service with the employer,
- who have not reached age 25 before the beginning of the plan year,
- who are part-time or seasonal,
- who are covered by a collective bargaining agreement if health benefits were the subject of good faith bargaining,
- who are nonresident aliens with no earned income from sources within the United States.

QSEHRA: Employee Coverage Requirement

To receive reimbursements from a QSEHRA, an employee and any covered dependents must be enrolled in minimum essential coverage (MEC). In layperson's terms, this means that their health coverage meets the requirements of the ACA.

More on minimum essential coverage:

Insurance plans that meet the requirements of the Affordable Care Act (ACA) are considered to provide minimum essential coverage. These are the types of plans found on the ACA Marketplaces that provide the specified essential health benefits, follow established limits on cost-sharing (deductibles, copays, and out-of-pocket maximum amounts. They are also plans sold outside the ACA Marketplaces that meet these standards. [vi]

Proof of MEC Coverage

Before a QSEHRA can reimburse an expense for any plan year, the eligible employee must first provide proof that the employee has MEC for the month during which the expense was incurred.

This proof can consist of either:

- a document from a third-party, such as a health plan showing that the employee has coverage (for example, an insurance card) and an attestation by the employee that the coverage is minimum essential coverage, *OR*
- an attestation by the employee stating that they have minimum essential coverage, the date coverage began and the name of the provider of the coverage.

Proof of MEC Coverage (Continued)

An employer may rely on the employee's attestation unless the employer has actual knowledge the employee does not have MEC.

Additionally, following initial proof of coverage, with each new request for reimbursement for an expense in the same plan year, the employee must attest that they continue to have MEC.

Model Attestation for Initial Proof of MEC

Instruction – Complete the following to provide information on your current health coverage.

I am attesting to the following:

I, _____(*insert name)*_____, am covered under the following health coverage: *(insert name of the health coverage)*_____,

The coverage began on *(insert date coverage began)*

The coverage is minimum essential coverage (MEC).

Instruction – Also complete the following if a family member's expenses can be reimbursed from the QSEHRA.

The following family member _____*(insert name)*_____, is covered under the following health coverage: *(insert name of the health coverage)*_____.

The coverage began on *(insert date coverage began)*.

The coverage is MEC.

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

Below is model attestation language that an employer can choose to include on a QSEHRA's reimbursement form for the employee to satisfy the requirement to attest that the individual whose expense is being reimbursed continues to have MEC.

Model Attestation for Request for Reimbursement of an Incurred Expense

Instruction – Complete the following for any expenses being reimbursed from the QSEHRA.

I, _____*(insert name)*_____, am covered under the following health coverage:_____*(insert name of the health coverage)*_____,

The coverage continues to be minimum essential coverage (MEC). The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

Instruction – Also, complete the following if a family member's expense is being reimbursed from the QSEHRA.

The following family member _____*(insert name)*_____, is covered under the following health coverage:__*(insert name of the health coverage)*_____.

The coverage continues to be MEC. The submitted medical expense has not been previously reimbursed and reimbursement will not be sought for the expense from any other arrangement or health plan.

I hereby affirm that the above information is true and accurate.

Signed: _____

Date: _____

QSEHRA Contributory Limitations

Employers are limited in the amount they can contribute to each employee's HRA in any given year. These amounts are determined by the Internal Revenue Service and indexed annually. They are provided on both an individual (self-only) and family basis. Employers have flexibility in how these contributions are made. Some choose to make these contributions annually while other employers choose to make contributions on a monthly basis.

Click here for recent year contribution limits.

QSEHRA Contribution Limits (Annual)

Limit	**2020**	**2021**	**2022**
Individual	$5,250	$5,300	$5,450
Family	$10,600	$10,700	$11,050 [vii]

QSEHRA Contribution Limits (Monthly Basis)

Limit	**2020**	**2021**	**2022**
Individual	$437.50	$441.66	$454.17
Family	$833.33	$891.66	$920.84

QSEHRA: Same Terms Requirement

A QSEHRA must be offered under the same terms to all ***eligible employees***. As we saw previously, this includes all employees except those younger than 25, with part-time or seasonal employment, recently hired (less than 90 days of service), covered by a collective bargaining agreement, or nonresident aliens.

In general, the employer must make the same amount available to each employee. However, the amounts may differ for employees who pay different health premiums based on their age or family size. [viii]

Example: Joe pays a higher health insurance premium because he is older than Sally. Their employer's QSEHRA can allot more dollars to Joe than to Sally.

Further examples:

Example #1: In 2021, the ABC Company provides a QSEHRA that only reimburses premiums up to a self-only permitted benefit of $5,300 and a family permitted benefit of $10,700. Employee Adam purchases self-only coverage with and annual premium of $4,900 and is reimbursed $4,900. Employee Betty purchases family coverage for $9,700 and is reimbursed $9,700. Employee Charlie is older. He purchases self-only coverage for $6,500 and is reimbursed $5,300.

Result: This arrangement satisfies the same terms requirement.

Example #2: XYZ Company provides an arrangement the terms of which state that one category of eligible employees may be reimbursed for all medical expenses, but that another category of employees may only be reimbursed for premiums for individual health insurance policies.

Result: This arrangement fails to satisfy the same terms requirement.

QSEHRA: Same Terms Requirement (Continued)

Employers are not obligated to contribute the statutory maximums. The same terms requirement can be satisfied if a QSEHRA provides up to an equal percentage of the statutory dollar limits.

Example: In 2021, the Standard Company provides a QSEHRA with a self-only permitted benefit of $4,240 (80% of the 2021 statutory cap of $5,300 for self-only coverage) and a family permitted benefit of $8,560 (80% of the 2021 statutory limit of $10,700). [ix]

Paying for MEC Coverage

Now, that we have an overview of QSEHRA requirements, let's turn our attention back to the requirement that employees must have minimum essential coverage (MEC) in order to receive reimbursement for their medical expenses. Sometimes, that amount provided to an employee will be sufficient to cover the cost of health insurance. In other cases, the amount may prove insufficient to cover health insurance costs. In those instances, an employee might be eligible for the premium tax credit (PTC) available through the ACA health insurance Marketplace(s). Whether or not the PTC is available to the employee will depend on whether the amount provided by the employer allows the employee to purchase a policy that is **affordable**.

These concepts are complicated and can often best be explained through examples.

What Is Considered Affordable?

The only way an individual qualifies for the Marketplace savings offered is if their employer's HRA is not considered affordable. Simply put, this is a percentage of a person's income that is determined and indexed annually. It can also be impacted by legislation.

For plan years, beginning in 2022, a QSEHRA is *not considered affordable* for an employee if the monthly premium for the *second lowest-cost* silver plan for *self-only* coverage in the employee's area, minus the amount available under the HRA, is more than 9.61 percent of 1/12 of the employee's household income for the tax year. [x] This percentage has been reduced to 8.5 percent of annual household income

by the American Rescue Plan passed in 2021 in the wake of the COVID-19 pandemic. [xi]

Example #1: Kevin is 30 years old and works for an employer who offers a QSEHRA with benefits up to the maximum amount. For 2022, this means that Kevin can get up to $454.17 per month reimbursement to cover his individual insurance plan. The second lowest-cost silver plan through the ACA Marketplace available to Kevin has a full price of $320 per month. Kevin's QSEHRA benefit would cover the entire premium if he picked that plan. Thus, he would not be eligible for any premium subsidies regardless of his income because he would have no premium cost after the QSEHRA benefit is applied.

QSEHRA: More on Affordability

Let's take a look at another example dealing with affordability and the premium subsidies available through the ACA Marketplace(s). *(Note, these subsidies are not available outside the Marketplace(s)).*

Example #2: Hank is 55 years old and earns $30,000 per year. He also works for an employer that offers a QSEHRA with benefits up to the maximum amount. In 2022, Hank can also get up to $454.17 per month reimbursement to cover his insurance plan. Because he is older, the second-lowest silver plan will cost $750.20 per month. This would leave Hank with a cost of $296.03 per month or $3,552.36 per year. This represents 11.8 percent of Hank's household income and this makes him eligible for a premium tax credit subsidy.

PTC Offset for QSEHRA Dollars

Employees who participate in a QSEHRA and claim premium tax credits must include their QSEHRA dollars in the affordability calculations to determine the final amount of their tax credit. In other words, there is no "double dipping" – the PTC is reduced by QSEHRA dollars.

Example: Assume that Marie is an employee eligible for $400 premium tax credit per month and also receives a $250 QSEHRA allowance from her employer. To calculate her final PTC, the $250 would be subtracted from the $400, leaving Marie with a tax credit of $150 for the month ($400-250).

QSEHRA: Requirements Recapped

Before we leave the topic of QSEHRA, let's take some time and recap QSEHRA requirements: For an HRA to qualify as a QSEHRA the following must take place:

- The plan must be established by ***eligible employer*** with fewer than 50 full-time equivalent employees.
- The arrangement provides that an ***eligible employee*** must provide ***proof of coverage***, for the payment or reimbursement of the medical expenses incurred by the employee.
- The amount of payments and reimbursements must be no more than the ***statutory maximum.***
- The arrangement must be provided on the ***same terms to*** all eligible employees.

In addition, each eligible employee must receive a written notice at least 90 days before the QSEHRA starts.

QSEHRA Notice Requirements: 90 Days

An employer who offers a QSEHRA must provide each eligible employee a written notice at least 90 days before the QSEHRA program starts. Employees who are not eligible at the beginning of the year must also receive notice on or before the date they become eligible for the plan. [xii]

What Information Must Be in the QSEHRA Notice?

The written notice sent of eligible employees must contain the following elements:

1. **Amount** – The notice must state the maximum reimbursements that the employer will offer the employee for the year. The notice can be tailored to each employee's situation, or it can be a general template that lists all the reimbursement amounts according to employee age and family size. (Note, this amount is sometimes referred to as a permitted benefit).
2. **Duty to Inform Marketplace** – The notice must advise employees that if they apply for the advance premium tax credit (APTC) they must alert the ACA Marketplace of the amount of the QSEHRA reimbursement. The notice should also explain that the QSEHRA reimbursement may affect the employee's eligibility for and amount of any premium tax credit (PTC).
3. **MEC Requirement** – The notice must include a statement that if the employee does not have a health insurance plan that meets the minimum essential coverage requirements for any month, reimbursements made under the QSEHRA will be taxable. [xiii]

Click on the Resources tab to view an example of a QSEHRA Notice.

QSEHRA Sample Notice

Staff,
We are pleased to provide all eligible employees with personalized health care benefits. We recognize that different employees have different needs. Rather than offering a single health benefit plan, we are providing you choice and flexibility through a Qualified Small Employer Health Reimbursement Account (QSEHRA). The plan reimburses you for certain health care costs including health insurance policy premiums, copays, and coinsurance.

Your permitted benefit for (Plan Year) is ($XX Dollars) if you have self-only coverage or ($YY Dollars) if any members of your family also have coverage. These amounts are provided by month if you are not eligible on the first day of the plan year. Your permitted benefit applies to medical expenses incurred on or after (Date).

You are required to inform any Marketplace to which you apply for advance payment of the premium tax credit about the amount of your permitted benefit. This amount may affect your eligibility for a premium tax credit and will reduce the amount of the credit to which you are eligible. You should retain this notice because you may need it to calculate any premium tax credit available to you on your individual income tax return.

You must obtain health insurance that qualifies as minimum essential coverage. If you do not have minimum essential coverage for any month, you may be liable for an individual shared responsibility payment under section 5000A of the Internal Revenue Code and all of the reimbursement you receive under the arrangement for the month will be included in your gross income. For a list of examples of plans and arrangements that are considered minimum essential coverage you may refer to the instructions for Internal Revenue Service (IRS) Form 8965, available on the IRS website.
(*This sample is not legal advice and appropriate legal counsel should be sought in drafting QSEHRA documents).*

ICHRA

What Is an Individual Coverage HRA?

An individual coverage HRA (CHRA) is a new type of HRA available to employers as of January 1, 2020. Rules released by the Departments of Labor, Health and Human Services, and the Treasury permit employers to offer ICHRAs as an alternative to traditional job-based health coverage, subject to certain conditions. ICHRAs can be used to reimburse medical expenses such as out-of-pocket costs like copayments and deductibles.

ICHRAs can also be used to reimburse premiums for individual health insurance chosen by an employee, promoting flexibility, while also maintaining the same tax-favored status for employer contributions toward traditional health plans. In other words, those employer contributions are not included in an employee's income for tax purposes. [xiv]

What types of employers can offer ICHRAs to their employees?

Unlike QSEHRAs, employers of any size can offer an ICHRA plan to employees as a way to cover their medical expenses. Employers both large and small can elect this option but they must follow certain rules in the design of their program which we will discuss in further detail later.

How does an ICHRA work?

AN ICHRA reimburses the medical expenses of employees (and sometimes their family members), up to a maximum dollar amount that the employer makes available each year. The employer can allow unused amounts in any year to rollover from year to year.

Are employees required to do anything?

The plan must require employees and any covered dependents to be enrolled in individual health insurance coverage for each month the employee (or the employee's family member) is covered by the ICHRA. The individual health insurance coverage can be offered on or off the ACA Marketplace(s). However, it cannot be short-term limited duration insurance or coverage consisting solely of dental, vision, or similar benefits.

Alternatively, older workers or those eligible for Medicare due to disability can satisfy the ICHRA coverage requirement by enrolling in both Medicare Part A (hospital insurance) and Part B (physician and other services) or Part C (Medicare Advantage).

Under what terms can an employer offer an ICHRA?

An employer who offers an ICHRA plan must offer it on the same terms to all individuals within a class of employees. Like QSEHRA, amounts offered may be increased for older workers and workers with more dependents. [xv]

An employer *cannot offer* an ICHRA to any employee to whom the employer offers a traditional group health plan. The employer can however, offer an ICHRA to certain classes of employees and a traditional health insurance plan (or no coverage) to other classes of employees.

What classes of employees do the ICHRA rules recognize?

Employers make distinctions as to the coverage offered based on the following employee status:

1. Full-time employees,
2. Part-time employees,
3. Seasonal employees,
4. Employees in a unit of employees covered by a particular collective bargaining agreement,
5. Employees working in the same geographic locations (generally, the same insurance rating area, state, or multi-state region),
6. Employees who have not satisfied a waiting period,
7. Non-resident aliens with no US-based income,
8. Salaried workers,
9. Non-salaried workers (such as hourly workers),
10. Temporary employees of staffing firms, or
11. Any group of employees formed by combing two or more of these classes. [xvi]

Minimum Class Size Rule

The final rule permitting ICHRAs, also specifies that the classes must be of a minimum class size if an employer offers a traditional group health insurance plan to some employees and an ICHRA to other employees based on the following employee classifications:

- full-time versus part-time status,
- salaried versus non-salaried status, or
- geographic location if the location is smaller than a state.

Generally, the minimum class size rule also applies if an employer combines these classes with other classes. The minimum class size rule is designed to prevent adverse selection in the individual market. For example, grouping employees into classifications that would place older sicker workers in ICHRAs while younger healthier workers are offered traditional group health insurance coverage.

Minimum Class Size Rule (continued)

The minimum class size rule is as follows:

- ten employees for an employer with fewer than 100 employees,
- ten percent of the total number of employees, for an employer with 100 to 200 employees, and
- twenty employees for an employer with more than 200 employees. [xvii]

Remember, the minimum class size rules do not apply if an employer offers only an ICHRA plan to employees.

New Hire Rule

The final regulation that establishes ICHRAs, also has a new hire rule. Under this rule, an employer can offer new employees an ICHRA plan, while grandfathering existing employees in a traditional group health plan.

Are there statutory limits on employer ICHRA contributions?

The answer is no. Employers are given great flexibility. They can contribute as much or as little as they want to an ICHRA as long as they offer the ICHRA on the same terms to all employees in a class of employees. And, as we have discussed previously, an employer can increase the amount available based on the employee's age or number of dependents.

Large employers (generally, those with 50 or more employees) do need to be aware of the ACA employer mandate which can result in penalties if the employer contribution is too low.

ACA Employer Mandate & Affordability

The ACA includes an employer mandate to offer affordable health care coverage. Failure to comply with this mandate entails costly penalties. The mandate applies to employers with 50 or more full-time equivalent employees so small businesses with fewer employees are not impacted.

If the amount of the employer's ICHRA contribution is sufficient to cover an employee's premium, the mandate is satisfied, and penalty rule considerations do not come into play. If after applying the ICHRA benefit, the employee would have to pay more than the specified affordability percentage (9.61 percent in 2022 – dropped to 8.5 percent under the American Rescue Plan) of their household income for self-only coverage under the *lowest-cost* silver plan in the ACA Marketplace, the ICHRA does not constitute affordable employer-sponsored coverage.

Employee Options If Coverage Unaffordable

In situations where coverage is deemed unaffordable, an employee can reject the ICHRA and claim a premium subsidy in the Marketplace if they are otherwise eligible for one.

Where coverage is considered unaffordable, an employee can still decide to participate in the employer-sponsored ICHRA but has to forgo any potential premium subsidies.

QSEHRA vs. ICHRA Affordability

The affordability rules that apply to QSEHRAs and ICHRAs are similar but a bit different. Both rely on the same affordability percentage of household income for self-only coverage. The difference is the measuring plan:

QSEHRA	2nd lowest-cost silver plan
ICHRA	lowest-cost silver plan (LCSP)

Here is a formula that can help you understand affordability:

Step # 1. Monthly premium of LCSP – Monthly ICHRA benefit

Step #2. Employee' s Household Income X 1/12 = Monthly Income

Step #3: Monthly Income X Required Contribution Percentage (*Indexed Annually*)

If the employee's expected out-of-pocket does not exceed the required contribution amount the ICHRA is considered affordable.

Examples of ICHRA affordability:

Example #1: Let's assume the government issued standard of affordability for the year in question is 9.83 percent. Let's further assume that Bill has an annual income of $45,000 and that he is offered an ICHRA benefit of $200 per month and that the lowest Sliver plan for Bill has a cost of $550 per month. Now apply the suggested formula:

$550 - $200 = $350 Bill's expected out-of-pocket cost
1/12 of $45,000 (Bill's salary) = $3,750 X .0983 = $368.63
Result: **Affordable**. Bill's expected out-of-pocket cost for the lowest cost silver plan (LCSP) is $350 which is less than 9.83 percent of his monthly salary.

Example #2: Same facts as above except that Bill is earning $40,000.
$550 - $200 = $350 Bill's expected out of pocket cost
1/12 of $40,000 (Bill's salary) = $3,333 X .0983 = $327.67
Result: **Unaffordable.** Bill's expected out-of-pocket cost for LCSP is $350 which is more than 9.83 percent of his monthly salary.

Safe Harbor for Determining Employee Location

How is an employer to determine the lowest cost self-only silver plan for an employee? Under proposed rules, the employer can look to the Marketplace where the employee's primary site of employment is located. [xviii]To help with these determinations, the Centers for Medicare and Medicaid Services (CMS) has published a Lowest Cost Lookup Table. This table allows users in states that use HealthCare.gov to access individual market qualified health plans (QHP) data by geographic location. [xix]

Cafeteria Plans & ICHRA

You may recall that an employer can establish a cafeteria plan that facilitates employee salary reductions on a tax-favorable basis. The question thus arises whether an employer may allow employees to pay a portion of their individual health insurance premium that is not covered by the ICHRA on a tax-preferred basis through a salary reduction arrangement under a cafeteria plan?

The answer depends on whether health insurance coverage is to be purchased on or off an ACA Marketplace. An employer cannot permit employees to make salary reduction to a cafeteria plan to purchase coverage offered through a Marketplace. This restriction, however, does not apply to coverage that is purchased off a Marketplace.

ICHRA Notice Rules & Annual Employee Opt-Out Option

As a general rule, an employee who if offered an ICHRA must get written notice 90 days before the beginning of the plan year. As is the situation with QSEHRAs, there are exceptions to this general rule for employees who become eligible during the plan year and newly hired employees.

This notice must include information about the ICHRA and its interaction with the premium tax credit (premium subsidy). Employees must be permitted to opt-out of an ICHRA at least annually so they may claim the premium tax credit if they are otherwise eligible and if the HRA is considered unaffordable.

The Department of Labor has published an Individual Coverage HRA Model Notice which can be found at

https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB87/individual-coverage-model-notice.pdf

Excepted Benefit HRAs (EBHRAs)

EBHRAs: Regulatory Background

On June 13, 2019, the Departments of Labor, Treasury, and Health and Human Services joint issued a final rule (Final Rule) to expand the flexibility and use of HRAs. In addition to providing guidance for the establishment of Individual Coverage HRAs (ICHRA), the Final Rule created a new type of HRA – the Excepted Benefit HRA (EBHRA). [xx]

These are limited purpose HRAs that can be used by employers that offer traditional group health coverage.

EBHRA Purpose & Design

EBHRAs permit employers to reimburse what have been traditionally referred to as excepted benefits such as accident, dental, and vision coverage as well as other medical expenses such as copays and deductibles not covered by the primary group health plan. The EBHRA can be offered, even if the employee declines enrollment in the traditional group health plan.

EBHRA Dollar Limits & Carryovers

Employers can contribute a maximum of $1,800 (indexed for inflation) per plan year to an EBHRA. If there are unused funds at the end of a plan year these dollars can be rolled over and do not count against the following year's limit.

Example: In plan year 1, Wilbur's employer contributes $1,800 to his EBHRA. At the end of the year, $300 is left unspent. This amount can be rolled over, and Wilbur's employer can contribute an additional $1,800 in plan year 2 to the account.

What Can and Cannot Be Reimbursed?

As we've mentioned EBHRA may reimburse an employee as well as certain family members of the employee for traditional excepted benefits such as dental and vision coverage, including premiums, as well as out-of-pocket expenses such as copays and deductibles not covered by their primary health plan. In addition, the EBHRA may cover the cost of short-term limited-duration insurance.

An EHRA cannot be used to reimburse:

- Individual health insurance coverage premiums,
- Group health plan premiums (other than COBRA or other group continuation coverage), nor
- Medicare premiums (often paid for Medicare Parts B and D).

Nondiscrimination Rules

Employers that offer an EBHRA plan must make the plan available under the same terms and conditions to all *similarly situated individuals.* The EBHRA rules use the same definition found in the HIPAA nondiscrimination rules. Under these rules, a group health plan may treat participants as distinct groups

if the distinction is based on bona fide employment-based classifications, such as:

- Full-time and part-time employees,
- Different dates of hire,
- Employees working in different geographic locations, and
- Employees with different length of services. [xxi]

These rules are a bit different from the ICHRA rules. An ICHRA plan must be offered on the same terms to all individuals within a class of employees.

EBHRA + ICHRA = No

An employer cannot offer an ICHRA and an EBHRA to the same employee. Keep in mind, that an employer must *offer* traditional group health insurance to those participating in a EBHRA and the ICHRA requires the participant to obtain individual health insurance coverage.

Must An Employee Enroll in the Group Coverage Offered?

Employees do NOT have to enroll in the traditional group health plan offered by an employer sponsoring an EBHRA to enroll in the EBHRA. This allows an employee who is covered by a spouse's (or partner's) group health benefits to participate in the EBHRA.

Notice of EBHRA

As of this writing, EBHRAs are not subject to special notice requirements as are QSEHRAs and ICHRAs. It is recommended that employers who offered EBHRAs provide a Summary Plan Description to employees. This would typically include:

- conditions for eligibility to receive benefits,
- a description of the available benefits,
- circumstances that may result in disqualification or ineligibility for the benefits,
- circumstances that may result in the denial, forfeiture, loss, recovery, or suspension of benefits, and
- procedures governing the claims for benefits.

Reasons for Offering EBHRA

Why would an employer offer an EBHRA plan when they already offer a traditional group health plan? One answer is that an EBHRA is a way to offer a competitive benefits package particularly important in a labor market that has more job openings than workers.

Summary

Health reimbursement accounts (HRAs) have long been a way for employers to help their workers with medical expenses. The Affordable Care Act (ACA) effectively restricted their use, but Congress and key Federal agencies have once again opened the door for use of HRAs. The 21st Century Cures Act included an amendment to the Internal Revenue Code allowing for the creation of qualified small employer HRAs (QSEHRAs) for plan years beginning on or after January 1, 2017. This created a tool for businesses with less than 50 employees.

This was followed by regulatory action in 2019 (Final Rule) that laid out rules for individual coverage HRAs (ICHRAs). Available to employers of all sizes starting January 1, 2020, ICHRAs offer a way for employers who prefer a defined contribution approach to providing healthcare coverage for their workforce to proceed.

The Final Rule added another tool, the Excepted Benefit HRA (EBHRA), for employers who wish to help their employees handle medical costs not covered by traditional group health insurance plans. EBHRAs can provide dollars to cover items such as copays and deductibles, as well as dental and vision coverage.

Before leaving this module take a few minutes to review the QSEHRA-ICHRA comparison chart included below.

Comparison of ICHRA and QSEHRA Chart:

Comparison of ICHRA and QSEHRA

Topic	**QSEHRA**	**ICHRA**
Employers can offer this option to help employees pay for their medical care expenses and premiums	Yes, employers with fewer than 50 full-time employees may provide a QSEHRA	Yes, employers of all sizes may offer an Individual Coverage HRA (ICHRA)
Ability to offer traditional group health insurance	Employers providing a QSEHRA cannot offer group health plan coverage to any employees.	Employers offering an ICHRA cannot offer traditional group health coverage to employees in the same class with exception for current workers versus new hires.
Reimbursement model	Defined contribution – employers select how much money to contribute up to the allowed annual limit (adjusted annually for inflation)	Defined contribution – employers select how much money to contribute to employees and, if the employer chooses, to employees' dependents There is no annual maximum.
Affordability determined using…	Employee's self-only ***second lowest*** *cost* silver plan (SLCSP) and household income	Employee's self-only ***lowest*** *cost* silver plan (LCSP) and household income
If coverage is deemed unaffordable …	Employee must reduce monthly PTC, if they otherwise qualify for PTC, by their monthly QSEHRA amount	Employee must "opt out" to be PTC-eligible, if they otherwise qualify for PTC
Coverage selection by employees	Employees can generally choose how they use a QSEHRA as long as they use it for qualifying health care expenses, and they also have qualifying health care coverage, such as a plan from the ACA Marketplace.	Employees can generally choose how they use a QSEHRA as long as they use it for qualifying health care expenses, and they also have qualifying health care coverage, such as a plan from the ACA Marketplace
Notice	Employers can offer a QSEHRA at any time of the year but must give written notice to their employees 90 days in advance.	Employers can offer a IC HRA at any time of the year but must generally give written notice to their employees 90 days in advance.

Special Enrollment Period (SEP)	Employees with a newly provided QSEHRA or who newly gain access to an existing QSEHRA (like newly hired employees) will be eligible for a special enrollment period (SEP) to enroll in individual health insurance coverage in or outside the Marketplace.	Employees with a new ICHRA offer will be eligible for a special enrollment period (SEP) to enroll in individual health insurance coverage in or outside the Marketplace.
Tax Implications of Reimbursements	QSEHRA contributions are not taxed to the employee,	ICHRA reimbursements are not taxed to the employee.

Notes:

[i] HealthCare.gov, Glossary, available at https://www.healthcare.gov/glossary/health-reimbursement-account-hra/

[ii] 26 US Code Section 213 (d), Medical, dental, etc. expenses/definition, available at https://www.law.cornell.edu/uscode/text/26/213

[iii] 26 US Code Section 105 – Amounts received under accident and health plans, available at https://www.law.cornell.edu/uscode/text/26/105

[iv] 21st Century Cures Act, Public Law 114-255 (December 13 2016), Section 18001 available at https://www.congress.gov/bill/114th-congress/house-bill/34 See also,

[v] Internal Revenue Service (IRS) Notice 2017-67, Qualified Small Employer Health Reimbursement Arrangements, available at https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[vi] Healthcare.gov, Glossary, Minimum Essential Coverage, available at Internal Revenue Service (IRS) Notice 2017-67, Qualified Small Employer Health Reimbursement Arrangements, available at https://www.irs.gov/pub/irs-drop/n-17-67.pdf. See also, Healthcare.gov, Types of health insurance that count as coverage, Fact Sheet, available at https://www.healthcare.gov/fees/plans-that-count-as-coverage/

[vii] Rev. Proc. 2021-45, available at https://www.irs.gov/pub/irs-drop/rp-21-45.pdf

[viii] Internal Revenue Service (IRS) Notice 2017-67, Qualified Small Employer Health Reimbursement Arrangements, Question 12, available at https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[ix ix] Internal Revenue Service (IRS) Notice 2017-67, Qualified Small Employer Health Reimbursement Arrangements, Question 15, available at https://www.irs.gov/pub/irs-drop/n-17-67.pdf

[x] 9.61% based on Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Worksheet, Health Insurance Marketplace, available at https://www.healthcare.gov/downloads/qsehra-worksheet.pdf
The American Rescue Plan reduces this figure to 8.5 % of annual household income.

[xi] American Rescue Plan and the Marketplace, CMS Fact Sheet, available at https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace

[xii] 26 US Code Section 9831 (d) (4) (A) – QSEHRA Notice, available at https://www.law.cornell.edu/uscode/text/26/9831

[xiii] Internal Revenue Service (IRS) Notice 2017-67, Qualified Small Employer Health Reimbursement Arrangements, Question 38, available at https://www.irs.gov/pub/irs-drop/n-17-67.pdf, See also, 26 US Code Section 9831 (d) (4) (B) Contents of Notice, available at https://www.law.cornell.edu/uscode/text/26/9831

[xiv] FAQs on New Health Coverage Options for Employers and Employees, June 13, 2019, available at https://www.irs.gov/pub/irs-utl/health_reimbursement_arrangements_faqs.pdf

[xv] Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination in HRAs and Other Account-Based Plans, Federal Register Vol. 84, No. 119, June 20, 2019, Pages 28988-89, available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf

[xvi] Ibid, Pages 28991-92.

[xvii] Ibid, Page 29992.

[xviii] Health Reimbursement Arrangements and Other Account-Based Group Plans, Federal Register, Vol.84, No 119, June 20, 2019, available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf

[xix] Lowest Cost Look Silver Plan Look-Up Table, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Employer-Initiatives/Employer-Initiatives

[xx] Special Rule Allowing Integration of Health Reimbursement Arrangements (HRAs) and Other Account-Based Group Health Plans with Individual Health Insurance Coverage and Medicare and Prohibiting Discrimination in HRAs and Other Account-Based Plans, Federal Register Vol. 84, No. 119, June 20, 2019, Pages 28999-29000, available at https://www.govinfo.gov/content/pkg/FR-2019-06-20/pdf/2019-12571.pdf

[xxi] U.S. Department of Labor, FAQs on HIPAA Portability and Nondiscrimination Requirements of rEmployiers and Advisors, Question 19, available at https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance.pdf

11 Provider Organizations and Compensation Models

Learning Objectives

In this lesson, we discuss the Provider Organizations that are part of the healthcare environment. We start by explaining the meaning of "integration" and discussing the levels of provider integration found in provider organizations. We then describe specific types of provider organizations and compensation models.

After completing this lesson, you should be able to:

- Explain what it means for providers to integrate
- Describe some of the advantages of provider integration
- Discuss some of the types and levels of provider integration
- Describe the general characteristics of several types of provider organizations
- Discuss the impact of the Affordable Care Act (ACA) on provider integration
- Explain the difference between fee-for-service and value-based compensation models

Provider Integration

Provider Integration

Different provider organizations are characterized by different types and levels of provider integration. For providers, **integration** occurs when two or more previously separate providers combine under common ownership or control, or when two or more providers combine business operations that they previously carried out separately and independently.

Two Components of Provider Integration

As is evident from this definition, provider integration has two components:

- structural
- operational

Structural integration involves bringing previously separate providers under common ownership or control.

Operational integration is the consolidation of operations that were previously carried out separately by each provider into a single operation.

Structural Integration

As we have discussed, structural integration involves bringing separate providers under common ownership or control. Structural integration may be complete or partial.

In a complete structural integration, previously independent providers are brought under common ownership and control. Mergers and acquisitions are examples of complete structural integration.

Mergers and Consolidations

A **merger** occurs when two or more separate providers are legally joined. One provider may absorb the other entirely, or the providers may combine to form a new organization with all the original companies being dissolved. The second type of merger is called a **consolidation.**

Information on health plan mergers:

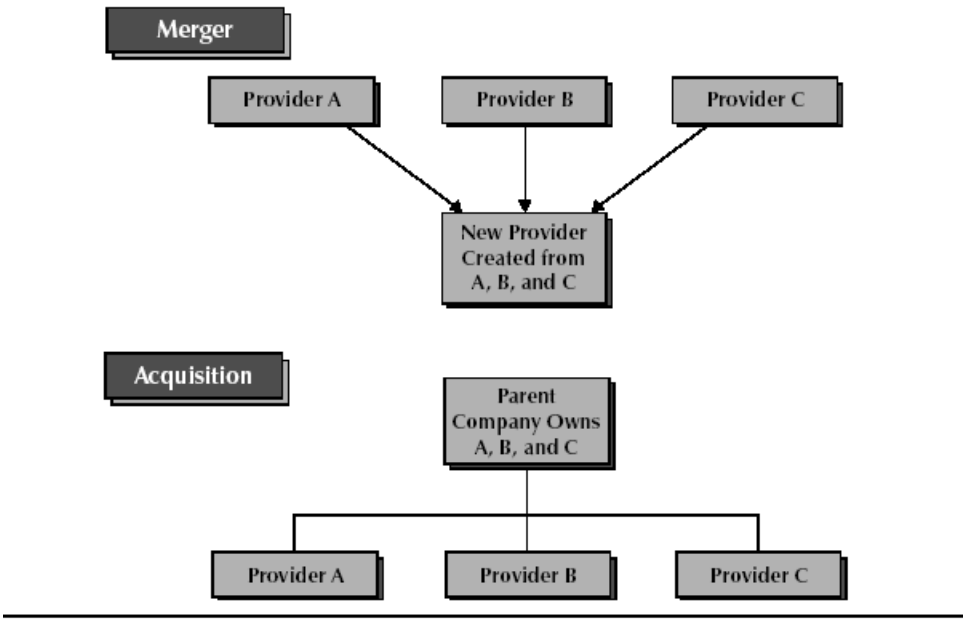
Mergers in the field of healthcare are not limited simply to providers. Mergers may also involve health plans and entitles that have long acted as intermediaries on their behalf. Such mergers in fact, are helping to reshape the healthcare industry. Recent examples include health plans merging with pharmacy benefit managers (PBMs).[i]

Acquisition

In an **acquisition**, one organization buys another organization. An organization that owns other organizations is often know as a parent company.

The organizations owned by the parent are often called subsidiaries. Subsidiaries owned by a parent company are often referred to as brother-sister organizations.[ii]

Illustration demonstrating integration by merger and acquisitions:



Joint Venture

One type of partial structural integration is a joint venture. In a **joint venture**, two or more separate organizations combine resources to achieve a stated objective.

The participating companies share ownership or the venture and share responsibility for its operations.

Although there is generally a single source of control over the joint venture, the venture itself is not a separate legal entity. Usually, the organizations maintain their separate ownership and also maintain separate control over their operations outside the joint venture.[iii] [iv]

Minimal Structural Integration

Other provider organizations are characterized by minimal structural integration.

In these organizations, the providers who are members of the organization execute contracts in which they agree to cooperate and act as one body in certain transactions.

However, each provider maintains complete separate ownership and may also maintain complete control over its operations in all other business transactions.

Operational Integration

Operational integration can be thought of as having two components:

- business integration
- clinical integration

Business Integration

Business integration involves combining one or more separate business (nonclinical) functions into a single function.

Example: A group of providers might decide to form an organization to carry out billing, collections, and contracting with health plans for the entire group of providers.

Clinical Integration

Clinical integration involves making a variety of health services available to patients from the same organization or entity.

Clinical integration offers a number of potential advantages for the delivery of high-quality healthcare. Patient information is often consolidated in one location – for example in a single medical record (even in this day of electronic medical records different systems may not be compatible).[v]

In addition, administrative processes are often more streamlined than in situations in which a number of providers furnish healthcare independently.

Example:

Suppose Jean Kelly's employer has contracted to receive healthcare for its employees from Aggregate Healthcare System, an integrated delivery system (we discuss integrated delivery systems later in this lesson). Ms. Kelly visits her primary care physician, who sends her to get her blood drawn and to get an X-ray, and refers her to a specialist. The specialist examines Ms. Kelly and schedules her for surgery.

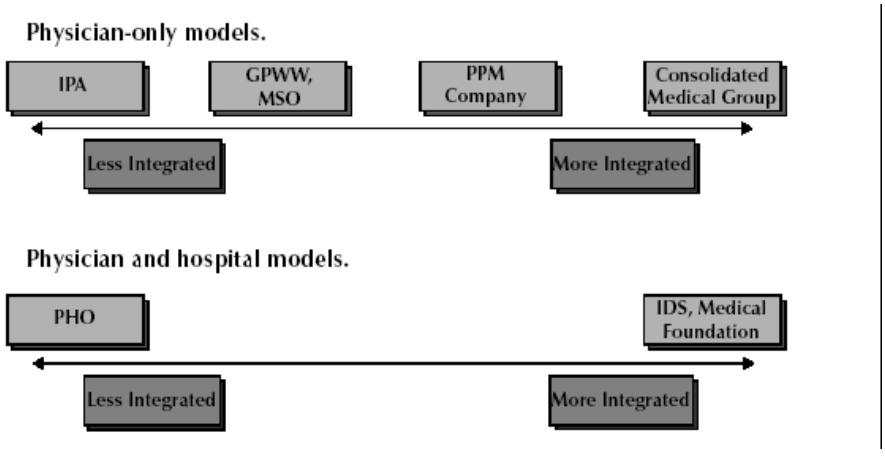
Later, Ms. Kelly is admitted to the hospital and the specialist performs the surgery. After the hospital stay, Ms. Kelly is visited by a home healthcare nurse once a day for several weeks. All the services that Ms. Kelly receives – primary care and specialist physician services, the blood tests and X-ray, hospital and surgical services, and home healthcare nurse – are furnished by a single provider organization: the Aggregate Healthcare System.

All the Aggregate healthcare professionals that treat Ms. Kelly work with the same medical record. Thus, each provider that treats Ms. Kelly has access to the same accurate and complete information regarding her health status, which helps ensure that she receives consistent and high-quality care. In addition, Ms. Kelly encounters a minimum of administrative requirements when receiving her various healthcare services.

Continuum of Operation Integration

The amount of operational integration displayed by each provider organization falls somewhere on a continuum stretching from minimally integrated to fully integrated.

This illustration demonstrates the continuum of operational integration.



Provider Organizations with the Lowest Level of Integration

In the provider organizations characterized by the lowest level of integration, the provider members create an organization to perform a single business function. Apart from this function, the providers maintain fully independent operations.

Example: Providers often form legal entities whose sole purpose is to negotiate with health plans on behalf of all the member providers. Many IPAs and PHOs, discussed later in this lesson, are examples of this type of private organization.

Integrated Delivery Systems (IDS)

At the opposite end of the continuum of operational integration are **integrated delivery systems** (IDS).

An IDS is a provider organization – highly integrated from a business and clinical point of view – that offers consumers a full range of healthcare services "from birth to death," including physician services, hospital services, and ancillary services.

Between these two extremes are organizations that provide a number of (usually business) services to providers but leave the responsibility for carrying out certain other operational tasks in the providers' hands.

Of the organizations that we discuss later in this lesson, group practices without walls (GPWWs), Management Services Organizations (MSOs), and Physician Practice Management (PPM) companies fall into this category of integration.

Business functions that providers sometimes transfer to an IDS:

Practice Management Services	Administrative Support Services
Consulting	Billing
Seminars	Collections
Marketing	Staffing
Strategic Planning	Appointment Scheduling
Practice and Procedures	Contract Negotiations with MCOs
Financial Services	Claims Processing
Legal Services	Medical Record Keeping
Information Management	Equipment Purchase and Maintenance

Advantages of Provider Integration

Integration promises advantages to both providers and other healthcare participants.

In a general sense, there are two potential advantages integration can supply to providers.

The first advantage is greater operating efficiency and effectiveness. If, instead of duplicating functions performed by other providers, providers share these functions, the cost of these functions to each provider should be smaller. In addition, an organization performing business functions for several providers, may possess or develop considerable expertise in these functions. Thus, the providers may benefit from better marketing, strategic planning, information systems, and other business services.

Advantages of Provider Integration (Continued)

Integration may also improve providers' contracting position with health plans. A group of providers can offer a more extensive array of services to a health plan than a single provider. The health plan may therefore be willing and able to offer more favorable contract terms to the provider group than to individual providers.

Disadvantages of Provider Integration

The main disadvantage to providers of integration is a loss of autonomy and control over their own work environment. There are some providers who prefer to work as independent, small business owners rather than as part of a larger group or as an employee of a large organization.

For health plans, healthcare purchasers, and healthcare consumers, provider integration offers greater provider operating efficiency and potentially lower costs for all participants.

Integration also has the potential to make it more convenient for consumers to obtain healthcare by allowing them to obtain a wider array of healthcare services from the same source. On the other hand, there are some consumers who prefer the intimacy of a long-term relationship with an independent practitioner providing healthcare services in their neighborhood.

Provider Integration Models

Provider Integration Models

In this section, we discuss prevalent types of provider organizations. Although we attempt to describe common characteristics of each model, the characteristics of the various types of organizations do evolve due to overall healthcare industry changes. Thus, some organizations you encounter may differ from our descriptions.

Some types of provider organizations feature physician integration only, others integrate physicians with one or more hospitals. Both types of organizations – physician-only or physician-hospital – may decide, in addition to providing healthcare services, to accept the insurance risk related to the services provided.

Physician-Only Integration Models

Physician-Only Integration Models

In this section, we discuss physician-only integration models. The models that we will discuss include:

- independent practice associations (IPAs)
- group practices without walls (GWWs)
- management service organizations (MSOs)
- physician practice management companies (PPMs)

These organizations can perhaps best be described as integrating to some extent, the practices of a number of physicians. Most of these organizations contract with health plans, and sometimes directly with healthcare purchasers, on behalf of the member physicians. In addition, many such organizations furnish providers with other services besides contracting with payors.

Independent Practice Associations (IPAs)

One minimally integrated physician-only organization is the **independent practice association (IPA)**.

An IPA is made up of individual physicians or physicians in small group practices. It generally performs only one service for its member physicians—contracting with health plans, employers, and/or accountable care organizations (ACOs) on their behalf.[vi]

In terms of contractual relationships, there are two types of IPAs:

- messenger model
- stop loss insurance

The Messenger Model

In the **messenger model,** the IPA does not enter into a contract with a health plan.

Its role is only to negotiate on behalf of its member physicians the terms of contracts between those physicians and health plans. The physicians themselves enter into contracts directly with the health plans, based on the terms negotiated by the IPA.

The **messenger model** is most often used with fee-for-service or discounted fee-for-service compensation arrangements.

More commonly, the physicians each contract with the IPA, and the IPA enters into a contract with the health plan.

The Messenger Model (continued)

In this model, the method by which the IPA is compensated by the health plan may or may not be the same as the method by which the IPA compensates its member physicians.

Example: An HMO might compensate an IPA by capitation, and the IPA might compensate its doctors by capitation or by some other method, such as fee-for-service or discounted fee-for-service.

Stop Loss Insurance

An IPA (or other organization) that accepts capitation from a health plan may limit its risk by buying **stop-loss insurance**.

In this arrangement, if the IPA spends more than a certain amount per year on an individual, the insurer issuing the stop-loss insurance reimburses the IPA for expenditures in excess of that amount.

***Example*:** An IPA might purchase stop-loss insurance to cover all spending on any individual in excess of $50,000 in a year.

Group Practice Without Walls (GPWW)

A model that generally has a greater degree of integration than an IPA is a **group practice without walls (GPWW)**, also called a clinic without walls.

This is a legal entity that combines multiple independent physician practices under one umbrella organization and performs certain business operations for the member practices or arranges for these operations to be performed.

A GPWW may maintain its own facility for business operations, or it may hire another company to provide this function. Physician income is usually based on the performance of both the individual physician and the group.

Who Owns a GPWW?

A GPWW may be owned by its member physicians, by a hospital, or by a physician practice management company.

When the member physicians own the GPWW, how does it differ from an IPA?

A GPWW performs business operations for physician members, while IPA members generally conduct their own business operations. (The IPA only negotiates contracts.) On the other hand, a GPWW differs from a consolidated medical group in that the GPWW physicians maintain their practices independently at multiple locations. [vii] [viii]

Management Services Organization (MSO)

Another physician-only model in the middle of the integration continuum is the **management services organization (MSO)**.

An MSO, owned by a hospital or a group of investors, provides management and administrative support services to individual physicians or small group practices.

One purpose of MSOs is to relieve physicians of nonmedical business functions so that they can concentrate on the clinical aspects of their practices. Because MSOs integrate business functions that were previously separate, they can generally achieve economies of scale, and these cost savings may be passed on to physicians, health plans, and purchasers.

MSO Arrangements

In some cases, MSOs simply provide business services to physicians for a fee. In other cases, MSOs purchase the tangible assets (buildings, equipment, and supplies) of physicians and lease them back to them.

In these situations, the physicians continue to own their own medical records and health plan contracts and continue to practice in their own offices. This arrangement relieves physicians of yet another nonmedical aspect of running a practice.[ix] [x] [xi]

Physician Practice Management (PPM) Company

One type of MSO is the **physician practice management (PPM) company**. This is an organization, owned by a group of investors, that purchases physician practices. Note that PPM companies generally purchase the entire practice, not just the tangible assets as previously discussed.

The PPM company usually gives a physician a long-term contract to continue working in his practice, and sometimes it gives him an ownership interest in the company. The PPM company manages the practice, particularly the non-medical aspects.

Physician Practice Management (PPM) Company (Continued)

Most PPM companies focus on developing a network of either primary care physicians or physicians in a certain specialty, such as cardiology or oncology. PPM companies were active in the 1990s and then fell from favor following several high-profile bankruptcies. In recent years, there has been a resurgence of PPM activity.[xii]

Consolidated Medical Group

Full structural and operational integration of physician practices is embodied by the **consolidated medical group**, also referred to as the medical group practice or clinic model. This is a large single medical practice that operates in one or a few facilities rather than in many independent offices. The group may be formed from previously independent practices. The group is often owned by a parent company or a hospital, and it may be a single-specialty or multi-specialty practice.

Advantages of a Consolidated Medical Group

A consolidated medical group can offer several advantages to health plans, including:

- lower costs because of economies of scale resulting from the group's integrated and centralized operations,
- access to a sizeable and stable group of physicians, and
- greater ability to monitor and manage quality and utilization.

Physician-Hospital Models

Physician-Hospital Models

In addition to organizations that integrate physician practices, there are also those that integrate, to a lesser or greater extent, physicians with one or more hospitals.

These organizations contract with health plans on behalf of the physicians and hospitals they represent and may contract directly with purchasers. Some serve other purposes in addition to contracting.

Physician-Hospital Organization

A **physician-hospital organization (PHO)** is a joint venture of a hospital and many or all of its admitting physicians. Its primary purposes are contracting with health plans and marketing.

Apart from these functions, the physician practices and hospitals typically do not merge their operations. They continue to be independently owned and operated, but they serve patients under the terms of the contract between the PHO and the health plan. Participating physicians and hospitals share responsibility for managing and administering the PHO.

Physician Hospital Community Organization

Many PHOs are affiliations of one or more hospitals and an IPA or other association of physicians.

A PHO is similar to an IPA, but it includes at least one hospital and usually a wider variety of providers. Sometimes a rural community contracts with a PHO and becomes a party to a health plan contract, resulting in an entity called a **physician hospital community organization (PHCO)**.

Two Types of PHOs

A PHO may be classified as one of two types:

- Open PHO
- Closed PHO

Open PHO

Membership in an **open PHO** is available to all of a hospital's eligible medical staff.

Typically, open PHOs have more specialists than PCPs. Sometimes an IPA or a GPWW represents all or some of the physicians in an open PHO.

Closed PHO

A **closed PHO** limits the number of specialists for each specialty.

A variation of the closed PHO is the **specialist PHO**, which includes only providers of a certain specialty, such as psychiatrists or pediatricians.[xiii]

Common Compensation Arrangements

Common compensation arrangements for PCPs in a PHO are discounted fees and capitation. Specialists are typically paid on a discounted FFS basis. Increasingly though there is a move to value-based care.

Because a PHO can offer a broad range of healthcare services under one umbrella, participating in a PHO gives physicians and hospitals greater leverage in negotiating contracts with health plans and employers. Also, joining a PHO enables hospitals to improve their relationships and enhance their collaboration with physicians and market their services more effectively. Other reasons hospitals and doctors form PHOs include sharing financial risk and enhancing the quality of care.

Integrated Delivery System (IDS)

As previously mentioned, an **integrated delivery system (IDS)** is a provider organization that is fully integrated operationally (both in terms of business and clinical) and provides a full range of healthcare services, including physician services, hospital services, and ancillary services.

Because of this comprehensiveness, an IDS can be in a strong position to attract and negotiate with health plans or purchasers.

Various IDS Integration Structures

Although an IDS is fully integrated operationally, it may or may not be highly integrated structurally.

- Some IDSs are structured as contracts between providers that maintain ownership and substantial control over their own practices.
- In other IDSs provider practices are owned and controlled by the IDS. This type, the **employment model IDS**, generally owns or is affiliated with a hospital, purchases or establishes physician practices, and retains the physicians as employees.
- Some IDSs assume insurance risk.[xiv]

Medical Foundation

In some states laws prohibit a corporation from owning a physician practice, making an employment model IDS impossible.

In these states some hospitals and health plans have instead created **medical foundations**, not-for-profit entities that purchase and manage physician practices. However, to maintain its not-for-profit status, a medical foundation must meet certain requirements related to the benefit it provides to the community, and this may make it difficult for it to compete with other organizations that are not subject to this requirement.[xv]

Provider Organizations That Assume Insurance Risk

Risk Organizations

Some of the provider organizations described in this lesson (such as some IDSs, consolidated medical groups, IPAs, and PHOs) not only integrate provider functions but assume insurance risk. They are commonly referred to as **at-risk organizations**.

An at-risk provider organization contracts directly with purchasers and health plans.

Division of Functions

For a health plan, contracting with an at-risk provider organization has the advantage of relieving the plan of all or part of the responsibility of developing a provider network. But certain issues may arise in relation to the division of responsibilities between the plan and the provider organization.

- The provider organization may want to handle credentialing and claims payment because it does so for other payors (such as Medicare) and wants to spread the costs over a broader business base. But the health plan may also want to perform these functions so that it can make sure they are done correctly and in accordance with the contract. The health plan also needs claims data for quality and utilization management.

- To control costs more effectively, the health plan may want fewer network providers than the provider organization.

This division of functions may be governed by state regulations or influenced by the requirements of accreditation agencies. For example, in many states, laws require HMOs to perform certain functions.

How an At-Risk Provider Organization Provides Insurance

To provide insurance, an at-risk provider organization needs to develop, acquire, or otherwise gain access to expertise in many areas of insurance operations, including actuarial science, underwriting, claims, and quality and utilization management.

The provider organization can perform these functions itself or contract with another entity such as an insurance company or other health plan to provide them.

Depending on the state in which it operates and exactly how it operates, an at-risk provider organization may have to obtain an insurance company license and comply with the laws and regulations that apply

to such organizations. In some states an at-risk provider organization does not need an insurance license but is required to maintain substantial financial reserves.

Emerging Models

Accountable Care Organization (ACO)

An accountable care organization (ACO) is a group of healthcare providers who deliver comprehensive and coordinated care with an emphasis on screening, prevention, and ongoing management of chronic diseases, thereby improving the quality of care received by patients.

***Example*:** In an ACO a primary care physician and a specialist might work together to treat an adult with type II diabetes, monitoring their diet and medication to prevent hospitalization and the possible amputation of a limb.

History of the ACOs

The term was first coined in 2006 in an article by industry leader Elliott Fisher.

Although many of the underlying concepts were already being pursued by private commercial health plans, ACOs received considerable attention due to their inclusion in the Affordable Care Act (2010) legislation which directed the Secretary of Health and Human Services (HHS) to create the Medicare Shared Savings Program.[xvi]

ACO Compensation Models

Private ACOs have considerable flexibility devising their compensation models. Although most include risk sharing, the extent of such risk sharing, upside, downside, or a combination of both can be tailored to the particular needs and competencies of participants.[xvii]

Example: An ACO might agree to accept a smaller share of upside risk rather than a higher portion of upside risk along with downside risk because it lacks the necessary insurance experience and financial resources to withstand a potentially huge monetary outlay.

Example: Another ACO with deeper experience and financial pockets might opt for a higher share of potential savings in return for assuming all or a portion of the downside risk.

Medicare Shared Savings Program

ACOs participating in the Medicare Shared Savings Program have less flexibility. They must participate in one of four tracks with various levels of risk:[xviii]

Four tracks offered by the Medicare Shared Savings Program:

Track	Financial Arrangement	Description
1	One-sided	Track 1 ACOs *do not* assume downside risk (shared losses) if they do not lower growth in Medicare expenditures.
1+	Two-sided	Track 1+ ACOs assume limited downside risk (less than Track 2 or Track 3).
2	Two-sided	Track 2 ACOs may share in savings or repay Medicare losses depending on performance. Track 2 ACOs may share in a greater portion of savings than Track 1 ACOs.
3	Two-sided	Track 3 ACOs may share in savings or repay Medicare losses depending on performance. Track 3 ACOs take on the greatest amount of risk but may share in the greatest portion of savings if successful.

As mentioned earlier in our studies, most ACOs are currently participating in either Track 1 or Track 1+ with limited risk sharing.[xix]

The goal of the CMS *Pathways to Success* program is to move increased numbers of ACOs providing coverage to Medicare enrollees into two-way (upside and downside) risk contracts. As part of this, CMS has replaced the four tracks with what are now termed Basic and Enhanced Tracks.[xx xxi xxii xxiii]

Patient-Centered Medical Home (PCMH)

A **patient-centered medical home (PCMH)** is a model of healthcare delivery in which each patient has a personal physician who is responsible for providing or coordinating care for them on a continuous basis.

In an effort to achieve better health outcomes and more efficient use of resources, the PCMH model seeks to replace healthcare delivery in which a person receives various medical services from a succession of different providers in reaction to illnesses that arise with a strong, long-term physician-patient relationship and continuity and coordination of care.

Main Features of a PCMH

The main features of a patient-centered medical home include the following:[xxiv]

- The personal physician
- Physician directed care
- Whole person and patient centered care

- Coordination of care
- Quality and Safety
- Enhanced Access to Care

The Personal Physician

The personal physician. Each patient in a PCMH has an ongoing relationship with a personal physician. The personal physician serves as the patient's first contact point when he/she needs care, and they coordinate his/her care with specialists, other healthcare professionals, laboratories, and hospitals.

The personal physician is responsible for providing or coordinating preventive care, the treatment of acute illnesses and chronic conditions, and (where appropriate) assistance with end-of-life issues. They are responsible for care across settings, including the doctor's office, the hospital, and the patient's home. They also play an educational role, helping patients understand test results, procedures, and treatment options.

Physician-directed Care

Physician-directed care. In a PCMH the personal physician leads a team of providers who collectively assume responsibility for ongoing care of the patient.

Example: For a particular patient the personal doctor might coordinate the services of a specialist, a lab technician, and a dietician.

Whole Person and Patient Centered Care

Whole person and patient-centered care. The strong and ongoing relationship between the patient and the personal physician allows an approach that includes the whole person and is patient-centered.

Instead of medical conditions being treated in isolation, a patient's total physical condition and health history are fully considered, so that overlapping and negative interactions of treatments are avoided.

Also, a personal doctor can be aware of both a patient's mind and body; can consider their personal values, preferences, and quality of life in weighing clinical alternatives and priorities; and can educate them and their family about their medical options and how to stay healthy.

Coordination of Care

Coordination of care. The PCMH model coordinates healthcare not just within a medical practice, but across all components of the healthcare system including specialty care, hospitals, nursing homes, home health agencies, community-based services, and even care provided by family and friends.

PCMH coordination relies heavily on technology, including electronic medical records and databases and registries.

Quality and Safety

Quality and safety. The PCMH model seeks to provide optimal outcomes by delivering evidenced-based medicine and using clinical decision-making support tools to guide treatment.

The PCMH design also avoids patient safety risks that can arise from the lack of communication and coordination of treatments that often occur in a fragmented healthcare delivery system.

Enhanced Access to Care

Enhanced access to care. The PCMH model seeks to make access to care more available through expanded office hours and technology. Alternatives to face-to-face communications, such as email and telephone conversations, can play a role in non-emergency situations.

Primary Care Provider Compensation

There are a variety of approaches to compensating the primary care provider at the center of the PCMH model. These include:

1. enhanced fee-for-service evaluation and management payments
2. additional codes for medical home activities within the fee-for-service payment system
3. per patient per month medical home payments to augment fee-for-service visit payments
4. risk-adjusted per patient per month payments

Mixed PCMH Payment Compensation

These four approaches are not mutually exclusive alternatives.

A PCMH model may include a mix of fee-for-service payment for physician visits, additional compensation for care management, and incentive payments for achieving measurable quality goals.

Upside shared savings can also be incorporated into the compensation received by participating providers in PCMHs. These varied approaches seek to recognize the time and effort physicians spend guiding patients' overall care and pays them for it, in contrast to pure capitation and pure fee-for-service.[xxv] [xxvi] [xxvii] [xxviii]

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12 Network Structure and Management

Learning Objectives

After completing this lesson, you will be able to:

- identify the main considerations in a market analysis for a health plan network
- list the factors in deciding the number, types, and locations of providers in a network
- describe the main steps of the provider recruitment and selection process
- describe provider credentialing
- identify the most important provisions of the provider contract
- briefly explain at least two key pieces of legislation and their impact on plans and providers

Network Structure and Management

Health plans arrange for the delivery of high-quality, cost-effective healthcare services to plan members.

This is accomplished by the development and management of the plan's provider network, which is the set of doctors, hospitals, and other health care practitioners that are part of the plan.

Since the plan's members interact with the organization primarily through its providers, the steps the plan takes to design, assemble, monitor, and maintain its network are critical to the success of the plan.

Network Structure and Management (Continued)

In this lesson, we begin our discussion of network management by describing factors that influence network design.

Next, we address some standard considerations in network structure, such as size and composition, with a particular focus on considerations relating to **narrow networks**. We then discuss some of the issues health plans address when selecting, credentialing, negotiating with, and contracting with providers. We will briefly discuss recently passed legislation, the No Surprises Act, and its impact on both plans and providers.

We finish the lesson with an overview of the activities that are necessary to maintain the network and cultivate provider satisfaction.

Market Analysis

Not all doctors and hospitals in a community are necessarily part of a health plan's provider network. To establish a provider network, a health plan must understand the characteristics of its proposed service area, the needs of its proposed members, and its proposed products and focus.

A **market analysis** is the tool used by plans to gather and analyze information on characteristics of the market, providers, competitors, employers, service area, general population, and the health plan itself.

Market analysis also includes an analysis of current economic conditions. With continuing advances in technology, health plans are now able to use increasingly sophisticated data analytics tools to conduct detailed health plan network comparison and analysis.

Market Maturity

One purpose of analyzing the market is to understand the level of health plan activity in a market—referred to as **market maturity**. The level of maturity in the market often indicates how knowledgeable providers and consumers are about health plans, how receptive providers and consumers are likely to be to health plans, and how active competition is among health plans in the service area. Markets at different levels of maturity require different network management approaches and strategies.

Example: In a market with little health plan activity, consumers and purchasers are likely to be more receptive to loosely managed plans, such as Preferred Provider Organizations (PPOs) and Point-of-Service (POS) plans, than to tightly managed plans such as Health Maintenance Organizations (HMOs) or Exclusive Provider Organizations (EPOs).

The Provider Community

The purpose of analyzing the provider community is to understand the types, numbers, and locations of healthcare providers in the proposed service area, as well as utilization patterns and healthcare costs.

Providers include physicians, hospitals (the services they provide and the number of beds), and other practitioners (such as, e.g., nurse practitioners, therapists, and other clinicians) and facilities.

Analysis of the provider community also includes understanding the locations of the providers, including distances between provider locations and members' homes and workplaces as well as any geographic barriers that may affect access.

Why is this Important?

It is critical for the health plan to also understand existing referral patterns and established provider relationships in the service area, as well as hospital admitting/procedural privileges. Many physicians have established relationships with particular healthcare professionals in their community.

Why is this Important? (Continued)

In some communities, groups of physicians may be affiliated with one entity (such as a hospital, a physician group or organization, or a physician/hospital-type organization). Understanding the existing referral patterns and the relationships of the providers in the proposed service area allows the plan to utilize network approaches and techniques reflective of these relationships.

For example, if many of the physicians in the service area are affiliated with a single entity, the plan will most likely need to contract with that entity, while if most physicians are not affiliated with a single entity, the plan has more contracting options

The Competition

Analysis of the competition includes understanding and assessing other health plans in the market. This assessment should include the following types of information for each competitor plan in the proposed service area:

- competitor product types and premiums,
- competitor network characteristics, including provider numbers, types, locations and physician- to-member ratios,
- network overlap (where the same providers participate in multiple networks) and exclusivity (where certain providers are exclusive to a single health plan network),
- network volatility, including (i) the number of providers added and dropped from competitors' networks and (ii) geographies where competitors are strengthening networks by adding providers, focusing efforts on network expansion in new areas, or contracting networks,
- cost-containment strategies used by competitors; and
- provider satisfaction with competitors.

Employer-Provided Insurance

Employer-provided insurance remains a cornerstone of the US health care system, covering millions of individuals. Analysis of the employers in the area is thus an important component of market analysis. Part of this analysis includes understanding the size of employers.

Affordable Care Act

While the Patient Protection and Affordable Care Act of 2010 (also known as the **Affordable Care Act (ACA)**, Healthcare Reform, or Obamacare) imposed new requirements for employers of more than fifty (50) full time equivalent (FTE) employees to offer certain types of coverage or else face penalties, it remains the case that fairly large employers (more than 1,000 employees) tend to adopt health plans more quickly and are more likely to offer a choice of health plans than small companies.

Smaller companies, on the other hand, may have less experience with health plans and lack the financial and administrative resources necessary to offer multiple health plan options.

The Service Area

Analysis of the proposed service area includes understanding whether it is primarily rural, suburban, or urban.

Rural Service Area

Rural communities typically have more limited numbers and types of providers and facilities, including fewer hospitals. This can make it difficult for health plans to build a comprehensive network that

satisfies member demand for a complete range of healthcare services. Also, in rural areas with few providers, the health plan may have little or no choice about which facilities to include in its network.

Urban Service Area

Urban areas (population greater than 500,000) have larger numbers of physicians and facilities. The characteristics of urban areas offer health plans with more flexibility in provider contracting. However, with more providers there may be increased pressure on the plan to offer larger networks. This in turn can complicate the plan's management of costs, quality, and satisfaction levels.

A recently emerging alternative is for a plan to offer smaller, more selective networks, regardless of the number of physicians and facilities in the area. This phenomenon, known as **narrow networks**, will be discussed in more detail later in the lesson.

The Population

Analysis of the population includes understanding key demographic characteristics. Characteristics of the population in the proposed market often influence the mix of providers and facilities included in the network. Some important population characteristics are:

- ages
- income levels
- ethnicities
- religions

***Example*:** Health plan networks that serve the elderly (Medicare) often need to include post-acute care facilities (rehabilitation centers and skilled nursing facilities) in their networks. Plans that serve populations with large ethnic, racial, or religious groups should have networks that accommodate diverse language, cultural, and medical needs.

The Health Plan

The characteristics of the health plan affect the requirements for its network. Some of the characteristics of a plan that affect network requirements are:

- products offered by the health plan (number and types)
- geographic scope and market focus
- particular population
- plan type

Nested, Customized, Sub-networks

Health plans that offer more than one type of plan may choose to develop separate networks for each plan type. Another option is to coordinate provider networks through a system of interrelated networks, sometimes referred to as **nested, customized, or sub-networks**. Typically plans that offer only one type of health plan establish a single network designed around a unique set of goals and strategies.

Economic Conditions

Network design and management can be influenced by the level of growth or decline in an economy.

A growing economy typically leads to increases in employment, population growth, and eventually growth in the medical community such as more hospitals, physicians, and other providers.

On the other hand, a declining economy would likely have the opposite effect.

Regulatory Requirements and Accreditation Guidelines

In addition to understanding the characteristics of the proposed market, a health plan must understand and comply with the wide range of federal and state laws and regulations. And if the plan is or seeks to be accredited, it must meet the standards set by accrediting agencies that are applicable to its network.

Laws and Regulations

Laws and regulations affecting health plans will be discussed in more detail in a later lesson, but at this point it is important to understand that some are applicable to a plan's provider network, including those that address issues such as network adequacy, patient access to healthcare services, surprise billings laws, quality of care, mandated benefits, and providers' right to contract.

In this section we will summarize some of these laws.

The Federal Employees Health Benefits Program

Originally established in 1960, the Federal Employees Health Benefits (FEHB) program requires health plans serving federal employees and their dependents to provide:[i]

- immediate access to emergency services,
- urgent appointments within 24 hours,
- routine appointments within one month, and
- average office waiting times of no more than 30 minutes.

HMO Act of 1973

The HMO Act of 1973 established certain standards for federally qualified HMOs, including requirements to provide:[ii]

- geographic accessibility to primary care and most specialty providers with "reasonable promptness" and "within generally accepted norms for meeting projected enrollment needs,"
- access to medically necessary emergency services 24 hours a day, seven days a week; and
- a detailed description of service areas and provider locations.

The Affordable Care Act

Since 2014, the Affordable Care Act (ACA) has required most health plans to cover a comprehensive set of healthcare services, including:

- preventive and wellness care
- prescription drugs
- mental healthcare
- emergency care
- ambulance services
- other services - as stipulated by the Secretary of Health and Human Services (HHS).

The ACA also set a national standard for network adequacy, requiring "a network that is sufficient in number of types and providers," and that "all services will be accessible without unreasonable delay." But the interpretation of "sufficient" and "reasonable" was left to the states.[iii] Over the years since the passage of the ACA, network adequacy standards, requirements, deference to state regulators, and definitions have evolved and continue to do so as changes in presidential administrations occur. Most recently, the Biden Administration set forth its priorities for plans to be sold on the ACA Marketplace(s) including the prohibition of discrimination based on sexual orientation and gender identity, and the advancement of health equity.[iv]

Health Benefit Plan Network Access and Adequacy Model Act

To guide state adequacy standards, in November 2015 the National Association of Insurance Commissioners (NAIC) updated its 1996 Managed Care Plan Network Adequacy Model Act and renamed it the Health Benefit Plan Network Access and Adequacy Model Act.[v]

Network adequacy is the extent to which a network offers the appropriate types and numbers of providers in the appropriate geographic distribution according to the needs of the plan's members.

The Revised Model Act

The revised Model Act includes standards for:

- provider-enrollee ratios (including as to primary care providers (PCPs) / by specialty),
- geographic accessibility of providers,

- geographic variation and population dispersion,
- appointment waiting times,
- hours of operation,
- the network's ability to meet the needs of all covered persons regardless of income, condition, or English language proficiency),
- other health care service delivery system options (such as, e.g., telemedicine, mobile clinics, or centers of excellence); and
- volume of technological and specialty care services available in the service area.

Under the revised Model Act, health plans are required to file, maintain, and follow an access plan showing how specific standards will be met.

Any Willing Provider (AWP) Laws

State **Any Willing Provider (AWP) laws**[vi] require health plans to allow any provider who is willing to accept the terms and conditions of the plan's provider contract to participate in the plan's network.

Such laws can be broad in scope, either identifying the list of providers covered by the provisions (such as physicians, pharmacists, chiropractors, optometrists, etc.) or asserting that the provisions apply to all providers licensed in the state without specifically listing any.

Georgia's AWP statute is an example of the broad type of law, as it applies to "*[e]very doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider within a class approved by the health care corporation….*"[vii]

They can also be limited in scope, such as laws applying only to pharmacies or pharmacists.[viii] A plan's ability to include economic criteria (such as average cost per case or per member) as a term or condition of the contract depends on particular state laws. In some cases, any willing provider laws apply to PPOs but not HMOs and similar plans.[ix]

Freedom of Choice Laws

State **freedom of choice (FOC) laws** permit a member to obtain reimbursable health care services from any qualified provider even if the provider has not signed a contract with the plan.

These laws often compel plans to pay the same amount to a non-network provider chosen by an enrollee as they pay to a network provider. This does not guarantee, however, that a member will incur the same out-of-pocket costs.[x]

Mandated Benefit Laws

State **mandated benefit** laws typically require health plans to:[xi]

- include in the plan's benefit design specific benefits (such as chiropractic, hospice, home healthcare, and hospitalization for maternity care of a specified length);

- include in the network specified providers or provider classes (such as behavioral healthcare professionals); and

- grant direct access without referral by the primary care physician to specified provider classes (such as dermatologists, obstetricians/gynecologists, and pediatricians).

Mandated Provider Laws

Mandated provider laws, which are a subset of state **mandated benefit** laws, typically require group health plans to cover the services of particular groups of licensed providers who are not physicians (such as chiropractors, optometrists, physical therapists, psychologists, registered nurses, and social workers).[xii]

The ACA federalized these state **mandated provider** laws, with a provision that bars group plans from discriminating against "any health care provider who is acting within the scope of that provider's license or certification under applicable State law."[xiii]

Surprise Billing Laws

Surprise billing laws also have emerged in a number of states.[xiv] This type of legislation is designed to protect consumers from surprise bills when services are performed by a non-participating (out-of-network) doctor at a participating hospital or ambulatory surgical center in an insurer's network or when a participating doctor refers an insured to a non-participating provider. These laws also typically protect consumers from bills for emergency services. [xv]

California's surprise billing law, passed in 2016, applies annual out-of-pocket caps on covered benefits inclusive of out-of-network emergency care received up to the point of patient stabilization.

Connecticut's surprise billing law, also passed in 2016, requires carriers to establish a process to ensure that beneficiaries receive benefits at in-network levels in circumstances when there is no available provider to provide covered benefits or when covered benefits cannot be provided without unreasonable travel or delay.[xvi]

In 2020, Congress enacted the No Surprises Act (NSA) effective January 1, 2022. This legislation seeks to provide a pathway to answer the questions:

- Who pays for medical care when a patient receives a surprise medical bill?
- How much does a patient receiving a surprise bill owe?

The NSA includes measures such as requiring both providers and health plans to treat out-of-network services as if they were in-network when calculating patient cost-sharing.[xvii]

Guidelines of Accrediting Agencies

Standards established by independent accrediting organizations also influence network design and management. The National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) are two of the best known accrediting agencies. You will learn more about health plan accreditation in a later lesson.

Network Structure, Composition, and Size

Structure

When it comes to health plan structure, considerations include how to structure the provider network (i.e., either as a **closed panel** or an **open panel**) and whether to require use only of **in-network providers** or to allow members to see and be reimbursed for care received from **out-of-network providers**.

Closed Panel Plan

In a **closed panel** plan, providers see only health plan members and generally operate out of health plan facilities and offices. Providers are either employed directly by the plan (**staff model**) or belong to a group of providers that hold contracts with the health plan (**group model**). In this type of plan, insureds typically must select a primary care physician who has control over referrals to other physicians.

Open Panel Plan

In an **open panel** plan, independent physicians or providers who meet the health plan's standards of care may be eligible to contract with the plan. Providers see both plan members and nonmembers and typically serve members out of their own facilities and offices.

Whether a plan structures its network as a closed or open panel network depends on the structure and characteristics of the health plan.

Use of In-Network and Out-of-Network Providers

Plans that Provide In-Network Care Only

- Plans in this category, typically HMOs and EPOs, provide covered benefits only through their provider networks. This means they do not pay for care received from out-of-network providers.

- Another feature these plans might have for in-network providers is known as a **tiered network**. A **tiered network** has different levels of providers that are grouped based on whether they are higher performing in terms of quality, safety, and efficiency, or lower-performing in these areas when compared to their peers.

Plans that Provide In-Network and Out-of-Network Care

- Plans that offer access to both in-network and out-of-network care may include PPOs and POS plans.

- Plans in this category may offer lower cost-sharing requirements when members use care delivered by in-network, preferred providers.

Composition

As we learned previously, a health plan ensures that its members have convenient access to healthcare services. To provide good access, health plans must see that their networks include;

- the appropriate types of providers,
- the appropriate number of providers, and
- providers in the appropriate locations.

Maintaining Adequate Networks

Regulations and standards require that networks be "adequate."[xviii]

Guidelines have been established and are used to develop and maintain networks that are adequate in structure, composition, and size, to meet the needs of plan members and ensure access to services without unreasonable delay.

The composition of a plan's network is important to the health plan for many reasons, including marketing and product differentiation, member satisfaction and retention, and compliance with laws and standards specific to network adequacy.

Types of Providers

Primary Care Providers

A health plan's provider network typically includes a mix of the following types of providers.

Primary care providers (PCPs). In most cases primary care providers are general practitioners, family practitioners, internists, or pediatricians. Some plans classify obstetricians/gynecologists (OB/GYNs) as primary care providers, while others consider them specialists. Some plans also include nurse practitioners (NPs) and physician assistants (PAs) in their primary care panels, but NPs and PAs typically work under the supervision of a physician, and their ability to provide services independently may be limited by state law.

Specialist

Specialists. A specialist is a healthcare professional whose practice is limited to a certain branch of medicine, based on specific services or procedures (such as anesthesia), specific body systems (neurology), certain types of diseases (oncology), or an age group (pediatrics or gerontology). Ideally, all specialty categories will be represented in a provider network.

Hospitalists

Hospitalists. A hospitalist is a physician who exclusively manages inpatient hospital care. Hospitalists may be employed by a hospital or be in a medical group. Hospitalists allow other physicians to focus on the outpatient care of their patients.

Healthcare Facilities

Healthcare facilities. Health plans contract with a variety of facilities including hospitals, ambulatory surgery facilities, ambulatory diagnostic and treatment centers, retail health clinics, sub-acute care facilities, and skilled nursing facilities.

Ancillary Service Providers

Ancillary service providers. "Ancillary services" is an umbrella term for a variety of healthcare services that are an adjunct to primary, specialty, and facility-based care. Ancillary services include diagnostic services (such as laboratories and radiology), therapeutic services (including home healthcare), physical and occupational therapist, pharmacists, and durable medical equipment and supply companies.

Number and Locations of Providers

Factors such as health plan characteristics, provider access, population characteristics, purchaser and consumer preferences, and health plan goals influence network design. We will now review how these factors specifically influence the number and locations of healthcare practitioners, hospitals, and facilities needed by the health plan.

Practitioners

Plan Characteristics

Level of managed care. In general, more highly managed plans (plans that practice more managed care techniques and concepts) need fewer providers than more loosely managed plans. For instance, an HMO, which is highly managed, requires fewer providers than does a PPO or POS product with the same number of members.

Size of plan. Large plans typically need fewer providers per 1,000 members than do small plans because large plans can benefit from economies of scale and other efficiencies. However, if the membership in a large plan is geographically widespread, the plan may need a broader panel to provide adequate access to care and services.

Provider Access

A provider-to-member ratio is a ratio of the number of providers available to plan members to the number of members (usually number of providers per 1,000 members). Ratios can be used for both PCPs and specialists.

Geographic distribution is based on the number of providers within a certain number of miles and/or a certain number of minutes of driving time. Software is used to measure the accessibility of healthcare networks and evaluate geographic distribution for specific provider types.

Click here for an Example of Geographic Distribution.

Example: To maximize access a plan may require that its network have at least two PCPs within a three-mile radius of each ZIP code in the service area. Or a network might include at least two PCPs within a given radius of members' homes (such as an eight-mile radius for urban areas or a 20-mile radius for rural areas). Drive time refers to how long members must drive to reach a provider. Drive time is typically set at 15 minutes for urban areas and up to 30 minutes for rural areas. In some states, health plan licensure bodies (such as the Department of Insurance) have established requirements for access based on time or distance.

Other considerations. Provider capacity to accept patients and the clinical skills of various providers are other factors that can also impact staffing needs.

Population Characteristics

Demographic Characteristics

Demographic characteristics of plan membership such as age, sex, income, ethnicity, and education level influence both the numbers and types of providers in the network.

For example, networks of plans with large numbers of women and children typically include large numbers of OB/GYNs and pediatricians. Plan networks serving Medicare beneficiaries typically have larger numbers of providers and a broader mix of specialists than networks serving similarly sized younger populations.

Purchaser and Consumer Preferences

Primary factors that influence customers' selections among health plans are perceptions of quality, access to care, and costs.

Perceived quality. If perceived quality is the dominant consideration, then the actual composition of the network and provider selection criteria are key elements of the network development.

Access. If access is the major issue for customers, a large, very inclusive network is desirable.

PCPs

For purchasers and members, the primary care panel is typically the largest and most important component of the provider network.

Larger PCP panels tend to result in higher market share and high levels of member acceptance and satisfaction, but they can result in higher plan costs.

Limiting the size of the PCP panel can reduce costs for administration and network management, but these reductions historically have been outweighed by customer preferences for larger PCP panels.

Specialists

The size of the specialist panel is typically less important to customers than the size of the PCP panel.

Therefore, health plans can often limit specialist panels to include only providers who offer the highest-quality, most cost-effective care in the service area.

Hospitals and Other Facilities

The goal of a health plan is to include enough facilities in its network to effectively serve the plan's membership. Therefore, the network needs the appropriate number of hospitals and facilities of the appropriate types and in the appropriate locations.

Many of the factors that affect the number of practitioners needed in a network also affect the number and locations of hospitals and other facilities. Considerations include:

- access by plan members
- service capacity
- types and quality of services offered
- accreditation status
- reputation within the service area
- cost and use of resources
- level of participation in health plans
- willingness to agree to contract terms acceptable to the health plan.

Member Preferences

Member preference may also affect the number of facilities included in a network if preferences are strongly divided among facilities.

Also, if a plan wants to contract with a hospital that is part of a multi-hospital entity, the plan may also have to contract with the other hospitals that belong to the entity.

Narrow Networks

A recent trend in the health insurance industry is the emergence of **narrow network** health plans, which offer a smaller number of providers and in-network facilities than traditional provider networks, often resulting in lower premiums.

These types of plans go by many names, including: **custom**, **high-performance**, **tailored**, **select**, **high-value**, and **narrow networks**. Generally, the networks available for such plans are smaller because they are limited to a set of doctors and hospitals that meet additional performance standards.

History of Narrow Network

Narrow network plans first appeared in the 1990s as part of an effort to control premium costs by restricting patient access to a select group of low-cost providers.

Such plans subsequently fell out of favor, however, for allegedly sacrificing quality for cost, with benefits managers instead opting for full-service HMOs and open access PPO alternatives.

Narrow Networks Today

With employers and patients now seeking greater value for their health care dollars, businesses increasingly are showing more willingness to offer narrow network products that encourage members to use more efficient health care alternatives, either by:

- restricting networks to the most efficient providers
- and/or by having different copays and coinsurance for providers in different tiers of the

network Narrow Network Compliance

Narrow network plans must comply with state and federal laws and regulatory requirements, including network adequacy standards.

Ensuring member satisfaction despite a smaller network requires various measures, such as:

- active cooperation and collaboration between the health plan and participating providers
- a focus on quality measures as a key part of the criteria used for provider selection and inclusion in a plan's network.

The Narrow Network Choice

Some reports suggest that consumers are picking narrow network plans over broader options with increasing frequency and generally are satisfied with their choices, and there is some evidence suggesting that such plans perform just as well as plans that offer access to a broader range of providers.

Concerns sometimes arise about the ability of such plans to provide timely access to care, including services from specialists and high-performing hospitals, however, potentially leading to litigation and increased oversight from federal and state legislators/regulators. [xix] [xx] [xxi]

Provider Recruitment and Selection Facilities

Recruitment

During a health plan's analysis of the market, discussed earlier in this lesson, the plan gathers, analyzes, and understands important information about the provider community in the service area, including the number and locations of providers.

Information Used in the Recruitment Process

The following sources provide additional information about providers and may be used in the recruitment process:

- Purchasers, plan members, plan personnel, and other providers. Recommendations from purchasers and enrollees are very valuable to the plan. Inclusion of providers recommended by purchasers and enrollees can give the health plan a competitive advantage when negotiating with purchasers and can also help sell the plan to potential members.
- Local, state, and national medical societies
- Directories and lists
- Provider directories from competing plans

Communication During Recruitment Phase

During the recruitment phase of the network development process, a health plan typically sends a mass communication to the providers in the service area.

This communication introduces the health plan and gives information about it. It usually describes the plan's credentialing process and may include a copy of the plan's fee schedule and a provider contract.

Selection

To be selected by a health plan for its network, a provider must demonstrate to the plan that he or she is able to meet the needs of the plan and its members. Major components of provider selection process are:

- application,
- credentialing
- recredentialing

Application

The selection process begins with the submission of an application by the provider. Although application forms vary, most include questions on the following:

- basic demographic information
- office information (location, phone numbers, limitations)
- education and training
- work history
- professional licenses

- certifications (specialty, DEA)
- specialty care certification or eligibility
- hospital affiliations
- malpractice insurance information
- malpractice claims history
- references

Click here for more on DEA.

> Health care providers are registered with the United States Drug Enforcement Administration and are assigned identifier numbers allowing them to write prescriptions for controlled substances.[xxii]

Credentialing

Once a health plan receives the provider application, it begins the credentialing process.

This includes:

- reviewing and verifying the information submitted on the application form
- determining the provider's current clinical competence
- verifying that the provider meets the health plan's preestablished criteria for participation in the network

The Importance of Credentialing

A principal goal of health plans is to offer members a delivery network that includes high-quality providers. Specifically, credentialing addresses these objectives:

- evaluating providers and determining which are the most qualified,
- minimizing the liability and other legal risks associated with medical practice by eliminating providers whose histories and practice patterns indicate that they might pose a legal risk for the plan, and
- meeting the requirements of accrediting bodies and regulators for accreditation or licensure.

Because credentialing is such an important part of the selection process, we will examine credentialing in detail, review who typically performs credentialing, describe how the credentialing process works, and discuss standards used in the credentialing process.

Credentialing—Who Does It?

The responsibility for credentialing varies from plan to plan.

In some plans credentialing is handled by a committee or department, while in others it is performed by an individual.

In other plans, credentialing is contracted to external entities called **credentialing verification organizations (CVOs).** Practitioners are usually included in the credentialing committee or serve on the review body; they provide technical knowledge and peer perspectives in the credentialing process.

The Credentialing Process

As mentioned, the credentialing process begins with the provider's submission to the health plan of a completed application (and required supporting documentation).

The next steps in the process are completed by the health plan and include:

- review of the application
- verification of the documentation and information
- determination of the need for additional documentation or follow-up
- request for any information required to verify credentials

The health plan may also perform site inspections of the provider's offices and may inspect and evaluate medical records on site.

Note that the credentialing process typically is completed before the health plan contracts with the provider.

Standards Used in Credentialing—Guidelines, Policies, Procedures, and Criteria

Health plans establish and utilize plan-specific guidelines for credentialing, with each plan's guidelines reflecting the unique characteristics of the plan.

- Written policies define the requirements for participation in the network and identify the specific documentation that will be used to verify requirements.

- Procedures describe how the process is performed.

- Criteria are used to assess a practitioner's ability to deliver necessary care to health plan members and typically include, e.g., completed education, licensure, relevant training and/or experience, any certifications issued in the practitioner's area of specialty, and disclosure of any issues that may affect care delivered (such as health issues).

Verification

As noted, during credentialing the plan verifies the information submitted by the provider on the application form and validates that the provider meets the health plan's preestablished criteria for participation in its network.

To ensure that credentialing decisions are based on accurate and current information, health plans are required to obtain documents directly from educational institutions and agencies (primary sources). Health plans often delegate primary source verification activities to third-party CVOs.

Verification (Continued)

Many of the standards and criteria used by health plans in credentialing verification are based on existing standards established by accrediting agencies such as NCQA and URAC.

In addition, a health plan is required to obtain information relating to malpractice, licensure, actions taken related to professional reviews, actions taken by the Drug Enforcement Agency (DEA), and Medicare/Medicaid exclusions.

The Data Bank

The **Data Bank**, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB),[xxiii] is a repository for information relating to malpractice, licensure, and actions taken related to professional reviews.

Credentialing—Organizational Providers

During the credentialing process, health plans are required to evaluate the quality of organizations such as hospitals, nursing homes, and home health agencies. Health plans must verify that these organizations are in good standing with regulatory bodies and accredited by the appropriate accrediting body.

The Selection Decision

The health plan's decision to either select or not select a provider for its network is based on the needs of the health plan and the provider's qualifications. Selection decisions cannot be based solely on the provider's membership in another organization such as a hospital or medical group. Health plans must apply standards consistently and fairly. Applying standards consistency and fairly and adhering to the plan's written policies and procedures reduce issues that can result in legal actions by providers.

Recredentialing

As noted, the credentialing process begins before the provider receives a final contract.

Once a plan contracts with a provider, it begins an ongoing process of periodically reviewing the qualifications of the provider and verifying that the provider still meets the standards for participation in the network. This process is known as **recredentialing** and is typically performed every two to three years.

During recredentialing, the health plan verifies the information in the provider's credentialing data file that is subject to change over time.

Examples include licensure, sanctions, certifications, competence, or health status that might affect the provider's ability to perform services defined in the health plan contract. Many plans also consider results from their quality management and utilization management programs as well as member satisfaction surveys and any member complaints.

Contracting

Once a health plan has selected a provider for its network, the plan presents to the provider an initial contract that specifies the terms of their agreement.

The health plan and provider may negotiate and agree to change some of the terms of the contract.

When both parties have reached final agreement on the terms, they each sign the contract and it takes effect.

Properly Executed Contracts

A properly executed contract serves the following important purposes:

- ensuring that both parties understand and consent to their responsibilities to each other,
- providing a reference for clarification of responsibilities in case there is a misunderstanding or disagreement between the parties, and
- serving as evidence in a legal action by the aggrieved party if either party feels that the other has failed to live up to its responsibilities.

Contract Provisions

Health plan provider contracts generally include many provisions. Provisions may be included in the body of the contract, included in exhibits attached to the contract, or incorporated by reference in the contract.

Incorporation by Reference

Incorporation by reference occurs when a document is made a part of the contract by being referred to in the body of the contract. For instance, a health plan's provider manual is often incorporated by reference into provider contracts.

Since provider contracts are based on the characteristics of the health plan, contracts and contract provisions vary from contract to contract. Additionally, there are important provisions that typically exist in provider contracts.

The Provider Manual

A **provider manual** is a document that contains information about a provider's rights and responsibilities as a part of a health plan's network.

Provider manuals are usually incorporated by reference into the contract or are included as exhibits, as these documents tend to change frequently.

By including the provider manual as an exhibit or incorporating it by reference, the manual can be changed without necessitating a change to the entire contract.

Provider Responsibilities

The contract defines the responsibilities of both the provider and the health plan. The following are some provider responsibilities commonly found in provider contracts:

- *Provider services.* The contract typically includes a general description of the healthcare services that the provider agrees to furnish and a more detailed and specific description of how the services will be provided.

- *Administrative policies.* The contract generally defines the health plan's administrative policies and procedures that the provider agrees to follow. These policies are typically related to billing, including the required type of claim form and coding and requirements for timely filing of claims.

- *Credentialing and recredentialing.* Contracts normally require that the provider cooperate with the health plan's credentialing and recredentialing processes.

- *Utilization management and quality management.* The contract generally requires providers to cooperate with the plan's utilization management and quality management programs.

- *Medical records.* The contract typically requires providers to maintain complete and accurate medical records and allow health plan staff to access them when needed. Health plans need access to medical records for a variety of purposes such as quality management, utilization management, accreditation, audits and other types of reviews.

- *Payment in full.* Most contracts include a no balance billing provision, which requires the provider to accept the amount that the plan pays for medical services as payment in full and to agree not to bill the plan member for additional amounts except for copayments, coinsurance, and deductibles. Most contracts also include a hold harmless provision, which forbids providers from seeking compensation from patients if the health plan fails to compensate them because of insolvency or for any other reason.

Health Plan Responsibilities

The following are some health plan responsibilities commonly found in provider contracts:

- *Payment.* The contract specifies how the plan will compensate the provider. Since this changes frequently, it is typically included as an exhibit attached to the contract rather than in the body of the contract.

- *Timely payment.* The contract specifies the time period within which the health plan will provide payment to the provider for services rendered.

- *Risk-sharing and incentive programs.* The contract describes any incentive or risk-sharing plans such as withhold arrangements.

- *Eligibility information.* The contract affirms the health plan's responsibility to provide information on member eligibility and benefit levels. This information helps providers identify members and services covered by the plan. The contract also specifies how the health plan will provide this information (telephone, voice response unit (VRU), electronically, real time or batch, etc.).

Termination Provisions

Termination provisions, which are applicable to both the health plan and provider, stipulate how and under what circumstances the parties may end the contract.

Generally, the provider and the health plan have the same rights to terminate the contract. Contracts generally can be terminated with cause or without cause, and health plans use different procedures for each.

Termination With Cause

Termination with cause is permitted by all standard contracts. A termination with cause occurs when one party does not live up to its contractual obligations or breaches the contract.

For example, a provider fails to provide the services required by the contract, or a plan fails to compensate the provider. Contracts generally include a **cure provision**, which gives the party that breaches the contract a specified a time period (usually 60 or 90 days) to remedy the problem and avoid termination. Also, most contracts include a **due process clause**, which gives a provider that has been terminated with cause the right to appeal.

Termination Without Cause

Termination without cause may or may not be allowed by a contract; some states do not permit it. A termination without cause occurs when the plan or provider terminates the contract without providing a reason or offering an appeals process.

The terminating party is often required to give at least a 90-day notice. Generally health plans terminate providers without cause for business reasons rather than reasons related to the provider's performance.

The Tone of the Contract

In addition to describing the responsibilities of the parties, the contract gives both parties an opportunity to establish the tone and objectives of the relationship.

The contract can define the working relationship between the health plan and the provider as either detailed and formal or open-ended and informal. The contract can also either allow for substantial independent authority or include multiple checks and balances.

Impact on Business Relationship

The tone and structure of the contract also provide an opportunity for the health plan to influence the nature of the business relationship with the provider.

For example, the provider contract can be used by the plan to establish a collaborative relationship with the provider—one in which the provider is included in decisions regarding policies that affect them, such as quality management or utilization management.

These types of relationships tend to result in increased provider cooperation with health plan initiatives.

Network Maintenance and Provider Services

Following provider recruitment, selection, and contracting, the health plan focuses on activities essential to maintaining and managing the network.

In this section we discuss three important network management functions:

- provider orientation
- peer review
- provider services

Provider Orientation

The health plan provides orientations to introduce itself to new providers and acquaint them with its systems and operations. Additionally, the plan provides training in various systems such as utilization review, authorization systems, quality control, and others, as well as in processes and information relevant to the provider's specific contract and services.

Written Policy Manual

The plan provides a written manual of its policies and procedures relevant to the participating provider.

The purpose of this manual is to ensure that the provider understands the various aspects of participation and the procedures to follow. Health plans typically review the manual with the provider during the orientation meeting.

Communication of Updates

During orientation the health plan informs the provider of its system of regular communications between the health plan and the providers.

Health plans provide updates such as new or revised clinical guidelines, benefit changes and claims/coding information, and other information necessary to keep providers informed of changes and updates.

Updates are provided through various mechanisms including meetings, newsletters, and/or bulletins.

Peer Review

Another important network management function is peer review.

Peer review is the evaluation of a provider's performance by a peer—usually another provider in the same medical specialty and geographic area. Peer review programs and processes will be discussed further later in this course.

Provider Services

The goal of health plan provider services is to maintain communications with providers.

Provider services staff typically visit provider offices or clinics to distribute, share, and explain information.

Provider services staff also give support, provide training to the provider office staff, and in some cases offer onsite problem-solving to providers who are experiencing administrative difficulties.

Increasing Provider Satisfaction

The provider services area and staff are also responsible for designing and implementing the health plan's strategies for ensuring provider satisfaction with the health plan.

Strategies used by some plans to increase provider satisfaction include:

- conducting surveys of provider satisfaction and needs
- communicating through meetings, newsletters, and office visits
- including providers in decisions and programs that affect them (such as quality and utilization management)

Conclusion

In developing and maintaining a provider network, a health plan must consider a large number of factors. In setting up its network, it must look at the existing market, including providers, competitors, employers, population, service area, and economy.

The plan must take into account its own characteristics (plan type, products, etc.), as well as applicable laws, regulations, and accreditation standards. The plan must ensure that its network meets the needs of its members in terms of provider types, the number of providers, and their locations.

Doing so involves a variety of activities such as provider recruitment, selection, credentialing, and contracting. It also possesses ongoing activities needed to maintain the network, such as recredentialing, peer review, and provider services.

Notes:

[i] 5 U.S.C. § 8901, et seq available at: https://www.law.cornell.edu/uscode/text/5/part-III/subpart-G/chapter-89

[ii] 42 U.S.C. ch. 6A § 300, et seq.available at: https://www.law.cornell.edu/uscode/text/42/300e

[iii] 42 U.S.C. 18001, et seq. (2010) available at: https://www.hhs.gov/sites/default/files/ppacacon.pdf

[iv] Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2023 (Proposed Rule), Federal Register, Vol.87, No. 3, January 5, 2022, available at https://www.federalregister.gov/documents/2022/01/05/2021-28317/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2023

[v] NAIC, Health Benefit Plan Network Access and Adequacy Model Act, 2015, available at: https://content.naic.org/sites/default/files/MO074.pdf

[vi] For more information about Any Willing Provider (AWP) laws, *see* Ashley Noble, *Health Insurers and Access to Health Care Providers: Any Willing* Providers, National Conference of State Legislatures (Nov. 5, 2014), available at http://www.ncsl.org/research/health/any-willing-or-authorized-providers.aspx.

[vii] GA. CODE ANN., § 33-20-16 (2010).

[viii] Connecticut and Delaware, among others, have on the books limited AWP laws that apply only to pharmacies. *See* CONN. GEN. STAT. ANN. § 38a-471; 18 DEL. CODE ANN. § 7303.

[ix] H. Carter Sanders, Kenton J. Coppage & Dorothy H. Cornwell, *Any Willing Provider Law Applies to Provider Network, But Not to HMO*, ERISA and Life Insurance News (Aug. 21, 2012), available at http://www.smithmoorelaw.com/Any-Willing-Provider-Law-Applies-to-Provider-Network-But-Not-to-HMO-08-21-2012.

[x] *See* Hellinger, F., Special Report: Any-Willing-Provider and Freedom-Of-Choice Laws: An Economic Assessment, Health Affairs, Winter 1995; 14 (4):1, available at https://www.healthaffairs.org/doi/10.1377/hlthaff.14.4.297.

[xi] For more information about state mandated benefit laws, *see* Laugesen MJ, Paul RR, Luft HS, Aubry W, Ganiats TG. A Comparative Analysis of Mandated Benefit Laws, 1949–2002. J. Health Serv. Res., 2006 Jun; 41(3 Pt 2): 1081–1103, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1713218/.

[xii] *See* National Conference of State Legislatures, *Insurance Carriers and Access to Healthcare Providers – Network Adequacy* (Feb. 1, 2017), available at http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx.

[xiii] 42 U.S. C. § 300gg–5(a), available at: https://www.law.cornell.edu/uscode/text/42/300gg-5

[xiv] Maanasa Kona, State Balance-Billing Protections, Maps and Interactives, The Commonwealth Fund, February 5, 2021, available at: https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

[xv] *See* CAL. HEALTH & SAFETY CODE §§ 1367.006, 1367.007; CAL. INS. CODE §§ 10112.28, 10112.29.
[xvi] CONN. GEN. STAT. ANN. § 38a-591(b).
[xvii] NAIC, Network Adequacy, August 25, 2021, available at: https://content.naic.org/cipr_topics/topic_network_adequacy.htm.
[xviii] *See, e.g.,* 45 C.F.R. § 156.230 (Network Adequacy Standards for Qualified Health Plans under the ACA, available at: https://www.law.cornell.edu/cfr/text/45/156.230

[xix] *Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care*, Georgetown University Center on Health Insurance Reforms and Urban Institute, June 2014; Eggbeer, Bill, *Narrow, Tailored, Tiered and High Performance Networks: An Emerging Trend*, http://www.bdcadvisors.com/wp-content/uploads/2015/08/bdc_jan_2013_narrowtailoredtieredandhighperformancenetworks.pdf (accessed July 2018)
[xx] Giovannelli, Justin and Ashley Williams, *Regulation of Narrow Networks: With Federal Protections in Jeopardy, State Approaches Take on Added Significance*, Feb. 2, 2017, https://www.commonwealthfund.org/blog/2017/regulation-narrow-networks-federal-protections-jeopardy-state-approaches-take-added (accessed July 2018)

[xxi] O'Connor, James T. and Juliet M. Spector, *Milliman Report: High-Value Healthcare Provider Networks*, July 1, 2014, https://www.ahip.org/milliman-report-high-value-healthcare-provider-networks/

[xxii] U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, Registration , available at: https://www.deadiversion.usdoj.gov/drugreg/index.html
[xxiii] *See* National Practitioner Data Bank, http://npdb-hipdb.com/ (accessed October 2021).

Additional Recommended Reading:

AHIP Foundation, *A Consumer Guide to Understanding Health Plan Networks*, available at https://www.ahip.org/wp-content/uploads/2018/08/ConsumerGuide_PRINT.20.pdf (accessed October 2021).
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Affordable Care Act – Standards for Health Insurance Provider Networks: Examples from the States, Families USA, Issue Brief (November 2014), available at https://familiesusa.org/wp-content/uploads/2014/11/ACT_Network-Adequacy-Brief_final_web.pdf.

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National Conference of State Legislatures, Insurance Carriers and Access to Healthcare Providers: Network Adequacy, February 1, 2018, available at: http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx

13 Utilization Management

Learning Objectives

After completing this lesson, you will be able to:

- identify and describe the main strategies of utilization management;
- define case management and describe how it works;
- describe disease management; and
- define clinical practice guidelines, evidence-based healthcare, and health literacy.

Medical Management

Operational Efficiency of Health Plans

To operate effectively, a health insurance provider (also, commonly referred to as a health plan) must be able to manage both the cost and the quality of healthcare services.

Without adequate cost management, a plan may not be able to maintain its financial viability. And without adequate quality management, it may not be able to meet the healthcare needs of members, providers, purchasers, and regulatory and accrediting bodies.

The system that health plans and their providers use to achieve and maintain both high quality and cost-effectiveness is referred to as **medical management** (sometimes referred to as managed care or **care management**).

Three Broad Categories of Medical Management Activities

Medical management activities can be divided into three broad categories:

- Utilization management
- Clinical practice management
- Quality management

Utilization Management

Utilization management (UM) refers to health plan programs that manage the use of medical services so that plan members receive necessary and appropriate care in a cost-effective manner and in an appropriate setting.

Simply stated, the goal of UM is for the member to receive the right services at the right time in the right place. UM includes many strategies, techniques, and approaches, including case management and disease management.

Clinical Practice Management

Clinical practice management involves the development and implementation of criteria and parameters for the delivery of healthcare services to plan members.

Quality Management

Quality management (QM) is an organization-wide process of measuring and improving the quality of the healthcare and services a health plan's members receive.

Utilization Management

Basics of Utilization Management

In this lesson, we will introduce the basics of UM.

The following UM strategies will be discussed:

- preventive care
- self-care
- decision support
- utilization review

An overview of case management and disease management will also be provided.

Additionally, this lesson will discuss issues that arise in relation to these approaches, such as:

- clinical practice guidelines
- evidence-based healthcare
- health literacy

Note that utilization review is examined in detail in the next lesson, and QM is addressed in two later lessons.

Components of UM

UM involves all the components of a health plan's care delivery system, including:

- primary care
- specialty care
- both inpatient and outpatient care in hospitals

- other facilities

It also affects:

- emergency care
- pharmaceuticals
- ancillary services (such as X-ray and laboratory work)

A health plan may conduct its own UM, or it may contract with an external organization that specialized in UM to perform some or all UM functions.

UM Strategies and Techniques

How UM strategies are applied by a health plan depends on its member population.

This is largely dependent on how UM strategies are used. They are used either to:

- address the needs of members with existing health conditions (in the case of utilization review, case management, and disease management)
- help members at risk of developing conditions (preventive care)

Preventive Care Programs

Preventive care programs are designed to help plan members stay healthy and can reduce healthcare costs by reducing the need for diagnostic and therapeutic services, pharmaceuticals, and inpatient hospital care.

Health plans are also required to provide a range of recommended preventive services without any patient cost-sharing. [i]

As a result, health plans offer a variety of such programs and encourage members to obtain preventive services.

Assessing Members' Healthcare Needs

To help determine which programs are likely to be the most effective for their member populations, health plans must identify and assess their members' healthcare needs and health risks. Health plans typically do this by means of an analysis of healthcare claims and/or a health risk assessment.

Health Risk Assessment

A **health risk assessment (HRA)** (or **health risk appraisal**) is a process by which a health plan uses information about a plan member's current health status, personal and family health history, and health-related behaviors to determine the member's likelihood of experiencing specific illnesses or injuries.

By identifying members who are at risk of developing certain health problems and helping them take steps to reduce their risk, the plan can improve health outcomes, reduce the need for complex and extended care, and reduce costs.

Source of HRA Information

Health plans can gather HRA information from a variety of sources, including providers, plan records, and surveys administered to members.

To analyze HRA data, health plans typically use software programs that enable them to tabulate data for whole member populations or for certain segments based on risk levels for specific diseases and/or demographic characteristics (such as occupation, age, gender, income level, race, or ethnicity).

Preventive Care Programs

After a health plan has identified the health risks present in its member population, it can develop and promote appropriate preventive care programs to address the needs of its members.

Example: Members at high risk of developing coronary artery disease (CAD) can be provided with information about CAD, such as its symptoms, possible complications, and recommendations for reducing risks. Most often members receive such information from their primary care practitioners (PCPs), but it may come directly from the plan.

Example: A plan might send members regular reminders about healthy behaviors and encourage screenings at appropriate intervals.

Services Included in Preventive Care Programs

- Immunization programs
- Health promotion programs (wellness programs)
- Maternity management programs
- Screening programs

Immunization Programs

Immunization programs monitor and promote the administration of vaccines to children for chicken pox, mumps, and measles, as well as adults for influenza and pneumonia. In recent and future years, it is also likely to include vaccination and booster efforts against COVID-19 and its variants.

Health Promotion Programs (Wellness Programs)

Health promotion programs (**wellness programs**) educate members and motivate them to prevent illness and injury and promote good health through lifestyle choices, such as stopping smoking, managing weight, eating healthily, exercising, and managing stress.

Maternity Management Programs

Maternity management programs are commonly included in health promotion programs; they provide education to promote prenatal care and help identify high-risk pregnancies.

Screening Programs

Screening programs seek to determine if a health condition is present even if a member has not experienced symptoms.

Commonly used screening tools include blood pressure measurements, cholesterol level checks, fecal occult blood tests, and (for women) cervical cancer screening and mammograms.

Self-Care Programs

Health plan members frequently have minor health problems that they can treat themselves without the assistance of healthcare professionals.

Self-care programs educate members on how to distinguish between minor illnesses or injuries and serious conditions and how to effectively treat minor problems with readily available means such as diet, application of heat or cold, or over-the-counter medications.

These programs can lower healthcare utilization and costs by reducing unnecessary visits to doctors' offices or emergency rooms. However, self-care programs are not intended to supersede or eliminate physicians' services but to complement them.

Accessibility to Self-Care Programs

Plans make self-care information available to members in a variety of ways, including: newsletters, websites, and recorded messages accessible by telephone or via telemedicine; through providers; or in group help sessions.

Newsletters and websites can include guidance on the treatment of minor illnesses and injuries and instructions on how to perform screenings such as breast or testicular self-examinations, skin cancer checks, or blood pressure monitoring.

For members with medical conditions requiring ongoing management (such as arthritis, diabetes, and asthma), there may be more detailed self-care guides providing easy-to-understand information about the condition and describing steps members can take to reduce symptoms, prevent complications, and improve day-to-day functioning.

Decision Support Programs

Plan members often know they need medical care but don't know which services are most appropriate, so they seek care that is unnecessary or inadequate.

Decision support programs provide members with educational materials and advice from healthcare professionals to help them make informed healthcare decisions.

Frequently Used Decision Support Programs

The types of decision support programs health plans use most often are:

- web-based or digital decision support tools,
- telephone triage programs, and
- shared decision-making programs.

Web-Based or Digital Decision Support Tools

Health plans maintain websites with health and wellness information for members, and they have developed a number of web-based tools to deliver targeted information and personalized support.

Some plans have also provided members with digital tools for tracking and monitoring their health care status.

In this way plans foster better healthcare decisions by members and reach out to those with chronic conditions, and by doing so they promote the appropriate utilization of healthcare services and improve health outcomes.

Common Web-Based or Digital Decision Support Tools

Some of the most common tools are the following:

- Health risk tools and trackers
- Health and prevention information
- Drug information
- Provider report cards
- Personal health records (PHRs)

Health Risk Tools and Trackers

Health risk tools and trackers—online tools with which members can measure certain indicators of health risk (such as body mass index (BMI)) determine their health status, gives them a personal risk assessment, and directs them to next-step tools.

Health and Prevention Information

Health and prevention information—education on health and fitness topics and on the prevention and treatment of common conditions like hypertension and diabetes.

Drug Information

Drug information—comparisons of different drugs used for the same conditions, and sometimes information on drug interactions and on the plan's drug formulary and how members can save money by using certain drugs.

Provider Report Cards

Provider report cards—physician and hospital data to assist consumers in making decisions on where to seek care.

Personal Health Records (PHRs)

Personal health records (PHRs)—an application that enables a person to create, review, annotate, and maintain a record of their health conditions, medications, allergies, vaccination history, visit history, and communications with their healthcare providers, and to share this information with appropriate healthcare providers.

Telephone Triage Programs

Many health plans offer **telephone triage programs** (**medical advice lines**) to help members determine if they need medical attention and if so what kind.

Example: A person may wonder whether a fever and sore throat are simply symptoms of a cold or rather indications of something more serious such as strep throat, and a triage program can advise him/her. Some of the problems commonly reported are headaches, cough, sore throat, nausea and vomiting, fever, ear pain and stuffiness, skin problems, chest pain, abdominal pain, and lower back pain.

Importance of Telephone Triage Programs

Telephone triage programs help members decide if they should seek immediate attention at an emergency room, make an appointment with a healthcare provider, or treat the condition themselves.

If the situation is urgent, triage staff can notify a local emergency room or urgent care center of the member's needs and planned arrival.

If the case is not urgent but requires care by a physician, staff can assist in scheduling an appointment. In some cases, triage staff can also authorize referrals and expedite appointments for specialty care. If self-care is indicated, staff can provide information on ways to relieve symptoms and hasten recovery.

Telephone Triage Program Staffing

Telephone triage programs are typically staffed by nurses or nurse practitioners who are trained to assess members' needs and direct them to the appropriate care.

They are generally directed by physicians with relevant clinical experience and training in managing telephone triage lines.

Triage programs also use non-clinical personnel to answer calls, obtain non-medical data, and route calls to the appropriate clinical staff.

Decision Support Tools in Telephone Triage Programs

Staff use a variety of decision support tools to assist them in handling calls, ranging from simple lists of questions and responses to interactive computer programs with preprogrammed algorithms of questions and instructions.

Clinical staff can usually contact the members' physicians or other healthcare professionals such as pharmacists for direct assistance as well.

Technology has also increased opportunities for telemedicine consultations, where members can interact with health care providers by leveraging Zoom and other kinds of connectivity. [ii] In fact, ninety-five percent of businesses with 50 or more employees offered at least some telemedicine coverage during a recent pandemic year. [iii]

Shared Decision-Making Programs

Healthcare providers routinely give patients information about procedures or treatment options so that they can make informed choices.

Shared decision-making programs take this a step further by providing members with in-depth information about diseases, procedures, and treatment alternatives and encouraging them to actively participate in healthcare decisions.

Some plans call this **value-based healthcare** because the member's decisions are based on his/her own personal values as applied to his/her situation, including his/her age, general health or quality of life, and perception of the effects of a treatment (such as chemotherapy). [iv]

Sources for Shared Decision Making

Although information for shared decision-making comes primarily from healthcare providers, there are a variety of sources.

- printed materials
- websites

- audiotapes
- personal or group counseling
- support groups
- interactive computer programs

These sources can provide up-to-date information about conditions, diagnostic and treatment options, and expected outcomes. Health plans can also provide checklists of questions that members can use as a guide in talking to providers or conducting independent research.

What is Appropriate for Shared Decision-Making Programs?

Not all conditions are appropriate for shared decision-making programs. For some illnesses and injuries, the medical community considers one approach to care clearly superior in terms of safety and effectiveness, and the provider may discuss only this approach, its risks and benefits, and the risks of no treatment.

For other illnesses and injuries (such as breast cancer, prostate cancer, low back pain, and infertility), several treatment options are accepted as valid and effective, and in these cases shared decision-making allows members to weigh the risks and benefits of various alternatives and to choose their own course of treatment. (In either case, however, the decision is ultimately up to the member.)

Utilization Review

What is Utilization Review?

Utilization review (UR) is an evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

UR can be conducted before treatment begins (pre-service review), while it is in progress (concurrent review), or after it ends (post-service review).

UR is most often used for hospital admissions but may also be applied to some outpatient services.

Utilization Review Organization

UR is performed by healthcare professionals, such as nurses or physicians, employed by or contracted with the health plan.

Many health plans contract with an outside **utilization review organization (URO)**.

Because a URO is independent of the health plan, its involvement can give patients and purchasers added assurance that UR decisions are correct and appropriate. Health plans must give members and providers the right to appeal decision to not approve certain services, and a plan may contract appeals to a URO.

Case Management

What is Case Management?

A key UM technique is **case management**, a process of identifying members with special healthcare needs, developing an individualized strategy to meet their needs, and coordinating and monitoring their healthcare.

Case management is sometimes referred to as **resource management** as a key concept to assist the member in finding and utilizing available and applicable resources, which include but are not limited to healthcare.

What Does Case Management Do?

Case management programs are designed to:

- improve or stabilize a member's overall health status by preventing complications and the deterioration of existing medical conditions,
- optimize the use of healthcare and other resources,
- improve member compliance with provider recommendations for care,
- improve coordination and continuity of care, and
- utilize community resources to enhance and support the member's health.

Goal of Case Management

The ultimate goal of case management is to achieve the optimal healthcare outcome in an efficient and cost-effective manner. The case management process includes five basic steps:

1. case identification
2. assessment and planning
3. implementation
4. monitoring
5. evaluation

The Application of Case Management

Health plans commonly use case management for high-risk, high-cost, and/or chronic cases.

High Risk Case

A **high-risk case** involves a complex or catastrophic illness or injury that requires extensive medical intervention and treatment.

Often there are multiple medical problems. An example would be someone who suffered multiple broken bones and internal injuries in an accident and will require ongoing rehabilitation and staged surgeries.

High-Cost Case

A **high-cost case** requires large expenditures or extensive human and technological resources. An example would be a premature infant requiring months in a neonatal intensive care unit, home health follow-up, parental training, and frequent out-patient check-ups.

Chronic Case

A **chronic case** involves conditions that persist for long periods or for the patient's lifetime (such as chronic respiratory conditions).

Some of the medical conditions for which case management may be appropriate include AIDS, stroke, burns, chronic respiratory conditions, kidney failure, amputation, cancer, neonatal complications, brain injuries, certain cardiovascular conditions, congenital defects, and spinal cord injuries.

Case Identification

To identify members who might be good candidates for case management, health plans examine the following factors:

- the medical condition or diagnosis
- the type of treatment being received
- the use of prescription drugs
- the level of resource utilization (such as consultation by multiple providers)
- the cost of care, especially when it is above a certain threshold (such as $25,000)
- the length and frequency of hospital stays (hospital stays that are unusually long or multiple readmissions for the same diagnosis)
- financial, social, and psychosocial factors that may affect the member's medical condition

Determining Member's Eligibility

After this information has been collected, it is evaluated to determine the member's eligibility for participation in the case management program.

The majority of cases are identified during UR, but health plans also receive referrals from providers, family members, employers, health plan personnel, and hospital UM or discharge planning staff. Plans can also identify cases through health risk appraisal and the analysis of utilization data.

Assessment and Planning—The Case Manager

A member entering a case management program is assigned a **case manager**, who assesses his/her healthcare needs and develops a plan of treatment. In doing so, he/she works with the member, his/her physician or physicians, any other relevant members of her medical team, and (if the member wishes) family members.

Who Can Be a Case Manager?

Case managers are typically nurses but may be physicians, community health workers, social workers, or other healthcare professionals. A health plan may employ case managers or contract with an outside organization. Provider groups may have their own case managers.

Qualifications of a Case Manager

The case manager is knowledgeable about medical conditions and interventions as well as the benefits of the health plan, and he tries to achieve the best possible use of the member's coverage.

Case managers are often also familiar with community resources and may recommend them to supplement or support the member's healthcare and/or their family's ability to care for them. Community resources may include transportation services, religious or other support groups, respite care to relieve family caregivers, and others.

In addition to the areas of knowledge mentioned above, a case manager should be familiar with psychosocial issues; legal, regulatory, and ethical issues related to case management; and UR processes and techniques. They need research and analytical skills, interpersonal and communication skills, project management skills, and computer skills. [v]

Implementation/Monitoring

During the course of treatment, the case manager works with the member's healthcare team to coordinate and monitor services and identify the goals of planned interventions. He or she documents the member's progress to determine if they are compliant with physicians' recommendations, if the stated goals are being achieved, and if the original goals are still appropriate.

As the patient's condition evolves, new measures and approaches to care may be needed, or the care plan may need to be adjusted. During all of this, the care manager educates the member and their family. He/she remains in close communication with the physician in charge, who approves all care decisions.

Evaluation

After case management ends, the case manager conducts a final evaluation of the effectiveness of the case management services that were provided. This evaluation focuses on quality of care, member and family satisfaction, continuity of care, and outcomes. Results of the evaluation are reported to the health plan.

Disease Management

What is Disease Management?

Disease management (DM) (also called **disease state management** or **population management**) is a coordinated system of preventive, diagnostic, and therapeutic measures intended to provide cost-effective, high quality healthcare for a patient population that has a certain chronic illness or medical condition or is at risk of developing it.

DM focuses on the comprehensive management of a patient population over time rather than on individual episodes of medical care.

Spending on Chronic Diseases

One of the reasons for the development of disease management is the high level of spending on chronic diseases.

It is estimated sixty percent all American adults have at least one chronic condition such as cardiovascular disease, cancer, arthritis, back pain, depression, diabetes, osteoporosis, and asthma, and this number will surely continue to grow with the aging of the population.

And according to the Centers for Disease Control and Prevention (CDC), four in ten adults in the United States have two or more chronic diseases. The costs of the diagnosis and treatment of these conditions are enormous. [vi]

The Growth of DM

Another factor in the growth of DM is the need to provide high quality care to patients with chronic diseases.

Long-term and short-term outcomes of the treatment of these diseases vary greatly, and these results, at least in part, from inconsistencies in treatment approaches from one provider to another and from one patient to another.

DM improves the quality of care by developing a more comprehensive and uniform approach to treatment.

DM and Traditional Medical Care

One way to better understand what DM is, is to look at how it differs from traditional medical care: [vii]

- DM focuses on populations of patients, not individuals.
- In DM, the delivery of healthcare is highly coordinated and integrated across providers, sites, and patients. Providers work together in teams to reduce inefficiencies and fragmentation and improve the overall quality of care.
- DM promotes standardization of care, encouraging all physicians in the program to provide the same level of care as the doctors with the best outcomes.
- DM programs often apply business approaches such as total quality management, data analytics, and continuous quality improvement.

The Application of DM

DM programs are most effective for common chronic illnesses that have variable outcomes and high costs. Specifically, DM may be indicated for medical conditions that:

- are chronic in nature;
- are likely to have high costs over time;
- have high variability in patterns of treatment from patient to patient and physician to physician;
- have a high rate of preventable complications, some or all of which may result in the use of more costly services such as emergency room visits and hospital readmissions;
- have low rates of patient compliance with recommended treatments;
- have optimal treatments described in the medical literature or for which evidence- based guidelines exist or can be developed; or
- can be managed on an outpatient basis using low-technology, nonsurgical approaches that the health plan can provide.

DM and Health Plans

DM programs were first developed in the early 1990s by pharmaceutical companies, but today many health plans have them. A plan may have its own DM program, operate one in conjunction with a drug company, or contract out to an independent DM organization.

A health plan DM program is typically an outreach and support program for plan members with certain diseases. A plan may use medical records, referrals, or claims information to identify such members. The goal is to ensure that these people receive the most appropriate healthcare and have access to support services.

DM and Health Plans (Continued)

Some plans' DM programs focus on a single illness, while others address multiple illnesses. Ancillary providers, such as durable medical equipment suppliers, oxygen/respiratory therapy services, and home health agencies provide additional support to DM programs.

Health plans may also address chronic illnesses by distributing information to members through cooperative ventures with organizations such as the American Diabetes Association or the American Lung Association.

In addition, many plans offer online information and provide links to health websites.

Other Issues

Clinical Practice Guidelines

Clinical practice guidelines are an important element of UM, DM, and quality management.

They may include recommendations not only on the best treatment approach but also on how to implement this approach to obtain the best results. Additionally, they are intended to help providers achieve the best clinical result in the most cost-effective way and to reduce the variation in treatment from one provider to another and from one patient to another.

Clinical practice guidelines can be developed by a health plan itself or obtained from outside sources (as will be discussed in the lesson on quality management).

How Does a Health Plan Disseminate Information?

A health plan typically gives providers and members information about clinical practice guidelines and how to follow them.

Example: A plan's guidelines for diabetes patients include annual glaucoma screening, so each year the plan reminds patients (by email, mail, or telephone) to schedule an eye exam. It may also remind primary care physicians to encourage the members to have this done.

Understandability of Clinical Practice Guidelines

One challenge presented by clinical practice guidelines is to make them sufficiently specific and clinical that providers can understand and follow them, yet also understandable to members. Guidelines may need to take different forms for different audiences.

Example: For providers a health plan may use the clinical practice guidelines for diabetes from the U.S. Preventive Services Task Force, but for members it may use educational materials from the American Diabetes Association. [viii]

Evidence-Based Healthcare

In **evidence-based healthcare,** the best evidence from current medical research is used in making decisions about the care of a patient.

When a therapeutic intervention is being considered, the question should be asked:

Does valid clinical research show that if a certain drug, therapy, surgery, etc., is used the patient's condition will not only improve, but improve faster than if one does nothing or uses another approach?

For a diagnostic test or procedure, the question is:

Will the results of the test or procedure provide information that is not already known, and will the information aid the physician in selecting the appropriate treatment? [ix] [x]

Involvement of Health Plan Members

In this lesson, we have mentioned a number of ways in which health plan members can be involved in their healthcare and in making decisions about it—*self-care, shared decision-making, DM, and clinical practice guidelines*.

But to be involved in this way, and indeed even to follow instructions from healthcare providers, members must be able to understand the information and communications they receive.

If they do not, they cannot really participate in their own healthcare decisions, and they may even inadvertently fail to adhere to treatment or behavioral recommendations, leading to poor health outcomes and often unnecessary healthcare expenditures.

Health Literacy

The issue here is **health literacy**, the ability to understand communications related to health and healthcare.

A person may be well educated, but that does not mean she can understand a document that uses medical or legal terminology. Many people do not have much education or are not native English speakers. To address this problem, health plans must strive to convey information to members in language the average person can understand.

Right to Information

Accreditation agencies and government regulators require health plan communications with members to be written in simple and comprehensible terms. Many also have requirements for meeting the needs of non-English-speaking members.

The Federal Department of Health and Human Services leverage their National Action Plan to Improve Health Literacy, which seeks to engage organizations, professionals, policymakers, communities, individuals, and families in efforts to improve health literacy.

The plan is based on the principles that everyone has the right to health information that helps them make informed decisions and that health services should be delivered in ways that are understandable and beneficial.[xi]

Conclusion

Managing the utilization of healthcare services by health plan members is not just about controlling costs—it is also about improving the quality of care. By reducing both overutilization and underutilization of services, health plans can help members obtain necessary and appropriate care—the right services at the right time and at the right place.

UM benefit members in other ways as well. Preventive care programs decrease the incidence of illness or injury, facilitate early detection and treatment, and reduce the need for complex, extended care.

Self-care and decision support programs give plan members greater control over their own care.

Case management and DM programs help members obtain comprehensive, high-quality, cost-effective care.

Notes:

[i] Preventive Health Services Fact Sheet, Healthcare.gov, available at: https://www.healthcare.gov/coverage/preventive-care-benefits/

[ii] Rachel Z. Arndt, The Growth of Telemedicine Improves Continuity of Care in Rural Communities, Modern Healthcare, June 9, 2018, available at: http://www.modernhealthcare.com/article/20180609/NEWS/306099954?template=print

[iii] Jesse Hellmann ,"Employers Expanded Telemedicine Coverage Amid Pandemic " *Modern Healthcare*, November 10, 2021, available at https://www.modernhealthcare.com/insurance/employers-expanded-telemedicine-coverage-amid-pandemic

[iv] National Learning Consortium, Shared Decision Making Fact Sheet, December 2013, available at: https://www.healthit.gov/sites/default/files/nlc_shared_decision_making_fact_sheet.pdf

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[vi] CDC National Center for Chronic Disease Prevention and Health Promotion, "Chronic Diseases in America, last reviewed January 12, 2021, available at https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

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[xi] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. National Action Plan to Improve Health Literacy, available at https://health.gov/communication/initiatives/health-literacy-action-plan.asp

14 Utilization Review

Learning Objectives

After completing this lesson, you will be able to:

- state the main purposes of utilization review (UR)
- describe prospective, concurrent, and retrospective UR
- list the criteria used by health insurance providers to decide which services will be subject to UR
- identify the main care settings that UR may direct members to
- identify the main steps of the authorization process.

In the last lesson we looked at the types of programs that health insurance providers (health plans) use to manage utilization of healthcare services. In this lesson we further explore one of these, UR.

Utilization Review

What is Utilization Review?

In **utilization review (UR)**, a clinical professional working for a health plan reviews a healthcare service that another clinical professional recommends for a plan member or has already provided to the member.

After the review, a determination is made of whether that service is medically necessary, clinically appropriate and safe and, therefore, whether the health plan will cover the costs for the service.

UR can be conducted before treatment begins (prospective review), while it is in progress (concurrent review), or after it ends (retrospective review). It is used most often for hospital admissions but also for some outpatient services.

UR Authorization

UR commonly involves authorization—a member or provider submits a request to the plan for a proposed service, and the plan's UR staff makes a determination of whether it will be covered.

UR also involves the collection of information and data that a plan uses not only to make particular authorization decisions but also to monitor utilization and promote quality and safe, cost-effective care.

UR Authorization (Continued)

It should be noted that UR may be conducted by entities other than health plans.

When a medical group provides healthcare services to the members of a health plan and is compensated by the plan by capitation, the group bears the financial risk for high utilization of services.

Therefore, to manage utilization the group may design and operate its own UR and authorization system. However, the group typically provides utilization data to the plan so that it can exercise oversight and guard against underutilization.

The Purposes of UR

UR and authorization have three main functions in a health plan:

- To ensure that benefits are paid correctly
- To promote high quality and safe, cost-effective care in part through clinical practice guidelines
- To analyze information and data collected to show patterns in the utilization of services and evaluate overall network performance

Benefit Payment

A health plan authorizes payment for a healthcare service only if it is:

- covered by the plan and
- medically necessary, appropriate, and safe

Medically Necessary Healthcare Services

Whether a service is covered of course depends on the health plan's benefit structure and the language of the insurance contract.

Clinical staff (usually physicians) make decisions about medical necessity, safety, and appropriateness.

A healthcare service is considered medically necessary if a physician (or other healthcare provider) is required to identify and treat an illness (or injury) and is:

- consistent with the symptoms, diagnosis, and treatment of the member's condition;
- in accordance with the standards of good medical practice;
- not solely for the convenience of the member, member's family, physician, or other healthcare provider; and

- furnished in the least intensive type of medical care setting required by the member's condition [i]

Safety of Healthcare Services

A service is safe if it does not pose any harm or interfere with any other part of the patient's treatment plan.

A service is appropriate if the expected health benefits exceed the risks by a margin wide enough to justify the service. [ii]

Payment of Healthcare Services

In UR, health plan staff make a determination of whether the plan will pay for a service, not whether the member may receive the service.

If payment is not authorized for a service, because it is not covered or not considered medically necessary and appropriate, the member may obtain it by paying for it themselves.

For instance, a person might at their own expense have cosmetic surgery or undergo a treatment that is experimental and of unproven effectiveness and safety.

Quality and Cost-Effectiveness

Health plans are most concerned with the quality of services provided to their members.

Authorization decisions are made by physicians familiar with a wide range of treatment options. As part of the authorization process, these doctors can direct members to the treatments most likely to produce the best outcomes and to the most appropriate providers and care settings, thereby promoting quality and cost-effective care.

Adopting Clinical Practice Guidelines

UR staff also improve quality and cost-effectiveness by using clinical practice guidelines to reduce inappropriate variations in provider practice.

Many physicians have busy schedules and find it difficult to stay abreast of the current research on all the conditions they treat. Consequently, they sometimes lack the information they need to choose the optimum treatment for a patient.

Health plans can support doctors in this area by adopting clinical practice guidelines based on medical research and community standards of medical care. UR decisions are rooted in these guidelines and can be an effective strategy to identify and reduce unnecessary and ineffective practices.

Variation Necessity

It should be clarified that the goal of UR and clinical practice guidelines is not to eliminate all variation and completely standardize medical care. Some variation is a normal and necessary

feature of high-quality care—a doctor's practice may diverge from the norm in a particular case because of such factors as an allergy to the standard medication or a patient's own decisions based on their quality of life.

UR Data

A great deal of information and data are collected by UR programs and used for a variety of purposes. UR data can show patterns in the utilization of services and areas that may need more utilization management because of over- or underutilization.

For instance, there may be numerous referrals to orthopedic surgeons for uncomplicated lower back pain that can by treated by PCPs with medication and exercise or by physical therapists or chiropractors, indicating that a stricter authorization process may be needed. Or data may reveal that a high percentage of members with diabetes have not been referred to a dietitian, and better education of PCPs may be needed.

Other UR Data Uses

UR data have many other uses. They can be used to evaluate overall network performance or to profile an individual provider's practice patterns.

A plan can determine if it needs more or fewer specialists by considering members' utilization of different specialty services.

Diagnostic and treatment information can be provided to a plan's claims processing systems to detect possible errors. And UR data are used to comply with internal and external reporting requirements, including those related to accreditation.

Common Utilization Measures in UR

Among the most common utilization measures used in UR are hospitalizations per member per year, hospital bed days per admission, hospital bed days per member, hospital bed days per 1,000 members, specialist encounters per member, authorizations or referrals per PCP per 100 encounters, and authorizations or referrals per 1,000 members per year.

Types of UR

Prospective Review

Prospective review takes place before a service is provided. It is generally preferable to retrospective review because the member, the doctor, and the plan can reach an understanding before treatment begins about which treatment alternatives and care settings are appropriate, and because the plan can make clear before any expenses are incurred what will be covered and what will not.

Precertification

Prospective UR typically involves **precertification (prior authorization)**. If a certain service is proposed, the member or the physician in charge of their care (often their PCP) is required to request authorization of payment beforehand.

The UR staff evaluates the request and approves it; or suggests an alternative treatment, provider, or setting; or denies it. In making this decision, UR staff consider a range of alternatives and, using clinical practice guidelines and other established standards of care while taking into account the particular circumstances of the case.

Precertification (Continued)

It is important that a prescribed therapy is safe and effective for a patient's specific condition, provides the greatest value, and is a covered benefit.

Particularly with respect to services prone to overuse or misuse, prior authorization can be used to ensure care takes place in the most appropriate setting, at the most appropriate frequency, and is delivered by the most appropriate provider.

Precertification is normally required for a hospital admission and for some outpatient services such as complex diagnostic tests. In some plans a PCP must obtain an authorization to refer a member to a specialist for treatment. [iii]

Precertification Tools

A number of tools are used by UR staff in making precertification decisions:

- Utilization guidelines
- Experience-based criteria
- Site appropriateness listings
- Length of stay (LOS) guidelines

Utilization Guidelines

Utilization guidelines (such as clinical practice guidelines) indicate accepted treatments for common medical conditions, based on medical research and established standards of care.

Experience Based Criteria

Experience-based criteria incorporate generally accepted community standards of practice and the experience and expert opinion of medical directors and other healthcare providers. They are used when medical research is not available.

Site Appropriateness Listings

Site appropriateness listings indicate the most appropriate settings for common procedures. Many surgical procedures that were once performed only in a hospital are now routinely done on an outpatient basis.

Length of Stay (LOS) Guidelines

Length-of-stay (LOS) guidelines indicate the average number of days a patient stays in a hospital or other facility based on diagnosis, the severity of the condition, and the type of services and procedures prescribed.

Hospitalization

If UR staff approve a hospitalization, they determine the expected length of stay; confirm that all parties are aware of the plan's preadmission testing policies and begin the process of discharge planning.

Preadmission Testing

Preadmission testing policies require members to have tests completed (such as X-rays and laboratory tests) before a procedure is done on an outpatient basis before entering the hospital.

Otherwise, a member may be admitted, have a test result that requires postponing the procedure, and be discharged, resulting in an unnecessary stay.

Preadmission testing also allows a member to be admitted on the day the procedure is performed instead of earlier, shortening their stay.

Discharge Planning

Discharge planning addresses what will happen when a patient leaves the hospital.

During prospective UR, discharge planning typically involves:

-determining what treatments and services should be completed before the member is discharged

-where they will go (for instance, to their home or to a skilled nursing facility),

-what equipment and services they may need there (such as a wheelchair or home healthcare).

It may also identify members who could benefit from case management and disease management and have these services in place by the time they are discharged.

Concurrent Review

Concurrent review takes place while treatment is in progress. It is typically used for a long hospital stay and for outpatient services that continue over a considerable time, such as:

- chemotherapy and/or radiation therapy
- physical, occupational, and/or speech therapy
- home health care
- counseling

What Does Concurrent Review Involve?

Concurrent UR involves tracking a patient's progress and any complications, directing them to appropriate and cost-effective services, and updating goals.

UR staff may evaluate and authorize in advance requests for additional services (that is, grant prior authorization) and help direct the course of care by recommending that the patient receive a different level of care or move to a different care setting.

For inpatient hospital care, a UR nurse gathers information about the patient's progress, tracks the total length and cost of care, and continues discharge planning.

Retrospective Review

Retrospective review is performed after treatment has been completed. In some cases, such as emergency care, there may be an immediate retrospective review of the medical necessity and appropriateness of services provided to a member. But more typically, retrospective review consists of an analysis of claims data and medical records.

The Use of Retrospective Review

Retrospective UR obviously cannot direct the course of care, but it enables a health plan to identify areas where utilization can be improved.

For instance, a retrospective analysis of provider practice patterns might reveal that certain specialists prescribe expensive drugs when comparable outcomes can be achieved using less costly alternatives. It might show many hospital admissions of diabetic patients, indicating the need for more member education. It might identify the inappropriate use of services, which exposes members to health risks and adds to costs.

In such cases, UR staff can identify providers whose practice patterns fall outside the norm, discuss their utilization criteria with them, and thereby improve the quality and cost-effectiveness of care.

Billing Errors and Fraud

Retrospective review of claims data can also reveal billing errors and sometimes even fraud.

Such cases often involve billing codes or numerical codes that correspond to medical services or procedures and that providers use in submitting bills.

Honest **coding errors** often occur—a provider inadvertently uses the wrong code for a service, resulting in a payment that is too high or too low. But in some cases, a provider may engage in fraudulent billing schemes, such as upcoding and unbundling.

Upcoding

Upcoding is deliberately using the code for a service that is similar or related to the service actually provided but is more expensive. For instance, a doctor might submit a claim using the code for an office visit, when in fact they merely spoke briefly to the patient over the telephone.

Unbundling

Unbundling is the submission of separate claims for services that should be billed together as one combined service.

Health plans require that certain related services, or certain services performed at the same time, be billed together as a combined service, using one billing code. By unbundling, the provider receives more in total fees than they would have received had the claims been properly submitted as one.

Example: Instead of submitting a single claim for multiple tests performed at the same time, a laboratory bills each test separately and improperly receives a greater payment.

Identifying and Managing Errors or Billing Scheme

Software can be used to analyze claims data and indentify inconsistencies and patterns that may indicate errors or billing schemes. When fraud is suspected, the case is normally turned over to the plan's special investigations unit (SIU).

Services Subject to UR

Services Subject to UR

Health plans cover a very large number of healthcare services, and it would be impossible to apply UR to all of them. Even if it were feasible, it would not be desirable, as UR is not worthwhile or cost-effective for many services.

How Many Services is UR Used For, and Which Ones?

This varies by plan, and it depends on a plan's size, structure, and level of management control.

The following factors are taken into account:

- access requirements,
- frequency of utilization,
- cost and risk,

- total expenditures,
- level of inappropriate utilization, and
- cost of review.

Access Requirements

In all types of health plans, members can directly access their primary care providers (PCPs) and do not need a referral from anyone or authorization from the plan for an office visit.

In most plans members can also directly access certain nonprimary care such as obstetrics/gynecology (OB/GYN), pediatrics, and dental and vision care.

Some plans allow a member with a serious chronic condition (such as AIDS, diabetes, advanced rheumatoid arthritis, and congestive heart failure) to select a specialist as their PCP, so that referral or authorization is not required to see the specialist. Some states also require direct access to chiropractics and other forms of complementary and alternative medicine (CAM).

For other types of nonprimary care, members may be required to obtain a referral from their PCP or authorization from the plan.

Frequency of Utilization

Some services are performed so frequently and consistently that they are considered part of a provider's normal practice.

Example: PCPs routinely have certain laboratory tests done in conjunction with annual physical examinations, OB/GYN specialists routinely order Pap tests as part of a gynecological examination, and cardiologists routinely administer electrocardiograms (EKGs) during regular office visits. Authorization and UR is typically not required for these services.

Non-Routine Procedures

On the other hand, procedures that are not routine usually require authorization and UR.

Example: A PCP would typically be free to order X-rays of a member's broken leg but would have to obtain authorization for an MRI study, and a cardiologist could administer an EKG as part of a regular office visit but would probably need authorization for an echocardiogram.

Cost and Risk of a Service

Low-cost, low-risk services generally do not require authorization and UR, while high-cost or high-risk procedures and treatments generally do.

Authorization is also typically required for services that are not widely accepted as effective, are being proposed before trying less costly or more conservative treatment or, must be performed by a non-contracted provider.

Total Expenditures on a Service

In addition to the cost of a service, the total amount the plan spends on that service in a year is an important consideration. A low-cost service can have a high total cost for a plan if it is provided frequently. For instance, physical therapy (PT) costs less than many healthcare services, but if many members receive it then the plan's total expenditures on PT might be considerable, making authorization and UR desirable.

Level of Inappropriate Utilization

If authorization is frequently denied for a service, this may be an indication that the service is often used inappropriately. Therefore, the higher the denial rate for a service, the more likely the service will require authorization and UR.

Cost of Review

UR takes time and resources. Another consideration in deciding whether a service should be subject to UR is whether the savings realized or the improvement in quality of care justify the costs of conducting UR.

Plans must periodically review the services covered by their UR programs in terms of value and cost-effectiveness and eliminate unnecessary or ineffective requirements, especially for frequently used services.

Cost of Review (Continued)

In many plans, most PCP requests for authorization for nonprimary care services are approved, indicating that PCPs are adequately managing utilization of these services.

In these cases, UR is an unnecessary cost for the plan and an unnecessary administrative burden for PCPs. Many plans also allow specialists to perform certain services without authorization because the cost savings of UR do not outweigh the cost of performing it.

Care Settings

One of the primary purposes of both prospective and concurrent UR is to determine the setting of care (level of care) most appropriate for a patient.

Acute care facilities such as hospitals are necessary for severe medical problems that require around-the-clock intensive treatment by healthcare professionals. However, they are not always appropriate for patients who need immediate evaluation and treatment, which can often be provided more effectively in emergency departments, urgent care centers, and observation care units.

For those recovering from an acute illness or injury, continued care can often be delivered more cost-effectively in alternative settings such as subacute care facilities, step-down units, or patients' homes, rather than in a hospital.

Emergency Departments

Sometimes the immediate diagnosis and treatment of a severe injury or critical illness is needed, and this is usually best provided by an **emergency department (ED)**, such as the emergency room of a hospital.

Health plans generally encourage members to use EDs only when necessary. On the other hand, a visit to an emergency room can both improve outcomes for the member and reduce the long-term utilization of resources.

Example: Emergency treatment for a patient suffering a severe asthma attack can often reduce the length of subsequent inpatient care or even eliminate the need for hospitalization.

Necessity of EDs

On the other hand, a plan can incur high costs when members use EDs unnecessarily or inappropriately, as when a member repeatedly goes to an emergency room when they really should make an appointment with their PCP.

In response to this problem, plans sometimes require members or providers to obtain authorization for an ED visit within 24 hours after treatment, and if this is not done benefits may be denied or reduced. Some plans also conduct a retrospective review of ED claims and may deny payment if it is determined that emergency care was not really needed.

Prudent Layperson's Standard

Keep in mind however, that some states prohibit health plans from requiring authorization for emergency services. Many states require plans to use the **prudent layperson's standard** in determining whether emergency care was appropriate and should be paid for, and most plans have adopted this standard.

A condition is considered a legitimate emergency if a prudent layperson (a person with an average knowledge of health and medicine) could reasonably expect the absence of immediate medical attention to put their health in jeopardy.

It should be clarified that the prudent layperson's standard is based on the symptoms that lead a person to seek emergency care, not their eventual diagnosis

Example: It is considered reasonable for a person with severe chest pain to think they may be having a heart attack and go to an ED, even if it turns out to be only severe indigestion.

Urgent Care Centers

People with injuries or illnesses that require immediate attention but are not a serious threat to their health or life, such as cuts, sprains, or fevers, may best be treated in an **urgent care center**.

Some centers are located in or near hospital EDs, which refer patients to them, while others are free-standing.

Although the cost of care in an urgent care center is generally higher than in a physician's office, it is lower than in a hospital ED, so many health plans cover it. But other plans do not—they require emergency care to be delivered in an ED and all other care to be coordinated by the member's PCP.

Observation Care Units

Hospital **observation care units** are for patients who have conditions requiring continuous monitoring but who do not currently need either emergency interventions or acute care.

Click here for examples on who utilizes observation care units.

- Women with symptoms of pre-term labor
- Diabetic patients waiting for glucose levels to stabilize following treatment for an acute episode
- People with cardiac irregularities who are waiting for test results

Most patients directed to hospital observation care units have a reasonable chance of stabilizing and being released to a non-acute care setting within 24 hours. Those patients whose conditions do not resolve satisfactorily in the observation unit can be admitted for inpatient care.

The facilities, equipment, and staffing requirements for observation care units are much less costly than for emergency departments, so their use can result in lower costs for a health plan. For Medicare patients, observation care can prove to be more costly because care is covered not under Medicare Part A but Part B which entails greater cost-sharing. [iv]

Subacute Care Facilities

Subacute care facilities provide the continuing care needed by people who are too sick to be cared for at home but do not need the intensive treatment and supervision of a hospital.

These facilities typically provide 24-hour professional nursing care, physician direction and contact, and extensive ancillary and rehabilitative services (such as physical therapy).

The goal is to optimize the patient's medical condition and functional ability so that they can be sent home or to a lower level of care.

Step-Down Units

A **step-down unit** is a section of a hospital that provides subacute care to patients following a period of acute care. They provide the same services as stand-alone subacute care facilities and are an alternative to them (and are more convenient for physicians and UR nurses).

There are also step-down units that provide an intermediate level of care between a critical care unit and a regular nursing unit of a hospital.

Example: A heart attack patient who no longer needs the services of a critical care unit but who still needs more monitoring than patients on a regular nursing unit may be transferred to such a

step-down unit. Because step-down units use fewer medical resources than higher levels of care, the cost is generally lower.

Home Healthcare

Home healthcare covers a wide range of services that can be given in the home for an illness or injury. It is for people who need some nursing care, therapy, or assistance with activities of daily living (ADLs), such as bathing or dressing, but who generally do not need 24-hour care. Examples of home healthcare include changing the dressing of a surgical wound, administering injections, as well as assistance with showering. [v]

List of ADLs:

Activities of Daily (ADLs) Living include:

- Bathing
- Dressing
- Transferring (getting in an out of a bed, chair, wheelchair)
- Toileting
- Continence
- Eating

Long-term care insurance benefits are often triggered when an insured can no longer perform two ADLs.

Who Uses Home Healthcare?

Most of those receiving home healthcare are elderly or disabled people who have an ongoing need for help with ADLs because of a chronic physical impairment or supervision because of a cognitive disorder such as Alzheimer's disease, and health plans do not cover such care (long-term care insurance does).

Services and Equipment Provided in Home Healthcare

Health plans do cover home healthcare for members who need it for a limited time (such as a few weeks) while they are recovering from an acute illness or injury. Services include basic nursing care, wound care, administering of medications, help with ADLs, and therapy and rehabilitation. Durable medical equipment (such as walkers and wheelchairs) may be provided, and in some cases a nonprofessional home health aide may prepare meals and do housekeeping and laundry.

Hospice Care

Hospice care consists of services and support for the dying and their families. The purpose is not primarily to treat the medical condition of the patient, which is incurable, but rather to improve the quality of life for the time that remains.

Care focuses on pain and symptom management, social services, and emotional and spiritual support for the individual and family members. Hospice care may be provided in the patient's

home or in a facility. Care is provided by a team that includes nurses, home health aides, social workers, therapists, chaplains, and bereavement counselors. Volunteers are also involved.

Hospice Care Coverage

Most health plans that cover hospice care model their coverage on Medicare, specifying that benefits are available only to those who have a life expectancy of six months or less and have agreed to forego medical or surgical interventions that prolong life and receive only healthcare services that support comfort.

It should be noted however, that Medicare will cover services unrelated to the terminal illness. [vi] For example, if an individual falls and breaks their arm while receiving hospice care. [vii]

The Authorization/UR Process

Steps of the Authorization/UR Process

The authorization/UR process consists of a series of steps.

1. Data collection
2. Data transmittal
3. Data Evaluation and Decisions
4. Administration Review
5. Medical Review
6. Authorization

Data Collection

In prospective review, information is obtained about the member's condition and the proposed treatment, for use in making the authorization (precertification) decision.

During concurrent review, information is needed to monitor the member's progress and treatment and direct them to the best care options.

For retrospective UR, a variety of data on utilization, outcomes, and costs are collected. Information and data can be obtained from members, physicians, hospital records, other providers, encounter reports, and claim forms.

Data Transmittal

Information for UR may be transmitted to the health plan via the following ways: manually, telephonically, or electronically.

Manual (Paper) Transmittal

A provider may complete a paper authorization form and send it to the health plan, and plan employees then enter the information into the computer system.

Manual transmittal has traditionally had a high degree of physician acceptance, as paperwork can generally be completed at the physician's convenience, without intruding into busy office hours or disrupting patient care.

Today's technology and the move toward electronic records is likely to disrupt this preference for manual (paper) transmittal.

Telephone Transmittal

In telephone transmittal providers call a central number and either speak to a plan employee or report information to an interactive voice response (IVR) system.

For doctors, a well-designed telephone system is faster, less cumbersome, and less labor-intensive than paper transmittal. But poorly structured systems can result in long delays and unnecessary repetition, especially when telephones are busy or operators put providers on hold.

Example: In systems with multiple levels of input, a clerk may ask for demographic information and then transfer the provider to a nurse or physician who collects clinical information. The provider is often put on hold during each transfer. In addition, if information is not carried forward, it must be repeated at each level.

Telephone Versus Manual Transmittal

For the health plan, telephone transmittal is often more accurate and complete than manual transmittal. Providers are less likely to omit necessary information when dealing with a service representative or following instructions on automated systems. Telephone transmittal also reduces data entry errors because data are entered only once (either directly by the provider through an IVR system or by plan personnel).

Electronic Transmittal

Electronic systems allow providers to transmit UR information through computers linked to the health plan's network (intranet) or over the Internet.

Electronic transmittal is generally faster, less labor-intensive, and more complete than other transmittal methods, and because it has less opportunity for human error (such as data entry errors), it also tends to be more accurate.

However, electronic transmittal of healthcare information is subject to more stringent regulatory requirements than other methods. For example, HIPAA includes extensive guidelines related to electronic transmittal of personal and protected health information.

Data Evaluation and Decisions

The data evaluation and decision-making stage of authorization and UR consists of two components: an administrative review and a clinical review.

Administrative Review

Administrative review addresses coverage issues: Basically, is the patient covered by the plan, and is the proposed service covered by the patient's benefit package? If the answer is no, authorization is denied and no further evaluation is necessary.

Example: Authorization is denied during administrative review if the proposed service is specifically excluded under the benefit plan (for instance, cosmetic surgery or experimental procedures). In some plans administrative review is conducted by employees who are not medical professionals, while in others it is performed by UR staff.

Medical Review

If the patient and proposed service are covered, a medical review is conducted—a medical professional (usually a nurse or physician) evaluates the medical necessity and appropriateness of the proposed service.

Typically, nurses only have the authority to approve authorization requests that meet certain criteria; the decision to deny authorization based on medical necessity or appropriateness must be made by a physician. Medical review may result in authorization, modified authorization, pended authorization, or denial.

Medical Review Results

- If the service is deemed necessary and appropriate, authorization is granted (payment is approved).
- In some cases, UR staff grant modified authorization—they do not approve the service exactly as proposed, but rather with some change. For example, they may approve payment for a wheelchair but require that it be bought from a company contracted with the plan. UR staff may approve an alternative treatment (such as a different drug, provider, or diagnostic test), but only after consulting with the treating physician and reaching consensus on the decision.
- If UR staff question the necessity or appropriateness of a proposed service, there may be a "pended" authorization—action is delayed while the case is submitted for additional review to the plan's medical director, UM committee, or expert consultants. Additional information may be requested from the physician.
- If a service is clearly not medically necessary, safe or appropriate, authorization of payment is denied. However, plans evaluate cases carefully before denying payment, as denials may result in member dissatisfaction, appeals, and even legal action.

It should be clarified and emphasized again that UR staff do not determine what services a member may receive, only what the health plan will pay for.

The Scope of Authorizations

An authorization may vary in terms of the services or time it covers.

Single-visit Authorization

Single-visit authorization. Health plans sometimes require PCPs and other gatekeepers to submit a separate authorization request for each specialist visit or nonprimary procedure. Additional visits or services are not covered without an additional authorization.

This approach provides a high level of management, but it is difficult to implement and enforce, and providers find it onerous.

Limited-visit Authorization

Limited-visit authorization. Under this approach, a single authorization covers a certain number of specialist visits or treatment for a certain amount of time. For visits or services beyond these limits, an additional authorization must be obtained.

Prohibition of Secondary Referrals

Prohibition of secondary referrals. In most cases, only a PCP or other gatekeeper can give referrals for nonprimary care; specialists (unless they serve as gatekeepers) cannot make referrals without plan authorization.

For example, a PCP refers a member to a specialist for a certain treatment. If the specialist decides the member needs additional visits, different treatment, or the care of a different specialist, the specialist cannot authorize this; PCP must make an additional request for authorization.

Inpatient Care Authorization

Inpatient care authorization. For inpatient care in a hospital or other facility, health plans often allow authorization for one service or procedure to cover related services.

For example, authorization of a surgical procedure may cover services related to the surgery, such as preoperative testing, radiology, anesthesia, and postoperative follow-up care. In most inpatient situations, extension of an authorization by means of concurrent review is a more efficient and effective way to manage complex cases than requiring a new authorization request.

Individual Needs and Circumstances

UR is based on the individual needs and circumstances of patients, and under each of the listed approaches exceptions may be made for conditions that require multiple visits, specialists, or therapy options (such as chemotherapy and radiation therapy, mental health and substance abuse treatment, and obstetrics).

In these cases, the scope and duration of services are typically determined by the specialist. Authorization requirements, including limits and exceptions, should be clearly identified in the health plan's UM program and communicated to members and providers.

Notes:

[i] W. Clark. 1995. "Negotiating Successful Health Plan Contracts," *Healthcare Financial Management* (August 1995): 28.

[ii] Mark A. Shuster MD, Elizabeth A. McGlynn, and Robert H. Brook MD. 1997. "Why the Quality of U.S. Health Care Must Be Improved," *National Coalition on Health Care*, October 1997.

[iii] Ani Turner, George Miller, Samantha Clark, "Impacts of Prior Authorization on Health Care Costs and Quality," Center for Value in Healthcare, Nov. 2019, available at www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf

[iv] John L. Roberts, "hospital Observation Status Can Be Financially Devasting for Seniors, *Aging Care,* April 8, 2021, available at https://www.agingcare.com/articles/hospital-observation-status-can-be-financially-devastating-175991.htm

[v] Medicare.gov, What's Home Health Care?, Fact Sheet, available at: https://www.medicare.gov/what-medicare-covers/home-health-care/home-health-care-what-is-it-what-to-expect.html

[vi] CMS, Medicare Hospice Benefits, Product No. 02154,March 2018, available at: https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF

[vii] CMS, Hospice Fact Sheet, December 1, 2021, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice

15 Quality Assessment and Improvement

Learning Objectives

After completing this lesson, you will be able to:

- define and understand the importance of healthcare quality,
- understand how patient safety fits into the overall context of healthcare quality,
- define and give examples of the three main types of quality measures and state the advantages and disadvantages of each,
- identify the three main categories of data that health plans use to assess quality, and
- describe four approaches to improving health plan quality.

Quality Management

Utilizing healthcare resources efficiently is an important objective of healthcare management, but equally important is ensuring that health plan members receive high-quality care and service.

In this lesson, we describe how health plans use **quality management (QM)** to establish goals for quality, measure and monitor performance, and make improvements. Quality measures, standards, and accreditation will be examined in more detail in the following lesson.

Quality Assessment and Improvement

Although QM is a continuous process that consists of a variety of interrelated activities, this lesson will divide QM into two broad categories:

- **Quality assessment** includes activities designed to define and measure quality and performance and identify any need for change.
- **Quality improvement** involves planning and implementing changes and then reapplying quality assessment techniques to assess the impact of those changes on outcomes.

Healthcare Quality

What Is Quality?

Although there is a consensus that quality is an essential goal in healthcare, there are many different ideas about how to define quality, how to recognize it, and how to provide it.

In its most general sense, the term **quality** in the context of a health plan refers to the plan's success in providing healthcare and other services in such a way that plan members' needs and expectations are met and that meet generally accepted clinical quality standards.

Two Types of Health Plan Quality

There are two broad categories of quality in a health plan:

- Service quality
- Healthcare quality

Service Quality

Service quality generally refers to a health plan's success in meeting the needs and expectations of plan members with regard to nonclinical (nonmedical) customer services.

It has to do with such matters as how well member services representatives answer member's questions and resolve administrative issues, how long a member must wait for a response to a complaint, or how friendly and helpful provider office staff are.

Healthcare Quality

According to an often-quoted definition formulated by the Institute of Medicine (IOM), (now, called the National Academy of Medicine) **healthcare quality** is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

In common language, healthcare quality refers to whether health plan members receive care based on the most up-to-date and effective medical practices and their medical conditions are successfully cured or managed.

Information on the "Triple Aim" – a framework for understanding healthcare quality:

The Institute for Healthcare Improvement (IHI) developed a widely accepted framework for understanding healthcare quality known as the *Triple Aim.* This framework posits that health services are optimized when they simultaneously pursue three dimensions:

- improving the patient experience of care (including quality and satisfaction);
- improving the health of populations; and
- reducing the per capita cost of healthcare[i]

Why Is Quality Important?

The mission of a health plan is to provide top-quality healthcare to its members at an affordable price. Therefore, the most straightforward answer to the question, "Why is quality so important for health plans?" is that quality is a major part of a plan's reason for being.

A health plan's purpose is to, as effectively as possible, maintain and restore members' health while *protecting their safety*—in other words, offer high quality care.

There are also good business reasons for a health plan to provide quality and make known that it does so. For many consumers, employers, and other purchasers, quality is an important factor in choosing a health plan, and the ability to demonstrate superior quality gives a health plan a competitive advantage.

Actual Quality of Managed Care Plans

Because managed care plans have been in the forefront of efforts to hold down healthcare costs, some people have expressed concerns that they have compromised on quality. However, many studies show that the quality of care provided by managed care plans equals or exceeds that of traditional fee-for-service insurance.[ii] Health plans may still need to demonstrate quality to dispel such doubts and earn the public's confidence.

Six Domains of Health Care Quality: STEEEP

There are several ways the Triple Aim can be achieved and how quality can be measured and improved. Several frameworks exist for assessing quality. One of the most influential is the framework put forth by the IOM (now called the National Academy of Medicine). This framework includes the following six goals for the healthcare care system:

- **Safe** – Avoid harm to patients from the care that is intended to help them.
- **Timely** – Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Effective** – Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.
- **Efficient** – Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** – Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.
- **Patient-Centered** – Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring patient values guide all clinical decisions.

These domains are sometimes referred to as **STEEEP**.[iii iv]

Patient Safety

Patient Safety

One of the most important reasons to promote healthcare quality is to ensure patient safety and reduce healthcare (medical) errors. The National Patient Safety Foundation (now, part of the IHI), defines **patient safety** as "avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of healthcare."

It also defines **healthcare (medical) error** as "an adverse event or near miss that is preventable with the current state of medical knowledge."[v]

Medical Errors

Medical errors can occur in a variety of ways including:

- Commission
- Omission
- Execution
- Adverse Event

Commission

An error of commission is doing the wrong thing. This includes administering an incorrect treatment or performing the wrong procedure. For example, the wrong dosage of a medication is given to a patient.

Omission

An error of omission is perhaps best understood as not doing something that is needed by a patient. For example, a patient does not receive the appropriate test or does not receive it in a timely manner.

Execution

An error of execution is doing the right thing in the wrong way. A planned treatment or procedure is delivered incorrectly. For example, the wrong knee is mistakenly treated during a surgical operation.

Adverse Event

An adverse event is any harm a patient suffers that is caused by something other than his or her underlying condition. The cause might be a medical error, a deficiency in the patient's care, or some other cause.

More on medical errors:

A federal Quality Interagency Coordination (QuIC) Task Force has defined a medical error as "the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.[vi]

A useful brief definition of a medical error is that it is a preventable adverse event.[vii]

Causes of Medical Errors

Medical errors have a number of causes. In some cases, it is an individual practitioner that makes a mistake but more often a medical error results from a breakdown in the overall healthcare system.

Several factors that may cause a medical error:

- Lack of communication
- Lack of reporting
- Lack of verification

Lack of Communication

Communication among healthcare providers can be limited and/or faulty leading to medical errors. To give a simple example, a doctor writes an illegible prescription leading to the dispensing of an incorrect medication.

Example: An outpatient diagnostic center fails to contact a physician about a patient's chest x-ray showing pneumonia. As a result, the patient does not receive timely treatment for the pneumonia and has to be hospitalized. The problem of poor communication is compounded when many providers participate in a patient's care.

Lack of Reporting

Lack of Reporting – Most healthcare organizations have internal systems for reporting such incidents as adverse drug interactions and minor medical errors. These organizations also often report such incidents to external agencies.

Example: Hospitals are required to report data to the CDC's National Healthcare Safety Network. However, even with these systems in place, incidents can go unreported. And, without adequate reporting, plans often cannot identify the causes of medical errors or develop effective strategies to prevent them.

More information about the National Healthcare Safety Network:

The National Healthcare Safety Network is the nation's most widely used healthcare-associated infection (HAI) tracking system and federal law requires adverse drug reactions be reported to the Food and Drug Administration (FDA).[viii]

Lack of Verification

Lack of Verification – Many treatment decisions are based on the single analysis of an individual's test results without secondary verification. This can result in medical errors.

Information on one area where progress has been made in reducing medical errors:

One problem that is being addressed is the lack of coordination among parties concerned with medical errors. The Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act) authorized the creation of Patient Safety Organizations (PSOs) to improve quality and safety by reducing the incidence of events that adversely affect patients. PSOs are required to collect and analyze data in a standardized manner called the Common Formats to help providers uniformly report patient safety events and to improve health care providers efforts to eliminate harm.[ix]

Information on the tracking of medical malpractice:

The National Practitioner Data Bank (NPDB) centralizes healthcare quality reporting in relation to practitioners. It is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and supplies. State licensing agencies, health plans, malpractice insurance carriers, criminal courts, and others are required to report quality of care incidences to these databases. Established by Congress in 1986 and enhanced by subsequent legislation,[x] NPDB is a workforce tool that prevents practitioners from moving from state to state without disclosure or discovery of previous damaging performance. This has significantly reduced the ability of a poor-quality practitioner to move from one state to another without the new state's licensing board being aware of prior issues.[xi]

Patient Safety: A Closer Look

In this section, we will discuss additional patient safety issues including:

- hospital acquired conditions (HACs)
- the impact of patient safety issues on healthcare quality and quality programs
- ways in which the healthcare community is addressing patient safety issues

Hospital-Acquired Conditions

A hospital-acquired condition (HAC) is an undesirable situation or condition that affects a patient and that arises during a stay in a hospital or medical facility. In other words, it is a condition that is not present at the time of admission.

Examples of HACs include:

- Falls and trauma that occur within the facility such as fractures, dislocations, intracranial injuries, crushing injuries, and burns;

- Objects left in a patient's body during surgery;
- Development of an air embolism;
- Provision of incompatible blood; and
- Catheter-associated urinary tract infections.

Impact of Patient Safety Issues on Healthcare Quality and Quality Programs

The incidence and severity of medical errors and adverse events resulting in patient harm are well documented. Both public and private payers, through payment penalties, have sought in to reduce HACs. In addition, legislation has sought to reduce such incidents.

Example: The Hospital-Acquired Condition Reduction Program (HACRP) was established as part of the Affordable Care Act (ACA) legislative program. HACRP reduces Medicare payments by one percent for hospitals in the lowest performing quartile based on a series of risk-adjusted HAC quality measures.[xii]

Other examples of efforts to reduce HACs, include the Alabama Hospital Quality Initiative. This is a statewide program representing the partnership efforts of Blue Cross of Alabama and hospitals within the state aimed at controlling and reducing hospital-acquired infections.[xiii]

Addressing Patient Safety

There are several ways in which healthcare providers, health plans, and other entities have sought to ensure patient safety and reduce medical errors:

- **Medical error reporting systems** allow healthcare providers and facilities to analyze common errors and identify aspects of the healthcare delivery process that result in such errors.
- **Medical alert systems** apply pre-programmed criteria to identify test results that fall outside acceptable ranges.
- **Drug checking systems** link physician and pharmacy order entry information systems and automatically alert physicians and pharmacists of possible drug interactions or allergic reactions to a prescribed drug.
- **Electronic medical record systems** allow providers and health plans to track and analyze clinical data and provide reminders for needed services.

Assessing Quality in a Health Plan

Performance Measurement

Recognizing that quality is important and easy. But as we will see in this section, it is a more complex task for a health plan to define precisely what quality is in certain contexts and, based on that definition, determine whether the plan is delivering quality.

Performance measurement can help a health plan determine how well it is doing in meeting members' needs and can provide information the plan needs to improve its performance and effectively allocate resources.

Patient-Reported Outcomes

Improving the patient's experience with care is one of the key dimensions of the Triple Aim. The patient voice is critical to assessing healthcare quality and many stakeholders are focused on improving patient-reported outcomes (PROs). PROs are defined as any report of the status of a patient's (or person's) health condition, health behavior, or experience with healthcare that comes directly from the patient, without interpretation of the patient's responses by a clinician or anyone else.

Key PRO's

Key PRO domains include:

- Health-related quality of life (including functional status)
- Symptoms and symptom burden (e.g. pain, fatigue)
- Health behaviors (e.g. smoking, diet, exercise)

Satisfaction

When discussing PROs and quality, it is important to distinguish between patient ***satisfaction*** and patient ***experience***. If satisfaction involves giving the patient what they want regardless of whether it is clinically indicated, that would likely be in direct conflict with providing quality care.

> ***Example:*** *A member is dissatisfied with their doctor because they refuse to prescribe an antibiotic for their sore throat. But in fact, the antibiotic is not necessary or useful for their ailment. Moreover, the overprescribing of antibiotics for viral infections of the throat and respiratory tract has not only increased healthcare expenditures unnecessarily but led to the growth of antibiotic resistant organisms.*

Experience

Experience on the other hand, may involve how well a provider communicates key information to a patient, an important aspect of quality care even if it does not directly influence the patient's physical outcome.

***Example**: A health plan contracts with a medical group because the group's physicians have strong credentials and are recognized as experts in their fields. A plan member visits one of these physicians and feels that the physician is unfriendly, and the member does not understand their explanation of their illness or their plan for treatment. They undergo the treatment however and get better. Objectively, based on the provider's qualifications, the treatment delivered, and the results indicate the member received high-quality care. The member however, may not think so.*

The Issue of Perception

While science and objective criteria take priority, consumer perceptions are also important. They may reflect important aspects of care, such as a doctor's communication skills.

Purchasers base their decisions about health plans in part, on the perceptions of the consumers they represent. Consequently, as we will see, while many quality measures are based on scientific criteria, others reflect the perceptions of members.

Assessing Service Quality

As noted, the term "service quality" is used for nonclinical (nonmedical) services. It involves the customer service that health plan members receive both from the plan's own staff and from its providers.

Health Plan Staff

The quality of the service delivered by health plan staff may include:

- how long a member must wait for an answer when calling the plan;
- the attitude, competence, and efficiency of the member services staff;
- how quickly member services representatives can resolve issues for members;
- the accuracy and timeliness of claims payments;
- the availability and understandability of educational materials for members; and
- the clarity and accuracy of materials explaining to members benefits, limitations, and administrative processes.

In using these measures, a health plan can compare its performance to established standards and/or its own previous performance.

Healthcare Providers

For healthcare providers, service quality may include:

- how easily members can get through to a doctor's office by phone
- how long members wait for an appointment
- how long members wait in the office before seeing the doctor
- the attitude, competence, and efficiency of office staff
- the doctor's "bedside manner." This includes how friendly and understanding the doctor is, how well she explains clinical findings and treatment options, whether the patient feels that they listen to their concerns, etc.

Assessing Healthcare Quality

The National Academy of Medicine (NAM), (previously called the Institute of Medicine (IOM.), defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge.

Quality Measures

A healthcare quality measure (or performance measure) is a way to calculate whether and how often the healthcare system does what it should.

Measures are based on scientific evidence about processes, outcomes, perceptions, or systems that related to high-quality care. Measures of quality are generally divided into three categories.

- Structure measures
- Process measures
- Outcome(s) measures

Structure Measures

Structure measures relate to the nature, quantity, and quality of the resources that a health plan has available for member service and patient care. For instance, a health plan might calculate how many dermatologists it has per 1,000 members, or what percentage of its physicians are board-certified.

Process Measures

Process measures relate to the methods and procedures a health plan and its providers use to furnish service and care.

A plan might calculate what percentage of members received regular check-ups over a certain period, or how often a certain medication was not prescribed when it should have been.

Outcome(s) Measures

Outcome(s) measures gauge the extent to which services succeed in improving or maintaining patient health. A plan might calculate the percentage of patients with a certain condition who are still alive five years later.

Other Outcome Measures

Many of the measures currently used to evaluate health plan quality are structure and process measures, but the trend is toward greater use of outcomes measures.

Structure, process, and outcomes are interdependent. Structure and process lead or are believed to lead to better outcomes, and the best structure and process measures are those that can be explicitly linked to improved outcomes.

Other Outcome Measures (Continued)

Conversely, outcomes are the results of structure and process, and the most useful outcomes measures are those that can be related to specific processes or structures. If health plans can link outcomes to processes or structures, they will have a better idea of which processes or structures to improve and how to improve them, and can improve patient health outcomes.

Structure Measure Examples

Structure measures of healthcare quality may include:

- the number of primary care providers in the plan's network
- the number of specialists
- the number of providers accepting new patients
- the geographic distribution of providers within the service area,
- the percentage of providers who are board-certified
- physician turnover in the plan
- hospitals in the plan's network
- the number of hospital beds
- emergency room access
- the availability of member education programs

The Benefit of Structure Measures

The benefit of structure measures is that they provide an indication of a healthcare organization's capacity to provide high-quality care. They also are relatively easy to calculate and report.

The limitation is that they do not directly measure the quality of care received or indicate whether a patient's health was improved as a result of that care. However, it does seem highly probable that many structure measures are related to quality.

Example: Other things being equal, a health plan with more board-certified physicians very likely provides higher quality care, on average, than a plan with fewer board-certified physicians and timely access is more certain. Likewise, it seems clear that if so few doctors are available that members must wait a very long time for an appointment, healthcare outcomes will be adversely affected.

Process Measures

Process measures relate to the methods and procedures a health plan and its providers use to furnish service and care.

Among the most popular process measures are preventive care statistics. They are relatively easy to calculate and understand, and they fit well with the current emphasis on prevention.

Examples:

- the percentage of children receiving immunizations;
- the percentage of adults (particularly the elderly) receiving regular medical checkups;
- the percentage of members receiving certain screenings, such as mammograms, pap smears, or cholesterol screening; and
- the percentage of members receiving advice on smoking cessation or other risk-reducing programs.

Inappropriate Care

Health plans also use various process measures related to how providers treat patients. One important element is appropriateness of care—appropriate care can improve health outcomes and increase member satisfaction, while inappropriate care can lead not only to poor outcomes but to adverse events. In general, *inappropriate care* can be divided into three categories:

- Overuse of care
- Underuse of care
- Misuse of care

Overuse of Care

Overuse of care is unnecessary tests, medications, or procedures. Overuse of care not only wastes resources and increases costs, it can reduce the effectiveness of appropriate treatments and expose the patient to unnecessary risks and possible adverse effects.

Underuse of Care

Underuse of care occurs when a provider fails to render a service or treatment that would likely improve the patient's health (an error of omission). For example, despite evidence of their benefits, beta blockers are not always routinely administered to patients following a heart attack.

Misuse of Care

Misuse of care occurs when the wrong treatment is provided (an error of commission) or when the correct treatment is delivered incorrectly (an error of execution).

Standard of Care

In many cases *appropriate care* is codified as professionally recognized standards of care. A **standard of care** is a diagnostic and treatment process that a provider should follow for a certain type of patient, illness, or clinical circumstance. Standards of care (sometimes referred to as guidelines of care) are generally published by medical organizations such as the American Medical Association (AMA) and others.

Process Measure Advantages

The advantage of process measures is the same as for structure measures—they are relatively easy to determine and report. They also give providers clear, actionable feedback and a straightforward way to improve their performance. But while links have been established between some process measures and positive health outcomes, for others they have not.[xiv]

Types of Outcome(s) Measures

Outcome(s) measures gauge the extent to which services succeed in improving or maintaining patient health. A plan might calculate the percentage of members with hypertension whose blood pressure was adequately controlled, or the proportion or the number of acute inpatient hospital stays that were followed by an unplanned readmission within 30 days.

Outcome(s) measures can be divided into three types: clinical status, functional status, and patient/family/caregiver experience.

Clinical Status

- **Clinical status** relates to biological health outcomes, either for an individual or for a population served, such as the following:
    - the change in tumor size for patients treated for cancer,

- the five-year survival rate for cancer patients (the percentage still living five years after treatment),
- the occurrence of chest pain in patients who have received coronary angioplasty,
- the survival rate of patients receiving coronary angioplasty,
- the number of hospital admissions for members with certain medical conditions,
- the average length of hospital stays by type of injury or illness,
- the number of patients contracting an infection in the hospital,
- the incidence of certain conditions that commonly afflict long-term diabetes patients (such as foot ulcers or blindness),
- the occurrence of infants with low birth weight or of premature births,
- patient safety issues (such as the outcomes of patient falls).

Functional Status

Functional status refers to a patient's ability to perform certain normal activities. Can they go to work? Can they bathe, get dressed, and get around without help? Is their bowel function or sex life impaired? These are a commonly used type of patient-reported outcome(s) measure (PROM), Functional status outcomes measures are commonly used in these areas:

- stroke rehabilitation (physical, occupational, and speech therapy)
- cardiac rehabilitation (following a heart attack or open-heart surgery)
- orthopedic surgery (following total hip and/or knee arthroplasty)
- sexual function impairment following surgery or certain drug therapies

Patient/Family/Caregiver Experience

Patient/family/caregiver experience, another type of PROM, refers to patients' perception of their care, including the interpersonal aspects of care.

These measures assess aspects of care ranging from the clarity and accessibility of information that health plans provide, to whether doctors tell patients about test results, to how quickly patients are able to get appointments for urgently needed care.

Patient/Family/Caregiver Experience (Continued)

These three types of outcome(s) measures (clinical stratus, functional status, and patient/family/caregiver experience) do not always match to give a clear indication to providers and patients of the best course of treatment.

Example: For a certain type of cancer, Treatment A offers a smaller chance of remission than Treatment B. On the other hand, Treatment A impairs the patient's day-to-day functioning less than Treatment B. In this case clinical status and functional status outcomes measures conflict.

Advantage of Outcome Measures

The advantage of outcome(s) measures is that they directly gauge the extent to which the ultimate goal of healthcare quality—better patient health—has been achieved.

For this reason, outcome(s) measures are typically preferred by healthcare stakeholders over process and structure measures. However, these measures are not without their limitations. It is important to understand that provider or plan behavior can actually influence an outcome.

Concluding and Implementing Outcome Measures

Conclusions about quality based on outcomes could be inaccurate if outcomes are not risk-adjusted for characteristics that are outside of the plan's or provider's control, such as age, gender, patient comorbidities, or socioeconomic factors (where appropriate).

When implementing outcome(s) measures, care must be taken to ensure that their use does not result in any unintended consequences.

Example: Providers avoiding treating the sickest patients in a facility in order to perform well on disease-specific mortality measures.

Note: *In this section we have discussed measures of quality in general terms. In the next lesson we will look at specific quality measures and quality standards and the organizations that sponsor them, including the HEDIS measure set developed by the National Committee for Quality Assurance (NCQA) and the star system for rating Medicare Advantage plans.*

Collecting, Analyzing, and Reporting Quality Assessment Data

Collecting, Analyzing, and Reporting Quality Assessment (Continued)

In this section, we will discuss:

- three key sources for data collection,
- data analysis, and
- reporting quality assessment data.

Sources for Data Collection

The data health plans collect for quality assessment can be divided into three categories:

- financial data
- clinical data
- customer satisfaction and experience data

Financial Data

Financial data describe the costs of physical, technological, and human resources needed to provide administrative and healthcare services to plan members.

Financial data are used to analyze how efficiently health plans and providers use resources. They typically come from the health plan's claims and encounter reports, its administrative records, and hospital records.

Clinical Data

Clinical data include data related both to certain diseases and to general health and functional status. Disease data, patient medical records, claims, and encounter forms are the primary sources.

Quality measure data contained in patient records can be electronically extracted or queried from an Electronic Health Record (EHR) or manually abstracted by a healthcare professional from paper forms or electronic sources that cannot be queried.

Collection of Clinical Data

Clinical data can also be found in patient registries, organized systems that use observational study methods to collect uniform data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure.

Information on members' general health and functional status can be collected directly from members using such tools as the SF-36 and HSQ-39 (Health Status Questionnaire) surveys.

Collection of Clinical Data (Continued)

A significant amount of information is available from these sources, but their usefulness depends on the feasibility of using the source for data collection and accurate measure reporting.

Example: Poor documentation and multiple sources of information can make collecting data from paper medical records (or outdated IT systems) time-consuming and expensive. Information from claims is readily available, but it is limited to diagnostic and treatment codes and costs of services.

Customer Satisfaction and Experience Data

Customer satisfaction data describe how a health plan's members, providers, and purchasers view the way the health plan delivers services.

Customer satisfaction and experience data also provide health plans with information about which plan services work best and which services are most important to members, providers, and purchasers.

Member Satisfaction Data

Member satisfaction data address both members' overall satisfaction with the plan and their experience with key factors such as access, quality of care, and administration.

Member satisfaction and experience information is typically gathered through telephone or mail surveys. One of the most commonly used surveys is CAHPS®, discussed in the next lesson.

Provider Satisfaction Data

Provider satisfaction data address healthcare providers' satisfaction with the plan overall and with key factors such as availability of contracted ancillary services (x-ray, labs, durable medical equipment, etc.), the delivery and availability of information regarding best practices, and administration.

Customer satisfaction and experience data also provide health plans with information about which plan services work best and which services are most important to members, providers, and purchasers.

Data Analysis

The analysis of financial, clinical, and customer satisfaction and experience data provides a snapshot of a health plan's current level of performance.

By comparing actual performance to established standards, past performance, or another plan's performance, a health plan can identify areas that need improvement.

By comparing current performance against past performance, a plan can identify areas of improvement and of decline.

Reporting Quality Assessment Data

The final step in the quality assessment process is reporting results. Performance reports serve two primary purposes, internal and external.

Internal Purpose

Internally, performance reports can be used to help a health plan improve the quality of healthcare and services by identifying the plan's strengths and weaknesses, giving guidance on where to focus quality improvement efforts.

External Purpose

Externally, performance reports provide accountability to the health plan's customers and outside agencies. Health plans are often required to report quality measure results to federal and state governmental agencies, accreditation entities such as NCQA, and purchasers.

By comparing one plan, provider group, or delivery system to another, analysts can use performance reports to identify differences or problems in performance. Health plan customers can use this comparative information to make informed healthcare decisions.

Quality Improvement

Quality Improvement

Quality improvement consists of producing better healthcare outcomes (clinical, functional, and member perception/satisfaction). Health plans can accomplish this by changing the structures and processes that underlie their clinical and administrative services.

In other words, a health plan can improve its services by increasing or improving its resources and by changing the ways it performs services. For example, a health plan could improve access to care by expanding its provider network (a structure change) or by changing its authorization procedures (a process change).

Elements of Quality Improvement

To be effective, changes to structures and processes must include the following elements:

- Planning
- Implementation
- Evaluation
- Communication
- Documentation

Planning

Planning. Before taking any action, a health plan must identify where improvement is needed, define desired outcomes, identify causes of problems and barriers to change, and decide what actions are most likely to achieve the desired outcomes.

Implementation

Implementation. Tasks are assigned to departments and individuals, target dates set, activities monitored, and completion tracked.

Evaluation

Evaluation. After changes are implemented, outcomes are measured and compared to previous performance and to the goals set.

Evaluation is ongoing—repeated measurement and analysis provide a "moving picture" of the quality improvement effort, showing whether it is having a positive effect over time. When goals are not being met, problems or barriers can be identified, and changes or additional actions can be taken.

Communication

Communication. The health plan must convey information about its quality improvement efforts and the results through the organization and to its customers. Effective communication helps define and support the plan's mission, satisfy members' expectations, improve provider performance, and demonstrate health plan value.

Documentation

Documentation. Accrediting organizations and regulatory bodies require health plans to provide documentation of quality improvement assessment, planning, and evaluation. They also require documentation of the actions planned, responsible parties, and intended completion dates. This provides a written record of the health plan's activities and their impact on its customers.

Quality Improvement Approaches

Health plans use a variety of strategies and tools to improve quality. We will describe some of the most common:

- Benchmarking
- Clinical practice guidelines
- Provider profiling
- Peer review

Benchmarking

Benchmarking is one of the most effective quality improvement methods. It consists of identifying the best practices that produce the best outcomes and reproducing those practices to equal or surpass those outcomes.

> ***Example*** *(improving service quality): A health plan wants to improve member satisfaction with claim resolution. The plan's managers identify another plan with extremely high customer satisfaction in this area, analyze its practices, and implement them.*
>
> ***Examples*** *(improving healthcare quality): A health plan identifies a hospital with extremely high survival rates for patients undergoing coronary artery bypass surgery. It uses that hospital's practices to develop clinical practice guidelines for treating such patients.*

Medical best practices are widely accepted in healthcare professions, so their use by a health plan is generally supported by the plan's providers.

Clinical Practice Guidelines

Clinical practice guidelines are based on approaches that have been proven to be successful. They are used to help providers consistently deliver services that will improve their patients' health and reduce unnecessary variations in patient care.

Clinical practice guidelines can be developed in-house by joint health plan-provider committees. Or they can be obtained from outside sources. Such outside sources include professional associations such as the AMA, the American Academy of Pediatrics (AAP), and the many associations of medical specialists. Like best practices, clinical practice guidelines are generally accepted and supported by providers.

Provider Profiling

Provider profiling involves collecting and analyzing information about the practice patterns of individual providers. It is used during credentialing and recredentialing to determine how well a provider meets a health plan's standards.

Profiling also identifies providers whose practices vary significantly from the norm—they may use substantially more or fewer resources than other providers, or they may use them differently. By analyzing providers' practice patterns, the health plan can sometimes determine whether an individual's patterns produce better or worse outcomes and whether they are cost-effective.

Provider Profiling (Continued)

Provider profiling can be useful, but it can also be controversial. It is commonly used to educate providers—for instance, a plan might inform a pediatrician that their immunization rates for children are much lower than their peers, and this should encourage them to assess their practices.

But some health plans have acted punitively toward providers based solely on utilization rates or have posted such information publicly, and they have found themselves involved in class action lawsuits. Comparing providers statistically can be complex and difficult, requiring adequate risk adjustment, and consequently it may be difficult to demonstrate that comparisons are valid and fair and defend a punitive or public action.

Peer Review

In **peer review** a panel of medical professionals evaluates the care delivered by a provider. Unlike profiling, peer review is not based primarily on statistics. Peer review can focus on a single episode of care or take a broader look at a provider's practices.

The appropriateness and timeliness of the services delivered are reviewed, as well as outcomes and in some cases patient perceptions (as when a member complaint or negative responses to satisfaction surveys have been received). Results can be used to educate a provider and identify opportunities for improvement or to provide a measure of quality.

PDCA and Lean

One advantage of peer review is that a physician is likely to be more receptive to education and recommendations offered by other physicians than by health plan administrators. Should a

health plan have to take disciplinary action against a provider (such as termination of their contract), that action will be easier to defend if it is based on the recommendation of a committee of their peers.

Other approaches used to improve quality include:

- PDCA
- Lean

More about PDCA:

Plan-Do-Check-Act (PDCA) is an iterative four-step method used for the continual improvement of processes (and products). The method is based on the work of Edward Deming, whose work in quality improvement was successfully adopted by industry in post-World War II Japan.[xv]

More about Lean:

Lean is a set of operating philosophies and methods that help create maximum value for healthcare patients by reducing both waste and wait times. Lean management emphasizes the health consumer's needs, involvement of employees, and continues improvement.[xvi]

Notes

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16 Quality Standards, Accreditation, and Performance Measures

Learning Objectives

After completing this lesson, you will be able to:

- define quality standard
- define accreditation
- identify two major accrediting organizations for health plans
- define performance measure
- list a few of the ways the Affordable Care Act (ACA) and MACRA addresses healthcare quality

Learning Objectives (Continued)

In the previous lesson, we described the methods health plans use to measure and improve the quality of administrative and healthcare services delivered to plan members.

In this lesson, we describe how quality standards, accreditation, and performance measures help health plans demonstrate the quality of their programs and services to plan members, purchasers, providers, and other external parties.

Quality Standards

Standards

Health plans typically rely on standards to assess the quality of the services they provide. **Standards** are defined by the National Academy of Medicine (NAM), (previously called the Institute of Medicine (IOM)[i] as "authoritative statements of minimum levels of acceptable performance or results, excellent levels of performance or results, or the range of acceptable performance or results."

Standards represent the expectations of the health plan, members, purchasers, and outside agencies for resource utilization, healthcare and administrative processes and procedures, and outcomes. Standards also provide a means of holding health plans, their network providers, and their staffs accountable for providing quality services.

Qualifiable Standards

To qualify as a valid measure of quality and performance, a standard must

- relate to conditions that are important to the plan and its enrollees and providers;
- focus on structures, processes, and/or outcomes that can be influenced through quality improvement initiatives; and

- address situations that are controllable by the organization.

Usage of Standards in Health Plans

Health plans may use internal or external standards to measure and evaluate the quality of their services.

Internal Standards

Internal standards are developed by the health plan itself and are based on the organization's historic performance levels. Health plans generally use internal standards to measure the quality of administrative services, such as customer service, claims processing, etc.

External Standards

External standards are based on outside information, such as published industry-wide averages or benchmarks (sometimes referred to as best practices). Health plans usually use external standards to evaluate healthcare services, such as the rates of childhood immunization or breast cancer screening exams provided to enrollees. Many external standards are developed by accreditation organizations and are used in the accreditation process.

Accreditation

Accreditation is an evaluative process in which a healthcare organization undergoes an examination of its operations and processes to determine if they meet designated criteria as defined by the accreditation organization and to ensure that they meet a specified level of quality.[ii]

Accreditation Organization

The **accreditation organization** (also called the **accrediting body**) measures plan compliance with standards by means of document review, onsite visits and interviews, medical record review, and the evaluation of member services systems.

Several organizations provide accreditation for health plans and providers. While there is some overlap, each organization has its own standards. As a result, external customers sometimes have difficulty determining which accrediting body is the most appropriate in a particular case. In this section we will look at two major accreditation organizations for health plans, NCQA and URAC.

NCQA

NCQA (the National Committee for Quality Assurance) is a nonprofit organization that accredits, certifies, and recognizes:

- health plans (including PPOs, HMOs, POS plans, and others)
- managed behavioral health organizations (MBHOs)
- credentials verification organizations (CVOs)

- case managers for long-term services and supports
- disease management (DM) organizations
- physician organizations and patient-centered medical homes (PCMHs)

More than seventy percent of all health plan members in the U.S. are covered by an NCQA-accredited plan.[iii]

The Accreditation Process

Prior to 2020, NCQA's accreditation process consisted of two parts: an onsite survey of standards (processes, policies, and procedures) and an offsite evaluation of audited results of selected measures of effectiveness of care and consumer satisfaction included in NCQA's **Healthcare Effectiveness Data and Information Set (HEDIS)**.

Since 2020, plans obtain accreditation by earning a minimum number of points in each standards category (explained in further detail later in this lesson). Subsequently, plans submit HEDIS/CAHPS reporting during the reporting period after their first full year of accreditation and annually thereafter.[iv]

NCQA uses the HEDIS CAHPS 5.1H survey, which is a combination of the original HEDIS member satisfaction survey and the CAHPS survey developed by the Agency for Healthcare Research and Quality (AHRQ) to measure consumer satisfaction.[v] The core CAHPS survey questions are administered separately to commercial, Medicare, and Medicaid populations.

NCQA Quality Standards

During the onsite visit evaluators interview health plan staff and review materials to measure the organization's practices against standards in the following areas related to quality management and improvement and patient care:

- program structure
- program operations
- health services contracting
- availability of practitioners
- accessibility of services
- member satisfaction
- complex case management
- disease management
- clinical practice guidelines
- continuity and coordination of medical care
- continuity and coordination between medical and behavioral healthcare
- standards for medical record documentation

- delegation of quality improvement

NCQA Accreditation Process

In accrediting a health plan, NCQA also reviews processes for utilization management (such as the review and authorization of medical care); credentialing and recredentialing of providers; members' rights and responsibilities; and member connections (such as innovations in member service, pharmacy benefit, and interactive consumer health tools).

In addition, NCQA accreditation standards address consumer protection issues related to internal and external processes for reviewing and evaluating medical appeals. Accreditation standards are updated regularly.

The NCQA Accreditation Decision

Results of the onsite visit are organized into the following standards categories:

1. Quality Management and Improvement
2. Network Management
3. Utilization Management
4. Credentialing and Re-Credentialing
5. Member Connections
6. Population Health Management
7. Members' Rights and Responsibilities
8. Medicaid Benefits and Services

Scoring

Scores in each of these categories are calculated and used to arrive at an accreditation decision. Health plans can earn one of five accreditation levels: excellent (highest), commendable, accredited, provisional, and denied.

The accreditation scores for health plans are based on the points earned by meeting factors in each of the standards categories. If plans earn over 80% of the total applicable points, they earn accreditation. Plans earning between 55-80% of applicable points earn accreditation and a provisional status. Plans earning less than 55% of applicable points are denied accreditation.

Once accreditation status is earned, plans begin reporting HEDIS/CAHPS results annually.[vi]

URAC

URAC is a nonprofit organization that grants accreditation to health plans, dental plans, health networks (medical and dental), accountable care organizations (ACOs), health call centers,

community pharmacy organizations, drug therapy management programs, and credential verification organizations (CVOs).

URAC Core Standards

URAC accredits entire organizations based on Core standards, with which most URAC accredited entities must comply. These Core standards serve as the foundation of most URAC accreditation programs. Additionally, URAC has accreditation programs that focus on a single functional area within an organization, including case management, claims processing, comprehensive wellness, consumer education and support, credentialing, disease management, drug therapy management, health website, HIPAA compliance, utilization management, and others.

Subsequently, any organizations accredited under a program that include Core standards are required to meet basic requirements of these core standards, as well as the function-specific requirement for the specific accreditation program.

The URAC Accreditation Process

URAC has separate accreditation programs for health plans and health networks, but for both the process consists of a desktop review of plan policies and procedures and an onsite visit to verify the accuracy of the documentation and the plan's compliance with accreditation standards.[vii]

URAC Quality Standards

The quality standards used for both plans and networks are fundamentally the same and address these general areas:

- risk management
- operations infrastructure
- performance monitoring and improvement
- consumer protection and empowerment[viii]

In some cases standards apply only to health plans; in other cases the standards are the same for both plans and networks, but the scope is different. For example, credentialing requirements are different for plans than for networks.

Components of URAC Standards

URAC standards consist of components called elements. A "primary element" is one that has a direct and significant impact on the welfare and safety of consumers and patients.

A "secondary element" is one that does not have such an impact but is a desirable feature of a high-quality program.

URAC does not currently include performance data as part of the overall accreditation process for health plans or health networks, but it is developing such measures for some functional areas. Quality management standards require health plans and networks to engage in quality improvement projects, and URAC allows HEDIS measures to satisfy some of these requirements.[ix]

Clinical Quality Measures

Clinical Quality Measure (Continued)

There are many types of measures on which payers and providers collect data and report. These measures can include both clinical processes of care (e.g. what percentage of diabetic patients received tests to measure their level of blood sugar) and performance measures.

Performance Measure

A **performance measure** is a quantitative measure of the quality of care provided by a health plan or provider that consumers, payers, regulators, and others can use to compare the plan or provider to other plans and providers. Additionally, some programs require the collection of patient experience of care (whether clinicians are adequately communicating with patients) data.

These types of measures can also be incorporated into contracts between payers and providers to incentivize focus on areas of care specific to a patient's diagnosis or condition.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS), administered by NCQA, is a performance measurement tool designed to help healthcare purchasers and consumers compare the quality offered by different health plans. Specified HEDIS measures of effectiveness of care are used as part of NCQA's accreditation program for health plans.

7 Domains of HEDIS

HEDIS divides performance measures into 6 domains:

- **Effectiveness of Care**—whether plan members receive specific health services during stated time periods and whether the plan meets the needs of sick members and helps well members avoid sickness.

- **Access/Availability of Care**—whether members obtain services in a timely manner without undue burdens or inconvenience.

- **Experience of Care**—what current members think about the plan and the care provided (includes CAHPS measures).

Information on CAHPS:

> CAHPS is a survey which measures members' satisfaction with their care in areas such as claims processing, customer service, and getting needed care quickly.

- **Utilization and Risk Adjusted Utilization**—what services a member receives and the utilization of those services.
- **Health Plan Descriptive Information**—enrollment data, board certification of network providers, and the race/ethnicity and language diversity of members.
- **Measures Reported Using Electronic Clinical Data Systems**—the plan's use of electronic clinical data for specific measures (utilizing XML platform).

Information on XML:

> **XML** (Extensible Markup Language) Extensible Markup Language (**XML**) is **used** to describe data. The **XML** standard is a flexible way to create information formats and electronically share structured data via the public Internet, as well as via corporate networks.

HEDIS Updates

HEDIS is updated annually to enhance the quality of its evaluations and satisfy consumer demands.

***Example*:** HEDIS 2020 and 2021 added measures for cardiac rehabilitation, kidney health evaluation for patients with diabetes, and osteoporosis screening in older women. NCQA also made changes to existing measures in the areas of well-child visits, controlling high blood pressure, cervical cancer screening, breast cancer screening, comprehensive diabetes care, follow-up after emergency department visit for alcohol and other drug abuse or dependence, and initiation and engagement of alcohol and other drug abuse or dependence treatment.[x]

Additional Sources of Quality Standards, Performance Measures, and Data

Information that can be used to improve the quality of healthcare and enhance consumers' ability to make informed healthcare decisions is also available from commercial sources, government agencies, and professional societies.

Quality Compass

NCQA offers benchmarking information in **Quality Compass**, a national database of performance and accreditation information submitted by health plans.

Performance measures for Quality Compass are drawn from HEDIS and CAHPS. Participation by health plans is voluntary, but many public and private purchasers now require HEDIS reporting, so many plans find it necessary to participate in order to compete effectively for customers.

Data in Quality Compass is broken into three difference product lines – Commercial, Medicare and Medicaid.[xi]

Agency for Healthcare Research and Quality (AHRQ)

The **Agency for Healthcare Research and Quality (AHRQ)** (formerly the Agency for Healthcare Policy and Research) is the primary research arm of the federal Department of Health and Human Services (HHS). In addition to the CAHPS surveys previously discussed, AHRQ has initiated a series of projects to develop quality measures and improvement strategies for medical care. More information can be found on the programs undertaken by AHRQ on its program website.[xii]

The Affordable Care Act and Quality

The Affordable Care Act (ACA), enacted in 2010, promotes healthcare quality improvement in a number of ways. It creates a variety of demonstration projects addressing provider compensation, information collection and analysis, and financial disclosure. It funds research on the comparative effectiveness of various medical treatments.

These efforts also called for the establishment of a National Health Care Strategy and Plan by the Secretary of Health and Human Services (HHS).[xiii]

National Quality Strategy

The National Quality Strategy (NQS) report was first published in 2011 through the collaborative efforts and inputs of a wide range of groups representing all sections or the health care industry and the general public. The 2011 report set forth three aims:

- Better care – Improve the overall quality, by making health care more patient-centered, reliable, accessible and safe.
- Healthy People/Healthy Communities – Improve the health of the U.S. population by supporting proven interventions to address behavioral, social, and environmental determinants of health in addition to delivering higher quality care.
- Affordable Care – Reduce the cost of quality health care for individuals, families, employers, and government.

The goals remain today. Since its start NQS, led by the Agency for Healthcare Research and Quality (AHRQ) on behalf of HHS, has issued a series of reports including reports to Congress.[xiv] [xv]

The ACA also made changes to the Medicare and Medicaid programs intended to improve quality. Those relating to Medicare will be discussed shortly.

Recent Legislative Activity: Impact on Medicare

Medicare is a public program that provides healthcare coverage to millions of seniors, age 65 and older, as well as younger individuals who are severely disabled or, suffer from specified

serious illnesses or diseases. In this section of the lesson, we will cover some of legislative initiatives passed in recent years which have sought to improve the quality of the program while at the same time curbing costs. The initiatives which we will discuss include the:

- Affordable Care Act (2010)
- Medicare Access and CHIP Reauthorization Act (2015)

ACA and Medicare: Impact on Quality and Payment System

The ACA brought about changes to both the Original Medicare (Part A and Part B) program and Medicare Advantage – a program offered by private health plans to provide services equal or greater than those offered through Original Medicare. The ACA, as enacted, sought to improve quality and implement payment reforms in both programs.

ACA and Original Medicare

Before the passage of the Affordable Care Act (ACA), most Medicare beneficiaries paid a copayment for preventive services and depending on their coverage, possibly a percentage of overall provider's bill.

The ACA improved quality of care received for Medicare beneficiaries by implementing an annual free wellness visit. It also called for the inclusion of other preventive type screenings at no cost to Medicare enrollees.[xvi] *(Note: In some cases, out-of-pockets fees are due for collateral services rendered).*

ACA and Medicare Advantage

The most significant changes made by ACA in the area of quality pertain to Medicare Advantage. **Medicare Advantage (MA)** plans are Medicare-approved private-sector health plans that provide Medicare coverage and some other benefits. Medicare beneficiaries have the option of enrolling in an MA plan instead of traditional Medicare, and many do (currently over 40 percent). [xvii] (MA plans are described in more detail in a later lesson.)

MA plans are paid by the federal government for providing coverage to Medicare beneficiaries. ACA reduced payments to MA plans, but it also gave MA plans the opportunity to obtain higher payments by meeting certain quality criteria.

MA Plan Rankings

MA plans are ranked in a star system: five stars (excellent), four stars (very good), three stars (good), two stars (fair), and one star (poor). Medicare beneficiaries usually have more than one MA plan available to them, and these rankings are designed to help them choose. The rankings are based on HEDIS and CAHPS data and on performance measures in the following areas:

- process indicators (e.g. screenings, tests, and vaccines)

- outcome indicators (e.g. blood sugar levels for diabetes)
- timelines of appeals decisions
- patient satisfaction (e.g. rating of a health plan)[xviii]

How Rankings Affect Payment

Under the ACA, the star rankings affect the amount an MA plan receives from the government in two ways:

- Rebates
- Bonuses

Rebates

Rebates. Each MA plan submits a bid to Medicare, offering to provide Medicare coverage for a certain amount per member. Medicare will not pay more than a benchmark amount, which is a percentage of what it costs the government to provide Medicare coverage itself. (Benchmark percentages vary by county based on healthcare costs.)

If a plan's bid is lower than the benchmark, it is allowed to keep a percentage of the difference (a rebate). The plan can use this rebate to provide supplemental benefits to members, lower premiums, or reduce cost-sharing, making the plan more attractive to potential members. The rebate percentage a plan receives will depend on its ranking. The higher the number of stars, the greater the rebate percentage.

Example:

Example: The MA benchmark in a certain county is 105 percent of Medicare costs, and the MA Plan A submits a bid based on 95 percent. Plan A has three stars, so it can keep a rebate of 50 percent of the 10 percent difference between its bid and the benchmark, or 5 percent of costs. Plan B also submits a bid of 95 percent, but it has five stars so its rebate is 7 percent (70 percent of the 10 percent difference).

Bonuses

Bonuses. MA plans that earn four or more stars receive a quality bonus payment (QBP) of 5 percent. These bonus payments are designed to provide plan members with enhanced benefits and/or reduced premiums.[xix]

Medicare Access and CHIP Reauthorization Act (MACRA)

The Medicare Access and CHIP Reauthorization Act (MACRA) is an example of bipartisan legislation signed into law on April 16, 2015.

MACRA is intended to keep physicians and other healthcare professionals from leaving Medicare (thereby reducing beneficiaries' access to care) by changing how they are compensated. It repealed the Sustainable Growth Rate (SGR) formula, which had linked annual increases in provider payments to earlier spending and growth in the gross domestic product (GDP).

MACRA (Continued)

Many providers felt that this approach resulted in insufficient compensation, and they threatened to stop serving Medicare beneficiaries. For years, Congress responded with a series of short-term "doc fixes"—laws that temporarily overrode the SGR system to raise provider payments for a limited time. MACRA represents a permanent solution to this problem. MACRA thus seeks to enhance the availability of quality care to Medicare beneficiaries.

Payment System Options

Equally important, MACRA seeks to move Medicare away from fee-for-service to a value-based system—one that rewards providers not for the quantity of services they deliver but for the quality of their care. The law calls for the implementation of the Quality Payment Program, under which physicians and other healthcare professionals who serve Medicare beneficiaries must participate in one of two payment systems:

- Merit-Based Incentive Payment System (MIPS)
- Alternative Payment Model (APM)

MIPS

Under MIPS, four factors are taken into account: quality activities, clinical improvement activities, advancing care information performance, and cost/resource use. A provider's compensation may be increased for good performance or decreased for poor performance. In these areas (or if they is in an average range, it may not be affected).

APM

MIPS can be thought of as the basic program and the Alternative Payment Model as the advanced alternative. APM entails more risk for providers – it offers higher rewards for good performance but also greater penalties for poor performance.

Small providers and those with few Medicare patients may quality for exemptions. Moving forward, the successes and failures of this system for Medicare are likely to influence how providers operate and how they are compensated by other payers, such as private-sector health plans.[xx] [xxi] [xxii]

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17 Marketing

Objectives

After completing this lesson, you will be able to:

- discuss the main considerations in product development
- identify and describe the main distribution channels for health plan products
- define market segmentation and positioning
- discuss the marketing approach to the individual market
- compare the small, large, and intermediate group markets
- discuss the impact of the Internet on the marketing of health plan products
- gain an understanding on how rising consumerism must be considered in the development of marketing plans

The marketing of health plan products is a complex process that involves a variety of activities and personnel. In this lesson, we examine the elements of the marketing process, the main health plan market segments, the approaches used for each segment, the impact of electronic communications and rising consumerism upon the marketing of health plan products.

The Marketing Process

Marketing involves learning about the needs and wants of potential customers through research, developing products to satisfy those needs and wants, setting prices for these products, making customers aware of their availability and features, and selling them. The last four of these five elements—product, price, promotion, and distribution—are often referred to as the **marketing mix**.

Example

A health plan organization conducts market research to find out the needs and preferences of employers and employees. It designs a PPO product with a set of benefits and features that it believes will meet those needs and preferences. It sets a premium rate (a price) that it thinks will be attractive while covering its costs and allowing for a reasonable profit. It develops promotional materials to communicate the availability of the product and the advantages it offers. Finally, the organization works with sales representatives to persuade employers to sponsor the product and employees to enroll in it.

Research

Marketing begins with the identification of potential customers and their needs and preferences, through research. Who are a health plan's potential customers? They are commonly employers who would sponsor a plan and employees who would have the option of enrolling in it. They might include other kinds of group sponsors, such as professional associations. They may be persons who need individual coverage. Or they may be beneficiaries of government programs such as Medicare or Medicaid who have the option of obtaining coverage through a private-sector health plan.

What does a health plan want to know about its potential customers? It asks these questions: What do employers want in a health plan? What do employees want (which may not be the same thing)? What price are employers and individuals willing to pay? What balance between price and quality are they looking for?

Focus Groups

To find out the answers to these questions, health plans use several marketing research techniques including surveys, interviews, and focus groups. A **focus group** is a structured but informal meeting of about six to ten people (held in-person or online), led by a moderator who asks questions to guide the group in an in-depth discussion of a given topic. Focus groups give marketers insights into consumers' opinions and attitudes.

Health plan marketing differs from marketing in many other industries in an important way: The market for health plans is generally local or regional, not national, and the healthcare system and customers' wants and needs often differ from one place to another. Consequently, although some market data can be obtained nationally, in many cases research must be conducted separately in each market, adding to costs.

Market Research Cont'd

The information that researchers gather has an impact on the four elements of the marketing mix—the products an organization develops, the prices it charges, the advertising and other promotional methods it employs, and the distribution channels it uses. Also, through market research a health plan may discover an unmet need or want that it is able to address. For example, some years ago it was learned that many HMO members were dissatisfied with their lack of provider choice and direct access to specialists, and this led to the development of POS products.

Product Development

Product development (or **benefit design**) is the process of deciding what benefits a product will include and what other features it will have. Product development includes:

- stipulating the healthcare services that will be covered (and not covered), including deciding whether ancillary items such as prescription drugs and dental and vision care will be included

- stipulating any exclusions or limitations

- setting benefits amounts and levels
- setting cost-sharing amounts (deductibles, coinsurance, and copayments) and any annual limits on the amount members can pay in cost-sharing
- establishing rules for referrals and authorization
- deciding how the provider network will be organized and what credentialing criteria will apply
- deciding whether out-of-network care will be covered, and if so at what level and with what cost-sharing
- deciding if any benefits will be carved out and delivered by another organization
- determining what mix of metallic level of products, if any, to offer based on the actuarial value (AV) of the benefit designs for sale on the Affordable Care Act (ACA) Health Insurance Marketplaces
- deciding what health plan financing accounts to offer: health savings accounts (HSAs), flexible spending accounts (FSAs), and/or health reimbursement accounts (HRAs)

Health Plan Marketing Objectives

In making these decisions, a health plan has these objectives:

- clearly defining what is and is not covered and what benefits will be paid
- clearly establishing the responsibilities of members (regarding cost-sharing, referrals, authorization, etc.)
- promoting both cost-effectiveness and high quality by utilization management and other means
- developing a product that is appealing to potential customers and competitive in the market

Health Plan Marketing Objectives (Continued)

Product designers must keep the following in mind:

- **Trade-offs.** A plan must balance features that will make a product attractive to customers with a price that they will be willing to pay. All customers would like to have a wide range of services covered, easy access to specialists and nonnetwork providers, and low cost-sharing, but are they willing to pay a premium high enough to support such a product?
- **Geography.** As noted, customer needs and preferences may differ from one area to another, and a product must be designed to be attractive in the locality where it will be

marketed. For instance, a product that would be competitive in a large city might not be in a rural area.

- **Trends.** We have seen how changes in customer preferences have led to changes in product design. Product developers must be aware of current and emerging trends and create innovative products to address them such as increasing enrollments in high deductible health plans (HDHP) coupled with the availability of tax-favored health savings accounts (HSAs).

State and Federal Compliance

There is another important consideration: a product must comply with state and federal regulations. State laws for example, often mandate that HMOs provide comprehensive coverage including prenatal care, various preventive care services, emergency care both in and out of the service area, mental healthcare, and physical, occupational, and speech therapy. There may also be state requirements for PPOs and other plans, although they tend to allow more flexibility. And under the federal Affordable Care Act (ACA) of 2010, plans are required to cover a comprehensive set of healthcare services, including preventive care, prescription drugs, mental healthcare, and emergency care. The ACA also restricts other aspects of product design—for instance, sets annual limits on cost-sharing, and prohibits annual and lifetime limits on benefits. (The ACA is covered in a later lesson in this course.)

Product Lines

Successful product development requires the support and input of all functional areas of an organization, including finance (underwriters and actuaries), claims, information systems, provider contracting, utilization management, medical management, customer service, compliance, and sales.

Many health plan organizations develop products in multiple **product lines**—for instance, a company might offer an HMO, a PPO, a POS product, and a high deductible health plan. This can enable a company to compete more effectively, especially among large employers who often want their employees to be able to choose among several options. But marketing a diverse collection of products can present challenges. Each product line may need to be promoted and sold in a different way.

Pricing

Of course, the price of any product is a major factor in its competitiveness, and health plans are no exception—price is in many cases the most important consideration for customers. Therefore, an organization will want to set the price as low as it can. But at the same time, it must exercise great care and planning to ensure that the premium is adequate to cover costs and allow for a reasonable profit. Premium is developed based on the expected medical claims costs, administrative expense, demographic changes, and geographic location of customers. Under the ACA, health plans are required to spend at least 80 percent of their premium dollars on medical expenses for small group and individual customers, and 85 percent for large group customers. The benefit design and product type thus influence the pricing of the product.

Promotion

In **promotion,** a business informs potential customers about its products and itself. A health plan lets employers and consumers know what products it offers, how much they cost, and how they can be obtained. It seeks to highlight the advantages of its products and persuade employers to sponsor them and employees to enroll in them (or individuals to buy them). It also promotes itself as an organization and differentiates itself from others—it makes the case that it provides better quality, service, and convenience than its competitors. To help distinguish themselves and their products from others, businesses engage in **branding**—using a name, design, symbol, etc. to quickly identify a product or organization.

Promotion Mix

There are four main promotion tools, together called the **promotion mix**:

- **Advertising**—communication about a product or organization through the mass media that is paid for by the seller (television commercials, newspaper and online ads, etc.)

- **Publicity**—communication through the mass media that provides information about a product or organization but is not paid for. For instance, a health plan might sponsor a community event such as a charity run or hold seminars on health topics that the local news media cover. It might issue a press release to announce its accreditation, and this might be reported as news. Social media provides health plans with a platform to promote its involvement in community events (future and past), raise awareness on quality initiatives, and wellness programs among other issues.

- **Personal selling**—person-to-person communication with the goal of selling a product. Typically, sales representatives visit or call potential customers and try to persuade them to buy.

- **Sales promotion**—the use of incentives to encourage customers to buy a product or sales representatives to sell it.

Note that personal selling and sales promotion, while considered elements of the promotion mix, are considered to be distribution.

Distribution

Distribution is making products available to those who want to buy them—in other words, selling. Health plans have five main **distribution channels**:

- the internal salesforce

- agents

- brokers

- employee benefits consultants

- direct marketing

A health plan may use one channel or another or a combination for a particular product or targeted market segment.

Most distribution channels involve salespeople of some sort, who communicate directly with customers to try to persuade them to make a purchase. They also serve as a communication link between the health plan and the customer during the sales process and afterwards, answering their questions and helping them deal with the organization.

The Internal Salesforce

A plan's **internal salesforce** are salespeople who are its employees (as opposed to agents, brokers, and consultants, who are not). This includes sales representatives, support staff, and managers. An internal salesforce may be organized by product lines (HMOs, PPOs, POS plans, etc.), market segments (individuals, large groups, etc.), geographical areas, or in other ways.

Agents

An **agent** is a person authorized by a health plan to act on its behalf to negotiate, sell, and service health plan contracts. **Captive agents** represent only one health plan; **independent agents** sell the products of multiple companies. Agents are typically compensated by commission on sales. Most agents sell primarily to the nongroup and small group markets.

Brokers

A **broker** sells and services contracts of multiple health plans (like an independent agent), but they are considered to be acting on behalf of the buyer, not the plan. Brokers review the needs of their clients and recommend the most suitable product at the best price. Most brokers work with groups. Like agents, they are typically compensated by commission.

Employee Benefits Consultants

An **employee benefits consultant** is a specialist hired by employers to advise them on health plan purchases. They evaluate and compare proposed products to determine which is most advantageous for the employer, and for large groups they may solicit proposals from many health plans. Some consultants may also be licensed brokers or agents, but unlike them they are paid by the employer, not the health plan. For this reason, some believe that their judgment is more objective.

Direct Marketing

In **direct marketing** (or direct response marketing), a health plan contacts consumers directly, rather than through a salesperson. **Direct mail** is a common method. Typically, the plan mails material about a product to consumers along with a response card that they can mail back to the plan if they want more information or to be contacted by the plan's internal salesforce. (Note that in the past consumers might be contacted by telephone, but this is now highly restricted by law.)

Direct marketing allows a health plan to reach a large number of people quickly and inexpensively, and it can be targeted to a particular population, such as Medicare beneficiaries or people in a locality who do not have group health coverage. Response rates are usually low, but costs are also low compared to other distribution channels.

Database Marketing

Database marketing is related to direct marketing. A database is developed with information on potential customers, including demographic data, information obtained from direct mail surveys, any past contact with the plan, concerns and questions raised by the customer, etc. This allows direct mail campaigns to be more narrowly focused on people who are likely to be interested in the product, resulting in more inquiries and sales.

Market Segmentation and Positioning

Market segmentation is the division of the total market for a health plan's products into smaller and more homogeneous subsets of customers, called **market segments**. This is necessary because different groups of customers present different marketing challenges and require different approaches. To begin with, the health plan market can be divided into a few broad segments:

- The **group market** is the market for group health plans, generally sponsored by employers for their employees (or associations or unions for their members). This can be further divided into the large and small group markets.

- The **non-group market** has three subsets:

    - The **individual market**—people who need individual health coverage (those who do not have access to a group plan or want to supplement their group coverage in some way);

    - The **Medicare market** (the **senior market**)—Medicare beneficiaries (mostly individuals over age 65), who can enroll in Medicare Advantage or Medicare Part D plans offered by private-sector health plans or buy Medicare supplement (Medigap) insurance policies from private insurers.

    - The **Medicaid market**—those Medicaid recipients (low-income people) who have the option of enrolling in a private-sector health plan or are required to do so.

A health plan may break these categories down further into smaller market segments based on a number of variables (such as group size).

Positioning

Positioning is choosing a target market segment or niche for a product or organization in relation to the other products or organizations in the marketplace. For example, a health plan might offer a less generous benefit package with a lower price to appeal to the small group market. This plan would compete with similarly positioned plans, not with more comprehensive

plans offering enhanced benefits. Or an organization might offer a wide range of health plan products to compete in the large group market with organizations who do likewise.

Additionally, health plans are developing Accountable Care Organizations (ACOs) and other narrower, smaller provider network products to offer higher quality, lower cost plans. A health plan may also wish to offer products that complement individual coverage health reimbursement account (ICHRA) programs established by some employers. During the development of the marketing strategy, it is important for a health plan to identify a reference brand to assist in the determination of the positioning strategy.

The Individual Market

The **individual market** has traditionally been divided into two categories:

- The **regular individual market** consists of people who, for some reason, are not covered by a group plan. Their employers do not sponsor a plan, or they are not eligible for it, or they choose not to enroll in it. Or they are self-employed, or college students without student group coverage.

- A separate group is made up of people who had employer-sponsored coverage but have left their jobs and are not (or not yet) eligible for another group plan. These people can often convert their former group coverage to an individual policy.

Agents and health plans' internal salesforces are active in the individual market, and advertising and direct mail is also often used.

ACA and the Individual Market

The ACA has had an enormous impact on the individual market, creating in effect, a third category – individuals seeking coverage on the ACA Health Insurance Marketplaces (sometimes also referred to as Exchanges).

- For those with moderate and low incomes, subsidies (in the form of tax credits) are available.

- Health coverage is marketed directly to individuals or through the government-sponsored Marketplaces and organizations working with them to provide information to consumers about available health plans and facilitate enrollment.

- In the Marketplaces, or off the Marketplaces, individuals must be offered coverage on a guaranteed issue basis (without medical underwriting, that is, without consideration of current health, medical history, or family medical history). It is no longer permitted to require applicants to complete health questionnaires and provide medical information, as was often done prior to the passage of the ACA.

(Again, the ACA is discussed in more detail in a later lesson.)

ICHRA and the Individual Market

Earlier in this course, we studied account-based programs including the requirements for individual coverage health reimbursement accounts (ICHRAs). You may recall that employers through these vehicles can provide a source of funds for their workers to purchase health coverage. Some commentators have compared the recently sanctioned ICHRA programs to be the health insurance equivalent of 401(k) retirement plans and anticipate substantial marketplace growth.

The Medicare (Senior) Market

Medicare is a federal healthcare benefits program available to people 65 or older, those with severe, long-term disabilities, and a few others. It is examined in detail in a later lesson. People eligible for Medicare constitute a market for three types of products offered by private-sector health plans and insurers:

- **Medicare supplement (Medigap) insurance**. Traditional Medicare coverage (Medicare Parts A and B) is extensive, but it currently does not include some health-related expenses (such as dental and vision care), and beneficiaries must pay substantial deductibles, coinsurance, and copayments. Beneficiaries can buy Medicare supplement (Medigap) policies from private insurers to cover some cost-sharing and a few noncovered items.

- **Medicare Advantage (MA) plans**. Those eligible for Medicare can choose to enroll in a Medicare Advantage plan instead of traditional Medicare. MA plans are private-sector health plans (including HMOs and PPOs) that provide Medicare Part A and B coverage and some additional benefits as well. (Note that Medicare Advantage enrollees do not need and cannot buy Medigap policies.)

- **Medicare Part D prescription drug plans (PDPs).** Medicare beneficiaries choose whether they want Part D, a prescription drug program. If they do, they must select and enroll in a private-sector PDP and pay premiums to the PDP. (Most MA plans also offer Part D coverage.)

To protect the seniors, the federal government has strict regulations regarding marketing to the Medicare population. The Centers for Medicare and Medicaid Services (CMS) must approve most marketing materials, door-to-door selling and certain other practices are prohibited.

Various Marketing Methods

Health plans use a variety of methods to market to seniors. Television and newspaper advertising are common, as is direct mail. A health plan can obtain mailing lists of seniors from various sources including list clearinghouses and local or national senior organizations. Some plans hold meetings in retirement centers, in which plan representatives offer refreshments and talk about healthcare concerns and the plan's products although these meetings are less common following the COVID-19 pandemic. Both agents and a plan's internal salesforce are typically active in the senior market.

The Medicaid Market

Medicaid is a federal-state program that pays for healthcare for low-income people who meet certain criteria. (It is discussed in a later lesson.) Some states mandate that Medicaid recipients (or certain categories of recipients) receive coverage through a private-sector health plan.

The Medicaid market is in many ways similar to the Medicare market. Direct mail is common. Meetings may also be held either in-person or online. And many states have strict regulations designed to protect poor people, who often have little education. States may require preapproval of marketing materials; prohibit giveaways of such things as t-shirts, buttons, balloons, and key chains; and prohibit door-to-door solicitation.

Here too, the ACA has brought changes. To date 38 states and the District of Columbia have chosen to expand coverage to adults previously not covered such as single individuals in good health with low incomes. [1]Here the marketing challenges include not only initial enrollment but maintaining enrollment for those who continue to be eligible for benefits. Coordination with the Marketplaces and their grassroot organizations that promote enrollment becomes important if a health plan chooses to participate in this market.

The Group Market

The group market is mostly employers sponsoring coverage for their employees. This includes private businesses, state and local governments, and the federal government. But group plans may be sponsored by multi-employer groups, labor unions, and professional and other associations.

Marketing to groups has two levels. A health plan must first sell the product to the employer, and then, when it is offered to employees, it must persuade them to enroll. Employees of some large companies choose from several products offered by different organizations, so that a plan must convince them that their product is the best.

The Small Group Market

A **small group** is most commonly considered to be one with less than 100 members, but this varies somewhat by health plan. Many small businesses find it difficult to afford health coverage, so they tend to want the cheapest product possible. This often means a basic benefit package within the context of the ACA mandates, high cost-sharing, and aggressive cost-control (such as no out-of-network coverage and strict referral and authorization policies). In addition, small employers often seek to lock in premium rates for two or three years, and they tend to change plans frequently in their efforts to get the lowest price.

Some small employers join to form local alliances to purchase health coverage, often under the sponsorship of the Chamber of Commerce or a small business association. Their combined employee numbers give them the power to negotiate better rates and terms with health plans. Health plans usually treat these purchasing alliances as large groups for marketing purposes. In addition, small employers may obtain coverage for their workers through the Small Business Health Options Program (SHOP) marketplaces established under the ACA.

Typically, an agent or broker or the health plan's internal salesforce sells coverage to small groups. Because small businesses normally have no employee benefits staff, they rely heavily on agents and brokers for expertise on health plans. Direct mail is also sometimes used to reach small businesspeople.

The Large Group Market

A health plan may consider a **large group** to be one with 250 or more members, or sometimes 500 or 1,000 is the criterion. The large group market includes both local accounts (employers with employees in only one locality, historically manufacturing companies and city and state governments) and national accounts (employers with employees in different localities covered by a single insurance contract). Unlike small employers, which usually sponsor only one health plan, large businesses often make available to employees a selection of health coverage options, sometimes from several organizations. And because big employers can offer health plans large numbers of potential members, they are in a stronger position than small groups to negotiate favorable rates and terms.

Self- Funded

Large groups are often **self-funded** (self-insured)—that is, the employer pays healthcare benefits to employees of out its own funds, instead of buying insurance. In this case, a health plan may offer its services as an administrator of the employer's plan, helping hold down administrative and healthcare costs. (Self-funded are discussed elsewhere in this course.)

Small vs Large Groups

As for small groups, cost is a very important factor, but large groups tend to also give a good deal of weight to other factors, such as healthcare quality, a variety of product line offerings, a high-quality provider network, service, employee satisfaction, and accreditation. For national accounts, network coverage of all regions where employees live is a requirement. Large groups often expect health plans to customize the design of a product to their needs and preferences.

A large employer's decision to buy a health plan is made by the health benefits manager and sometimes also the CEO and chief financial officer. Large employers often use employee benefit consultants, who may request proposals from multiple health plans.

In marketing a product to employees, the health plan's sales representatives often work through the employer's health benefits manager. Typically, employee meetings are held in the workplace (sometimes in-person and sometimes online); a presentation about the product is made, questions answered, and promotional materials distributed. Large employers may also hold health fairs (often during an annual open enrollment period) in which representatives from all the health plans offered to employees promote their products. A large employer may also use an internal website to inform employees of their health plan options and enroll them.

The Intermediate Group Market

Medium-sized or **intermediate groups** (often defined as 100 to 250 members) are in some ways like small groups and in other ways like large groups. As with small groups, price is often the determining factor, partial self-funding may or may not be an option, and often only one plan is

sponsored. But these employers are big enough to have some negotiating power with health plans, and although they cannot require customized products, they can make some demands regarding variations in product design.

Rise of Consumerism

In addition to the marketing considerations discussed elsewhere in this lesson, health plans need to consider the rise in consumerism and the overall movement away from the traditional business-to-business (B2B) model to a business-to-consumer (B2C) model. As employers began to increasingly shift costs to employees, particularly with the rise of high-deductible health plans starting in the early 2000s, those individuals began to take increased notice of their healthcare costs. They also began demanding more transparency around cost and the quality of health care services. The move to consumerism was further reinforced by increased cost-sharing brought about in the wake of the Great Recession (2007-2009). It was also reinforced by the implementation of the Affordable Care Act (ACA) and its introduction of government-sponsored health insurance Marketplaces which sought to provide consumers with an online experience similar to that offered by retailers of goods and services on the Internet.

Rather than seeking solely to communicate with top line officials at employers, health plans must seek to engage with their employees. Health plans must consider innovations, such as online health care decision support tools, and other actions that can build life-long connections with individual consumers. These might include for example, programs that support wellness and help prevent and control chronic illnesses such as diabetes. Health plans might also offer enrollees for example, education about pain management techniques as well as assistance in identifying providers who can assist enrollees in dealing with pain.

What Does All This Mean for the Marketing Professional?

For health plan marketing professionals this means adopting a more retail approach and mindset. This is likely to include providing tools so that consumers can more accurately calculate their out-of-pocket costs for specific services. In product design for example, health plans might give consideration to using retail tactics such as offering warranties for some surgical procedures.

A final word, the rise in consumerism means increased attention to understanding consumer segments and the preferences of those segments. This will facilitate the development of targeted products and along with it increased health plan loyalty.

More about one way to view potential consumer segments when evaluating a health plan's product portfolio

Consumer Segments to Consider in Crafting Marketing Plans/Product Introductions

Content and Compliant [Estimate: 34% of consumers]	Satisfied with physician, hospital, and health plan. Passive consumer – not particularly inclined to challenge professional recommendations, or query clinicians.

Casual and Cautious [Estimate 22% of consumers]	Not engaged, no current need for health care, but is cost-conscious
Shop and Save [Estimate 4% of consumers]	Seeks options and will switch for value, saves for future health care costs
Out and About [Estimate 9% of consumers]	Actively seeks and uses alternatives. Will use online tools for information and seeks guidance from experts but tends to make decisions independently.
Sick and Savvy [Estimate 14% of consumers]	Consumes considerable health care services. Seeks to partner with medical professionals to make health care decisions.
Online and Onboard [Estimate 17% of consumers]	Online user and learner, satisfied with care but interested in alternatives and technologies.

Notes:

[1] Status of State Medicaid Expansion Decisions: Interactive Map, Kaiser Family Foundation, January 18, 2022, available at https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/#:~:text=To%20date%2C%2039%20states%20(including,have%20not%20adopted%20the%20expansion.

Additional Readings

Lola Butcher, "Agency of the year: Matching the message to the mission," *Modern Healthcare,* October 30, 2021, available at https://www.modernhealthcare.com/marketing/matching-message-mission

Jay Greene, "Hospitals marketing themselves alongside COVID-19 vaccinations," *Modern Healthcare,* May 10, 2021, available at https://www.modernhealthcare.com/hospitals-marketing-themselves-alongside-covid-19-vaccinations

18 Underwriting, Rating, and Plan Funding

Learning Objectives

After completing this lesson, you will be able to:

- define underwriting and explain how it works
- describe and compare the main rating methods
- understand the impact of the Affordable Care Act (ACA) on underwriting and rating
- compare fully funded and self-funded health plans

Learning Objectives (Continued)

In previous lessons, we discussed financial arrangements that a health plan makes with its providers, payors, and purchasers. This lesson examines:

- how a health plan evaluates risk (underwriting)
- determines the amount to charge for an assumed risk (rating)
- various ways businesses fund employer-sponsored coverage
- examine the ways in which the marketplace reforms of the Affordable Care Act (ACA)have impacted underwriting and rating in the individual and small group marketplaces
- how underwriting and rating might apply in a post-ACA environment and should the ACA be repealed, substantially amended, or ruled unconstitutional in future years

Pricing

Pricing is one of the factors in the marketing mix. In the context of health plans, **pricing** is the process of deciding the premium to charge for a health plan or a given set of benefits.

It consists of two similar but separate processes: underwriting and rating.

Underwriting: An Overview

Underwriting

For a health plan to provide appropriate healthcare coverage to individuals or group members at an appropriate price, the company must determine the degree of risk it will be assuming by providing coverage. The process of identifying and classifying the risk represented by an individual or group is called **underwriting**.

Anti Selection (Adverse Selection)

A health plan cannot assume that each proposed risk is the same. Not all individuals of the same age, sex, occupation, and or geographic location have the same likelihood of suffering a health-related loss.

In addition, those individuals who believe that they have a greater-than-average likelihood of loss tend to seek healthcare coverage to a greater extent than do those who believe that they have an average or less-than-average likelihood of loss.

This tendency is known as **anti-selection** or **adverse selection**. The task of the underwriter is to analyze each individual or group applying for insurance in order to identify the characteristics that contribute to risk, measure the amount of risk, and determine whether the amount of risk is acceptable.

Rating: An Overview

Rating

Once a health plan has assessed the risks that an individual or group presents and has identified which risks are acceptable, it can determine the cost of covering those risks.

Rating is the process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs of delivering medical services, and the expected marketability and competitiveness of the health carrier's plan.

Premium

A **premium** is typically a prepaid payment or series of payments made to a health plan by purchasers, and often plan members, for medical benefits.

Impact of ACA on Underwriting and Rating

Impact of ACA on Underwriting and Rating

The Affordable Care Act (ACA) has had a substantial impact on underwriting and rating for medical insurance in the individual and small group marketplaces (generally, groups of less than 50 full-time equivalent employees).

Factors Affecting Premiums

Health plans that are considered qualified under the ACA may not consider pre-existing conditions in whether or not to offer coverage or set premium rates.

Plans can however, charge different people different premiums based on just the following factors:

- Age

- Tobacco use
- Family size
- Geographic location

Age

The ACA states that older individuals (who typically incur higher medical expenses) can be charged more than younger individuals, but the following rules apply:

- Children through age 20 – All must be charged the same premium.
- Adults 21 through 63 – The oldest can be charged no more than three times as much as the youngest. Within this age range, premiums can be graduated by one-year increments (with a 34-year old paying slightly more than a 35-year old, etc.)
- Adults 64 and older – All must be charged the same premium. [i]

Tobacco Use

Plans can charge up to 50 percent more to those who use tobacco. Tobacco use is defined as at least four times a week within the last six months (with religious or ceremonial use excepted).

A plan may charge less than 50 percent and may charge different tobacco users different amount. For instance, a plan may charge younger smokers 25 percent more and older smokers 50 percent more. And,a small group plan must give smokers the opportunity to quit through a tobacco cessation program. [ii]

Family Size

Health plans may charge a higher premium for family coverage than for self-only coverage. Plans may charge larger families more than smaller families, but families with four or more children can be charged no more than those with three. The age of the parents and whether they use tobacco can be taken into account in setting family premiums.

Geographic Location

Premiums can vary depending on where an individual or family lives. States are divided into rating areas based on counties, three-digit zip code areas, or metropolitan statistical areas (MSAs) and non-MSAs.

ACA: Scope Limitations & Future

While the ACA has had a major impact on medical underwriting and rating in the small and group marketplaces, it is also important to remember that many of its provisions do not apply to the large group marketplace or self-insured plans.

Products other than medical insurance are exempted from its provisions.

***Example**:* The ACA rules regarding underwriting and rating do not apply to individual disability income and long-term care insurance.

Exceptions to ACA Underwriting Rules and Provisions

The ACA underwriting rules do not apply to products that are considered *excepted products.* In other words, products that are not regulated by the ACA. These include supplemental insurance products such as dental and vision plans, accident policies, critical illness plans, and hospital indemnity plans. The ACA rules also do not apply short-term medical coverage (generally, coverage for less than a year in duration) where pre-existing conditions and the health status of individuals can be taken into consideration. [iii]

It is also important to understand that while the provisions of the ACA, apply to products offered in the individual and small group markets, health plans must still consider whether to offer products in these marketplaces. They must also take into accounts the risks they face in setting premium rates for medical or other types of health insurance in order to maintain solvency.

ACA Rules and Provisions (Continued)

As of this writing the future of the ACA seems secure however, the law has faced repeated legislative efforts to repeal its provisions. The law has also faced several judicial challenges including two before the Supreme Court. The last as recently as a 2021 decision.[iv] Whether or not all or some of its provisions remain in-place moving forward cannot be predicted.

With this backdrop in mind, it is important to take a closer look at underwriting and rating, how these factors apply today, how they have traditionally been applied to both medical and non-medical health products, and how they might come into play once again should the ACA be repealed outright, or various provisions be repealed and replaced. [v vivii]

Evaluating Risk for Individuals and Groups

Evaluating the risk represented by a given individual generally begins with an assessment of the typical incidence of illness or injury among individuals of the same age and gender.

Using this rate as a reference point, underwriters then consider the effect of risk factors specific to the individual, such as occupation and health status, to identify the amount and type of risk the individual represents.

Underwriting Manual

Underwriters can find much of this additional information in an underwriting manual prepared by the plan's actuaries.

An **underwriting manual** is a document that provides background information about various underwriting impairments and suggests the appropriate action to take if such impairments exist. [viii]

Underwriting Impairments

Underwriting impairments are factors that tend to increase an individual's risk above that which is normal for their age. In underwriting for individual insurance policies, persons with an average risk of loss are typically classified as **standard risks**, those with lower-than-average risk as **preferred risks**, and those with higher-than-average risk as **substandard** or **unacceptable risks**.

Risk Characteristic

When evaluating the risk for a group policy, underwriters focus on the risk characteristics of the group as a whole.

Group characteristics include the following:

- the reason for the group's existence,
- the size of the group,
- the flow of new members into the group,
- the stability of the group,
- the number of eligible group members who will participate in the plan,
- the way in which benefit levels will be determined, and
- the activities of the group.

Predictability of Underwriting Purposes

Because health plans accept all eligible plan members, underwriting for groups focuses primarily on whether the group presents a good distribution of risk—that is, whether the good health of a large number of individuals offsets the higher utilization of healthcare services by unhealthy group members.

Although few groups are large enough to provide entirely predictable experience, a health plan generates enough business so that the combination of many groups provides predictability for underwriting purposes.

Underwriting Standards and Marketing Goals

The primary goal of a health plan's underwriting function is to accurately assess risk so that the health plan can charge premiums that are adequate to cover its expected costs. That goal, however, must be consistent with the health plan's marketing goals.

A health plan that has very strict underwriting requirements may save money on healthcare costs, but the plan probably will have significantly lower plan enrollment. On the other hand, a health plan with relaxed underwriting may obtain numerous contracts with various groups, but it may experience increased costs because of anti-selection.

Striking a balance between underwriting standards and marketing goals is critical to a health plan's success and ultimately its survival. Today, underwriting departments sometimes use technology tools such as artificial intelligence (AI) to cull through data to help assess risk and strike this necessary balance. [ix]

Underwriting Requirements

There are several types of **underwriting requirements**- requirements that health plans sometimes impose in order to provide healthcare coverage to a given group.

Some of these requirements relate to group characteristics, while others relate to financing measures such as cost-sharing (which we have seen before).

Together they are designed to balance a health plan's knowledge of a proposed group with the ability of the group to voluntarily select against the plan (anti-selection).

Note, however, that a health plan, prior to the ACA could be prevented from imposing these requirements in certain situations because of state regulatory requirements or market demand for guaranteed eligibility.

Common Underwriting Requirements

Common underwriting requirements for medical insurance prior to the ACA, some of which are still applicable post-ACA, include the following:

- ***Minimum participation requirements***—A percentage of total eligible employees or group members that must enroll in the health plan
- ***Benefit limitations***—A maximum number of hospital days or treatments for certain health conditions or a lifetime maximum dollar amount of benefit payments.
- ***Deductible***—An upfront dollar amount that a plan member must pay for covered healthcare costs before the health plan pays benefits.
- ***Coinsurance***--After a plan member has satisfied the deductible, the plan pays a percentage of remaining covered healthcare costs (typically 80 percent) and the member is responsible for the rest of costs (typically 20 percent), up to a specified maximum out-of-pocket cost to the plan member.
- ***Enrollment restriction***-- Members may enroll in a plan only during defined enrollment periods, such as on joining a group as a new employee, during annual open enrollment periods, or at birth (for a dependent of a member).
- ***Health statements***—Statements made by proposed insureds during the medical underwriting process attesting to their good health and insurability.

ACA Restrictions

ACA restricted these underwriting requirements:

- Lifetime limits on benefits were prohibited as of 2010.

- Annual limits on benefits were restricted as of 2010 and prohibited in 2014.
- For most health plans there are limits on the total cost-sharing (deductibles, coinsurance, and copayments) an insured can be required to pay during a year.

Closer look at pre-ACA small group medical underwriting:

Medical Underwriting for Group Plans: Pre-ACA

Medical underwriting refers to the evaluation of health questionnaires submitted by all proposed plan members to determine the insurability of the group. Based on the underwriting assessment, an underwriter could recommend that group policies include:

- **Waiting periods**—periods of time during which insured group members' medical expenses are not covered.
- **Preexisting conditions provisions**—limitations or exclusions of health coverage for conditions that arise before the effective date of coverage.
- **Benefit exclusions**—exclusions of health coverage for specified medical conditions.

The purpose of these policy provisions and exclusions was to enable the health plan to cover the group at a reasonable cost.

Prior to the ACA, in states where it was not prohibited, some health plans conducted medical underwriting for small groups. As mentioned before, should the ACA be repealed, amended, or judicially overturned these prior practices could return. [x]

Renewal Underwriting

A health plan typically guarantees a premium rate for a specified period, usually one year. At the end of the initial period, and usually each year thereafter, the health plan's underwriters reevaluate the contract.

Through **renewal underwriting** underwriters review all the selection factors that were considered when the contract was first issued, then compare the group's actual utilization rates to those the health plan predicted during its initial underwriting of the group.

Based on this, the underwriters determine the group's renewal rate. At a minimum, renewal underwriting has traditionally involved a reevaluation of two factors:

- the group's experience
- the level of participation in the health plan

Experience

A group's **experience** is the cost of providing healthcare to the group during a given period of coverage. Changes in this experience can have a significant effect on the premium amount the group is charged for coverage.

Example: If a group's actual experience is greater than its predicted experience, the health plan will most likely increase the group's premium at renewal to account for these increased costs.

Participation

Underwriters verify the degree of employee participation in a plan to ensure that a sufficiently high level of participation exists to reduce the chance of anti-selection.

In some cases, if the degree of employee participation drops below an acceptable level, an underwriter may require increased participation before renewing the contract.

Successful renewal underwriting requires that a health plan support a database to track utilization, demographic factors, and other relevant data in order to obtain information on costs per plan member and the amount and frequency of utilization by type of medical benefit.

Legal Requirements

State laws have traditionally defined the ways in which health plans could underwrite and price healthcare products.

For example, in some states a health plan could increase its price to an employer if the health plan determines that the employer represents a greater risk than that assumed in calculating the base rates.

Similarly, the health plan would be able to price the product lower than its base rate if the health plan determined that the employer represented a lower risk than that incorporated into the base rate.

Legal Requirements (Continued)

Some states prohibit a health plan from charging more than the base rate listed in its rate manual for specified products or plans. In such cases, the health plan may be able to decline coverage for a group if the group's expected risk is greater than that assumed in calculating the base rates.

Looking toward a possible future, the role of state laws could assume additional importance. For example, should the ACA be overturned in an effort to retain the gains in coverage achieved through the ACA, some states might require residents to maintain coverage (state-based individual mandates) thus impacting underwriting through greater rates of participation. [xi]

Rating: A Closer Look

Rating: A Closer Look (Continued)

Rating, as mentioned earlier, is the process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs of delivering medical services, and the expected marketability and competitiveness of the health carrier's plan.

Actuaries

The insurance professionals who perform the mathematical analysis necessary for setting insurance premium rates are called **actuaries**.

A health plan's actuaries are responsible for ensuring that the plan's operations are conducted on a financially sound basis. The actuaries' goal, therefore, is to ensure that the premium rates that the health plan charges purchasers are adequate to cover expected plan costs.

Actuaries (Continued)

Premium rates, however, must also be competitive, to encourage a large number of healthy individuals to enroll in the plan. The balance between the actuarial function (ensuring that the plan is financially sound) and the marketing function (ensuring that the plan is marketable) is a critical component of product development. Regular review of its rating method provides a health plan with information on whether the plan is achieving both actuarial and marketing goals.

Methods Used in Developing Premiums

Health plans use a variety of rating methods in developing premiums.

The most commonly used methods are:

- community rating
- manual rating
- experience rating
- blended rating (traditionally used to set premiums for medical insurance)

Community Rating

Community rating is a rating method that sets premiums for financing medical care according to the health plan's expected costs of providing medical benefits to the community as a whole rather than to any subgroup within the community.

Both low-risk and high-risk classes are factored into community rating, which spreads the expected medical care costs across the entire community. If claim costs exceed the premiums received, the plan is financially responsible for the additional costs.

Who Uses a Community Rating?

Community rating is seldom used for large groups, except where required by state law, because other rating methods are more competitive. However, the premium rate obtained by the community rating method is often calculated first as a point of reference for calculating the premium rate under other rating methods. On the other hand, several state initiatives prior to the implementation of the ACA mandated community rating methods for small groups. And, the ACA calls for the use of it. [xii]

Small groups benefit from community rating because they incur less fluctuation in premium rates and more stable health plan contract relationships.

Standard Community Rating and Tiers

Under **standard community rating** (also called **pure community rating**), a health plan considers only community-wide data and establishes the same financial performance goals for all risk classes.

A health plan charges all employers or other group sponsors the same dollar amount for a given level of medical benefits or health plan, without adjustments for age, gender, industry, experience, etc.

Tiers

Health plans can vary the rates within a single plan, however, by dividing members into **tiers** (classes) according to the number of individuals covered. No other factors are used to distinguish among the members in each tier.

Various Tier Arrangements

Two-tier arrangements, with an employee-only tier and a family tier (the employee and one or more dependents) are commonly used under all rating methods.

Three tiers (employee only, employee and one dependent, and employee and two or more dependents) are also common. Sometimes four or five tiers are used. The premium a plan member pays depends on the tier into which she fits.

Example: In a two-tiered system all members who enroll in Tier 1 (employee only) pay the same monthly premium, which differs from the premium paid by all members who enroll in Tier 2 (family).

Various Tier Arrangements (Continued)

Health plans can also adjust the total premium amount charged to a group to reflect the number of covered members in each tier.

Example: If Employer A has four covered members per family contract, the health plan can charge it a higher premium than it charges Employer B, which has 3.5 covered members per family contract. The premium rate applied to each group, however, must be the same.

Manual Rating

When an underwriter has no recorded or reliable claim experience for a group, they typically use manual rating to establish the group's premium.

Manual rating is a rating method under which a health plan uses the plan's average experience with all groups (and sometimes the experience of other health plans), rather than a particular group's experience, to calculate the group's premium.

Manual rates are sometimes called **book rates** because a health plan often lists them in a rate book, underwriting manual, or rate manual.

Health plans often use manual rates to set premiums for groups that have had no previous health coverage. Underwriters also use the manual rate as a starting point when using other rating methods.

Experience Rating

Underwriters typically use experience rating to calculate the premiums for groups that have a credible claim history.

Experience rating is a rating method under which a health plan analyzes a group's recorded healthcare costs by type and calculates the group's premium based partly or completely on the group's experience.

Under experience rating, a health plan charges lower premiums to groups that have experienced low utilization of healthcare services and higher premiums to groups that have experienced high utilization. Because a group's experience changes over time, a health plan typically uses at least two years of a group's experience to calculate experience rates.

Experience Rating Application

In most cases the size of the group is important in determining the degree to which experience rating applies. Health plans typically experience-rate large groups.

The definition of what constitutes a large group varies among health plans. A health plan may define a large group as consisting of anywhere from 50 to 1,000 members. However, most health plans experience-rate groups that have 1,000 or more members. Since the ACA focused primarily on the individual and small group marketplaces, experience rating remains especially relevant when dealing with large employer-sponsored plans.

Experience rating methods include prospective experience rating and retrospective experience rating.

Prospective Experience Rating

Under **prospective experience rating**, a health plan uses a group's past experience to estimate the group's expected experience for the next period.

Premium rates are calculated according to this expected experience.

If the group's actual experience during the rating period is different than expected, the health plan absorbs the gains or losses. Twelve months is a typical prospective experience rating period for primary care; shorter rating periods may be use for specialty services such as vision care and dental care.

Retrospective Experience Rating

Under **retrospective experience rating**, a health plan looks back at the end of a rating period and evaluates the gains and losses experienced by a group during that period.

If the group's experience during the period is better than expected, the health plan refunds part of the group's premium in the form of an **experience rating dividend**. If the group's experience during the rating period is worse than expected, the health plan charges the group for the excess costs, either in a lump sum or in future premium increases.

Federally qualified HMOs cannot use retrospective experience rating.

Pooling

Health plans sometimes also experience-rate small groups by underwriting a number of small groups as if they constituted one large group and then evaluating the experience of the entire large group. This practice is known as **pooling**.

The purpose of pooling is to allow small groups to take advantage of the lower premium rates often available to large groups.

Blended Rating

For groups that have some, but not extensive, recorded claim experience, health plans often use blended rating. Under **blended rating** a health plan forecasts a group's cost of benefits based partly on the health plan's manual rates and partly on the group's experience.

Credibility

The amount of weight the health plan gives to the manual and experience rates depends on the credibility of the group's experience.

Credibility is a measure of the statistical predictability of a group's experience. Typically, a health plan assigns a credibility factor—usually expressed as a percentage or a decimal between 0 and 1—to a group's experience rating.

This credibility factor represents the degree to which the health plan has estimated that the available experience data accurately represent the group's risk. The experience of a large group is generally more credible than that of a small group.

Calculating the Blended Rate

To calculate a blended rate, the health plan multiplies the group's experience rate by the group's credibility and multiplies the applicable manual rate by 1 minus the group's credibility. The sum of these two calculations is the blended rate.

Example: *A group's manual rate is $130 per member per month. Its experience rate is $115 per member per month. The credibility factor is 70 percent (0.70). The experience rate is multiplied by the credibility factor ($115 X 0.70 = $80.50). The manual rate is multiplied by 1 minus the credibility factor ($130 X 0.30 = $39). The two dollar figures are added, yielding a blended rate of $119.50, less than the manual rate but somewhat higher than the experience rate.*

Legal Requirements

Federal or state laws may require that health plans use a particular rating method in determining premium rates. For example, qualified health plans in the ACA Marketplaces must effectively use community rating. Health plans working with Centers for Medicare and Medicaid (CMS) to offer Medicare Advantage (MA) products must follow its dictates.

Similarly, plans providing benefits through the Federal Employees Health Benefit (FEHB) Program are obligated to follow its rules. States, such as New York and California, have continued to closely monitor health plans offering products to their citizens both within and outside the ACA Marketplaces.

Role of Technology in Underwriting and Rating

Role of Technology in Underwriting and Rating (continued)

Today, technology is increasingly playing a role in many aspects of health insurance.

As we briefly touched upon earlier, underwriting and rating are not immune to this movement. As consumers increasingly look for health products geared to their specific needs, technology makes it possible for plans to harness broad streams of data to create such products and profitably underwrite them. [xiii]

Plan Funding

Plan Funding

Plan funding is the method that an employer or other payor or purchaser uses to pay medical benefit costs and administrative expenses.

A health plan may be financed or funded in a variety of ways, subject to federal and state requirements. In this section we describe two common types of plans:

- fully funded plans
- self-funded plans

We also briefly discuss third party administrators.

Fully Funded Plans

In a **fully funded plan,** an insurer or health plan bears the responsibility of guaranteeing claim payments, paying for all incurred covered benefits, and administering the health plan.

If the dollar amount of claims or administrative expenses exceeds the dollar amount of premiums collected, the health plan or insurer is responsible for the difference.

On the other hand, if the group has fewer claim expenses than anticipated, the health plan or insurer has an opportunity to make a profit that is greater than anticipated. A fully funded plan is the traditional funding arrangement for a group health plan. The group's policyholder, typically an employer, makes monthly premium payments to the health plan.

Self-Funded Plans

In a **self-funded plan** (also called a **self-insured plan**), an employer or other group sponsor, rather than a health plan or insurance company, is financially responsible for paying plan expenses, including claims made by group plan members.

The group sponsor, typically a large employer or group of employers, assumes complete financial responsibility for the incurred covered benefits and related expenses. A group may be partially or fully self-funded. Under the Employee Retirement Income Security Act (ERISA), a self-funded plan is exempt from specified state insurance regulations and some requirements of the ACA.

Funding Vehicle

In a self-funded plan, the money that an employer and employees would have paid in premiums to an insurer or health plan is deposited into an account, called the **funding vehicle**, until the money is paid out.

Employers pay only for incurred healthcare costs in a self-funded plan, so they save money when employees' utilization of medical care is lower than expected. However, employers are responsible for all incurred claims and other expenses, even if the funded amount is exhausted.

Stop-Loss Insurance

If a self-funded group experiences catastrophic medical claims or actual utilization is significantly greater than expected during a year, the employer might not have the financial resources to pay all the claims. For this reason, many self-funded employers choose to purchase **stop-loss insurance**, which enables them to place a dollar limit on their liability for paying claims.

Stop-loss insurance can be purchased in several forms.

Individual Stop Loss Coverage

Individual stop-loss coverage (or **specific stop-loss coverage**) provides benefits for claims on an individual that exceed a stated amount in a given period.

Aggregate Stop Loss Coverage

Aggregate stop-loss coverage provides benefits when the group's total claims during a specified period exceed a stated amount. Under the terms of the stop-loss contract, the employer pays all incurred healthcare costs up to the amount specified in the contract out of its own funds.

Stop Loss Carrier

The stop-loss carrier assumes financial responsibility for all costs in excess of the specified amount. The stop-loss carrier does not make benefit payments directly to the insured group members; instead, the carrier reimburses the employer, which retains responsibility for making claim payments.

How the ACA has impacted the self-funding of plans:

Self-funding has traditionally been used by large employers of at least several hundred employees. In an effort to retain lower premiums smaller employers have been adopting self-funded plans since the passage of the Affordable Care Act (ACA). The increased ability of smaller companies to obtain stop-loss coverage has also facilitated this movement toward self-funding. [xiv]

Administration

In a fully funded plan, the insurer or health plan usually handles both the administrative and claims paying functions. But in a self-funded plan an employer or group sponsor must decide whether to perform the administrative duties on its own.

An employer has several options in plan administration.

Third Party Administrator

The employer may self-pay, which means that the employer administers the plan itself by hiring a staff and purchasing the appropriate information management systems. Alternatively, the employer may hire an independent third party to administer the plan.

A **third-party administrator (TPA)** is an organization that administers group benefit plans for self-funded groups, but that does not have the financial responsibility for paying benefits. The employer retains the financial responsibility for paying claims for the self-funded group.

Administrative Services Only Contract

Examples of administrative services that TPAs provide to self-funded groups include claims administration and membership services. A TPA may also offer advice to clients on the purchase and design of employee benefits programs.

The contract between an employer and an insurer or other TPA is called an **administrative services only (ASO) contract**. Third-party administrators are usually paid a fixed fee per employee for administering the terms of the ASO contract.

Conclusion

Conclusion (continued)

In this lesson, we have learned about:

- Underwriting – A function of a health plan that assesses the risk it will assume by providing coverage to an individual or group. The underwriter identifies factors that contribute to risk, estimates the amount of risk, and determines whether the risk is acceptable.

- Rating – A function of a health plan that calculates the premium it should charge an individual or group for coverage. The amount is based on the risk presented by the individual or group, the expected cost of medical services, and marketability and competitiveness.

We also examined plan funding—how an employer pays for employee healthcare benefits and related administrative expenses. An employer-sponsored health plan may be fully funded, with claims and administrative costs and liability borne by a health plan or insurance company, or self-funded (self-insured), with the employer bearing those costs and liability.

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19 Information Management

Learning Objectives

After completing this lesson, you will be able to:

- describe the kinds of information and information system capabilities needed by health plans,
- discuss some of the main challenges in managing information,
- list four practices commonly employed to enhance Internet security,
- describe the use by health plans of information technologies, including e-business and e-commerce, electronic data interchange (EDI), business intelligence (BI) and decision support systems (DSSs), data warehouses, electronic medical records, networks, and personal health records (PHRs) and electronic health records (EHRs),
- explain what is meant by the "retailization" of healthcare, and
- gain an understanding of the current and potential roles of cloud computing and blockchain technology in the healthcare industry.

In this lesson we explore health plans' needs for information and information management capabilities. We discuss challenges involved in data management and describe some of the ways health plans can use information technology to help them operate effectively and efficiently.

Information Management Needs

Having current, correct information available to the right person at the right time in the right format is critical to the success of health plan operations. Therefore, a health plan needs an accurate, efficient method of information and data management. **Information management** (IM) is the combination of systems, processes, and technology that a health plan uses to provide its employees with the information they need to carry out their job responsibilities and to provide plan members, providers, purchasers, and other companies and organizations with the information they need to do business with and otherwise interact with the plan.

More about the role IM in a consumer centric environment:

Health Information Management (HIM) acts as the central hub of patient information, hence every task – from scanning medical records to fulfilling the release of information requests – must run efficiently accurately, and on a timely basis.

Other Important Purposes of IM

Other important purposes of IM are to ensure the security of health plan information— that is, to see that only authorized parties have access to it—and to facilitate the exchange of information. Health plans need capabilities for information exchange among internal functions and with external entities.

Example: Quality management program directors need member satisfaction information from member services to include in reports to external parties such as purchasers, providers, members, regulatory agencies, and accrediting bodies. The accounting department needs information from network management and claims to correctly reimburse providers for healthcare services delivered to members.

Common Information Needed by Health Plan Personnel

- descriptions of benefit structures of the health plan's products,
- member eligibility rosters,
- current information about network providers,
- reimbursement arrangements with participating providers,
- information to support the authorization process,
- reports on utilization and quality management programs,
- information on member and provider satisfaction with the health plan,
- information on claims and claims processing,
- premium billing and payment information for various purchasers,
- the results of performance measurements for various health plan departments, and
- financial information for accounting and financial reporting purposes.

Needs for Information System Capabilities

An IM is an interactive combination of people, computer hardware and software, communication devices, and procedures designed to provide a continuous flow of information to the people who need it to make decisions or perform activities vital to providing quality patient care. Health plans have three basic types of information systems:

- systems to assist plan personnel with day-to-day operations and transactions (such as processing claims or billing purchasers for premium payments);

- systems to support the analysis of accumulated data and information and to report the results of that analysis (for instance, preparing periodic financial statements or evaluating preventive care, case management, or disease management programs); and

- systems to support electronic transactions and information-sharing between itself and others—members, providers, and other individuals and organizations that work with the plan.

Five Core IT Systems

Looked at another way, it can be aid that generally the healthcare payer IT environment can be broken down into the following five (5) core systems:

1. Member Management System(s),
2. Plan Benefits Administration System(s),
3. Claims Administration System(s),
4. Provider Management System(s), and
5. Billing/Accounting System(s).

Specialized System Capabilities

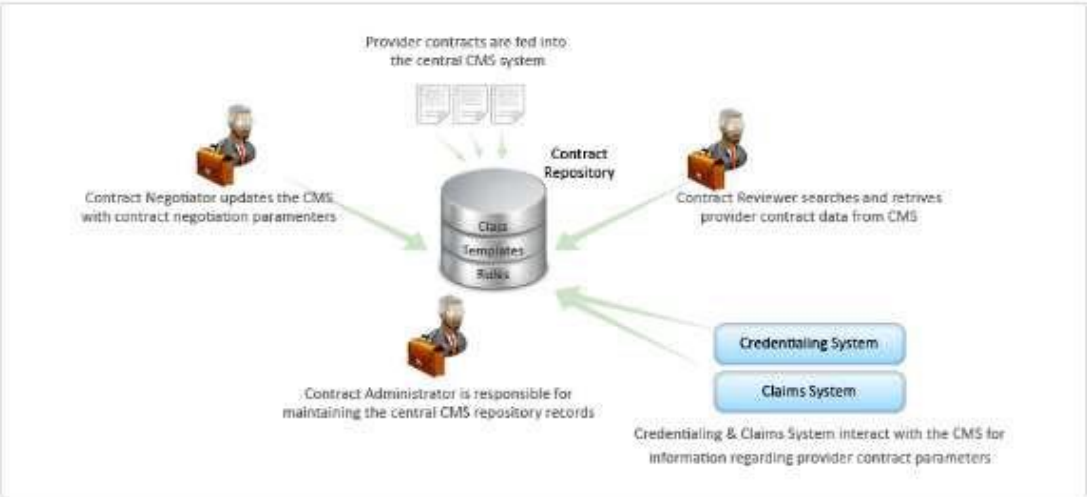
In addition to the five general transaction and reporting systems, plan managers typically need some or all of the following specialized system capabilities to support various activities in the organization.

Credentialing

Credentialing-Plan managers need to obtain and review the documentation of healthcare professionals and institutional providers, including licensure, certifications, facility privileges, evidence of malpractice insurance, malpractice history, etc. A credentialing system tracks provider credentials and generates notices of the need for recredentialing, based on license expiration dates, the date on which the provider's credentials were last reviewed, continuing education requirements, minimum qualification requirements, and other similar matters. Based on the outcome of the re-credentialing processes, providers and practitioners are notified of continued participation or termination from a health plan's network.

Contract Management

Contract management for health plans can be complex, particularly under capitation. If a health plan is unable to track costs and patient encounters and treatment accurately, it will be unable to reconcile capitation payments and manage risk pools, and if it is unable to monitor eligibility, it runs the risk of paying benefits for ineligible people. Factors that often affect members' eligibility status are changes in employment, changes in marital status, or coverage under more than one plan. A contract management system incorporates membership data and provider reimbursement arrangements and analyzes transactions according to contract rules. It may also include features such as decision support, modeling and forecasting, cost reporting, and contract compliance tracking. The contract management system also facilitates other operational functions such as the payment of claims. By making for the ready availability of accurate member information a contract management system interfacing with an automated claims payment system can result in fewer denials and reduced over and under payments.



A sample provider contract management system environment

Provider Contracting

Provider contracting- Health plans must establish and maintain networks of providers to provide services to their members. Initial contract terms must be tracked as well as periodic

updates of negotiations and agreements. To do this, health plans are increasingly viewing provider contract management systems as an essential component of their informational systems. A provider contract management system incorporates membership data and provider reimbursement arrangements. It also analyzes transactions with providers according to detailed contract rules. In summary, these systems incorporate features that aid health plans by managing provider contracts from initial negotiations, updated agreements, and through reporting.

Utilization Management

Utilization management- Health plans and providers need information systems for managing authorization transactions and utilization. In a health plan environment, pre-established guidelines determine which services require authorization of payment from the health plan. Many automated systems incorporating authorization requirements can facilitate the processing of requests for initial authorization of care. Utilization management systems can also be used for approvals of additional treatments, while a member-patient continues to need related medical treatments. To monitor the actual use and costs of care, health plans require systems that track the utilization of services by type of service and provider.

Many health plans also want systems specifically designed to manage access, utilization, and quality of care under case management or disease management programs. In addition, the Department of Health and Human Services through the Office of the National Coordinator for Health Information Technology is encouraging providers to adopt electronic prior authorization standards. [i]

Quality Management

Quality management seeks to improve the effectiveness of treatments and increase patient satisfaction with those services. Positive outcomes of treatment and lower incidence of illness define value to customers. To compare plans and make purchase decisions, customers need information about providers, treatment options, care outcomes, and plan performance. Health plans need information systems that can store, analyze, and report on large amounts of clinically significant data over time to support the development of quality indicators, outcome measures, and clinical protocols and guidelines.

Provider Profiling

Provider profiling is critical to managing the quality and cost of the care provided by network providers. Profiling helps a health plan detect overutilization, underutilization, and inappropriate utilization of medical resources. Managers need systems that enable them to identify those providers whose costs of care or whose treatment patterns deviate significantly from the norm.

Enterprise Scheduling

Enterprise scheduling- In large healthcare organizations (particularly provider-based health plans and staff model HMOs), there is a need to manage the use of services and resources such as MRI equipment and surgery centers. An enterprise scheduling system permits physician groups, hospitals, and other facilities within an enterprise to function as a single organization in arranging access to facilities and resources by providing resource availability information on a real-time basis. Such systems typically allow individual users the ability to build and modify schedules. Enterprise scheduling systems facilitate improved resource use efficiency and reduce patient waiting time thereby increasing patient satisfaction. Such systems also help to reduce patient no-shows and cancellations. Enterprise scheduling systems can also be used to reduce the risk billing for bogus treatments and concomitant fraud.

Claims Processing

Claims processing depends on the accumulation and analysis of a vast amount of information about plan members, providers, compensation arrangements, fee schedules for specific types of services, authorization requirements, and plan structure and benefits. The information gathered by the claims department is also used by other functional areas within the health plan, including member services, marketing, finance, medical management, contracting, and provider relations. Health plans must ensure that the information collected and disbursed by its claims administration process is accurate, complete, and up-to-date. Use of an electronic claims processing system also aids in the reduction of administrative time and processing costs. Fewer manual hours are needed in the processing of most claims and there tends to be lessened reconciliation activity for stakeholders.

Marketing

Marketing- The ability to communicate information about plan membership, benefits, and services is critical to the survival of a health plan. Health plans need to convey information to purchasers and members (both current and potential) concerning plan performance and effectiveness. Often, employers offer employees a choice of health plans, and it is easier to make this choice when there are common measures of plan performance in place. Health plan marketing departments also need information about current customers, potential customers, competing health plans, and sales force activities to plan and implement their marketing strategies.

Member Services

Member Services- Health plans need information systems that make access to information, transaction processing, and other types of services fast and convenient for members. Such systems typically incorporate data management with communications systems. Members should be able to access information about claims, the health plan and its programs, and health and wellness through online portals. Some plans are also introducing cost comparison tools to help members assess their out-of-pocket costs. [ii]

Sales

Sales- To facilitate sales through brokers or direct channels, plans need systems that automate quoting, contracting, and enrollment functions. These systems may be stand-alone e-commerce systems (discussed later in this lesson), or they may provide information to other entities for incorporation into their e-commerce systems.

Finances

Finances- From the general ledger to accounts payable and procurement systems, health plans see the pass-through of very large sums of money, as premiums come in and medical claims are paid. Financial systems must account for all payments as well as for financial assets and reserves.

Challenges in Managing Information and Data

In effectively managing information and data, health plans face several significant challenges.

- A high volume of data from multiple sources
- Different types of data
- Quality of data

- Usability of data
- Different formats.
- Lack of integration between clinical and administrative systems.
- Reporting requirements.
- Security and privacy.
- Mobile computing.
- Sharing patient data outside a closed system.

High Volume of Data from Multiple Sources

A health plan must be able to manage a large volume of data from both internal and external sources. A plan generates tremendous amounts of internal data including documentation of its business operations and detailed records of the services it delivers to purchasers, providers, and plan members. Providers generate additional data in the course of treating members. The plan also receives external data from purchasers who maintain records on plan members and from a wide variety of state and federal agencies.

Different Types of Data

Providers generate clinical data related to healthcare services and outcomes. Regulators and accrediting agencies provide operational information about legal requirements and quality standards. The health plan generates provider and member satisfaction data and financial data related to revenues and expenses. The health plan must be able to understand all of these types of data and the relationships between them.

Quality of Data

Health plans often experience difficulties acquiring data that is complete, accurate, and consistent from one source to another. Medical management, network management, and claims processing activities frequently rely on coded information submitted by providers, such as codes for a member's diagnosis and the healthcare services delivered to them. However, the coded information does not always provide enough detail for the health plan to process the transactions associated with those services. For example, if the coded information is incomplete, the health plan may not be able to evaluate provider or health plan performance or to process requests for authorization of payment, provider reimbursements, and payments of claims. Inaccuracies in data often result from provider or health plan staff errors made while inputting the diagnostic and procedural codes. Inconsistencies arise because different providers sometimes use different diagnostic codes for similar types of patients or different procedural codes for the same procedure.

Usability of Data

The data that is readily available and easy to collect may not be the most relevant for the health plan's transaction processing or reporting needs. The health plan may need to manipulate the data or process it through additional analytic tools before it is meaningful for plan operations.

Different Formats

A health plan must be able to manage different data formats. Data from providers and plan members are still frequently in paper documents. Much of the data generated by a health plan is in electronic form, but it is often distributed in separate databases, such as a provider database, a member database, and a claims database, each of which may have different organizational structures and use different software. In many cases, the approach to IM varies among different programs within the same health plan function. The lack of coordination and compatibility among IM processes typically result in higher costs and less efficiency.

Lack of Integration Between Clinical and Administrative Systems

Within health plans, there often occurs an integration gap between patient care and administrative systems. Medical records maintained by physicians and on a hospital floor need to be reflected for the purposes generating accurate insurance claims and patient billing. To accomplish this, a health plan's data management system has to be configured for example, to ensure that treatment codes accurately reflect the care provided and tracked for both administrative purposes and analytics.

Reporting Requirements

A health plan's IM systems must be able to produce many different types of reports on different schedules. Report needs vary according to the nature of the function, the activities included in the function, the level of detail desired, and the type of analysis that has been performed on the data. For example, case management staff may need to examine the complete set of data about the patient cases they are managing, while the case management program director needs a concise summary of current case data along with notations of trends or problems. Ideally, the IM system can produce reports in the frequency, format, and level of detail appropriate for each report user's purposes. Although information users typically need information rather than raw data, on occasion they may need access to the data as well.

Security and Privacy

The security and privacy of sensitive medical information is of special concern for health plans, members, providers, and purchasers alike. In accordance with HIPAA, the Department of Health and Human Services (HHS) has established federal regulations to protect the confidentiality and security of members' medical information . The Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009 strengthens privacy safeguards for patients' protected health information. Adequate security is of particular concern, regardless of regulatory sanctions, because the cost of a data breach in the healthcare industry is significantly higher than in other industries. Not only are there financial concerns to both the health plan and its members, there are damages to the plan's reputation and the potential for lost membership due to that reputation being tarnished as a result of a breach. [iii]

Mobile Computing

Digitizing patient records has made healthcare more efficient. Today, rather than scribbling on hardcopy medical charts for later transcription, physicians, nurses, and other healthcare providers rely on computer tablets and handheld data entry systems to both enter information and access patient records. Direct data entry eliminates steps and reduces the chances for errors, however, it also means that health information system (HIS) managers must provide secure wireless access throughout a healthcare facility. Such a system must have sufficient bandwidth to support a what are likely to be a growing number of handheld workstations

Sharing Patient Data Outside a Closed System

Centralizing patient records within a closed system environment is one challenge that is usually successfully met, Enabling the sharing of data with practitioners located outside a central facility can be more challenging. Electronic health record (EHR) data systems within a healthcare provider environment (such as a hospital) can be standardized but external health providers (such as physician outside a network or pharmacies) may use different systems and protocols.

Sharing medical records between and among systems and integrating different systems remains an ongoing challenge.

Although IM in a health plan environment is typically a complex process, not all aspects of IM are completely or even partially automated. In many instances, health plan personnel manually perform some or all of the steps necessary to obtain and use information. The automation of IM for health plans requires technical expertise and is generally expensive and time-consuming, but it is essential.

IM Privacy and Security: A Closer Look

In today's cyber-attack prone environment, every healthcare organization must ensure that its members' information is appropriately and effectively safeguarded. Organizations are imposing a HITRUST Common Security Framework (CSF) Certification requirement, in part, because of the growing number of breaches involving third-party vendors. The certification seeks to address the multitude of privacy, security, and regulatory challenges facing healthcare organizations. [iv]

The HITRUST CSF

The HITRUST CSF was developed by healthcare and IT professionals to provide an efficient and prescriptive framework for managing the security requirements of HIPAA. The certification rationalizes healthcare-relevant regulations and standards into a single overarching security framework. HITRUST is important to the healthcare industry for many reasons, most significantly:

- It is the most widely adopted security framework in the United States healthcare industry.
- It is required by many healthcare payers.
- It is updated on a regular basis. [v] [vi]

Information Technology

Information technology refers to the wide range of electronic devices and tools used to acquire, record, store, transfer, or transform data or information. The types of information technology used by health plans vary greatly, but in this section we will look at some of the most important.

E-Business and E-Commerce

In a health plan context, **electronic business (e-business)** and **electronic commerce (e-commerce)** refer to a plan's use of computer networks to perform business transactions and facilitate the delivery of healthcare and nonclinical services to members. The term e-business generally encompasses all types of electronic business functions, including the exchange of information both within the plan and with plan members, purchasers, providers, regulators, accrediting bodies, and potential members and purchasers. The term e-commerce refers to online commerce, including merchandising, sales, and payment.

Some Types of Informational Usage

The Internet provides health plans with a cost-effective means of transmitting and obtaining information and conducting selected informational transactions. Health plans generally have their own websites, which they use for a variety of purposes. Informational uses include:

- marketing products and services to potential purchasers,
- explaining the plan's covered benefits and authorization systems to members,
- supplying a network provider list and information about those providers to members,
- educating members about healthy lifestyles and self-care,
- reporting information on healthcare and service quality, and
- disseminating member eligibility information, clinical practice management information, and formularies to providers.

Some Types of Informational Transactions

Transactions that can be performed include:

- changing members' administrative information (such as addresses),
- changing members' primary care providers,
- refilling prescriptions by mail,
- receiving and checking the status of claims filed by members and providers,
- receiving and processing providers' requests for authorizations of payment and transmitting the decisions on those requests,
- updating member eligibility lists based on changes submitted by purchasers, and
- receiving electronic payment from purchasers.

Slide - The Rise of "Retailization" in Consumer-Centric Environment

While health plans have historically lagged behind other industries in providing a high level of service online, many plans have enhanced or are now enhancing their websites and are providing a variety of self-service functions to consumers, providers, employers and brokers. They are expanding into e-commerce, enabling consumers to shop for their healthcare coverage needs, price their options, and buy products online. This process of "retailization" will be discussed shortly in the lesson in greater detail.

Rise of "Retailization" in Consumer-Centric Environment (Continued)

Consumers are becoming more sophisticated and increasingly involved in attending to their healthcare Many consumers are no longer content to rely solely on a provider for advice. For

example, when confronted with a medical question many search online before consulting a physician or other healthcare professional. And, when such consumers seek treatment they want it on their terms – taking into consideration their wishes and lifestyles. For less threatening healthcare issues, convenience is a key factor in where and from whom treatment is sought.

The Shift from B2C to B2B

Vaccinations and common ailments are often being handled at retail-based clinics. For slightly more complex services, consumers are increasing seeking treatment at urgent care centers that accept walk-in patients versus trips to the traditional hospital emergency room. The "retailization" of healthcare has been coupled with the increasing shift by health plans to business to consumer (B2C) models in contrast to the more traditional business (health plan) to business (employer) (B2B) model.

Resulting Repercussions

This shift to increased emphasis of interfacing with individual consumers has had repercussions for technology departments within health plans and other payers including:

- Access to patient data – Many health plan members now seeking access to their data on a near round-the-clock basis seven days a week (24X7).

- Mobile access – Many health plan members now wish to access to their information from mobile devices. In addition, an increasing number are using tools to help manage their health goals such as exercise tracking and weight management. At the same time, payers are realizing the benefits offered by mobility in bending the cost curve and seek to support it through m-Health initiatives.

- Transparency – Individual plan members are increasing seeking tools that provide information about price, quality, and the value of services offered.

Security Requirements and Considerations

In doing business online, a health plan needs to protect the information that it makes available to users, as well as other information that may reside in the plan's network. Since the Internet is open to everyone, the potential exists for unauthorized access to a health plan's proprietary systems and to confidential information about individual members. In light of federal legislation in health information security (such as the privacy and security provisions of HIPAA) and customer expectations of privacy and confidentiality, healthcare executives need to be sure that their enterprises are not vulnerable to security breaches and that the applications and networks are appropriately secured.

Main Types of IT Security Technology

Some of the main types of Internet information security technology are these:

- A **firewall** is a security system (hardware or software or both) designed to block unauthorized access to a network (such as an intranet) from the Internet while

- permitting authorized access by monitoring and controlling incoming and outgoing network traffic based on predetermined security rules.

- An **anti-virus program** is software designed to prevent, detect, and remove viruses or malicious software and other threats from a computer system and cleaning and restoring an infected computer.

- **Encryption** is the transformation of text or data by encoding it using an encryption algorithm to make it unreadable to those who do not have special knowledge of the key needed to decrypt the data. This is done so that the information is accessible only to those for whom it is intended.

- A **digital signature (electronic signature)** is an encrypted digital tag attached to an electronic communication to verify the identity of the sender.

Established Intranets

To obtain a higher level of security than presently exists on the Internet, some health plans have established intranets and secured extranets.

- An **intranet** is an internal (private) computer network built on web-based technologies and standards. Access to an intranet is available only to members of the computer network. Intranets are utilized by health plans to provide internal employees with access to the various IM systems, as well as important content such as company news, administrative systems, document management systems, and other knowledge-bases.

Secured Extranets

- An **extranet** is like an intranet, but it links selected resources of an organization to external entities or individuals. These external parties (in the case of health plans, providers, members, and regulatory and accrediting agencies) need a user ID and password (and sometimes encryption technology) to gain access. While many people may not be familiar with the term, they do often encounter and use extranets—secure access to a user's information is a common functionality provided by many companies online including banks, credit card companies, retail sites, and health plans.

The Real Major Threat to Data Security

The major threat to data security in a network is not a small number of external hackers but internal security breaches by employees or others authorized to use the network. The employee motivated by curiosity or malice, the careless employee who unwittingly provides an unauthorized user with access to a password, and the employee poorly trained in the use of a system remain the greatest threat to data security in any information network. Role-based security within an organization is essential to minimize such security breaches.

Site Monitoring and Analytics

Measurement of the availability and activity of a website is an important part of managing online capabilities. Monitoring software measures site availability and response time by running

automated transactions and measuring task completion and the time taken. Web analytics record site activity such as page views, new versus repeat visitors, and other indicators of how users are using the site. Analytics is an important tool for measuring the success of a website for both serving a plan's existing customers and attracting new ones.

Electronic Data Interchange

Electronic data interchange (EDI) is the computer-to-computer transfer of data between organizations using a data format agreed on by the sending and receiving parties. Information is routed through network systems and follows standards and procedures that allow output from one system to be processed directly, without human intervention, and input to other systems. Organizations doing business with one another by EDI are called trading partners. EDI differs from e-business in that EDI is the transfer of data, typically in batches, while e-business involves back-and-forth exchanges of information concerning individual transactions and often the performance of some type of service. The power of EDI is the fact that it standardizes the information communicated in business documents, which makes "paperless" exchanges possible.

The pressure on the healthcare industry to reduce administrative costs, due in part to the limits spelled out in the Affordable Care Act, has led likely to greater adoption of EDI in recent years and will continue to do so moving forward.

EDI Usage

EDI can be used by health plans for the following activities:

- the transmission of claims and encounter reports from providers to the health plan,
- the transmission of data from the plan's claims database to various medical management departments,
- the transmission of data among different health plan departments or locations,
- the exchange of data between a health plan and regulatory or accrediting bodies,
- the transmission of membership and eligibility data from an employer to a health plan,
- the transmission of member eligibility data from a health plan to its providers, and
- the exchange of information between a health plan and its providers regarding requests for authorizations of services and referrals.

List of some of the advantages offered by EDI:

The Advantages of EDI

- **Faster transmission and processing.** EDI reduces the time required for purchasing, claims processing, and other functions, and it increases employee productivity, reducing

costs.

- **Reduced paperwork.** The exchange of standardized electronic forms for activities such as purchasing and claims can slash paperwork and the associated costs. The largest cost of claims processing is labor, particularly for data entry and examination functions, and electronic transmission and processing of claims can lower staffing requirements greatly.

- **Improved data integrity.** In a manual process, each step has the potential for human error. For example, if a health plan receives paper claims or encounter reports, employees must enter the data into the plan's system, and they may do so incorrectly. When such data is transmitted automatically, the potential for errors can be minimized.

- **Improved business methods.** The use of EDI forces an organization to focus on and improve the details of repetitive transactions and to upgrade internal procedures. It creates an opportunity for process reengineering and realization of the efficiencies that reengineering can achieve.

- **Automation of operations.** The use of EDI drastically lightens the management burden. Many tasks, such as printing out business documents, enveloping, franking, or registering in the ERP, disappear completely. This in turn, tends to lead to overall reduced costs.

Technology Requirements for EDI

EDI requires a data communication link between the participating organizations or departments. The Internet may serve as this link, or data may be sent by standard telephone lines. EDI also requires a standardized data format—computers cannot process the information that moves between organizations electronically unless it is encoded in a manner that the computers at both organizations can recognize. For EDI to achieve its full potential, all entities in the healthcare industry need to agree on common standards. Several organizations have already created or are developing such standards for various functions and types of data.

Business Intelligence and Decision Support Systems

In addition to improving access to data and information, information technology can support problem-specific decision-making. A **business intelligence (BI)** system or **decision support system (DSS)** uses databases and decision models to enhance the decision-making process for health plan executives, managers, clinical staff, and providers. They do so by analyzing data from a database and reporting the results. They can detect trends or relationships in the data that are not immediately obvious. For example, health plans may use a DSS to analyze the effect of healthcare services on members' health, and this information can be used to identify the most effective medical interventions. Other capabilities often included in DSSs are provider profiling and tracking of provider reimbursement.

DSS and Healthcare Providers

For healthcare providers, DSS technologies focus on supplying information needed when clinical decisions are made. Such concurrent decision support systems provide users with patient-specific clinical information that can be used to develop treatment guidelines based on a specific diagnosis of a problem, warnings of drug interactions, etc., and to manage the appropriateness of referrals, procedures, and levels of care. These DSSs are viewed not as automated replacements for the expertise of providers, but rather as a tool to facilitate clinical and operational decisions.

Data Warehouses

A health plan's information and data are typically gathered independently by different functional areas of the plan or external sources, and as a result they are often divided among distinct, unlinked databases. This means that someone seeking organization-wide information may have to search several databases in different functional areas or even within a single area. This increases the time it takes to acquire information and labor costs. In addition, the data from the various databases may be in different, incompatible formats, or a person may not have ready access to all databases.

Enterprise Data Warehouse

To address these problems, many health plans use data warehouses. A **data warehouse** (**DW or DWH**) is a database (or set of databases) containing data from many sources (often both internal and external) linked by a common subject (such as a plan member). You may also hear of a data warehouse referred to as an **enterprise data warehouse** (**EDW**). The data from the various sources is integrated so that it is non-repetitive and in a standard format. The information in the warehouse is typically a mix of both current and historical data. Users can analyze the data in the warehouse through the use of query applications.

Data Mart

A **data mart** is a subset of a data warehouse. It is focused on one or more specific subject areas or lines of business. It is typically used by individual departments to facilitate access to data frequently used by or within the department.

Advantages of Data Warehouses

Data warehouses have many advantages:

- Health plan personnel are better able to prepare complete, accurate reports because they can merge data from various separate sources (such as claims administration and utilization review). A consistent format also makes possible the comparison of data across different types of health plan products (such as HMO versus PPO) and against data from other health plans.

- Data warehouses typically store large amounts of historical as well as current data, facilitating the analysis of information over time. For instance, suppose a medical management program director wants to know if the average age of the population

covered by the plan in a geographic region is increasing and if this correlates with changes in the incidence of and cost of care for specific illnesses. Individual databases would probably not have this information, but a data warehouse combining data from many sources could.

- A warehouse approach relieves individual databases from having to store large amounts of data that are not needed for daily operations and decreasing the amount of data in a database typically speeds the response time to a query.

- Data warehouses are the foundations of business intelligence and decision support systems. These systems analyze the data in warehouses to support decision-making.

Disadvantages of Data Warehouses

The principal disadvantages of data warehouses are the complexity and cost of implementing them. Typically, the construction of a data warehouse is very time-consuming and requires significant technological expertise and financial resources. Consequently, even though a data warehouse may make health plan operations more efficient and improve the quality of healthcare, the return on the investment in one may not be realized for several years.

Electronic Medical Records

The medical records of health plan members have traditionally been in the form of paper documents and kept at the site where care was provided. But increasingly, providers and plans are using an **electronic medical record (EMR),** also called a **computer-based patient record (CPR)**, a computerized record of a patient's clinical, demographic, and administrative data. [vii]

Types of EMR Data

- Clinical data can include a member's medical history, current and past medications, diagnoses, test results, current treatment status, and other healthcare information. Advanced EMRs can include digital images from CT scans, MRIs, and X-rays.

- Demographic data include the member's name, address, age, gender, and similar relevant information.

- Administrative data can include the plan type (HMO, PPO, etc.), plan sponsor (the purchaser), membership number, and providers who have treated the member.

Electronic Medical Records (Continued)

While the exact data in EMRs vary, all EMRs include medical information for an individual member and are designed to be used at the site of care (such as a physician's office, clinic, or hospital). This is in contrast to databases and data warehouses that typically organize information by categories such as the type of treatment or provider and are designed primarily for use in utilization and quality management. EMRs also include some clinical decision support for providers—for example, EMR software can be designed to alert a provider to possible drug interactions.

Health Information Networks

EMRs enhance healthcare quality, but they are used at a particular site of care, and it is even more advantageous if medical records can be transmitted across an entire network of providers. One approach to distributing EMRs is through a **health information network (HIN)** or **health data network (HDN)**, a computer network that gives the providers of a health plan access to a database of medical information.

Example of HIN Arrangement

In one type of arrangement, a health plan's HIN is linked to a data warehouse that stores the very large amounts of data that reside in the medical records of an entire provider network. The HIN makes the data in the warehouse available online to a defined set of users, such as health plan hospitals, physicians, pharmacists, and specified health plan personnel.

A health plan can also use a secured extranet design or a distributed database approach for the HIN. With a distributed database approach, a database system (including either the whole database or only the relevant portion) is located at more than one site. For example, the EMR database might be available at several different hospitals and at large provider groups' locations.

Most HINs are Internet-based rather than built on proprietary computer networks. Whatever the network infrastructure, the health plan typically houses a central database or data warehouse that accepts, organizes, and stores EMR information as it is entered and then makes EMRs available to authorized users.

Advantages of HINs

HINs improve the quality of medical care because all the information in a patient's medical history is readily available to each provider at the point of service.

Example:

Example: Suppose that a health plan operates a HIN that includes the hospitals, physicians, and pharmacies in the health plan's network. After examining a patient, a PCP might write a prescription and make a referral to a specialist. The PCP's staff updates the patient's EMR to reflect the services delivered during the office visit. The pharmacist filling the prescription can immediately check it against the diagnosis and against other medications the patient is currently taking and note that the prescription was filled. The specialist can see what medications were prescribed, what tests were conducted, and what notes the PCP made regarding the diagnosis. When the health plan reviews the claim, it can match diagnostic and treatment codes, verify authorization, and record utilization information.

HIN Supported EMRs

HIN-supported EMRs have a distinct advantage over non-networked forms of medical record-keeping, particularly the practice of using paper documents. A HIN allows multiple healthcare professionals, even in different locations, to access a member's chart simultaneously. With paper records, if a plan member receives care from providers at different physical locations, either the paper records must be copied and faxed or carried between locations, or the providers themselves must discuss the details of the chart. Further, with paper records, the possibility exists that records may be lost or at least temporarily misplaced.

How Health Plans Benefit from a HIN

The capacity of HINs to capture a large amount of data about healthcare services and outcomes in a uniform format also affords health plans the following benefits:

- **Improved care and service.** Immediate access to current, complete information about members facilitates providers' delivery of high-quality care in a timely and cost-effective manner. Improved access to information also improves continuity of care. For example, a HIN provides a means of reducing duplicate services and otherwise coordinating care among providers in different locations.

- **Cheaper information administration.** A HIN may help a health plan reduce its administrative costs by enabling more accurate and efficient claims processing, online authorization of payment for services, electronic transfer to mail-order pharmacy programs, improved credentialing, up-to-date online provider directories, up-to-date membership lists, and online case management.

- **Improved outcomes measurement.** Health plans can extract outcome trends from the HIN data warehouse using computer software designed for this purpose. This outcome information can be used for developing clinical practice management tools such as clinical practice guidelines.

- **Better management of provider performance.** Using data gathered through its HIN, a health plan can identify providers who have superior outcomes and who comply with utilization management (UM) and quality management (QM) programs.

- **Improved efficiency and accuracy of information entry.** Most HIN systems present providers and their staffs with computer screens that list standard options for entering data about patient care. Rather than type in this data or record it on paper, the provider or staff member can simply click on the appropriate option, which saves time and reduces the possibility for clerical error.

- **Reduced legal liability.** EMRs and HINs give providers a means of documenting their work to show compliance with quality programs, and they assist health plans in demonstrating that quality care is being uniformly delivered to plan members.

- **Easier reporting.** HINs give a health plan a vehicle for capturing information that may be required by regulatory agencies or accrediting bodies.

Health Information Exchange and Regional Health Information Organizations

The advantages of HINs are multiplied when medical records and other information can be accessed not only by all the providers of a health plan's network, but throughout the healthcare system. **Health information exchange (HIE)** is the electronic sharing of clinical information among the information systems of the various healthcare organizations within a region, community, or hospital system.[viii] Those created within regions are sometimes referred to as **a Regional Health Information Organizations (RHIOs).**

Goal of HIE

The goal of any HIE is to facilitate access to and retrieval of clinical data to provide safe, more timely, efficient, effective, and equitable patient-centered care. HIEs also often provide infrastructure for secondary use of clinical data for purposes such as public health, clinical, biomedical, and consumer health informatics research as well as institutional and provider assessment and improvement.

Goal of HIE (Continued)

HIE gives a physician or other provider access to records of the care and services a patient has received from many providers, both inside and outside her health plan's network, both current and past. This further extends the gains of a HIN, enhancing the quality of care and helping to avoid errors, as providers' decision can be based on complete and accurate information from all sources. HIE also has great potential for cost-savings, as the duplication of tests and services can be eliminated, referrals and consultations can be conducted more quickly and easily, and administrative time to obtain or send records can be reduced—again, even when care has been received outside a plan's network. HIE also provides a wealth of data for quality and utilization management and for research and public health goals.

HIE - The process of exchanging patient-centric electronic information between two or more healthcare organizations. (Image source: www.hims

Personal Health Records

A **personal health record (PHR)** is a history of an individual's health and their encounters with the healthcare system that is owned by the individual and securely maintained for them by a custodian, typically their health plan. A PHR is populated with claims and administrative data collected by the individual's health plan and in some cases, information entered by the person themself, and it forms a coherent, personal history of care that can be used to coordinate and track their encounters with the healthcare system. PHRs will eventually be portable across the healthcare system, so that as an individual changes health plans or employers or enrolls in Medicare, their PHR will go with them.

PHR and Partnerships

Many health plans offer PHRs to their members, often in partnership with entities such as WebMD, American Specialty Health, and others. In addition, both Google and Microsoft now offer online computer applications that enable people to store personal health information in a centralized place for access by themselves or other authorized people such as family members and providers.

The major barrier to widespread implementation of PHRs is the lack of a standard that would allow the information in a PHR to be both inter-operable (usable by different entities) and portable. While a number of current standards and data sets exist, gaps remain and there is no comprehensive "PHR standard."

Electronic Health Records

An **electronic health record (EHR)** is a provider-based history of care that compliments the personal health record by adding detailed information created by providers and facilities (such as X-ray images, physicians' notes, and information on compliance with statutory or regulatory requirements) that are part of the legal and permanent institutional records of patient care.

HITECH and EHRs

Adoption of widespread use of EHRs has proved to be relatively slow and held back in part by the COVID-19 pandemic,[ix] but the HITECH Act of 2009 mentioned previously has spurred increased innovation and use of EHRs. It provides incentive payments to organizations that can prove meaningful use of them and reduced Medicare reimbursements for those that cannot.
The Meaningful Use Stages 1 and 2 define the use of EHRs and the related technology within a provider organization. Achieving "meaningful use," as mentioned before, determines whether an organization receives payments from the federal government under either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program. Conversely, achieving "meaningful use" avoids the imposition and payment of non-compliance penalties.

Innovative Technology Trends in Healthcare IT

There are two key innovative technology trends that are impacting healthcare today:

- Cloud computing, and
- Blockchain

Cloud Computing

Cloud computing means that instead of relying on computer hardware and software sitting on your desk or elsewhere in your organization's network to handle your computing needs it is handled by a third-party. This third-party specializes in providing computer services and these services are accessed via the Internet. In other words, it is the practice of using a network of remote computing devices (servers) hosted on the Internet to store, manage, and process data rather than a personal computer (PC) or a local server. The word "cloud" is used as a metaphor for the "Internet" and the phrase cloud computing means services, such as servers, storage, and applications are delivered through the Internet. [x]

Simple example of cloud computing:

Jeff is using a personal computer (PC) located at his home. He types a query into Google, Jeff's PC is basically a messenger that sends his query to one of Google's hundreds of thoughts of clustered PCs, which search for the answer to Jeff's query. The reach work in finding the answer is not done by Jeff's PC but by a computer that might be sitting in California, Dublin or elsewhere in the world. [xi]

How does Cloud Computing Fit In with Healthcare?

What are the benefits of cloud computing to the healthcare industry? Cloud computing offers the following potential benefits to users in the healthcare industry:

- Administrative cost savings – Cloud computing provides the potential for reduced costs. Heavy capital expenditures can be avoided due the fact that resources are acquired on demand from a third-party. Rather than depreciated, these outlays can be handled as an

  operating expense. IT staffing costs may also be reduced since there is less need to maintain and support a large internal IT infrastructure.

- Enhanced Data Analytics – The power of cloud computing makes it easier to undertake data analysis. This analysis may look at clinical information for individual patients. The cloud also facilitates big data analysis to gain a better understanding of the best treatment pathways for a particular chronic disease, such as diabetes, to broader ways to improve overall population health.

Simple example of cloud computing:

> Big data in healthcare refers to electronic health data sets that are so large and complex that they are difficult (or possibly impossible) to manage with traditional software and/or hardware. Moreover, they cannot be easily managed with traditional management tools and methods. In healthcare big data is complex due to its volume but also because of the diversity of the data types and the speed at which it must be managed.

- Scalability – Cloud services offer scalability and the ability to adjust to changing needs quickly.

- Interoperability -Cloud-based IT services offer the potential for broad interoperability between payers and providers facilitating for example, the establishment of accountable care organizations (ACOs) and other forms of value-based care. It can also enhance collaboration among providers.

- Mobility – We have mentioned mobility before and its increasing role in the communications between health plans and their members. Mobility requires substantial IT support. Cloud computing provides one path to provide this support.

- Remote Patient Care – There are now mobile devices that enable healthcare providers to monitor patient's conditions. These allow for better monitoring for example of chronic conditions. A patient may use devices powered by cloud computing to transmit data to his or her physician. Where substantial physical distances between patients and providers, such as many rural areas in the United Sates, telehealth can allow patients and medical professionals a way to monitor conditions and catch signs of deterioration earlier and help prevent costly and debilitating episodes of acute care.

<u>Cloud Computing Drawbacks</u>

There are also potential drawbacks and risks that need to be considered entailed to the use of cloud computing. Chief among the risks to be considered is a breach of patient information.
While cloud service data centers are typically highly secure from both inside and outside threats questions to ask include:

- Is a particular vendor under consideration up to the task of maintaining high levels of security?

- Is the vendor compliant and pledged to remain compliant to HIPAA, HITECH and other legal requirements?

Other drawbacks to reliance on cloud computing include:

- Ongoing operating costs – Will cloud computing turn out to be more expensive?

- Dependency on cloud service providers – Will problems be resolved quickly – as quickly as would normally be handled by internal IT healthcare staff?

- System lockage – Is your health plan, hospital, or provider network locked into vendor- recommended systems? How easy would it be to migrate to another cloud service provider if the need arose? What happens if the cloud service vendor no longer supports the system that your organization has come to depend upon? [xii] [xiii] [xiv]

Blockchain

Blockchain is a log of transactions that is replicated and distributed across multiple decentralized locations. This is in contrast to a central authority (such as a bank, government, or health plan) where data is likely to be hosted on a particular server – making malicious activity easier to conduct. Each "block" represents a number of transactional records, and the "chain" component links them together. As records, are created, they are confirmed by a distributed network of computers and paired-up with the previous entry in the chain, thereby creating a chain of blocks or a blockchain.

Learn more about the origins of blockchain:

Although blockchain has only been effectively employed in recent years and is most notably associated with bitcoin and other crypto-currencies, its roots can be traced to academic research from the mid-1970s through the 1990s. [xv]

Why is the Healthcare Industry Interested?

There have been significant efforts to make health records interoperable however, there have been security-related risks associated with these efforts. Recent ransomware attacks and cybersecurity breaches have further added to the security concerns regarding health data. The use of blockchain technologies for documenting and transferring healthcare data is being considered as one of the solutions for achieving interoperability and overcoming data exchange issues.

What Are the Potential Uses of Blockchain in Healthcare?

The use of blockchain is being considered by IT healthcare professional in the following ways:

- Enrollee (Patient) Health Records – Blockchain might be used to create enrollee-patient health records. The records would compile illness episodes, laboratory test results, and treatments. Such records might include both inpatient and outpatient treatments.
- Claims Adjudication - Blockchain has the potential to be used for the automated validation of many healthcare claims. For example, software might include encrypted enrollee-patient identifiers, health plan information, and provider claims within a blockchain that is shared by payers (such as health plans) and providers. Due to the decentralized verification process associated with blockchain experts in the field believe this could lead to reduced instances of fraud.
- Prescription Drug Development and Distribution – Software based on blockchain might be utilized to ensure the transparency of the components used to manufacture

prescription drugs. It could also be used to track medication distribution and ensure the authenticity of prescriptions. [xvi] [xvii]

Are There Drawbacks to Blockchain?

While blockchain technology has much potential, there are drawbacks to consider which include:

- Lack of Standards – Currently, there are a lack of standards for the software used to create blockchain. This creates challenges in communicating between different blockchains and in turn, has led to slow adoption within the healthcare industry.

- Transaction Speed – As we mentioned earlier, blockchain is a decentralized system. This means that each time a block is added to the chain it must be verified by the various "players" in the decentralized system. Depending on the number of "players," this can take time – a lot of time.

- High Levels of Computing Power Required – Blockchain requires the use of many computers. This can mean higher budget requirements. From a more prosaic standpoint, it can a substantial escalation in power demands and costs. [xviii]

Outsourcing IM

The technical demands of designing, setting up, and maintaining IM systems and processes can be considerable. External vendors offer a wide variety of services and products, and they may be hired by health plans to help them design and establish new systems such as data warehouses or HINs. A health plan may also outsource some or all of its IM activities to an external vendor rather than conduct them itself. The plan specifies its IM requirements and provides data to a vendor that designs an appropriate system and conducts the IM activity on a day-to-day basis. The vendor also creates the reports that the health plan requires.

Technological Advances

Advances in technology and connectivity have made possible hybrids of insourcing and outsourcing. Software-as-a-service (SAAS) and cloud computing can now enable an organization to achieve the benefits of sophisticated systems without the investment in infrastructure or the operational costs of maintaining them internally. As cloud computing grows, the capabilities that it offers and the level and ease of integration with the variety of systems in use by health plans will evolve.

IM and Health Plan Operations

The purchase of IM products and outsourcing arrangements are typically long-term commitments for a health plan. Outsourcing often requires a significant financial investment and complex legal and administrative arrangements. And because IM is so critical to a health plan's operations, any disruption in the relationship between the plan and the vendor can be very costly for the plan. Therefore, a plan should select a vendor that is financially stable and has a reputation for high-quality products and technical support.

Summary

Health plans are increasingly information-driven, so a plan's approach to IM impacts virtually

every aspect of its operations. Information technology has grown in importance because many plans have discovered that its effective use can improve the performance of their people and processes. The trend toward greater investment in technology, particularly Internet-based technology, is likely to continue as health plans attempt to achieve quality and cost-effectiveness in a highly competitive industry.

Notes:

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[xii] Cloud Standards Customer Council, Impact of Cloud Computing on Healthcare-Version 2.0, February 2017, available at http://www.cloud-council.org/deliverables/impact-of-cloud-computing-on-healthcare.htm

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20 Claims Administration

Learning Objectives

After completing this lesson, you will be able to:

- explain the claims administration process in detail,
- describe the roles of technology and personnel in claims processing,
- discuss the use of codes and edits in claim processing, and
- state the main questions that must be answered in processing a claim.

In this lesson, we examine the processing of health plan claims by automated computer systems and by claims examiners and other personnel; learn about important elements of processing systems, such as standardized claim forms, diagnosis and treatment codes, and edits; and survey the adjudication of a claim by identifying the questions that must be answered before a claim can be paid.

What is a Claim?

A **claim** is a request to an insurer or health plan for payment of benefits. In health coverage, it usually takes the form of an itemized statement of healthcare services delivered by a healthcare provider to a covered person, along with the cost of those services. The person or entity submitting a claim is called the **claimant**; this may be an insured, but in health coverage it is most often a provider. **Claims administration** or **claims processing** is the receiving, reviewing, adjudicating, and paying of claims. (To **adjudicate** a claim is to make determinations and decisions about it.)

Example:

Mr. Kumar is insured by Lifecare PPO Health Plan. He suffers from a degenerating knee and visits Dr. Smith for an examination and treatment which consists of an injection to restore flexibility. Following the visit, Dr. Smith issues a bill for the services provided. Copies of the bill are sent by Dr. Smith's office along with a claim form to Lifecare. Upon receiving the claim form, Lifecare begins processing the claim for reimbursement and initiation of payment to Dr. Smith – the healthcare provider.

More About This Lesson

The claims process typically begins, in the traditional fee-for-service environment, when an insured individual visits their provider either due to illness or perhaps treatment for a chronic condition. Following the visit, the healthcare provider will issue a bill for the services provided. Copies of the bill will be sent along with a claim form to the insured's health plan.

List of helpful terminology in claims processing:

Helpful Terms

Allowed Amount – The sum a health plan (or other payer) will pay to reimburse for a healthcare service or procedure.

Appeal – The process by which a health plan enrollee or provider attempts to persuade a health plan (or other payer) to pay more (or, in some cases, pay any portion) of a medical claim.

Applied to Deductible (ATD) – The amount of money an insured owes to a provider that is applied against their annual deductible.

Assignment of Benefits (AOB) – Payments made by a health plan (or other payer) directly to a provider for medical services rendered to a patient.

Clean Claim – A claim received by a health plan (or other payer) that is free from errors and is successfully processed in a timely manner. Some providers send their claims to third parties, such as Clearinghouses, that focus on creating clean claims.

Clearinghouse – A third-party organization in the claims process, separate and apart from health care providers and payers. Clearinghouses review, edit, and format claims before forwarding them to payers. The processes employed by Clearinghouses is sometimes referred to as *scrubbing*.

Claims adjustor – An individual at a health plan (or other payer) who deals with claims that have been paid incorrectly.

CMS-1500 (Professional) – A paper form used to submit claims to the Centers for Medicare and Medicaid Services (CMS). The form is also used by providers to submit their claims to many commercial payers.

Explanation of Benefits (EOB) – A document that explains to a patient (or provider) the services that a health plan (or other payer) will cover and in what amount. EOBs are attached to processed claims and may also explain why a claim or portion of a claim has been denied.

Electronic Remittance Advice (ERA) – This is an electronic version of the EOB.

Fiscal Intermediary (FI) – An entity for a private company that has a contract with the Centers for Medicare and Medicaid Services (CMS) to determine and pay Medicare claims.

Medicare – A government-sponsored health insurance program that provides coverage to qualified individuals 65 and older as well as for some younger individuals with severe disabilities.

UB-04 (Institutional Claim)— This form is also referred to as **CMS-1450**. It is the claims form used by hospitals, nursing homes, and some home health agencies to submit billing. It is similar

in format to CMS-1500 and is one of the most common claim forms.

Health Plan Claims

Traditional Insurance and Health Plans

In traditional indemnity health insurance, the provider sends a bill to the insurer for the services delivered (or less commonly the insured pays the provider themselves and then sends a claim, often referred to as **claims form**, to the insurer with the provider's bill attached as documentation).
The insurer processes the claim to determine if payment is in fact due and if so pays the provider or insured.

Further explanation of the term claims form:

A claim form is a document that gives necessary information about a patient, treating provider, and coded treatment, including charges. It is filed for payment of benefits by the patient's health plan. [i]

Encounter Reports

In a health plan, the claims function varies by plan type and provider compensation arrangement. In some cases, a plan such as an HMO does not receive claims requesting payment for services rendered because providers are prepaid for delivering those services to members by means of a capitation payment, or because they are paid a salary. Instead, the plan receives **encounter reports**. An **encounter** is a visit by a plan member to a provider of healthcare or related services. An encounter report includes the services provided, the date of service, the diagnosis, and other information. A health plan uses encounter reports to track utilization and provider practice patterns and as a basis for future capitation amounts.

Fee-for-Service

However, most healthcare professionals are compensated by health plans on a discounted fee-for-service (FFS) basis or a combination of FFS and capitation, and hospitals are typically paid their regular charges minus a percentage discount, case rates, or fixed rates for specific procedures. In these cases, claims are submitted, and health plan claims processing is very similar to that of traditional insurance.

The Claims Lifecycle

Every claim goes through a progressive cycle from the date the claim is reported until the date the claim is closed. This is sometimes referred to as the claims lifecycle.

1. **Front Office** – This icon represents the office of the provider (a doctor). This is where the claim is initiated for a patient.

2. **Eligibility Verification** – The eligibility verification is performed at the provider's location. This includes checking as to whether a patient is a member of a certain plan, coverage information, type of coverage, as well as information about a patient's deductible and copayment.

3. **Services & Clinical Documentation** – The provider or the provider's support team (staff) documents the services or procedures performed for a patient.

4. **Coding** – The provider or the provider's support team provides the necessary coding for the services or procedures performed for a patient.

5. **Charge Entry** – This is the details of the bill and claim that are typically entered by the provider's staff.

6. **Claim Generation** – The claim is generated electronically or in some cases on paper once the provider's staff enters all details.

7. **Transmission** – The claim is then transmitted to the health plan for processing.

8. **Claim Processing** – This begins when the claim arrives at the health plan. The health plan performs a second eligibility verification and further processes the claim.

9. **Claims Adjudication** – The health plan performs a set of checks and verifications. These include whether the medical codes match the described procedure. If there is any mismatch of information, flags will be raised calling for further investigation. Following the adjudication process, the claim is what may simply be described as either a positive or negative sign. If it is positive, the claim can be paid. If it is negative, manual intervention is often required to re-examine the information to determine what aspect needs to be clarified (or is blatantly wrong -which may occur in the case of fraud), and make a decision whether payment is to be made or denied.

10. **Claims Payment** – Payment is made against the claim and an Explanation of Benefits (EOB) and Explanation of Payment (EOP) are generated and sent respectively to the patient and provider.

11. **Payment Analysis** (Over/Under) – An overpayment is any amount the provider receives in excess of the amount properly payable for the services rendered. Conversely, an underpayment occurs when the provider is paid less than the actual bill amount.

Click here for further information on reasons for overpayments.

Overpayments – Possible causes of overpayments include:

- Two health plans pay as a primary payer due to lack of coordination of benefits (COB).
- The provider bills incorrectly or in excess of actual valid charges.

- Duplicate submission of the same claims resulting in a double payment.

Once it is determined by a provider that an overpayment has occurred a refund process should be initiated. This includes the following actions:

1. The provider sends a letter to the health plan that an overpayment has occurred.

2. The health plan sends instructions to the provider as to how the matter should be handled. Some health plans prefer to recoup the overpayment through offsets of future remittances.

If an overpayment is received from Medicare or Medicaid, the process may vary from those that pertain with commercial plans.

In instances where it is the health plan that discovers its overpayment, in most cases it will contact the provider and request a refund. As part of this outreach, it will also provide instructions.

12. **AR Calling** – This icon represents calls made by a provider's Accounts Receivable (AR) department.

13. **Claims Compilation** – This represents compilation of all claims submitted to a health plan.

14. **Health Economics** – This depicts the analytics performed at a health plan to determine profit or loss and other metrics relevant to claims. For example, the number of claims processed. For further example, the number of claims adjudicated.

Click here for further information on reasons for underpayments.

Underpayments – The majority of underpayments stem from four (4) main causes:

1. Providers bill incorrectly and/or they do not provide the appropriate clinical documentation for the services provided.

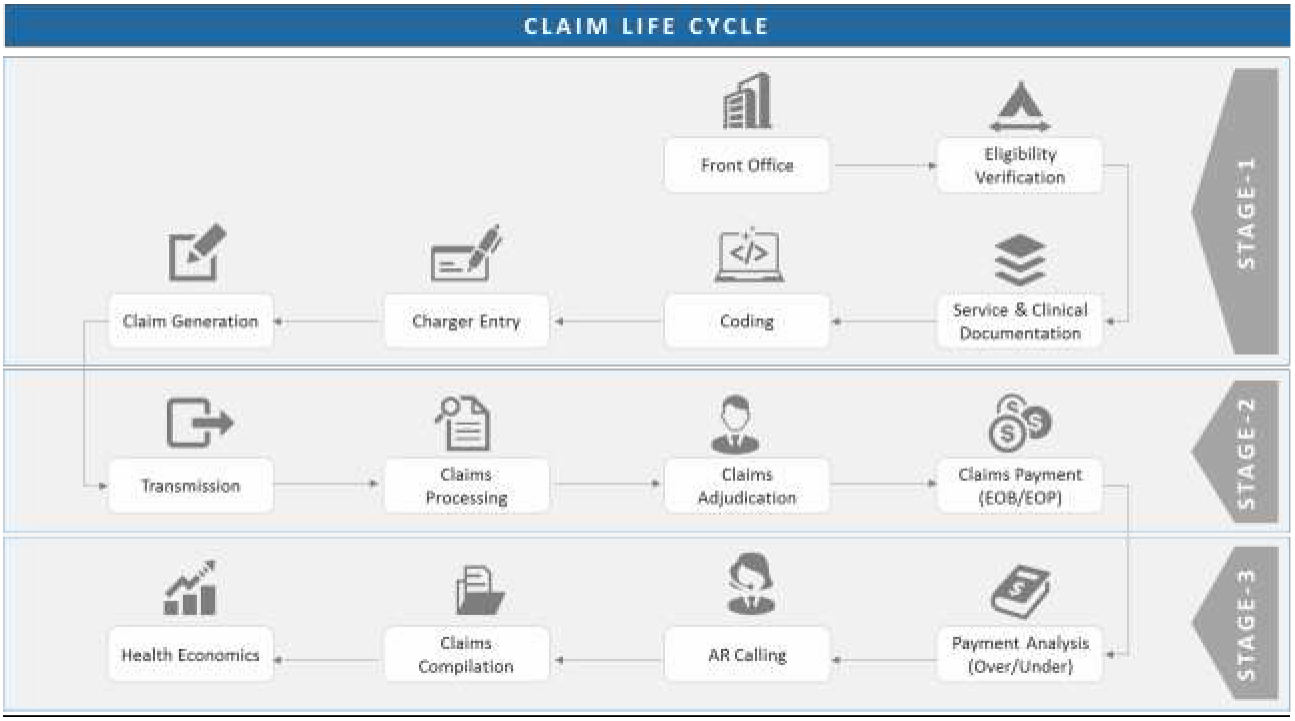
2. Payers pricing claims using incorrect contract terms.

3. Payers calculating the allowed amount incorrectly and providers not immediately identifying the incorrect payment.

4. Contract terms interpreted in different ways by the payer and the provider.

A fifth reason for underpayments, cited by providers is misinterpretation of data by artificial intelligence systems used to process claims. [ii]

The Claims Lifecycle



Technology

Optical Character Recognition

In the past health plan claims were mostly paper documents received by mail and reviewed and adjudicated by plan employees. Today, typically between 80 and 90 percent of a plan's claims are processed by automated, computerized systems, sometimes more. Providers generally transmit claims to a plan by electronic data interchange (EDI) (discussed in the preceding lesson). When paper claims are received, the data is entered into the electronic system so that they can be automatically processed. Increasingly, **optical character recognition (OCR)** technology is used to convert printed or even handwritten text into electronic files.

Auto- Adjudication

Electronic claims processing systems perform routine and simple tasks, such as verifying that an individual is a plan member or that a doctor is a network provider. And most health plans also use such systems to make decisions that require more in-depth analysis. A database containing member profiles, member benefit packages, provider profiles, provider compensation arrangements, and other information is either integrated with or part of an expert software system enabling the claims system to make higher-level claims decisions. Such a system

attempts to replicate the process an expert claims examiner uses to solve a problem to arrive at the same decision that the expert would. This process is commonly called **auto-adjudication**.

HIPAA and Claims

Federal legislation promotes the electronic transmission of claims and the automation of claims processing. Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standardize electronic claims submission and payment while safeguarding the privacy and security of individuals' health information. The Affordable Care Act contains provisions to encourage the implementation of electronic medical records and processes throughout the healthcare system. [iii]

Personnel

Of course, computers cannot do everything and cannot run themselves—many health plan employees are involved in processing claims. A claims administration department includes the following personnel:

- Data Entry Clerk
- Claims Examiners
- Processors
- Reviewers
- Analysts
- Adjudicators
- Claims Adjusters
- Specialist
- Supervisors and Managers

Data Entry Clerk

Data entry clerks key in information from paper documents, and other employees convert documents into electronic data in other ways (such as scanning and OCR). This function is often outsourced.

Other Employees

Other employees are variously called **claims examiners, processors, reviewers, analysts, or adjudicators**. Their exact duties may vary by title or plan, but essentially, they review and adjudicate claims that are not electronically processed for some reason, typically because they present some complication or there is an inconsistency in the data or other problem.

Claims Adjustors

Claims adjustors deal with claims that have been paid incorrectly. For instance, if an insufficient amount is paid and the provider protests, the adjustor reviews the case and ensures that the correct amount is paid.

Specialists

Specialists of various sorts handle complicated cases and address such matters as quality control, regulatory compliance, coordination of benefits, and medical management.

Supervisors and Managers

Supervisors and managers oversee the work of claims examiners, other employees, and automated systems. They may also handle complex and large-amount claims.

Explaining the payment or denial of a claim to a provider or member is typically handled by the member services department (discussed in the next lesson), not claims, although of course the two departments must work closely together.

Claims Administration Department

A claims administration department may be organized by plan type (HMO, PPO, etc.), service type (hospital, physician, etc.), in-network and out-of-network care, or employer group (especially for large groups). Some health plans (such as those sponsored by large self-funded employers) contract with insurance companies or third-party administrators to process certain types of claims, such as routine claims, out-of-network claims, or claims for specialty services such as radiology, behavioral health, and pharmacy.

Information

A claims administration department both takes in a great deal of information and supplies information to other plan departments. For a claims database the following types of information are needed:

- information on members and their covered dependents, including date of birth, gender, and PCP;
- information on providers, including the national provider identifier (NPI), network or non-network status, and any restrictions on the types of services a provider can perform for the plan;
- general information on provider compensation (such as fee schedules) and the specific compensation arrangement the plan has with each provider (including risk-pooling, discounts, etc.); and
- requirements for members, including cost-sharing (deductibles, copayments, and coinsurance) and authorization and referral requirements.

The information that is needed is also affected by compensation methods. If a provider is paid by capitation or salary, only encounter reports with a relatively limited amount of information is required. On the other hand, if a provider is compensated by fee-for-service, a fee schedule, a discount off charges, or similar methods, full claim information is needed. Typically, a plan's claims processing system must be able to handle both types of arrangements. For example, in an HMO a PCP may be paid by capitation but a specialist by discounted FFS.

Source of Information

The claims department is also a source of information for the plan. Data obtained in the claims process is transmitted to and used by other departments, including member services, finance, information management, medical management, provider relations, contracting, and others. It may also be used for marketing purposes, but there are regulatory restrictions—a member must agree to this.

Periodic Reports

A claims department uses data to generate a variety of periodic reports to help it manage its own productivity and quality. These include the percentage of claims processed within a certain timeframe, such as 30 days; the percentage auto-adjudicated; the percentage rejected or denied; and the percentage adjusted and/or appealed.

Key Elements of Claim Processing

Standard Claim Forms

Most health plans have done away with their own claims forms and require the use of these nationally standardized forms:

- UB-04 (Institutional Claim)
- CMS-1500 (Professional Claim)
- ADA Dental Form UB-04

(Institutional Claim)

This form is also referred to as **CMS-1450**. It is the claims form used by hospitals, nursing homes, some home health agencies to submit billing. The CMS-1450 form can be used when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. The form is also used for the billing of institutional charges to most Medicaid Agencies. [iv]

CMS-1500 (Professional Claim)

The CMS-1500, developed by the Centers for Medicare and Medicaid Services (CMS) is the standard claim form used by non-institutional professionals, such as physicians who qualify for a waiver from the requirement for electronic submission of claims. It is also used for the billing of some Medicaid State Agencies**. Form 837 P (Professional)** is the standard format used by health care professionals and suppliers, such as durable medical equipment companies, to transmit health care claims forms electronically. [v]

ADA Dental Form

The American Dental Association (ADA) claim form provides a common format for reporting dental services to a patient's dental plan. [vi]

Codes

To indicate in a claim a patient's medical condition and the service or treatment provided, claimants must use standard **diagnostic and treatment codes**. A code is a series of numbers and letters that corresponds to a specific diagnosis or treatment. These codes help simplify and standardize claims processing.

ICD-10

For diagnoses, the required code set is the International Classification of Diseases (ICD). As of October 1, 2015, for healthcare transactions covered by HIPAA (including most claims) the Tenth Revision of the ICD (ICD-10) code set is required. ICD-10 is the replacement for ICD-9, previously used for many years, the ICD-10 codes are copyrighted by the World Health Organization (WHO) which has authorized the development of an adoption of ICD-10 for use in the United States. [vii]

CPT

For treatments, the most frequently used code set is the **Physicians' Current Procedural Terminology (CPT®)**. This is a list of medical services and procedures performed by physicians, hospitals, and other healthcare providers, with a unique 5-digit code for each. CPT codes are maintained by the American Medical Association and are also referred to as Healthcare Common Procedure Coding System (HCPCS) Level 1 codes. [viii]

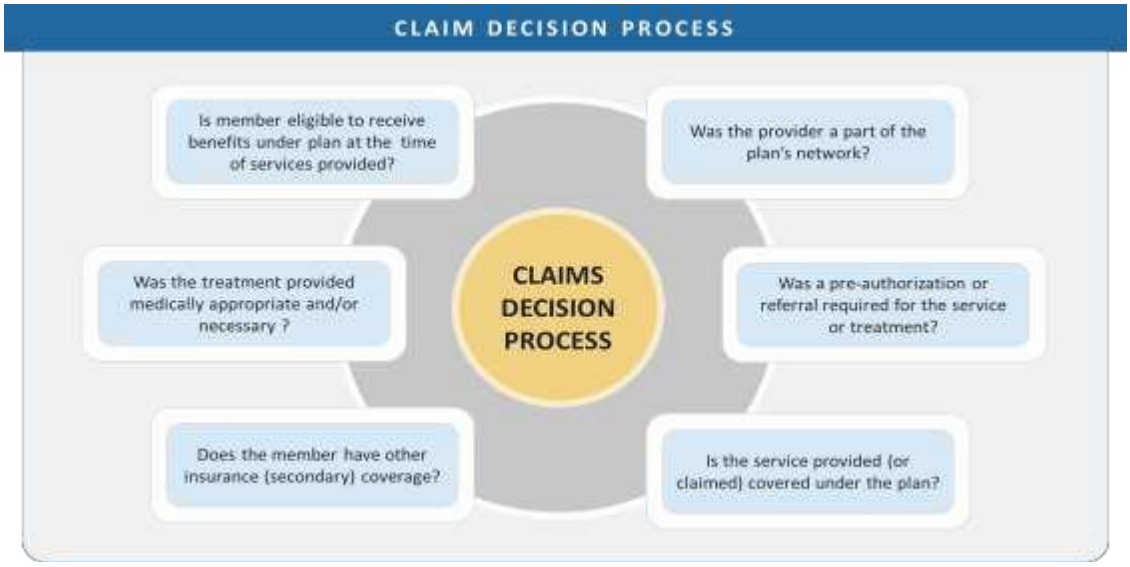
Edits

An electronic claims processing system, as well as the procedures followed by claims examiners, includes **edits**. These are criteria that, if unmet, result in a claim being "kicked out" of the process and "pended"—that is, the claim is not automatically processed, but instead payment is delayed while the claim is scrutinized and concerns addressed. For example, an electronic system generally includes an edit that identifies a claim in which the service provided is not generally associated with the diagnosis reported. Such a claim would be kicked out and reviewed to see if the service was in fact appropriate.

Adjudicating a Claim

Adjudicating a claim (determining whether it should be paid and if so how much) can be thought of as satisfying a number of questions about the claim. In this section we review the main questions.

Graphic depicting the claims decision process:



Member and Provider Status and Timely Billing

- The system must confirm that the person who received the services being billed was a member of the plan and eligible for benefits on the date the services were provided.
- It must be confirmed that the provider is enrolled in the plan's claims system. If not, the claim will be sent back to them with a request for information so that they can be enrolled.
- If a plan does not pay benefits for out-of-network care or pays a higher level of benefits for in-network care, it must be determined whether the provider is a network provider.
- Most plans require that a provider bill within a certain time (typically 90 to 180 days) after a service has been delivered. If a claim is submitted after that time, it is not generally paid, and the provider is not allowed to bill the member for the service. Therefore, it must be confirmed that the claim has been submitted within the required time after the service was delivered.

Edits relying on dates of service, member numbers, providers' NPIs, and other data are used to identify claims that do not satisfy the stated conditions and must be examined or denied.

The Healthcare Service

An automated claims system (or a claims examiner) must also ascertain whether the healthcare service provided to the member was a covered service under the member's benefit package, medically necessary and appropriate, authorized if required, and actually performed.

Uncovered Services

As we have seen, some healthcare services are not covered by a health plan. These might include experimental treatments outside a clinical trial as well as procedures not needed to

address an illness or injury (such as cosmetic surgery). Such uncovered services must be identified by the process and the claim denied.

Medical Necessity and Appropriateness

As we have learned in this course, health plans pay benefits only for healthcare services that are medically necessary and appropriate, and the claims process includes confirming that the services provided were in fact necessary and appropriate. This also promotes healthcare quality by ensuring that members receive the services that are most likely to result in positive outcomes. And it reduces a plan's medical malpractice liability—a plan can be liable for the negligent acts of its employees or medical staff and in some cases contracted providers, so it must take measures to ensure that the care they provide is appropriate.

Clinical Edits

Clinical edits flag claims for which additional medical information is needed, such as when diagnosis and treatment codes are missing, incomplete, or invalid. The claim is kicked out of the system, and the provider must resubmit it with complete and correct information. Edits are also triggered by conflicting information (a diagnosis code for tonsillitis and a treatment code for bursitis) or illogical responses or codes (a maternity service for a male). Such claims must be examined and clarified. Clinical edits are typically supplied by an external vendor whose software specializes in healthcare codes and is integrated with the health plan's claims system.

Authorization

As we have also learned, for some services (such as in-patient surgical procedures) most health plans have authorization or referral requirements that must be met for benefits to be payable. An electronic claims processing system is typically set up to recognize these services and look for a corresponding authorization in the plan's databases. If authorization is not found, the claim will be flagged and reviewed by a claims examiner.

If authorization was not obtained, the health plan is not obligated to pay for the service; more traditional plans may pay a reduced amount (typically 50 percent). In some plans the authorization for a particular case may stipulate how much will be paid.

Delivery

Obviously, if a service billed was not actually provided to a member, the plan will not pay, and fraud may even be involved. If information is insufficient to show that a service was in fact rendered, or if something indicates that the service may not have been rendered (such as a nonemergency service reported for a Saturday, or a physician billing for more visits on a certain date than would be reasonably possible during a working day), the claim must be examined and more information sought.

The Amount

The system (or claims examiner) calculates the amount to be paid for a claim based on numerous factors. These include the provider compensation arrangement that applies (fee schedule, discount off charges, etc); any cost-sharing owed by the member (deductible,

copayment, or coinsurance, including differences for network and non-network care); any payment instructions stipulated by an authorization; and other considerations.

It must also be ascertained whether a member is covered under another health plan, and if so, whether coordination of benefits applies. Recall that coordination of benefits provisions are designed to prevent a person covered under more than one health plan from receiving more in benefits than their actual expenses and to ensure that each plan pays the correct amount.

Summarizing the Process

The process by which a claim is adjudicated can be seen as satisfactorily answering a series of questions:

- Was the individual who received healthcare services a member of the plan and eligible for benefits when the services were provided?
- Is the provider enrolled in the plan's claims system? Is the provider in the plan's network?
- Has the claim been submitted in a timely manner?
- Is the service covered?
- Was the service medically necessary and appropriate?
- Was an authorization or referral required for the service, and if so, was it obtained?
- Was the service actually provided?
- What benefits are payable?
- Does the member have any other health insurance coverage?

Claim Investigations

If a claim lacks important information, a plan may simply deny it, and the provider must modify and resubmit it. In other cases, if a claim triggers an edit, or if a claims examiner has reason to question the claim, there may be a **claim investigation**—the plan seeks further information before making a decision. Usually this involves only short, simple searches or requests, such as checking a medical record or calling a doctor's office. Such basic investigations are typically handled by claims examiners by phone, e-mail, or mail or database search.

Extensive Claim Investigations

However, a few claims require extensive investigation. A good deal of information may be needed, or information may not be easy to obtain. An interview or extensive communications with a provider or member may be necessary. Expertise may be required, such as from the plan's medical staff. A claims specialist or supervisor may take over the claim.

Special Investigative Unit

Sometimes fraud is suspected.[ix] Such cases are turned over to a plan's special investigative unit (SIU), staffed by people trained and experienced in fraudulent schemes and how they can be detected and dealt with. If fraud is in fact detected, an SIU may work with the plan's legal department or law enforcement agencies.

NAIC Unfair Claims Settlement Practices Act

As previously mentioned, HIPAA promotes the electronic transmission of health plan claims in a standardized format. HIPAA also protects the privacy and security of members' health information while allowing health plans to conduct investigations. In addition, the **NAIC Unfair Claims Settlement Practices Act**, adopted in whole or in part by many states, sets standards for the handling and investigation of insurance claims. The Act lists certain insurer or health plan actions and defines them as unfair claims practices, and if a plan commits these actions so frequently that they can be considered to constitute a general business practice, the plan is in violation of the Act.

NAIC Standards

A health plan may not conceal from a claimant information relevant to a claim. A plan must promptly acknowledge receipt of a claim and communications related to the claim. It cannot delay paying a claim by asking for redundant or unnecessary information and documentation. It must generally process a clean claim (one that does not require the plan to seek additional information) within 30 days of receipt. It must have reasonable cause to delay adjudication of a claim, to conduct an investigation, and an investigation must be finished in 30 days unless it cannot be reasonably completed in that time. [x] [xi]

Conclusion

Prompt and accurate processing of claims is a key driver of member satisfaction with a health plan, and it is also critical to maintaining good working relationships with providers. Therefore, a successful health plan will select and train its claims personnel and manage its claims department with an eye to providing top-notch service.

Notes:

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[iv] CMS Institutional Paper Claim Form Fact Sheet, available at

https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/15_1450.html

[v] Medicare Billing: 837P and Form CMS-1500, Fact Sheet, available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf; See also Health Claim Form, available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1500.pdf

[vi] ADA Dental Claim Form (Sample), available at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/2019adadentalclaim-form_2019may.pdf

[vii] International Classification of Diseases, Tenth Revision Clinical Modification, Centers for Disease Control and Prevention (CDC) Fact Sheet, available at https://www.cdc.gov/nchs/icd/icd10cm.htm

[viii] Peggy Dotson, CPT® Codes: What Are They, Why Are They Necessary, and How Are They Developed?, Advances in Wound Care, 2013, Dec; 2 (10) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865623/

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[xi] Unfair Life, Accident, and Health Claims Settlement Practices Module Regulation, available at http://www.naic.org/store/free/MDL-903.pdf

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Shubham Singhal, Penelope Dash, MD, Tobias Schneider, MD, Sameer Chowdhary, and Himanshu Aggarwal, For Better Healthcare Claims Management Think "Digital First," McKinsey & Company, June 2019, available at https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/for-better-healthcare-claims-management-think-digital-first

21 Member Services

Learning Objectives

After completing this lesson, you will be able to:

- name and describe the four main categories of health plan member services
- discuss how health plans manage accessibility, personnel, processes, technology, and performance for member services
- describe several ways in which health plans use technology to facilitate the delivery of member services and enhance member engagement

Learning Objectives (Continued)

In this lesson, we first describe the types of activities that are included in health plan member services and how they are conducted.

We then look at how plans manage various aspects of member services to enhance both quality and cost-effectiveness. In both cases, we learn how technology is used to support a plan's activities and further enhance member engagement.

Member Services

Member Services

Member services consist of a broad range of activities that a health plan and its employees engage in to support the delivery of benefits to its members and to keep them satisfied with the plan.

Member services typically involve a mix of inbound member contacts (member-initiated requests for information, transactions, services, and assistance with problems) and outbound member contacts (those initiated by the plan). Meeting members' ongoing service needs in an effective and efficient manner presents a variety of challenges for a health plan.

Member Services Activities

Member services activities generally fall into four main categories:

- member education
- assistance with questions, transactions, and requests
- complaint management
- measurement and reporting of member satisfaction

Member Education

Member Education

Many of the problems that health plan members experience with their coverage arise because they do not understand the plan's benefits or the requirements for accessing them. The education of members about benefits, cost-sharing, and authorization before they need services can reduce member confusion, leading to fewer telephone calls and greater satisfaction when members actually use services.

Example: Proactive education about a plan's requirements for authorization of payment can reduce disputes about claims. Many plans also proactively provide members with information about preventive care and other health issues, which can enhance member satisfaction and reduce members' needs for healthcare services.

Member Outreach Programs

Proactive education programs are often referred to as **member outreach programs**. Outreach programs may focus on administrative information, health information, or both.

In many instances, these programs provide general information for the entire plan membership.

Typically, members receive information about the plan when they enroll, and information about new programs, plan changes, and health issues is distributed periodically.

Generally Distributed Information by Health Plans

Types of information that health plans generally distribute to all members include the following:

- services covered and excluded for different types of care (physician, hospital, emergency, ancillary, drugs, etc.)
- member responsibilities (paying copayments, deductibles, or coinsurance and obtaining referrals and authorization of payment when required)
- services requiring authorization and guidelines for obtaining it
- network providers, their locations and credentials
- differences in benefit levels for in-network and out-of-network care
- the drug formulary
- available programs and services (such as screenings, disease management, and telephone triage lines)
- general health information (on nutrition, exercise, safety, smoking cessation, common illnesses, and disease prevention)

Identifying Common Characteristics

A health plan may also identify groups of members with a common characteristic, such as age, gender, or a chronic illness, and send them relevant health-related information.

Example: A plan might send information on mammogram and Pap test screenings to all adult female members, or information on diabetes management to members with that illness.

Other ways a health plan may reach out to plan members:

Health plans may reach out to those suffering from chronic illnesses, such as heart disease or diabetes, to provide them with information about their disease, healthy lifestyle choices in living with the chronic disease from which they suffer, and to reinforce their participation in treatment plan(s) and medication adherence. Such outreach efforts can lead to increased member engagement and satisfaction with their health plans).

Distributing Information

Traditionally, health plans have used mass mailings of letters and newsletters to distribute information to members. But today, except when there is a regulatory requirement to notify members by mail of a change, plans more often use websites and email.

The Use of Websites and Emails

A website can provide the types of information previously listed, as well as answers to frequently asked questions, links to other health websites, and information on healthcare services available in the community. It should be noted however, that shifting priorities, such as the response to COVID-19, have stalled moves by insurers to digital transformation. [i]

The Target Audience

The target audience affects the way educational information should be presented. For instance, members with vision or hearing impairments must be accommodated, Medicare members may need large print, and languages other than English may be required.

Accessibility guidelines for websites and online communication should be followed as well as state requirements for communications for government program members. Finally, educational materials must clearly communicate the information in a way that the typical member can understand.

For this reason, health plans often conduct marketing research tests (such as focus groups) on their educational tools before finalizing them and making them available to members.

Assistance with Questions, Transactions, and Requests: Overview

Health plans must also answer members' questions about administrative, coverage, access, and health issues; assist them with transactions; and respond to other service requests. Some examples of typical member questions and requests are listed in the box.

Typical member questions and requests:

Some Typical Member Questions and Requests

Administrative issues:

- The information on my identification card is out of date, and I need a new one.
- Where to find a current provider directory.
- My PCP has moved out of the area, so I need to pick a new one.
- What is the mailing address for submitting a claim?
- I am unable to access my member portal, can you help?

Coverage:

- What benefits do I have for chiropractic treatment?
- Does the plan pay for prescriptions from out-of-network providers?
- What portion of the bill will I have to pay for my stay in the hospital when I have surgery?
- My doctor says I need eyeglasses. Are they covered?

Access:

- How do I get authorization for the echocardiogram my cardiologist ordered?
- Do I need a referral to see a dermatologist?
- How long does it take the plan to process a request for authorization of payment after a provider has recommended a procedure?
- What are my options if the plan does not authorize payment for a service recommended by my doctor?

Health plan programs:

- Who can I call if I'm not sure what kind of care I need?
- Does the plan have any programs for expectant mothers?

- I want information to help me manage my asthma better.
- What types of preventive care or self-care programs does the plan offer?
- How do I participate in a diabetes management program? Is this covered under my plan?

There are a number of means by which health plans can respond to members. Regardless of the communication medium, all inbound and outbound contacts should be tracked to ensure that any follow-up activities are completed and member needs are met.

Telephone Systems

Plans generally have toll-free telephone numbers for members to call. A plan may make available the numbers of different departments so that members can directly dial the one they need, or it may have one central number and route calls by means of **computer/telephony integration (CTI)**, a technology that unites a computer system and a telephone system. [ii]

Two Forms of CTI

Two forms of CTI commonly used by health plans are automatic call distributors (ACDs) and interactive voice response (IVR).

Automatic Call Distributor

An **automatic call distributor (ACD)** answers calls with a recorded message and then routes them to the appropriate unit based on information that the caller enters on the telephone keypad (such as his member identification number) or his phone number.

If no representative in the appropriate unit is available, the ACD places the call in a queue to be answered when a representative becomes available. ACDs prevent callers from receiving a busy signal during times of high call volume and expedite their connection to an appropriate representative. [iii]

Interactive Voice Response

An **interactive voice response (IVR)** system answers calls with recorded or synthesized speech and prompts the caller to respond to a menu of options by entering information through their keypad or speaking.

Each response takes the caller to the next appropriate menu until they receive the desired information, hang up, or speak to a representative.

Benefits of an Interactive Voice Response

An IVR system can handle many of the questions and requests that in the past required speaking with a member services representative.

Some IVR systems even allow self-service for certain transactions. For example, a series of IVR menus might direct the member through the process required to choose a new PCP, or check the status of a claim.

Another advantage of IVR is that it can handle many calls simultaneously. Members benefit from IVR because it enables them to obtain information at times when member services representatives are not available.

IVR can also serve as a tool for improving care. It can be used as part of a chronic disease management program, a tool to support medication adherence, as well as the care of special needs populations. [iv]

Mail and Fax

Letters and other paper documents sent through the mail still account for much of a health plan's inbound and outbound contact with members.

The mail is typically used to deliver important notifications (such as formulary updates and changes in authorization requirements); to respond to complaints or appeals; and to handle many routine transactions (such as premium payments, address changes, claims processing, and explanations of benefits).

The extent to which mail systems are automated varies among plans. In some cases, a plan may accept documents from members by fax.

Email

Email is an important means of communicating with members. A plan needs an internal tool that allows categorization and tracking of messages and a knowledge base that can be used to answer the most frequent questions.

Member service representatives need training in proper procedures. HIPAA requirements for protecting patient information (discussed elsewhere in this course) apply, and secure messaging or email encryption may be required.

Online

Many health plan websites enable members to access their accounts by entering a company-issued user ID or password and conduct certain transactions, such as changing their address, adding new family members to coverage, selecting a new PCP, obtaining forms, or filing claims.

People are increasingly accessing the Internet through mobile devices instead of desktop computers, and health plans need to address this change. Already, applications such as provider searches and prescription information are in use, and many more will no doubt become available.

Online Technical Support

A health plan may want to consider providing technical support for members having difficulty using its website, including co-browsing, where the member services representative shares the view of the member's screen in order to assist him.

A website may also allow a member to communicate with a member services representative by means of online chat. With a click-to-callback feature, a member can request a call from a service representative, either immediately or at a scheduled time.

Contact Centers

Health plans are increasingly moving toward the use of dedicated contact centers to provide their members with efficient services.

What is a contact center?

It is a central point from which all customer contacts are managed. Contact centers are also referred to as customer interaction centers or e-contact centers. They offer omnichannel customer support, including e-mail, online chat, voice-over IP (VoIP), and website support. Contact centers are used for both inbound and outbound communications.

Contact Center Infrastructure

The contact center infrastructure that is necessary to support communications may be located on the same premises as the contact center or the infrastructure may be located externally.

When the contact center is located on-premises, the same company that owns the contract center is also responsible for the management of its hardware and software. This requires staffing and technology investments that some contact centers choose to forgo by outsourcing these tasks to cloud providers or hosting companies.

More about cloud-based contact centers:

Cloud-based contact centers are hosted on a cloud provider's Internet server(s) and are the point from which all inbound and outbound communications filter. Cloud-based contact centers are accessible anywhere via the Internet and function the same as other contact centers. [v] [vi]

More about hosted contact centers:

Hosted contact centers are centers where the contact center infrastructure is outsourced to another company that maintains the IT systems externally. This offers the opportunity of a higher return on investment (ROI) for companies by minimizing upfront costs and maintenance of contract center infrastructure.

Some health plans and providers may consider a third variation of the contact center – one that is virtual. Virtual contact centers enable customer service representatives to work remotely from home or elsewhere providing the representatives with flexibility while offering the heath plan or provider the opportunity to lower costs.

Complaint Management

Complaint Management: Overview

Despite a health plan's best efforts, some members will disagree with certain actions or decisions taken by the plan or its providers.

Such disagreements often result in members' complaints about plan coverage, access to services, medical services received, nonclinical service from providers or their staff, or service from a health plan department.

Many complaints stem from the authorization process and decisions.

Examples of Member Complaints

Complaints about the plan:

- The person I talked to in claims was rude and wouldn't answer my question.
- The doctor told me I need to start physical therapy as soon as possible, but the plan hasn't authorized payment yet.
- The plan's procedures for getting authorization for payment are too complicated and confusing.
- I have to select a PCP, but none of the network PCPs near me is accepting new patients.

Complaints about providers:

- When I call for an appointment with a rheumatologist, the earliest time available for a new patient is two months away.
- The doctor was in a big rush and did not explain my problem in a way I could understand.
- My PCP does not return my phone calls.
- On my last visit to my doctor, I had to wait over an hour before I was seen.
- My PCP's office is too far away from my home, and there's never any parking available nearby.

- I don't think my doctor prescribed the right treatment for my illness.
- My PCP's office lost the results of the blood tests they did during my last visit.
- The hospital you sent me to didn't have the right equipment to treat my condition.

Adequately Addressing Member Complaints

There are a number of reasons health plans must adequately address member complaints.

First, there are generally regulatory requirements governing the resolution of complaints that health plans must comply with. Also, unresolved complaints lead to member dissatisfaction and can result in negative publicity—especially today with the popularity of social media and websites in which consumers comment on and rate businesses.

Finally, unresolved complaints may evolve into appeals, requiring more time and resources. For all these reasons, even if a complaint is considered to be unjustified, the member's perception that he has not been treated correctly needs to be addressed.

Complaint Resolution Procedures

Health plans establish **complaint resolution procedures (CRPs)** to address informal complaints, such as those made by phone or in a letter, as well as formal appeals, which occur when an informal complaint is not resolved to a member's satisfaction.

CRPs: State and Federal Laws

Many states have laws regarding CRPs; these vary from state to state, but they typically require plans to inform all members about procedures for complaints, track and report complaints, respond to complaints within a certain time, and give members the option of an independent external review when internal reviews are exhausted. [vii]

At the federal level, employer-sponsored health plans must meet the appeal requirements of the Employee Retirement Income Security Act (ERISA), and the Affordable Care Act (healthcare reform) also includes rules in this area. [viii]

Accrediting Agency Standards

Finally, accrediting agencies have standards for handling member complaints and appeals, which address documentation and investigation of complaints, notification of members about rights to appeal, qualifications of persons who review appeals, timeframes for appeals, notification of involved parties about appeal decisions, and members' rights to independent external review.

The Appeal Process

In a formal appeal, a dispute is reviewed and resolved by a party other than the person who made the initial decision or performed the service that led to the complaint.

The appeal process follows established procedures and typically includes at least two levels.

Level One Appeal

In a **level one appeal**, a medical director or other officer of the health plan reviews the original decision and any additional supporting information submitted by the complaining member and either upholds or overturns the decision.

If the decision is upheld, the member has the right to go to the next level.

Level Two Appeals

Level two appeals are generally handled by a health plan appeals committee, typically consisting of representatives of various areas within the plan, such as utilization review, member services, health plan operations, and legal affairs (and sometimes plan members).

If the appeal involves a medical issue, the committee includes a physician. The committee reviews all of the relevant documentation on the complaint and the previous appeal and collects new information as necessary before upholding or overturning the decision.

Alternative Appeal Processes

A health plan's CRPs specify maximum timeframes for conducting each level of appeal. There are also procedures for expedited appeals when following the standard time limits which may endanger the member's health.

Many states require an expedited appeal process for pre-authorization denials based on the plan's decision that the treatment is not medically necessary or experimental.

After she has exhausted a health plan's internal appeal process, a member may be able to pursue other avenues such as:

- Mediation or arbitration
- Government agencies
- Independent external Review

Mediation or Arbitration

Mediation or arbitration. In mediation an impartial person experienced in dispute resolution works with the member and the plan to help them come to an agreement acceptable to both. Arbitration is similar, but the mediator's decision is final and binding on both parties.

Government Agencies

Government agencies. Laws vary by state, but a member may be able to appeal to the state insurance or health department.

Members of a plan under the Federal Employees Health Benefits (FEHB) program can appeal to the federal Office of Personnel Management (OPM), and Medicare beneficiaries can appeal to the Centers for Medicare and Medicaid Services.

Independent External Review

Independent external review is conducted by a third party that is not affiliated with the health plan or a providers' association and has no conflict of interest or stake in the outcome of the review, often an **independent review organization (IRO)**, a company specializing in this area. It may involve mediation or a binding decision. Some states require that members have the option of an independent external review after they have exhausted the internal appeals process. [ix]

Measurement and Reporting of Member Satisfaction

Member Satisfaction Measurement and Reporting

Member satisfaction is, of course, critical to a health plan's success and survival. If a plan cannot maintain high levels of overall satisfaction and improve areas that members find unsatisfactory, members are likely to disenroll.

Member satisfaction is also important for maintaining the plan's positive image in publications that rate the performance of health plans and in the general media. It is also important financially to plans, such as those participating in the Medicare Advantage marketplace. [x]

Measurement of Member Satisfaction

Measurements of member satisfaction help a plan understand which of its services work well and which need improvement. These measurements are compared to plan, industry, and external standards and are tracked over time to identify trends.

Generally, a health plan considers its members' satisfaction with the following:

- the plan as a whole
- access to healthcare services (both the availability of providers and referral and authorization rules)
- the quality of healthcare
- the quality of nonclinical services (from both the plan and its providers)
- the plan's administration (member services, claims, billing, and authorization systems)

The two primary ways of measuring member satisfaction are member satisfaction surveys and complaint monitoring.

Member Satisfaction Surveys

Member satisfaction surveys can be conducted by phone, mail, or e-mail, or online. There are several types.

- Plans often survey members at a specified interval following contact with a provider. For example, a plan might contact members who recently had procedures performed at a hospital and ask these sorts of questions: How understandable was the authorization process? Was it conducted in a timely manner? Did any problems occur? How satisfactory was the medical care received? How about the nonclinical services? How clean and well-equipped were the facilities? What could the health plan or the hospital staff have done to make your experience better?

- Plans periodically survey a sample of the entire member population. This is done to measure the satisfaction of all members, not just those who have received healthcare services recently. Members who rarely need care cost the plan little, so it is important to ensure that they are happy and will remain members.

- A plan may also survey former members to determine why they left and get their input about the plan's benefits, medical care, and costs.

- Ongoing feedback mechanisms and online surveys are also conducted to determine the effectiveness of a plan's website and other online communication channels such as email, mobile, and chat.

Who Conducts Member Satisfaction Surveys?

Member satisfaction surveys may be conducted by member services employees or outside companies. [xi]Some accreditation programs and purchasers require health plans to use third parties for this.

The best-known third-party member satisfaction survey is the CAHPS survey mentioned in the lesson on quality standards.

CAHPS Survey

The core questions of the CAHPS survey cover specific aspects of customer service and overall measures of consumer experience with the plan. The CAHPS system provides questionnaires, directions for conducting surveys and reporting results, and sample formats for reports of results.

The CAHPS surveys also asks members to report on their experiences with a range of healthcare services at multiple levels of the delivery system. For example, out-patient care at physician offices as well as in-patient care at hospitals. [xii]

Complaints Monitoring

Member services personnel document, track, and report member complaints.

Complaints are categorized by type (enabling the plan to determine how widespread a problem is) and by the plan department or provider involved (to identify the source of a problem).

Periodic reports are generated, which managers can use to identify problems, assess their extent and seriousness, investigate and resolve them, and track them over time.

How Are Complaints Used?

Complaints often lead not only to improving unsatisfactory performance by plan and provider personnel, but also to changes in a plan's services and procedures.

Example: If a plan receives numerous complaints that its authorizations procedures are confusing, it might rewrite the information it gives members about these procedures to make them clearer, or it might even change the procedures themselves to make them simpler and easier to follow. Likewise, in response to member feedback a plan might add benefits or programs, such as coverage of alternative treatments such as acupuncture or massage therapy or a mail-order drug program.

Managing Member Services

Structure

Some health plans have a dedicated member services department, but in others the personnel of several departments (such as claims, enrollment, and account management) provide function-specific services directly to members.

Plans with defined networks, authorization systems, and a variety of programs to manage quality and utilization (such as HMOs and POS plans) typically have a separate member services department because they receive a large volume of inquiries and service requests from members. Plans with fewer network and medical management programs (such as PPOs) often handle member services through multiple departments. However, large and medium-sized plans of any type may find that the volume of their members' service needs justifies having a dedicated member services unit.

Product-Specific Units

Some health plans with separate member services departments have within them specialized units that focus on specific products, such as a company's HMO or PPO product or its Medicare or Medicaid plan.

Some plans have specialized units for particular accounts, such as large employers or government purchasers. This approach allows member services representatives to develop expertise about a manageable number of products or customer groups, enabling them to be more responsive to a population's needs and to serve it more effectively and efficiently.

Specialized Communication Units

A plan may also divide its member services representatives into work groups that specialize in different means of communication, such as telephone, mail, email, or website. Or they may be divided by function, such as claims or authorization. However, it is not uncommon for all member services representatives to handle many types of needs through different communication channels.

Goals

The shift to a consumer centric healthcare marketplace makes customer service particularly important in both attracting and retaining members. Health plans want their employees to demonstrate the following attributes in interacting with members:

- **Competence**—providing information, answering questions, completing transactions, and resolving problems accurately and in a timely manner.

- **Strong communication skills**—being articulate, listening effectively for expressed and unexpressed needs, and posing questions and responding to members clearly and relevantly.

- **Time management skills** – the ability to prioritize among tasks and deliver information in an efficient manner.

- **Professional demeanor**—being friendly, respectful, courteous, and willing to meet the needs of the individual members, even when those members are upset or angry.

- **Empathy**—being able to understand the member's emotional state and see the situation from their perspective. Empathy and compassion are important because employees often have contact with members who are in emotional crises because their own illness or the illness of a family member.

Health plans also have to consider cost when designing and delivering member services. We will now discuss how a health plan must manage accessibility, personnel, processes, technology, and performance to achieve both quality and cost-effectiveness goals.

Accessibility

Accessibility is the ease and convenience with which members can obtain services. It depends on the communication channels offered (telephone, mail, e-mail, and website), the hours of operation for each channel, and staffing levels.

Channel Accessibility

Ideally, a health plan would make all channels available 24 hours a day, seven days a week, 365 days a year to maximize convenience.

For channels that require the participation of employees, this is usually not cost-effective. More commonly, member services representatives are available only during the plan's standard business hours, or sometimes an hour or two before and after standard hours and for limited hours during the weekend.

During off-hours, self-service channels such as IVR or websites are available, and while they do not offer the full range of services, they are providing more and more information and transactions.

Channel Accessibility (Continued)

For communication channels that involve employees, accessibility is affected by staffing levels. The more employees available, the shorter the delay, such as telephone hold time, before a member receives a response.

Health plans strive to staff member services at a level that achieves adequate service without leaving employees frequently idle, based on the usual volume of member contacts for different days and times.

Member Services Representatives- Roles and Responsibilities

How many member services representatives are needed to achieve an adequate level of service for a certain volume of contacts?

This depends on representatives' responsibilities, the nature of the plan, and the availability of self-service options and members' willingness to use them. A broad scope of responsibilities, an active outreach program, a complex benefit structure, and complicated authorization requirements can increase the number of staff needed. The effective use of computer and telephone technology improves the productivity and effectiveness of representatives, thereby reducing staffing needs.

More on steps plans are taking to manage accessibility:

Health plans are taking the following steps to provide and manage member service accessibility:

- Increased use of multiple channels of communication such as e-mail, online chat boxes and chatbots [xiii]
- A focus on preventing calls through better member education and increasing the amount of information that can be found online.
- The use of intelligent routing to enhance the member experience and maximize the success of consumer service representatives.
- Measure and discourage abandoned calls and where such calls occur, have agents return calls to those members to provide service.

Personnel

Selecting and training the right people for the member services representative role is critical in maintaining high quality and efficiency.

Hiring processes and selection tools vary, but health plans generally have both aptitude and attitude requirements.

Member services representatives must have an aptitude for learning new information rapidly and using a computer and phone simultaneously, and their attitudes should include friendliness, the desire to help, and comfort in dealing with a steady stream of requests.

Training of Member Services Representative

The initial training of representatives is typically extensive, often requiring two or more months before the new employee is ready to handle member contacts independently.

New representatives generally receive instruction on a variety of topics and skills, including plan products, procedures, computer and telephone systems, general principles of customer service, sensitivity training, active listening, problem-solving, dispute resolution, and handling angry customers.

Ongoing training may introduce new skills or areas of knowledge or refresh existing skills. To help employees assimilate this wide range of knowledge and skills, health plans often use a mix of training methods, such as classroom instruction, simulated contact with members, and on-the-job training with mentoring.

Providing a Supportive Workplace for Member Services Representatives

People who provide customer service all day, every day, are subject to stress and "burn-out," so a plan faces challenges in motivating and retaining member services representatives.

Managers often develop recognition and incentive programs to reward staff members for good performance. Some plans conduct contests on an individual or team basis to encourage improved performance.

It is also important to provide a supportive, pleasant workplace and opportunities for professional development and career advancement.

Health Plan Processes

There are many member services processes, including fulfilling requests for provider directories, explaining benefits for different types of services, changing a member's PCP, assisting members with requests for authorization of payment, investigating and responding to claims inquiries, placing welcome calls to new members, and handling complaints.

Many interactions involve multi-step business processes. For example, the member may need to be contacted multiple times as information is gathered from both an internal department such as claims and outside third-parties such as the member's provider.

Health Plan Processes (Continued)

A health plan's processes must be both effective and efficient—that is, they must achieve their objectives while making good use of company resources, particularly time. Automation can help in this regard and should be considered wherever possible.

Standard processes must be clearly established, employees trained in them, and adherence to them monitored. Because a plan's products and member needs change over time, processes should be periodically reviewed and modified.

Technology

The effective use of technology can enhance the performance of member services personnel and processes.

Information management systems provide the information employees need to help members.

Communication Technology

Communication technology connects the member to the representative or other source of information quickly and accurately.

CTI improves employee productivity and accuracy by linking the information and communication systems so that employees have immediate access to information about individual members. CTI systems that record telephone calls for later quality review and track the volume of calls by type facilitate performance management.

Evolving Technology in Health Plan Processes

The types of technology and the ways they are applied vary greatly by plan and are continually evolving.

IVR systems and websites are being enhanced to enable members to perform some routine transactions. Decreasing the number of routine requests that go to member services representatives increases the availability of representatives for more complex questions and needs. With the use of online chat, somewhat more complicated matters can be handled online, sometimes more cost-effectively.

More ways technology can be used to engage members:

It is important for health plans to engage their members. Why? Two key reasons:

- Members who are engaged tend to pay greater attention to preventive steps they can take to avoid chronic disease. And for those that have chronic disease, engaged members are more likely to consider lifestyle changes and treatment adherence measures they can take to control the trajectory of those diseases. [xiv] [xv]

- Members who are engaged with their health plan tend to stay with their health. This increases the likelihood that members are retained while they are healthy for many years before they become patients and require care.

Today, technology can play a major role in engaging members. Earlier in this course, we discussed the move toward consumer directed healthcare. This has been accompanied by the

widespread introduction of high deductible health plans (HDHP) often and health savings accounts (HSAs). This has increased consumer awareness of healthcare costs and quality. [xvi]

Technology can help members navigate the healthcare system by for example, enabling them to compare likely out-of-pocket costs. It can also help direct them to benefits they may not have previously be aware of such as discounts of gym memberships and other activities designed to promote wellness and possibly, alert them to a discount available through an employer-sponsored plan.

The technology available today can be used to mine data that allows for a more consumer centric health care experience. For example, by asking members to answer a series of questions at periodic intervals (such as at plan renewal and at the time of annual physicals) regarding their preferences, a health plan can express its interest in its members – increasing their loyalty when they do not need care. Should ill health occur, clinical teams can devise treatments that reflects those individual values and preferences. [xvii]

Technology can also be employed to get a sense of what members want. For example, technology can be employed to conduct surveys and target services to specific members based on their preferences. Here it is important to keep in mind that no-one-size-fits-all, some consumers want to be partners with providers, while others may rely more on a provider's expertise to make decisions to guide their care but do want to access other types of information such as quality rankings. [xviii]

Use of e-mail and telehealth makes partnering more feasible than in the past, while a robust website allows members to access information about their physician as well as quality ranking of an institutional provider (such as whether a hospital is a center of excellence for a particular type of surgery). Still others may value convenience and once again, technology makes this possible by facilitating the scheduling of appointments through the digital submission of claims.

List of some of the online services consumers are likely to want from health plans:

According to a recent study health plan members are seeking the following services online from their health plans:

- Digital submission of claims and ability to support digital inquiries about claim status,
- Ability to print out ID cards or request them online,
- Delivery of explanation of benefits (EOB) via digital channels,
- Ability to pay provider bills and health insurance premiums via digital channels,
- Ability to choose wellness incentives, and

- Provision of an online or mobile health record.

At the same time, data privacy and security are a concern to a majority of the members surveyed. [xix]

Performance

Performance management addresses both the quality and the cost-effectiveness of member services.

For quality, in addition to the member satisfaction surveys and complaint reports previously mentioned, health plans evaluate certain statistics on member contacts, including the following:

- **Turn-around time**—the amount of time required to complete a particular member-initiated transaction.

- **First contact resolution rate**—the percentage of questions that are answered, requests that are fulfilled, and transactions that are processed and completed at the initial point of contact. First contact resolution is also colloquially called "one and done customer service."

- **Wait time**—the average amount of time that members stay on the telephone before they receive assistance.

- **Total service factor** – the percentage of member calls that are answered within a targeted time limit – for example, 30 seconds.

- **Call abandonment rate**—how often members who are put on hold hang up before receiving assistance. Typically, a shorter wait time results in a lower call abandonment rate.

- **Error rate**—the accuracy of information given and transactions processed.

Quality Assessment

Many health plans also analyze and even score the quality of individual episodes of contact between members and employees. Managers may monitor live or recorded telephone calls to check for accuracy of information, communication skills, courtesy, and empathy.

For cost-effectiveness, measures typically focus on the productivity of individuals, teams, or entire units. CTI applications enable plans to monitor and track a variety of productivity indicators, such as the number of telephone calls, e-mails, or letters handled in a particular time period; the average amount of time spent on each customer contact; and the amount of time spent on administrative duties, such as documentation of contacts, research, and follow-up activities. The first contact resolution rate is an indication of cost-effectiveness as well as of quality, since when members' needs are met in their first call they do not have to call again.

Service Levels

Health plans also measure the quality and cost-effectiveness of their websites, by means of member satisfaction surveys, the number of visitors and page views, and path analysis.

After collecting performance data, managers compare it to **service levels**, standards set by the plan. For example, the service level for wait time might be that at least 75 percent of calls are answered by a representative within 20 seconds of hold time. Health plans typically base their service levels on company or industry benchmarks, but some purchasers have their own requirements.

Increasing Member Satisfaction

To increase member satisfaction, some health plans are focusing more on improving quality service levels even if this results a worsening of cost-effectiveness service levels.

Example: A plan might encourage representatives dealing with complaints to take the time to be empathetic, acknowledge the complaint, explore the issue, and take appropriate action to resolve the complaint during the initial contact, even if this results in the average time required for each contact increasing.

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22 Federal Laws and Regulation

Learning Objectives

After completing this lesson, you will be able to:

- tell how federal antitrust and financial services legislation affects health plans
- identify and describe the most important federal laws governing employee benefits and health plans
- summarize the main provisions of HIPAA
- identify key provisions of the Affordable Care Act (ACA) in regard to availability of coverage and affordability
- explain the primary objectives of the 21st Century Cures Act and the No Surprises Act (NSA)

Federal Laws and Regulation

Like all business entities, health plans are subject to a variety of general business laws and regulations addressing issues such as trade practices, consumer protection, employment and hiring practices, workplace health and safety, contract negotiations, and taxation. In addition, as providers and financers of healthcare services, health plans are subject to laws and regulations specific to healthcare. In this lesson, we examine some of the key federal laws and regulations that affect health plans including a brief overview of the Affordable Care Act (ACA) and the 21st Century Cures Act as well as the recently passed No Surprises Act (NSA). In the next lesson, we discuss the ACA in further detail. Additionally, in later lessons, we study state laws and regulations and laws and regulations related to government healthcare benefit programs including the Medicare Access and CHIP Reauthorization Act (MACRA).

General Business Legislation

The federal government plays an important role in regulating business activities in order to protect the marketplace and consumers. Many federal laws and regulations do not specifically address health plans but nonetheless have a significant impact on their structure and operations. These include antitrust and financial services legislation.

Antitrust Legislation

Antitrust laws are designed to protect competition from unlawful restraints of trade, such as price-fixing, market allocation, and bid-rigging. The antitrust laws also prohibit unlawful acquisition or maintenance of monopoly power.

Main Federal Antitrust Laws

- The **Sherman Antitrust Act** of 1890 established as national policy the concept of a competitive marketing system. The Act prohibits companies from attempting to monopolize any part of trade or commerce or to engage in contracts, combinations, or conspiracies in restraint of trade. The Act applies to all companies engaged in interstate or foreign commerce.

- The **Clayton Act** of 1914 forbids certain actions believed to lead to monopolies. These include charging different purchasers different prices for the same product without justification and allowing a distributor to sell a product only if it agrees not to sell competitors' products. The Clayton Act applies to insurance companies only to the extent that state laws do not regulate such activities.

- The **Federal Trade Commission Act** of 1914 established the Federal Trade Commission (FTC) and gave it power to work with the Department of Justice to enforce the Clayton Act. The primary function of the FTC is to prevent unfair competition and deceptive business practices, which are presented broadly in the Act. As a result, the FTC also pursues violators of the Sherman Antitrust Act.

Antitrust laws also exist at the state level.

Antitrust Violations

Health plans and healthcare providers may be found in violation of antitrust laws if they engage in any of the following activities:

- **Price-fixing** involves the agreement by two or more independent entities on the prices that they will charge or pay for services. For example, independent providers generally may not collectively establish the fees that each will charge a health plan. A price-fixing violation need not involve a strict agreement on prices—for instance, it could entail agreement on terms of trade or price levels.

- A **horizontal group boycott** occurs when two competitors agree not to do business with another competitor or purchaser. For example, two independent hospitals generally may not agree to refuse to contract with a health plan until the health plan ceases contract negotiations with another hospital.

- **Tying arrangements** occur when an organization conditions the sale or purchase of one product or service on the sale or purchase of other products or services. For example, a specialty provider group contracting with a health plan for oncology services generally may be prohibited from requiring the health plan to contract with the group for other services as a condition for receiving the group's oncology services.

- **Horizontal allocation or division of markets** occurs when two or more organizations agree not to compete by dividing geographic marketing areas, product offerings, or customers. For example, two independent companies generally may not split purchasers into two groups and each agree to market their products to only one group.

Provider Contracting

Provider contracting is an area in which antitrust issues sometimes arise. Generally speaking, contracting with a select network of providers does not raise antitrust issues (although some states have limited this through any willing provider laws mentioned elsewhere in this course). However, some contract terms, such as exclusive contracts, may raise antitrust issues- depending on the specific facts and circumstances of the market.[i]

Antitrust concerns have also arisen in recent years as health plans have sought to merge horizontally[ii] [iii] Thus far, these horizontal merger efforts between health plans have been blocked. Antitrust questions have been raised regarding vertical integration efforts by health plans and pharmacy benefit managers (PBMs).[iv]

Financial Services Legislation and Regulation

In 1999, Congress enacted the **Financial Services Modernization Act**, referred to as the **Gramm-Leach-Bliley (GLB) Act**, which allows convergence among the traditionally separate components of the financial services industry—banks, securities firms, and insurance companies. Because health plans finance the delivery of healthcare services, they are also considered part of the financial services industry.

The GLB Act

In broad terms, the GLB Act stipulates how the financial services industry may be structured and how it is regulated and supervised. The GLB Act also establishes the rights of customers in regards to the protection of the privacy of personal financial information.

- All financial institutions must disclose their privacy policies regarding the sharing of nonpublic personal information with both affiliates and third parties. Such disclosure must take place at the time of establishing a customer relationship and not less than annually as long as the relationship continues.

- They must notify customers of any sharing of nonpublic personal information with nonaffiliated third parties.

- They must provide customers with an opportunity to opt-out of sharing nonpublic personal information subject to certain limited exceptions.

The GLB Act and Healthcare Organizations

Although the GLB Act does not specifically target healthcare organizations, it may have consequences for these organizations. For example, the GLB Act called on regulators in the states to enact laws governing specific financial services entities, and the National Association of Insurance Commissioners (NAIC) responded by proposing a Privacy of Consumer Financial and Health Information Model

Regulation to govern the activities of healthcare organizations and insurers. State regulations based on the NAIC Model Regulation, discussed later in this course, affect the way healthcare organizations, insurers, and other users share protected health information.[v]

Dodd- Frank Wall Street Reform and Consumer Protection Act

Following the financial crisis of 2008 and the severe recession of the mid-2000s, legislation was passed at curbing financial entities deemed "too big to fail" without jeopardizing the entire economy. These rules are contained in the **Dodd-Frank Wall Street Reform and Consumer Protection Act**. While health plans were once again not directly targeted, concerns were raised regarding the impact of the law on the financial dealings of some multi-line insurance carriers.[vi vii viii]

Employee Benefit and Healthcare Legislation

Several federal laws govern how employers provide healthcare benefits to their employees and how health plans provide insurance coverage or administer employee benefits. We will discuss a number of these laws in this section, and then in separate sections we will examine major federal healthcare laws including:

- the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- a brief overview of the Affordable Care Act of 2010 (ACA)
- the 21st Century Cures Act, and
- the No Surprises Act (NSA)

And as noted earlier, in the next lesson we will study the Affordable Care Act of 2010 (ACA).

Employee Retirement Income Security Act (ERISA)

The **Employee Retirement Income Security Act (ERISA)** is a broad law that establishes the rights of health plan and pension plan participants, standards for the investment of plan assets, and requirements for the disclosure of plan provisions and funding. ERISA applies to all employer-sponsored or union-sponsored health and pension plans.

ERISA contains strict reporting and disclosure requirements. Employers and plan **fiduciaries**—that is, persons or organizations that hold, manage, and have discretionary authority over money belonging to another person or organization—must prepare and distribute summary plan descriptions and file reports with the Department of Labor and the Internal Revenue Service.

Preemption Provision

One of the most significant features of ERISA is its **preemption provision**, stipulating that ERISA generally takes precedence over any state laws that regulate employee welfare benefit plans. However, the preemption provision leaves to the states the authority to regulate insurance, banking, and

securities. Consequently, state insurance laws (such as those relating to policy provisions, group size, group eligibility, and mandated benefits) apply to health insurance coverage provided to an employee benefit plan but do not apply directly to the plan. This is true regardless of whether the plan is fully funded (fully insured) or self-funded (self-insured). (Recall that in a self-funded plan the employer, rather than a health plan or insurance company, is financially responsible for paying claims and related expenses.)

The preemption provision encourages employers to create employee benefit plans by providing a uniform system of regulation and oversight. Furthermore, under ERISA self-funded plans are exempt from state taxes on insurers' premium revenues.

Example:

Alpine Corporation is self-funded—that is, it provides health benefits to its employees itself, with no insurance company involvement. Alpine's health plan is subject to ERISA but not to state laws and regulations governing insurance. On the other hand, Piedmont, Inc. is fully insured; its employee health plan is provided by Delta Insurance Company. Piedmont's involvement in its plan is subject to ERISA, and in addition Delta's involvement in the plan is subject to state insurance laws and regulations.

ERISA and Health Plans

ERISA's preemption provision also has important implications for health plans, especially in cases in which an employee raises questions about a plan's decision not to authorize benefit payment based on medical necessity or appropriateness. Under ERISA, persons who receive healthcare benefits through employee benefit plans must file legal challenges involving coverage decisions or plan administration at the federal level, and ERISA is generally the governing law for such cases.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

The **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)** addresses the continuation of group health coverage after an individual's normal eligibility ends. COBRA requires group health plans to allow employees and dependents to continue their coverage for a certain amount of time following the loss of eligibility, if that loss is caused by a qualifying event. Qualifying events include the termination of employment, reduced work hours, and the death or divorce of an employee.

Generally, COBRA applies to businesses with 20 or more employees. Many states have similar requirements for businesses with fewer than 20 employees (so-called "mini COBRA" laws).

COBRA Coverage

The plan administrator of a group health plan must notify covered individuals of their rights under COBRA when they become covered under the plan and when a qualifying event occurs. When a qualifying event occurs, the affected individuals have a specified time within which they can elect to continue their group health benefits.

Following termination or reduction in hours, an employee, his or her spouse, and dependent children can continue coverage for up to 18 months. If an employee dies or is divorced or legally separated, his or her spouse and dependent children can continue coverage for up to 36 months. A dependent child who ceases to be an eligible dependent under a group health plan can continue coverage for up to 36 months. Once an employee or dependent obtains other group health coverage (for example, through new employment), coverage under COBRA ceases.

The continuation coverage under COBRA must be identical to the regular coverage under the health plan. The employee normally pays the full cost of the continuation coverage, and the plan administrator may also charge an administrative fee of 2 percent of this cost. Employers are not required to pay any portion of cost.

HMO Act of 1973

As you recall from earlier lessons, the **HMO Act of 1973** and its amendments were instrumental in defining the structure and operations of HMOs and paved the way for HMOs to enter the healthcare market. The HMO Act also sets the requirements HMOs must satisfy to become federally qualified. These requirements cover the following four basic operational areas:

- **Benefits**. Federally qualified HMOs must offer a comprehensive benefit package that includes outpatient and inpatient services, unlimited home healthcare benefits, and outpatient behavioral healthcare. HMOs are allowed to deliver these services only through staff or group models, individual practice associations (IPAs), or direct contract arrangements. Benefit structures must require only minimal copayments by members.

- **Enrollment**. Qualified HMOs must enroll individuals eligible for group coverage without regard to health status.

- **Financing**. Qualified HMOs must have a fiscally sound operation and adequate protections against insolvency.

- **Quality assurance**. Qualified HMOs must establish ongoing quality assurance programs that meet the requirements of the Centers for Medicare and Medicaid Services (CMS). These programs must stress outcomes and performance review of services by physicians and other healthcare professionals.

Although federal qualification is voluntary and is less important in today's market than in the past, many HMOs still maintain their federal qualification status.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The **Health Insurance Portability and Accountability Act (HIPAA)** was enacted on August 21, 1996. Among other provisions HIPAA imposes requirements on employer-sponsored and union-sponsored group insurance plans and insurance companies that provide coverage in the group and individual markets. HIPAA provisions fall under five titles:

- **Title I-** amended ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code of 1986 (IRC) to improve the portability and continuity of health insurance coverage in the group and individual markets. Its provisions are designed to help workers maintain insurance coverage if they lose or leave their jobs.
- **Title II-** made changes to the Social Security Act and the federal criminal code. Title II is made up of seven subtitles, the provisions of which are aimed at combatting fraud, waste, and abuse in healthcare as well as administrative simplification. Issues concerning privacy rights and technology generally fall under Title II.
- **Title III-** contains health related tax provisions. Title III contains provisions related to the tax-qualification of long-term care (LTC) insurance and the deductibility of LTC premiums. Title III also has provisions relating to medical savings accounts – considered a precursor to today's health savings accounts (HSAs).
- **Title IV-** amended the PHSA and the IRC to establish guidelines for the enforcement of Title I group health plan requirements.
- **Title V-** includes several provisions aimed at increasing revenues to offset then anticipated revenue losses under other provisions of the Act. Among these provisions are rules tightening the deduction of interest on corporate-owned life insurance (COLI). [ix]

HIPAA Title I: A Closer Look

Title I of HIPAA increased mobility of the workforce through its portability provisions which predated the more liberal provisions of the Affordable Care Act (ACA) discussed later in this lesson. These provisions limited the use of "preexisting condition" exclusions in group health plans. Basically, a group health plan could impose a preexisting condition only if:

- it related to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received ending on the enrollment date into the plan
- the exclusion (non-coverage period for the condition) extended for a period of not more than 12 months
- the period of such preexisting condition exclusion was reduced by periods of "creditable
- coverage

Creditable coverage meant coverage an individual had through many enumerated sources including:

(1) another group health plan

(2) health insurance coverage (group or individual)

(3) Medicare

(4) Medicaid

(5) military-sponsored health coverage

(6) Indian Health Service or tribal health programs. The major caveat to creditable service was that it was not counted if there was a 63-day break period during which the individual did not have coverage.

Group Healthcare Coverage

Title I of HIPAA has been amended by subsequent acts that create additional protections for individuals with group healthcare coverage. These include the following:

- The **Mental Health Parity Act of 1996 (MHPA)** prohibits group health plans or insurers that provide coverage to businesses with more than 50 employees from applying more restrictive annual and lifetime limits on coverage for mental illness than for physical illness. It should be clarified that MHPA does not require health plans to offer mental health coverage, but it imposes requirements on those plans that do so. This law has been amended to expand the parity requirements to any financial requirement or treatment limitation that may be imposed by a health plan or insurer.

- The **Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)** specifies that group health plans or group healthcare insurers cannot require that hospital stays following childbirth be shorter than 48 hours for normal deliveries or 96 hours for cesarean births. NMHPA does not require group plans and insurers to offer maternity hospitalization benefits, but it imposes requirements on those group plans and insurers that do so.

- The **Women's Health and Cancer Rights Act of 1998 (WHCRA)** requires health plans (both group and individual coverage) that offer medical and surgical benefits for mastectomy to provide coverage for reconstructive surgery following mastectomy. Again, the law does not require group plans and insurers to offer mastectomy benefits, but it imposes requirements on those that do so.

Many of these additional protections were incorporated into the Affordable Care Act.

HIPAA Title II: A Closer Look

The Department of Health and Human Services (HHS) issued a series of regulations as part of its responsibility to implement Title II to protect the privacy and security of certain health information. To

fulfill this requirement, HHS published what are commonly referred to as the *HIPAA Privacy Rule* and the *HIPAA Security Rule*.

HIPAA Privacy and Security Rule

The HIPAA Privacy Rule, also referred to as *Standards for Privacy of Individually Identifiable Health Information,* establishes national standards for the protection of certain health information (whether in traditional hardcopy or electronic format).

The HIPAA Security Rules, also referred to as *Security Standards for the Protection of Electronic Protected Health Information,* establishes a national set of security standards for protecting certain health information that is held in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" must put in place to secure individuals' "electronic protected health information" (e-PHI). As we will discuss later when discussing the **HITECH Act of 2009** it also applies to the "business associates" of those "covered entities."

Background information regarding the Security Rule:

Prior to HIPAA there were no generally accepted security standards for protecting health information within the health care industry. At the time of HIPAA's enactment information technology was evolving and the health care industry began moving away from paper processes and relying more heavily on electronic information systems to pay claims, answer eligibility questions, as well as conduct other administrative and clinical functions.

Today, there is increasingly widespread use of technology throughout the health care industry. This includes electronic medical records, clinical diagnostic aids, and member self-service portals. While this translates into a more mobile and efficient system, the rise in the adoption of technology also increases potential security risks such as the hacking of and subsequent sale of medical records. A key goal of the Security Rule is to protect the privacy of individuals' health information while allowing the adoption of new technologies by covered entities (e.g health plans) and their business associates. [x]

Administrative Simplification Standards

Title II of HIPAA requires the Department of Health and Human Services (HHS) to develop **administrative simplification standards**. Some of these are designed to standardize electronic healthcare transactions, such as claims and eligibility inquiries. Others are intended to ensure the privacy and security of **individually identifiable health information** (health information that, by itself or in conjunction with other available information, identifies an individual). HHS has developed a number of regulations that establish Title II administrative simplification standards.

These standards apply to health plans, healthcare providers that use electronic transactions, and healthcare clearinghouses. A **healthcare clearinghouse** is a private or public entity that converts

provider data into the correct format for each health plan and converts health plan data into the appropriate provider format. The clearinghouse also sorts and transmits all data. Billing services, repricing companies, community health management information systems, and value -added networks may be healthcare clearinghouses.

HIPAA Privacy and Security Rules

HIPAA required HHS to develop standards to ensure the privacy and security of health information. These standards control the use and disclosure of health information by health plans, healthcare providers, and healthcare clearinghouses, and they provide individuals with certain rights with respect to their information. The privacy standards include the following rules:

- Healthcare providers must generally obtain an individual's written consent to use protected health information. Health plans, healthcare providers, and clearinghouses may use or disclose healthcare information for their own treatment, payment, or operations without obtaining the individual's consent.

- The transmission of individually identifiable health information for purposes other than medical treatment, payment, or healthcare operations without the patient's written authorization is generally prohibited.

- Patients are allowed to access their medical records and request amendment of incorrect or incomplete medical information.

- Patients are allowed to request that restrictions be placed on the accessibility and use of protected health information.

- Healthcare providers, healthcare clearinghouses, and health plans must institute privacy and security policies and procedures and workforce training programs.

- Healthcare providers, health plans, and healthcare clearinghouses must institute privacy protections in contracts with any business that uses health information on their behalf.

HIPAA Security Standards

HIPAA security standards are designed to prevent unintended access to protected health information and mandate features entities must include in their operations to ensure that such information is secure. These features include administrative procedures and physical devices and mechanisms to protect data integrity and confidentiality. The security standards are "scalable"—that is, the procedures and mechanisms used by a particular entity may vary depending on the size, structure, security needs, and business requirements of the entity.

HITECH Act of 2009

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) was passed as part of the American Recovery and Reinvestment Act of 2009. HITECH was enacted with the goal of spurring the implementation of electronic health records (EHR). In other words, the exchange of electronic protected heath information (ePHI) between physicians, hospitals, and other businesses that might store or use ePHI.

HITECH expands upon the scope of the HIPAA privacy and security protections. It increases the potential legal liability for non-compliance of these protections, and seeks to ensure more stringent enforcement. Key provisions cover the following:

- Breach notification
- Access to electronic health records
- Business associate(s) agreements and responsibilities

Key Provision of HITECH

Breach Notification: HITECH requires that patients be notified of any unsecured breach. If a breach impacts 500 patients or more the Department of Health and Human Services (HHS) must be notified. Breached patients must be notified via mail as to what has occurred and what steps have or are being taken to resolve the breach.

Access to Electronic Health Records: If a provider has implemented an electronic health records (EHR) system, patients have a right to obtain their ePHI. Charges equal to labor costs can be charged for such requests.

Business Associate Agreements & Responsibilities: You may recall that HIPAA, as originally enacted, applied to "covered entities" and this included health care providers, health plans, and health care clearinghouses. It did not include business associates. HITECH extends the HIPAA privacy and security rules to business associates. If a "covered entity" engages another party (business associate) to help carry out its health care activities and functions, the covered entity must have a written contract or other arrangement with the business associate that specifically spells out what the business associate has been engaged to do. The agreement must also specify that the business associate has to comply the HIPAA Rules' requirements to protect the privacy and security of protected health information.[xi]

Affordable Care Act of 2010

The Affordable Care Act (ACA) was enacted in 2010. Many of its provisions can be considered to have their origins in HIPAA. ACA provisions were phased-in over several years, with many of the most important becoming effective in 2014. Because of efforts since its passage to repeal and replace the ACA, as well as administrative efforts to curb various parts of the law – we will provide a brief review of the main elements of the law in this lesson. In our next lesson, we will look at the law in further detail.

ACA Coverage

The ACA is designed to make health coverage more broadly available. It does this in several ways:

- **Employer Mandate.** Large employers must offer group coverage to their employees or pay penalties.

- **ACA Marketplaces.** Online health insurance exchanges (currently referred to as Marketplaces) enable individuals and small businesses to compare health insurance plans and enroll in a plan.

- **Medicaid Expansion.** Eligibility is extended to more low-income people (primarily working-age adults), with the federal government covering 90 percent of the cost. As we will see later in the course, this extension depends on state action and not all states have opted for this expansion of Medicaid benefits.

- **Guaranteed Issue.** A health insurance plan cannot reject an applicant, charge them a higher premium, or limit her coverage based on any medical condition they have before coverage starts (**preexisting condition**). Remember HIPAA's provisions on preexisting conditions. In the ACA we see an expansion of those protections.

Example:

Melanie applies to enroll in Big Smile Health Plan. She has had type 2 diabetes for three years. Big Smile must accept her, it cannot charge her a higher premium than others her age, and it cannot refuse to cover her diabetes.

- **Guaranteed Renewal.** A health insurance plan cannot refuse to renew a person's coverage or raise his premium based on his health or use of healthcare.

Example:

Two years after enrolling in Feel Good Health Plan, Emily develops diabetes. Feel Good cannot refuse to continue covering Emily, and it cannot raise her individual premium. (The plan can, of course, raise the premium rates for all enrollees each year.)

- **Individual Mandate. The ACA as originally written required individuals** to have health coverage or pay a tax penalty. As we will discuss in our next lesson, focused on the ACA, moving forward this is no longer the case. Congressional legislation passed in 2018 effectively abolished the penalty by reducing it to zero.

- **Young Adult Coverage.** If a health insurance plan has dependent coverage for children, a parent must be able to continue to include a child in his or her coverage until the child turns 26—even if the child is married or has the opportunity to enroll in another plan (such as through an employer).

Making Health Coverage Affordable

The ACA also seeks to make health coverage affordable. It accomplishes primarily through:

- **Premium subsidies.** Middle-to-lower income people (up to 400 percent of the FPL) can obtain federal income tax credits to cover some of the cost of their health insurance premiums. Recent pandemic relief have expanded these subsidies.

- **Limits on premium variation.** An individual or small group health insurance plan may charge some individuals higher premium rates than others, but only based on a few criteria and within certain limits. These criteria are age, tobacco use, family size, and geography. A person's health or medical history cannot be considered. [xii]

21st Century Cures Act

The 21st Century Cures Act (Cures Act), effective January 1, 2017 was enacted on a bipartisan basis. As you may recall from our earlier lesson on account-based plans, it contains provisions allowing small employers to establish Qualified Small Employer Health Reimbursement Arrangements (QSEHRA). The Cures Act however, is focused primarily on medical issues including:

- Accelerating research into preventing and curing serious illnesses including cancer and brain diseases such as Alzheimer's.

- Speeding drug and medical device development.

- Addressing the opioid abuse crisis.

- Improving the delivery of mental health services.

- Improving information technology with the aim of improving delivery of care through the interoperability of electronic health records (EHRs). [xiii]

No Surprises Act: An Overview

One of the most recent pieces of federal legislation to be based is the No Surprises Act (NSA). which became effective on January 1, 2022. [xiv]This piece of federal legislation provides protections against "surprise billing" and balanced billing under certain circumstances with the aim of providing consumer protections in situations of emergency care and nonemergency care from out-of-network providers at a

health plan's in-network facilities. [xv]NSA also provides consumer with protections when using air ambulance services from out-of-network providers.

The consumer protections offered by NSA were incorporated in P.L. 116-260, the Consolidated Appropriations Act of 2021.

What are Surprise Medical Bills?

Consider these situations. You have health insurance either individually or through your employer. You knowingly obtain care from an out-of-network provider or an out-of-network facility. In these situations, you can often expect that your health plan may not cover the entire out-of-network costs, in other words, seeking such out-of-network care could leave you with higher costs than if you obtained care from an in-network provider or facility.

In addition, to any out-of-network cost-sharing you might owe, the out-of-network provider or facility could bill you for the difference between their billed charge and the amount your health plan paid, unless barred by state law. This is referred to as "balance billing." An unexpected balanced bill from an out-of-network provider is also called a surprise medical bill.

What Situations Have Triggered Surprise Medical Bills?

Surprise billing problems have often arose where patients have lacked a meaningful choice of provider for services – such as emergency care. For example, a patient with health coverage is rushed to an emergency room following a sudden collapse or accident and is treated by a medical team who is not part of their covered network.

In elective care situations, surprise billing issues occur when a health care enrollee chooses an in-network facility and principal physician but is unaware that the anesthesiologist, assistant surgeon, or other ancillary provider is *not* part of network.

These situations can prove to be very costly. Research by the Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that prior to the effective date of the law, surprise medical bills among private-insured patients were relatively common an could average more than $1,200 for services provided by anesthesiologists, $2,800 for surgical assistants, and $750 for childbirth related care.

Key Provisions of NSA

Key provisions of NSA include:

Emergency services – Regardless of where they are provided, emergency services must be treated on an in-network basis without requirements for prior authorization. In other words, health plans must treat these out-of-network services as if they were in-network when calculating patient-enrollee cost-sharing.

Ancillary care – Out-of-network charges for ancillary care, such as provided by an anesthesiologist or assistant surgeon, are prohibited at an in-network facility.

Other Out-of-Network care – Advanced notice must be provided in other out-of-network situations. Health care providers and facilities must provide patients with a plain language consumer notice explaining that patient consent is required to receive out-of-network care before that provider can bill at a higher out-of-network rate. [xvi]

The Arbitration Process

The NSA legislation also creates an arbitration process to determine how much insurers must pay out-of-network providers. In simple terms, if an out-of-network provider is dissatisfied with a health plan's payment, it can initiate arbitration.

Guidelines for this process have been drafted by HHS but have been the subject of dispute in the courts with providers contending that the guidelines favor health insurers.

Other Laws

A number of other federal laws have an impact on health plans.

Some Federal Laws That Affect Healthcare Organizations

Legislative Act	Who Must Comply	Protected Class	Effect on Healthcare
Age Discrimination in Employment Act (ADEA)	Employers with 20 or more employees	Employees age 40 and older	All active employees, regardless of age, must be eligible for the same healthcare coverages, and older employees cannot be charged more than younger ones.
Title VII of the Civil Rights Act	Employers with 15 or more employees and engaged in interstate commerce	All employees	Discrimination based on race, color, religion, sex, or national origin is prohibited. Employers must ensure that health plan provisions are not discriminatory.
Pregnancy Discrimination Act	Employers with 15 or more employees and	All employees	Employer-sponsored group health plans must provide coverage for pregnancy, childbirth, and related

(amendment to Civil Rights Act)	engaged in interstate commerce		conditions on the same basis as for other medical conditions.
Family and Medical Leave Act (FMLA)	Employers with 50 or more employees	Employees who are ill, need to care for a seriously ill family member, or have a new child (including adopted)	Employees must be allowed to take up to 12 weeks of unpaid leave during any 12-month period. Employers must continue to make group health benefits available during this leave.

In addition, keep in mind the **Medicare Modernization Act** (2003) which put into place the rules for the use of high-deductible health plans combined with health savings accounts (HSAs). These rules were discussed earlier in our studies. More recently, the **Tax Cuts and Jobs Act** (2017) allows eligible employers to claim a general business credit equal to a percentage of the wages paid to qualifying employees under the Family and Medical Leave Act.[xvii] [xviii]

Learn more about family medical leave the Tax Cuts and Jobs Act:

The Tax Cuts and Jobs Act promotes the payment of wages during family and medical leave by allowing eligible employers to claim a general business credit equal to a percentage of wages paid to employees on leave. To receive the credit, employers have to provide at least 2 weeks of leave and compensate workers at least 50 percent of their regular wages. The credit ranges from 12.5 percent to 25 percent of the cost of each hour of paid leave. The percentage depending on how much of a worker's regular earnings are paid during the leave period. For example, the credit will amount to 12.5 percent if employees receive 50 percent of their regular earnings and rises to 25 percent if employees receive their regular earning.

The credit can only apply to those workers who have been employed at least 1 year and paid no more than $72,000 (2017 figure indexed for inflation based on 60 percent of salary of individual considered highly compensated = $120,000). Also, the benefit must be offered to both full-time and part-time workers employed for at least 1 year.

Moving forward, it can be expected that regulations will be issued by the Internal Revenue Service (IRS) providing additional guidance. [xix] [xx] [xxi]

Notes:

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[xii] Centers for Medicare and Medicaid Services, "Overview: Final Rule for Health Insurance Market Reform" Feb. 27, 2013, https://www.cms.gov/CCIIO/Resources/Files/Downloads/market-rules-technical-summary-2-27-2013.pdf ; *Federal Register*, "Final Rule for Health Insurance Market Reforms," Feb. 27, 2013 http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

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[xv] No Surprises Act, https://www.congress.gov/bill/116th-congress/house-bill/3630?q=%7B%22search%22%3A%5B%22no+surprises+act%22%2C%22no%22%2C%22surprises%22%2C%22act%22%5D%7D&s=2&r=1

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[xvii] Act Section 13403, Tax Cuts and Jobs Act, https://www.congress.gov/115/bills/hr1/BILLS-115hr1enr.pdf

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23 The Affordable Care Act

The Affordable Care Act and Health Plans

The Affordable Care Act (ACA), enacted in 2010, has had a tremendous impact on health plans. The ACA has three primary aims with regard to health coverage:

- Expand **access** to coverage.
- Ensure that coverage is **comprehensive**.
- Make coverage more **affordable**.

This Lesson

This lesson provides an overview of the ACA, with a focus on how the law's provisions in these three areas affect health plans and their members.

Information on the ACA's impact in other areas (such as health care quality) and a more detailed analysis can be found in other courses in the AHIP curriculum.

The ACA continues to change, as the result of legislative and regulatory actions, as we will see in this lesson.

Learning Objectives

After completing this lesson, you should be able to:

- describe how access to health coverage is expanded by provisions of the Affordable Care Act, including the Marketplaces, guaranteed issue, Medicaid, and dependent coverage for young adults.
- explain how the ACA addresses adverse selection.
- describe how comprehensive coverage is promoted by ACA provisions, including requirements for essential health benefits and preventive care and prohibitions on annual and lifetime benefit limits.
- list ACA measures to make coverage affordable, including rules for premium rating, premium subsidies, limits on cost sharing, and medical loss ratio requirements.
- explain what is meant by the *family glitch* and recent proposed actions to correct it.

Access to Coverage

Marketplaces

The ACA sought to make it easier for people without access to affordable, comprehensive health coverage through their employers to buy individual policies. There are health insurance **Marketplaces**

(exchanges) for every state (some operated by the state, others by the federal government). These are websites where eligible individuals can:

- Learn about health plans offered by private-sector companies and compare them in terms of benefits, cost sharing, and premium.
- Apply for and enroll in a health plan.
- Apply for government subsidies, such as premium tax credits.

Guaranteed Issue and Renewability

The ACA also sought to ensure that no one would be unable to obtain coverage because of his or her health. The ACA mandates **guaranteed issue**—this means that a health plan under the ACA's rules cannot, based on an individual's current health or medical history:

- Decline to offer her coverage
- Exclude or limit coverage of any preexisting condition.[1]
- Charge her a higher-than-standard premium

The ACA also requires a health plan to renew a member's coverage each year if the member wishes it, regardless of her health or any claims she has made.[2]

Example

> ***Example:*** *Mark is applying for health insurance through one of the ACA Marketplaces. He has a preexisting condition, prostate cancer, for which he is currently being treated. Before the ACA, an insurer might have declined to offer him coverage, or charged him a higher premium, or included a preexisting condition exclusion in the policy, stating that no benefits would be paid for prostate cancer for the first six months of coverage. Under the ACA, none of these actions are permitted.*

The Risk of Adverse Selection

When anyone can buy health coverage whenever they want to, adverse selection (discussed in Lesson 2) is a risk.

> ***Example:*** *Jerry is young and healthy, so he doesn't buy health insurance. Then he has an accident and needs extensive and expensive surgery. What stops Jerry from buying a policy now, having the insurer pay for his surgery, and, once he is recovered, stopping paying premiums and dropping the policy? And if everybody did this, only those currently needing health care would have insurance, and the premiums would be exorbitant.*

Addressing the Risk: The Individual Mandate

Before the ACA, plans could prevent or discourage adverse selection in individual coverage by declining applications, charging the unhealthy more, or imposing preexisting condition exclusions. Without these options, what stops adverse selection?

The ACA sought to address this problem through the **individual mandate— requiring** the great majority of people to have health coverage throughout the year or pay a tax penalty. (Exempted are those unable to afford coverage or experiencing certain hardships, such as bankruptcy, homelessness, domestic violence, or the death of a family member.)

But in December 2017, Congress passed the Tax Cuts and Jobs Act (P.L. 115-97), which reduces the tax penalty to zero as of January 1, 2019, effectively ending the individual mandate.[3] It is worth noting that some states have implemented their own individual mandate that requires individuals to have qualifying health coverage or pay a fee with their state taxes.[4]

Addressing the Risk: Enrollment Periods

However, the ACA also sought to minimize adverse selection in another way—by restricting guaranteed issue to certain times—and this rule remains in effect. Guaranteed issue applies only during:

- An annual **open enrollment period** for all consumers (typically several weeks in the late fall for coverage for the following year)[5]

- **Special enrollment periods** for individuals who have had major life changes, such as having a baby, or have lost access to other coverage (for instance, by leaving an employer).[6]

If a consumer seeks to buy coverage at another time (say, when he develops an illness or has an accident), the health plan has the right to decline his application.

Medicaid Expansion

The ACA extended eligibility for the Medicaid program.

- Before the ACA, Medicaid was available only to those with very low incomes who belonged to certain categories: primarily children, pregnant women, and the elderly and disabled.

- Under the ACA, Medicaid coverage became available, in effect, to all those under 65 with incomes up to 138 percent of the federal poverty level, whether they fell into one of these categories or not.[7] Medicaid was extended to many more nonelderly adults particularly single individuals.

However, in 2012 the Supreme Court ruled that each state must have the option of adopting the ACA Medicaid expansion or not.[8] To date, 38 states (plus the District of Columbia) have adopted the Medicaid expansion , but 12 others (including some large ones such as Texas and Florida) have not, even though the federal government pays nearly all the cost of the expansion.[9]

Dependent Coverage for Young Adults

Finally, the ACA addresses the fact that many of those entering adulthood find it difficult to access and pay for health coverage. Under the ACA, health plans that cover members' children must make this dependent coverage available up to age 26.

This is required even if the adult child is married, does not live with the parent, is not financially dependent on the parent, is not a student, and has access to a health plan sponsored by their own

employer. (Before the ACA, many health plans offered continued dependent coverage for young adults, but only if they met some of these conditions.)[10]

Comprehensive Coverage

Essential Health Benefits

The ACA requires individual and fully insured small group health plans to include **essential health benefits (EHBs)**, which cover 10 categories of health care services.

ACA Essential Health Benefits (EHBs): 10 Categories of Health Care Services

Hospitalization (inpatient care)	Ambulatory patient services (outpatient care)
Prescription drugs	Laboratory services
Emergency services	Mental health and substance abuse services
Pregnancy, maternity, and newborn care	Pediatric services, including dental and vision care for children (not required for adults)
Rehabilitative and habilitative services and devices	Preventive and wellness services and chronic disease management

[11]

EHBs: Some Details

Some comments on EHBs:

- Plans must provide benefits in these 10 categories, but the specific services that must be covered in each category vary somewhat by state.
- Plans may offer benefits in addition to the EHBs. For example, some plans offer dental and vision care benefits for adults as well as children.
- Rehabilitative and habilitative services include physical and occupational therapy, speech-language pathology, and similar services. Rehabilitation is for those regaining abilities after an illness or injury; habilitation is for those acquiring new abilities (such as a person born with a disability).[12]

Not All Plans Must Provide EHBs

To repeat: EHBs are required for individual and fully insured small group health plans. This requirement does *not* apply to:

- Large group plans

- Self-insured (self-funded) group plans—in which an employer, instead of buying a group insurance policy, pays health benefits out of its own funds

- **Grandfathered plans**—plans that were already in operation when the ACA was enacted and have not substantially changed since.[13]

However, although these types of plans do not have to include EHBs, many offer a comprehensive package of benefits that cover the EHB categories.

Preventive Care

Under the ACA, all health plans (except for grandfathered plans) must cover a large number of preventive services, such as vaccinations and screenings for diseases. Certain services must be covered for women or children. For a partial list, see Appendix A located in the Resource tab.

Moreover, to encourage the use of preventive services (which tend to improve health and reduce health care costs), plans are required to cover these preventive services without cost sharing. That is, a plan member must receive the service at no charge (with no copayment or coinsurance), even if she has not met her annual deductible. (However, a plan may charge for preventive services obtained outside its provider network and an individual may be responsible for the costs of ancillary services performed in conjunction with preventive care.)

Annual or Lifetime Limits

In the past, some health insurance policies placed limits on the total dollar amount a person could receive in benefits, during a year or during the life of the policy, or both. If an insured incurred a very large amount of medical expenses, she would have to pay any costs above the limit out of her own funds.

The ACA severely restricts such limits:

- Lifetime limits for EHBs are prohibited for all plans, even grandfathered plans.

- Annual limits for EHBs are prohibited for all plans except grandfathered individual plans.

- Annual or lifetime limits are still allowed for non-EHB benefits (such as dental care for adults).

Levels of Coverage

In some health plans, members pay more in cost sharing (deductibles, copayments, and coinsurance) but a lower premium; in others, they pay less cost sharing but a higher premium.

Under the ACA, all individual and small group plans must offer one of the four **levels of coverage**, named for a metal, (or catastrophic coverage).

The Metal Plans

The "Metal" Plans

	For health care services covered by the plan, what percentage of costs (on average) do members pay in cost sharing, and what does the plan pay?	
	Members pay about…	The plan pays about…
Bronze	40%	60%
Silver	30%	70%
Gold	20%	80%
Platinum	10%	90%

Metal Plans Based on Averages, Not Individuals

To clarify: These percentages are averages for all plan members. An individual member will pay slightly more or less than this percentage in any year, depending on the particular health care services they receive.[14]

> ***Example:*** *Lydia, Jason, Carlo, and Paula all enroll in the same Silver plan. They will all pay about 30 percent of costs, but in any year one person might pay a bit more and another a bit less, depending on what health care services he or she receives.*

The higher the percentage of costs members pay, the lower their premium. Each metal category can include different health plan types, such as HMOs and PPOs.

Catastrophic Plans

In addition to the four metal plans, **catastrophic plans** are permitted. These plans have very high deductibles and so pay benefits only if the member incurs a very large amount of health care expenses, but they have low premiums.

However, catastrophic plans can be sold only to adults under 30 and some people facing severe financial hardships (such as bankruptcy). [15]

Affordability

Rules for Individual Premiums

As we mentioned earlier under guaranteed issue, the ACA seeks to ensure that no one will be unable to afford health coverage because plans charge them a very high premium based on a health problem they have. Under the law, plans cannot charge higher or lower premiums to individuals based on their current health or medical history.

Example: *Oren and Gary are both 40 years old. Oren has no health problems, but Gary has diabetes. A health plan cannot charge Gary a higher premium.*

Allowable Factors

The ACA also restricts the premium an individual or small group health plan may charge an individual in other ways. Plans can charge different people different premiums, but only based on a few factors and only within limits. These factors are:

- Age
- Tobacco use
- Individual vs family enrollment
- Geographic location
- Plan category

Age

Older people can be charged more than younger people, but the following rules apply:

- **Children through age 20:** All must be charged the same premium.
- **Adults 21 through 63:** The oldest can be charged no more than three times as much as the youngest. Within this age range, premiums can be graduated by one-year increments (with a 36-year-old paying slightly more than a 35-year-old, who pays slightly more than a 34-year-old, etc.)
- **Adults 64 and older:** All must be charged the same premium.[16]

Tobacco Use

Plans can charge up to 50 percent more to those who use tobacco. Tobacco use is defined as at least four times a week within the last six months (with religious or ceremonial use excepted).

A plan may charge less than 50 percent and may charge different tobacco users different amounts. For instance, a plan might charge younger smokers 25 percent more and older smokers 50 percent more.

For small group coverage (but not individual policies), the plan must give smokers the opportunity to quit through a tobacco cessation program.[17]

Family Size

Health plans may charge a higher premium for family coverage than for self-only coverage.

Plans may charge larger families more than smaller families, but families with four or more children can be charged no more than those with three.

The age of the parents and whether they use tobacco can be taken into account in setting family premiums.[18]

Geographic Location

Premiums can vary depending on where an individual or family lives. States are divided into rating areas based on counties, three-digit ZIP code areas, or metropolitan statistical areas (MSAs) and non-MSAs.[19]

Premium Tax Credits

The ACA enhances affordability by offering subsidies to help some people pay health insurance premiums. To be eligible, a person:

- Must enroll in a metal plan through a Marketplace.[20] Those with non-Marketplace plans or catastrophic plans are not eligible.[21]
- May have income up to 400 percent of the federal poverty level.
    - Note: The American Rescue Plan Act, enacted in 2021, makes premium tax credits available to households with income greater than 400 percent FPL for the first time and reduces the percentage of household income consumers at all income levels are expected to contribute to the monthly premiums for a benchmark plan for 2021 and 2022. The increased premium tax credits are set to expire after the 2022 plan year.[22] However, there are some efforts by more progressive members of Congress as of this writing, to make them permanent.

Premium Tax Credits and Income

The FPL in 2021 stood at $12,880 for a single person, $17,420 for a two-person family, and $26,500 for a four-person family.[23]

The higher one's income, the lower the subsidy, and while those who are only somewhat above the poverty level receive substantial help, those who earn more get only small amounts.

(For more on how the premium subsidy is calculated, see Appendix B located in the Resource tab.)

How the Credit Works

The premium subsidy takes the form of the **advanced premium tax credit (APTC)**. It works like this:

- When a person enrolls in a plan in a Marketplace, she provides income information.
- A subsidy amount is projected for her, and a monthly payment is made to her health plan, which uses it to reduce her monthly premium.
- Later, when she completes her annual federal income tax return, the amount paid on her behalf during the year may turn out to be more or less than she is entitled to, based on her actual income during the year. She may receive a refund or have to pay back an excess amount.[24]

Some Fall Through the Cracks

Because they were expected to be covered by Medicaid under the ACA expansion, those with income below the FPL are not eligible for premium subsidies.

However, as we have seen, some states have not adopted the expansion, and in those states some people with very low income are not eligible for either Medicaid or a premium subsidy.

Out-of-Pocket Maximum Limits

Health plans set limits on the total amount a member can pay in cost sharing during a year, called the **out-of-pocket maximum**.

Under the ACA, for all health plans except grandfathered plans, this maximum cannot be higher than a certain level; in 2022 the limit is $8,700 (self-only coverage) and $17,400 (family coverage) (adjusted annually). Plans may set maximums below this level, but not above.

The higher the out-of-pocket maximum, the lower the premium.

Out-of-Pocket Maximums Do Not Apply to Everything

Note that even though these are called out-of-pocket maximums, they do not apply to all the health-related expenses a person may pay out of her own funds. They do not apply to premiums, balance billing amounts for non-network providers, or non-covered services.[25]

> ***Example:*** *Chris has self-only coverage with a deductible of $2,000, coinsurance of 20 percent, and an out-of-pocket maximum of $6,500. He undergoes surgery costing $20,000. He pays the first $2,000 and 20 percent of charges after that, but when his total cost sharing reaches $6,500, the plan pays all remaining covered expenses. However, Chris may also incur some expenses for health care services or products not covered by his plan; he will have to pay for these himself, and they do not count against the out-of-pocket maximum.*

Cost-Sharing Reductions (CSRs)

The ACA requires Silver plans sold through the Marketplaces to make **cost-sharing reductions (CSRs)** for lower-income members. They must charge them less in cost sharing than other members and set a lower out-of-pocket maximum for them.

To qualify for CSRs (often called "extra savings" on Marketplace websites), a person must have income no higher than 250 percent of the FPL and be enrolled in a Silver plan through a Marketplace.[26]

Compensating Health Plans for CSRs

The drafters of the ACA intended that the federal government would compensate health plans for their loss in revenue resulting from CSRs, but some have argued that the language of the law does not require this.

The Obama Administration made payments to plans, but the Trump Administration did not. However, Silver plans are still required to make CSRs, placing a financial burden on them and forcing them to raise premiums.

There have been some attempts in Congress to restore payments to plans, but so far, they have not been successful.

Medical Loss Ratio (MLR)

The ACA seeks to ensure that health plans provide good value for the premiums members pay, through **medical loss ratio (MLR)** rules. The medical loss ratio is the percentage of the premium dollars received by a health plan that it uses to pay for health care services (and quality improvement activities), rather than administrative expenses, marketing, and profit.

Under the ACA, for large group plans the MLR must be at least 85 percent. For individual and small group plans (which have higher administrative costs), it must be at least 80 percent.

More on MLR Rules

There has been some debate over what must be counted as administrative expenses. Despite opposition by agent and broker groups, it has been decided that sales commissions must come out of the 15 or 20 percent allocated for administrative expenses. Health plans hoped to be able to count anti-fraud efforts as quality improvement (not administrative), but they may do so only to the extent that they result in recovery of monies.

If a health plan does not meet the MLR requirement for a year, it must pay rebates to members or give them credits against future premiums.[27] In group coverage, instead of paying a rebate, a plan may use the money to benefit members in some way.

The Impact of Recent Legislation and Administration Actions

Continuing Opposition to the ACA

The ACA was passed with only Democratic support, and Republican opposition to it remained strong for many years. Adversaries brought many legal challenges to the law; its constitutionality has been upheld by the Supreme Court, although (as we have seen) it was ruled that the Medicaid expansion had to be optional for states. During the Obama years, bills to repeal the law were repeatedly passed by Congress but vetoed by the President.

Limited Rollback

When the Republicans regained the White House in 2017 they renewed and repeated efforts to repeal the ACA in its entirety. These failed, but some important provisions of the law were rolled back by legislation and administrative action.

- The Tax Cuts and Jobs Act, passed in December 2017, reduced the tax penalties for not having ACA-compliant health coverage to $0, which in effect ended the individual mandate as of January 1, 2019.

- Funding for cost-sharing reductions was discontinued by the Trump Administration.
- Administrative efforts were made to promote association health plans, which could remove some people from the pool of those enrolling in Marketplace plans.

ACA: Increased Favorability

More recently, opposition to the ACA has lessened as the law has gained in popularity and increased numbers have accessed coverage through its Marketplaces. In contrast to the Trump Administration, , the Biden Administration has prioritized ACA expansion efforts including taking measures to increase premium subsidies and expand consumer assistance efforts. [28] And, as we will discuss shortly, the Biden Administration has sought to expand coverage for many by seeking to reinterpreting what constitutes affordable coverage for family members of those offered coverage through work.

Employer Mandate: Brief Overview

As part of its efforts to expand access to coverage, the ACA includes a provision commonly referred the ***employer mandate***. The mandate states that employers covered by the provision must offer health insurance that is both affordable and meets minimum value standards to all full-time employees and their dependents. Employers who fail to comply can be subject to penalties when an employee receives a premium tax credit for an individual plan in the ACA Marketplace (exchange).

In general, employers with 50 or more full-time equivalent workers are subject to the mandate and its penalty provisions if they fail to comply with its terms.

As originally interpreted by the Obama Administration, the ACA offers a W-2 safe harbor to employers to determine affordability. The safe harbor provides that an employer may calculate the affordability of the offered coverage based solely on the on the wages paid to an employee as reported on his or her W-2 and the cost of ***self-only*** coverage.

As enacted by the ACA, insurance is deemed affordable if the employee's contribution toward coverage does not exceed 9.5 percent of his or her household income (basically, W-2 earnings from an employer). This percentage is adjusted annually by the Internal Revenue Service (IRS). In 2022, this percentage was adjusted to 9.61 percent from 9.93 percent in 2021 and 9.78 percent in 2020. [29]

The minimum value standard is satisfied if a plan coverage at least 60 percent of the total allowed costs of benefits includes substantial coverage of both inpatient hospital and outpatient services. Simply stated, if an employer offers an employee coverage where the self-only cost of coverage are 9.5 percent (as adjusted annually) or less of his W-2 earnings, and it provides minimum value, the employer is in compliance of the ACA.

Family Glitch

Family Glitch: Background Information

As has been previously mentioned, in implementing the ACA, the Obama Administration adopted an interpretation of affordability based on self-only coverage. This means, that employees and their

spouses or dependents are ineligible for premium tax credit (PTC) if the annual employee contribution for self-only coverage is 9.5 percent or less (9.61 percent in 2022) of household income [30] As a result, many workers and their dependents are unable to pay for the cost of family coverage because they cannot take advantage of the subsidies offered by the PTC and in some cases, additional cost-sharing reductions.[31]

Biden Administration Proposed Rule

The Treasury and the IRS have now proposed a new affordability test for individuals related to an employee covered by employer-sponsored insurance. Simply put, this new interpretation of the affordability rule would allow individuals related to a covered worker to access subsidies to lower the cost of their health coverage. Related individuals include family members in an employee's tax household (i.e, spouse filing a joint return and dependents).

The proposed rule *does not* make changes to the affordability test for the employee. It adds a test.

This added test for related individuals is as follows: an offer of employer coverage would be deemed affordable for related individuals if the annual employee portion of the premium for family coverage does not exceed 9.5 percent (9.61 percent in 2022) of household income. If the contribution does exceed the threshold, those related family members would now be able to obtain coverage through the ACA Marketplace and access the PTC and in some cases, additional cost-sharing reductions.

A possible result of the proposed rule is that in some cases, an employee would have access to affordable self-only coverage through his employer while his related family members would have an offer of unaffordable coverage. Thus, enabling them to obtain coverage through the ACA Marketplace.

Examples of the proposed family glitch rule:

Example #1: - Determination of Affordability for Employee
For all of 2023, taxpayer Adam works for employer Milltown. It offers its employees and their spouses a health insurance plan under which, to enroll in self-only coverage that does not exceed the required contribution of Adam's 2023 household income. For illustration purposes, assume 9.61 percent.

Result: Because Adam's required contribution for self-only coverage does not exceed 9.1 percent, Milltown's plan is considered affordable. This, Adam cannot obtain coverage through the ACA Marketplace or access tax subsidies.

Example #2 – Determination of Affordability for Related Individual
Facts are the same as in Example #1, except that Adam is married to Jeanette. They file a joint income tax return. To enroll in Milltown's health plan requires Adam to contribute an amount for coverage for both himself and Jeanette that exceeds the required contribution amount of household income. Jeanette does not work for an employer that offers employer-sponsored coverage.

Result: Because Adam's required contribution for coverage of both Adam and Jeanette exceeds the required contribution percentage (assume 9.61 percent), Milltown's plan is unaffordable for Jeanette. However, Milltown's plan is affordable for Adam.

Implementation and Impact of Proposed Rule

As of this writing, the Biden Administration has an ambitious implementation of the proposed rule – basically, in time for the 2023 open enrollment period which begin November 1, 2022. Some commentators believe this to be too ambitious and a later date more likely.

It is estimated that 5 million Americans are impacted by the family glitch and that over half (2.8 million) are children. However, it is anticipated just 200,000 will gain coverage in the ACA Marketplace under the new rule. Some may prefer to remain covered under one family policy while others may simply choose to remain uninsured. Furthermore, legal challenges to the proposed rule could delay both implementation and anticipated Marketplace enrollment. [32]

Summary

Summary

The Affordable Care Act affects health plans and their members through a number of provisions in three broad areas.

- Access to health coverage is expanded by online Marketplaces where consumers can buy individual health plans, guaranteed issue requirements ensuring that no one is denied coverage because of her health, the extension of Medicaid eligibility to more people in many states, and the continuance of dependent coverage for children up to age 26.

Summary (Continued)

- Comprehensive coverage is promoted by requirements that individual and small group plans provide essential health benefits and that most plans cover preventive care without cost sharing, and by restrictions on annual and lifetime benefit limits.

- Affordability is enhanced by rules for setting premiums for individuals, premium subsidies in the form of tax credits, limits on cost sharing, and requirements that plans spend at least a certain percentage of premium dollars on health care (medical loss ratio requirements).

Appendix A: Some of the Preventive Care Services Required by the ACA

Adults

Immunization vaccines, including for influenza, hepatitis A and B, and others	Blood pressure screening
Cholesterol screening for those of certain ages or at higher risk	Diet counseling for those at higher risk for chronic disease

Colorectal cancer screening for those ages 45 to 75	HIV screening for everyone ages 15-65 and for those at other ages who are at increased risk
Depression screening	Lung cancer screening for adults 50-80 at high risk
Diabetes (Type 2) screening for those ages 40 to 70 who are overweight or obese	Tobacco use screening and cessation interventions for tobacco users

Women

Breast cancer genetic test (BRCA) counseling for women at higher risk	Cervical cancer screening for women ages 21 to 65
Breast cancer mammography screenings every 2 years for women 50 and over, or as recommended by a provider for women 40 to 49 or women at higher risk for breast cancer	Chlamydia infection screening for younger women and other women at higher risk
Breast cancer chemoprevention counseling for women at higher risk	Domestic and interpersonal violence screening and counseling for all women

Pregnant Women

Birth control	Gestational diabetes screening for those 24 weeks pregnant (or later) and those at high risk
Breastfeeding support and counseling from trained providers, and access to breastfeeding supplies, for pregnant and nursing women	Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
Folic acid supplements for women who may become pregnant	Expanded tobacco intervention and counseling for pregnant tobacco users

Children

Immunization vaccines from birth to age 18, including for diphtheria, influenza, measles, and chickenpox	Height, weight, and body mass index (BMI) measurement at various ages

Developmental screening for children under age 3	Hearing screening for all newborns and regular screenings for children and adolescents as recommended by their provider
Autism screening for children at 18 and 24 months	Blood pressure screening at various ages
Well-baby and well-child visits	Fluoride supplements for children without fluoride in their water source
Depression screening for adolescents	Alcohol, tobacco, and drug use assessments for adolescents

Appendix B: Calculating ACA Premium Subsidies

ACA premium subsidy amounts are set so that the recipient must pay a certain percentage of her income for health coverage (her expected contribution). As household income increases, this percentage increases, (amounts for 2020, adjusted annually), and subsidies decrease.[33]

Household Income (expressed as % of FPL)	Initial Premium Percentage	Final Premium Percentage
Less than 133%	2.06%	2.06%
At least 133% but lesson than 150%	3.09%	4.12%
At least 150% but less than 200%	4.12%	6.49%
At least 200% but less than 250%	6.49%	8.29%
At least 250% but less than 300%	8.29%	9.78%
At least 300% but not more 400%	9.78%	9.78%

Under the American Rescue Plan Act, consumers with household incomes between 100 – 150 percent of the FPL may be eligible for coverage options with $0 premiums, based on the cost of the plan minus the premium tax credit allowed for the plan. No one eligible for a premium tax credit will pay more than 8.5 percent of their household income towards the cost of a benchmark plan or a plan that is less expensive than the benchmark plan. Here is a chart providing the applicable percentages for consumers under the American Rescue Plan (Section 9661) for 2021 and 2022:

Household Income (expressed as % of FPL)	Initial Premium Percentage	Final Premium Percentage
Up to 150%	0.0	0.0

150% up to 200%	0.0	2.0
200% up to 250%	2.0	4.0
250% up to 300%	4.0	6.0
300% up to 400%	6.0	8.5
400% and above	8.5	8.5

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24 State Laws and Regulation

Learning Objectives

In the last lesson we discussed various federal laws that govern health plans (unless stated otherwise, "health plans" refers to risk bearing entities licensed under state law). In their roles as business entities and as participants in the delivery and financing of healthcare.

After completing this lesson, you will be able to:

- discuss the role of the NAIC in developing model laws to regulate health plans and their activities
- discuss the goals of state regulation of health plans
- identify the key requirements of the NAIC HMO Model Act
- list types of state laws governing other (non-HMO) entities
- list the main NAIC models for regulating health plan activities

The ACA and State Regulations

Although the Affordable Care Act (ACA) increased the Federal government's regulation of health plans, the bulk of health plan regulation continues to exist at the state level.

Moreover, regulatory flexibilities offered under the ACA allow for additional variation in state laws and regulations. Unless stated otherwise, "health plans" refers to risk bearing entities licensed under state law. [i] [ii]

In order to protect consumers, states regulate health plans. State regulation generally focuses on ensuring the solvency of health plans and ensuring the fairness of the relationship between the health plan and the consumer.

The NAIC

Founded in 1871, the National Association of Insurance Commissioners (NAIC) has long coordinated the regulation of insurance and health plans.[iii]

The NAIC is an association made up of state insurance regulators. Through the NAIC, these regulators establish standards and best practices related to insurance regulation and coordinate their regulatory oversight.

NAIC Model Statutes

NAIC model statutes and regulations are frequently the template for state laws, providing some uniformity to state insurance regulation.[iv] In addition, NAIC models laws have sometimes been the template when Federal laws regulating the relevant subject matter have been adopted. The NAIC offers uniformity to states and their regulated entities through such documents as the Uniform Certificate of Authority Application (UCAA), which allows insurers to file copies of the same application for admission in numerous states. [v]

NAIC Model Statutes (Continued)

As noted by the NAIC, state regulation of health plans is structured around several key functions, including licensing, product regulation, market conduct, financial regulation and consumer services.[vi]

Because state laws vary, in this lesson, we use NAIC model acts and guidelines to discuss specific provisions related to state regulation of health plans. However, it is important to remember that not all states have adopted these model acts (or the most recent model acts) and that they serve as examples of the types of activities states regulate and typical state laws.

Background

Health plans evolved from the indemnity insurance environment. Consequently, many of the provisions of early health plan laws mirrored traditional indemnity insurance laws.

As prepaid health plans emerged, state regulatory authorities faced the task of developing new laws that more appropriately addressed the new types of health plans.

Traditionally, two state agencies shared much of the responsibility for this: the insurance department and the health department. In general, state insurance departments handle most of the regulation related to financial issues, and state health departments address healthcare delivery and quality assurance issues.

Evolving State Statutes

As different types of health plans developed, states initially created different sections of codes for each type.

To understand what laws applied to which entities, one would have to look, for example, under the state HMO Act, the state law regulating non-profit medical services corporations (generally regulating BlueCross and/or BlueShield plans) or general accident and sickness statutes.

While these laws still exist, state statutes appear to be gradually changing to regulate health plans based on the functions in which they engage (e.g., maintaining a provider network or performing utilization review) and the markets in which they offer insurance (e.g., individual, small group or large group markets).

HMO Act of 1973

Before passage of the federal HMO Act of 1973, health insurance plans were subject to laws designed to regulate the operations of indemnity insurance companies or hospital and medical service corporations, and these laws often restricted the development of HMOs.

The federal HMO Act encouraged states to develop statutes that would facilitate rather than hinder the establishment and operation of HMOs. One of the most important steps in this movement was the NAIC's development of its Health Maintenance Organization Model Act (HMO Model Act).

Today every state has laws that address HMOs, most patterned after some version of the model act. [vii]

NAIC HMO Model Act

The NAIC HMO Model Act regulates the licensure and financial responsibility of HMOs. The Act also includes filing and reporting requirements.

When initially designed, the HMO Act also regulated healthcare delivery by establishing requirements for network adequacy, quality assurance, and grievance procedures. However, as different types of health plans were developed, the NAIC established separate model acts regulating issues that apply to a broader range of health plans.

Consequently, the HMO Act is designed to operate in conjunction with state laws based on other NAIC models such as the Health Benefit Plan Network Access and Adequacy Model Act, the Quality Assessment and Improvement Model Act and the Health Carrier Grievance Procedure Model Act, among others.

Certificate of Authority

An HMO that wishes to begin operations in a state is required to obtain a certificate of authority (COA), or license, from that state.

The COA provides proof that the organization has met the state's licensing requirements and has demonstrated that it is dependable, fiscally sound, and able to meet other specified standards.

Financial Responsibility Requirements Under the HMO Model Act

HMOs are also required to meet financial standards related to net worth or capital, financial reporting, liquidity, and accounting and investment practices.

Financial Deposit Requirements

The HMO Model Act also sets forth financial deposit requirements, including initial deposit requirements.

The initial deposit may be used by the state insurance department to protect the interest of the HMO's members and to pay for covered services if the HMO is put into receivership or liquidation.

Financial Standards

These financial standards are designed to protect plan members from the risk of an HMO becoming insolvent. Insolvency occurs when an organization's assets or resources are not adequate to cover its debts and obligations. An HMO is considered to be insolvent when it does not have enough resources to pay for its members' current and future healthcare needs.

If the state insurance commissioner finds that an HMO is or is likely to become insolvent, the commissioner can intervene by imposing a variety of sanctions including suspension of the certificate of authority.

Receivership

If more serious action is necessary, the HMO can be placed in receivership.

Receivership is a situation in which the commissioner, acting for a state court, takes control of and administers an HMO's assets and liabilities. The primary goal of receivership is to rehabilitate the HMO—that is, return the organization to normal operation. In this case, the HMO's business continues to exist.

If rehabilitation is not possible, the commissioner can liquidate the organization by transferring all of its business and assets to other health plans or by selling its assets to satisfy its obligations. Liquidation terminates the HMO's business.

HMO Model Act and Consumers

The HMO Model Act also protects consumers by requiring every HMO to include in its contracts with network providers or entities to which it delegates risk a "hold harmless" clause.

The clause prohibits risk bearing entities or providers from billing HMO members for covered services if the plan becomes insolvent or otherwise fails to pay the provider or risk-bearing entity.

Reporting Requirements

The NAIC HMO Model Act requires HMOs to satisfy a variety of filing and reporting requirements. For example, HMOs must submit copies of proposed provider and group contract forms, evidence of coverage forms, and premium rate methodology as part of the COA application process.

Changes to any of these forms must also be filed with the appropriate state agency. In addition, HMOs must file annual reports with state regulators describing their finances and operations. Annual reports must be filed on state-approved forms and verified by at least two of the HMO's principal officers.

To protect the interests of HMO enrollees, the model act authorizes state insurance departments to conduct periodic examinations to verify an HMO's compliance with financial, service delivery, and reporting requirements.

Regulation of Other Entities

Preferred Provider Arrangements

In addition to HMO laws, all states have laws to regulate health plans that include preferred provider arrangements.

These laws define a preferred provider arrangement (PPA) as a contract between a healthcare insurer and a healthcare provider or group of providers who agree to provide services to persons covered under the contract.

Preferred provider organizations (PPOs) and exclusive provider organizations (EPOs) are examples of health plans that include a preferred provider arrangement.

Definition of EPO:

Exclusive Provider Organization (EPO) Plan

A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Variances in PPAs

Laws governing PPAs of course vary by state, and they also differ according to the structure of a health plan.

For instance, an HMO offering a POS product and a PPO both provide enhanced network benefits and lesser non-network benefits, but a state may regulate the HMO under its HMO law and the PPO under their state insurance laws (e.g., by requiring a COA under its accident and sickness section).

HMO, EPO, and PPAs

Likewise, a traditional HMO and an EPO may both exclude benefits for out-of-network care, but the HMO falls under the HMO law and the EPO under insurance laws.

This can be important, as differences between a state's HMO law and its insurance code can result in differences in solvency requirements, premiums, some covered services, and

potentially consumer protections, even though the product concept is the same. Finally, it should be noted that a significant number of PPAs are self-funded employer plans, which are not subject to state insurance laws.

In the case of organizations offering preferred provider networks but not accepting financial risk, many states require these organizations to simply register with the state.

As noted elsewhere in the lesson, state laws, which can be quite detailed, regulate the adequacy of provider networks for preferred provider arrangements.

Prepaid Limited Health Services Organizations

Most states separately regulate prepaid limited health service plans – that is plans that offer a limited set of benefits, such as:

- dental plans
- vision plans
- plans that offer only mental health services
- substance abuse services
- podiatric care
- other services as the state insurance commissioner may designate

NAIC Prepaid Limited Health Services Organizations Model Act

These plans are frequently exempt from many of the broader state and Federal insurance market requirements.

The NAIC Prepaid Limited Health Services Organizations Model Act and its guidelines set forth the requirements for these plans to obtain a certificate of authority and sets forth standards for the solvency of such plans.

In addition, the model act provides for an examination of the plan by the insurance department, regulates the plan's contracts with its providers, sets forth filing and reporting obligations and gives the insurance department the right to take action if the plan failed to meet any other the relevant requirements. [viii]

Utilization Review

As set forth in the subsequent section, utilization review is generally subject to regulation if the recommendations affect a health plan's decision to cover a specific service.

Entities that perform utilization review (UR) that are not health insurers are called utilization review organizations (UROs).

URO Requirements

Although UR laws vary widely, most states require UROs to be licensed and to obtain some form of certification.

For a URO to be certified, its personnel must satisfy certain criteria related to education, training, and experience. UROs must also typically meet standards for accessibility and confidentiality of medical information. UROs that fail to comply with state laws are subject to fines and penalties.

UROs are also generally subject, directly or indirectly, to the same laws that apply to health plans in their performance of utilization review activities.

Third-Party Administrators

Third-party administrators (TPAs) are generally companies that provide administrative services to health plans or employers.

Some of these administrative services, such as underwriting and claims payment, are classified as insurance activities and as such are subject to state regulation.

NAIC Third Party Administrator (TPA) Model Act

Most of the state laws regulating TPAs are modeled on some version of the NAIC Third-Party Administrator (TPA) Model Act, which has now an NAIC guideline titled “Registration and Regulation of Third-Party Administrators.”

State TPA laws typically specify that to act as a TPA an organization must obtain a license from the state insurance department designating the organization as a TPA.

If the TPA only furnishes services to self-funded plans, it generally must only register with the state (unless it is an insurer). A TPA must also maintain, as a business record for each client organization, a written agreement describing the duties the TPA will perform, the compensation it will receive, and the standards that pertain to the business the TPA will administer.

Health Plan Responsibilities

Regardless of the terms of any TPA agreement, the health plan remains responsible for determining all premium rates, benefits, underwriting criteria, and claims payment procedures, and for ensuring that the plan is administered properly.

The TPA serves primarily as a fiduciary. As such, it must hold all funds it receives on behalf of the health plan in trust and must provide the plan with an accounting of all transactions performed on behalf of the health plan.

The TPA is required to notify the state insurance department of any material changes in ownership, control, or qualification for a certificate of authority.

Suspension or Revocation of a TPA

The TPA Model Act specifies mandatory suspension or revocation of a TPA's certificate of authority if the TPA is financially unsound, is using practices that are harmful to insured persons or the public or has failed to pay any judgment rendered against it within 60 days.

The state insurance department has discretionary authority to suspend or revoke a TPA's certificate of authority if the TPA has violated the state's insurance laws; refused to be examined or to produce its records for examination; refused, without just cause, to pay claims or perform services under its agreement; or been placed under suspension or revocation in another state. [ix]

Regulation by Market

State Regulation

States also regulate health plans according to the market in which they offer insurance products.

For example, different regulations apply to offerings in the individual market, small group market or group market in general.

Minimum Standards

Many of these regulations are dictated by Federal law or have Federal law that applies as a minimum standard or "floor."

These laws are generally intended to protect consumers. However, states may still be charged with implementing and enforcing these laws.

Such laws specify requirements such as the factors that may be taken into account in calculating premiums; when insurance must mandatorily be offered to, or renewed for, an individual or group; the minimum benefits that must be covered; and types of prohibited discrimination against individuals or groups.

Regulation of Health Plan Activities

Credentialing

The NAIC's Health Care Professional Credentialing Verification Model Act specifies requirements that health plans must satisfy to ensure that network providers meet minimum standards of professional qualification. These requirements include the following:

- verification of the credentials of all contracted healthcare professionals in accordance with written procedures that must be disclosed, on written request, to any applying healthcare professional;

- collection of a minimum set of credentialing information by either primary or secondary verification, with recredentialing required every three years; and

- establishment of a process by which providers can review and correct credentialing information.

Although credentialing is required for all health plans, meeting a plan's credentialing criteria does not ensure a provider's selection by that plan. [x]

Quality Management

Numerous states have enacted laws regulating the quality assessment and improvement activities of health plans, many of which are patterned after the NAIC's Quality Assessment and Improvement Model Act.

This model requires health plans to establish and report on systems for assessing the quality of care and services they provide.

NAIC Quality Assessment and Improvement

In particular, quality assessment laws require health plans to:

- establish an appropriate system for assessing the quality of healthcare services provided by each type of network

- report to the appropriate licensing authorities any problems that would offer grounds for provider termination

- file a written description of quality assessment programs with the state insurance commissioner or the secretary of the state health department

- describe quality programs to consumers through marketing and educational materials

- meet specified data confidentiality requirements

Closed Plans

The model also requires closed plans to implement a quality improvement program to identify the best and worst outcomes and utilization patterns and the providers responsible for each.

Closed plans are defined as health plans that require covered persons to use participating providers. Closed plans are required to develop treatment protocols, practice guidelines, and other quality improvement strategies and to report annually on the impact of these strategies.

Tiering

States are also regulating quality-related activities of health plans such as tiering provider networks based on quality and/or economic performance of participating providers.

Tiering refers to creating different levels of member cost-sharing for providers in order to encourage members to use certain providers. [xi] [xii]

State laws around these arrangements generally call for transparency regarding the quality or economic measures used to create the tiers and provide certain protections to providers, such as the right to see the data on which the decision was made and the right to appeal tiering decisions.

Network Access and Adequacy

Maintenance of a provider network is another function regulated by the states. Due to concerns about health plans offering narrow networks of providers, surprise bills from non-network providers and the need to establish rules for plans offered through the ACA marketplaces (exchanges), states have been engaged in significant activity related to their oversight of network adequacy.

The NAIC's Health Benefit Plan Network Adequacy and Access Model Act

The NAIC recently updated and expanded its model law on this topic, which addresses these concerns and recent industry changes in the organization of provider networks.

The NAIC's Health Benefit Plan Network Adequacy and Access Model Act regulates the creation and maintenance of health plan provider networks.

Model law's requirements:

The model law requires health plans to:

- maintain provider networks that are sufficient in numbers and types of providers to ensure health care services are reasonably available. It specifies a list of criteria, such as geographic distribution, waiting times and hours of operation, that states may use to determine if this standard is met;
- provide out-of-network services at in-network cost sharing if a particular type of provider is not available in-network or if the network is insufficient;
- file with the commissioner their access plans for the commissioner's approval and/or review;
- include in their provider contracts an obligation to hold covered persons harmless and provide continued coverage for uncompleted treatment in the event of plan insolvency as well as a list of other provisions;
- notify providers of their obligations about compliance with plan requirements related to

utilization management, dispute resolution, quality assessment, reporting and other policies and procedures;

- avoid provider selection criteria that would discriminate against high risk populations;
- adhere to specified disclosure requirements, including 60-day written notice to providers before terminating a contract without cause and 30-day notice to patients of a provider's contract termination;
- file sample contract forms with the state insurance commissioner; and
- make available, in the time and manner specified, provider directories that contain specific information listed in the model act.
- In addition, under this model act health plans may not:
- induce providers to deliver less than medically necessary care,
- prevent providers from discussing treatment options with patients, or
- penalize providers for advocating on behalf of patients in the grievance or appeals process.

A new section of the model law addresses non-contracting providers who furnish services at in-network facilities, which has become a prominent issue in recent years and an impetus for the recently enacted federal No Surprises Act.

It requires notice in the case of non-emergency services and provides certain financial protections in the case of emergency services. The model also addresses for the first-time tiered provider networks. [xiii] [xiv]

Utilization Review, Benefit Determinations and Appeal Procedures

All states have laws that regulate how health plans make benefit determinations and notify their members of those determinations as well as member appeals of health plan coverage and payment decisions.

Such regulation typically specifies the timeframes for making determinations or resolving appeals, the qualifications of the individuals making the decisions and the rights of members in connection with those decisions.

States regulate both the appeals handled internally by the plans and members rights to obtain a decision from an independent external review entity. Much of this state regulation has been updated in recent years to be consistent with requirements implemented under the Affordable Care Act, which set minimum standards for such activities.

NAIC Utilization Review and Benefit Determination Model Act

The NAIC Utilization Review and Benefit Determination Model Act applies to health plans and UROs furnishing services on their behalf. It specifies that all health plans that provide or perform utilization review must:

- implement a written utilization review program describing its utilization review procedures (including data sources, clinical review criteria, mechanism to ensure consistency of decisions and other specified information) and report annually on the program;
- use and make available to government authorities upon request documented clinical review criteria;
- use qualified health professionals, including using a clinical peer to evaluate the appropriateness of adverse determinations;
- make utilization review and benefit determinations available within specified timeframes;
- not tie reviewer compensation to the number of adverse determinations; and
- cover, without preauthorization, emergency services necessary to screen and stabilize a covered person, if a prudent layperson would believe an emergency exists. Health plans are required to pay for such services regardless of whether the provider furnishing them is a contracting provider. [xv]

NAIC's Health Carrier Grievance Procedure Model Act- First Level Review

The NAIC's Health Carrier Grievance Procedure Model Act calls for the development of written procedures for handling member appeals of adverse benefit/utilization review determinations and rescissions of coverage (referred to as grievances).

Second Level Review

Health plans may also voluntarily provide a second level review. They are obligated to report to the commissioner at least annually regarding the numbers and outcome of decisions. [xvi]

In instances in which a health plan misses its decision deadline or when a member is unhappy with the resolution of a grievances, members may appeal to independent review entities that are regulated both under state and Federal law.

The NAIC's Uniform Health Carrier External Review Model Act sets forth the standards on which many such state external review regulations have been based. [xvii]

Payment of Health Care Providers

While Federal law largely focuses on protection of consumers, state law often regulates the relationship between health plans and their providers. For example, states regulate the payment of health care providers by health plans.

Virtually every state has a law setting forth the timeframe in which a health plan must pay a health care provider who/that has submitted a "clean claim." In addition, state laws specify interest due to the provider if the health plan fails to meet that timeframe.

Most states also regulate the timeframe in which a health plan may make retrospective adjustments to payments made to health care providers. The state mandated timeframes run from 6 months to 24 months after the initial claims payments. [xviii]

Privacy of Health Information

While the Health Insurance Portability and Accountability Act (HIPAA), as subsequently amended, set forth national standards for the protection of individually identifiable health information, HIPAA set forth only the minimum standards.

Authorization and Disclosure of Sensitive Information

States could and have enacted laws that provide additional protections for health information.

One area in which states typically provide such protection is with regard to "sensitive" information, such as that related to mental health, HIV, substance abuse or sexually transmitted diseases.

States frequently place additional restrictions around the authorization and disclosure of this information. Some states simply provided greater restrictions, in general, around the allowable uses and disclosures of health information.

In addition, state laws may require disclosure of breaches in the privacy of health information in instances in which Federal law would not require such disclosures or require such disclosure to different individuals or entities and in shorter timeframes.

Public Option at State Level(s)

Public Option Movement

Recently, several states have sought to offer public health insurance options – something that progressive members of Congress sought but could not enact as part of the federal 2010 Affordable Care Act legislation. These efforts have been spearheaded by Washington State closely followed by Colorado and Nevada. Thus far, these efforts could best be described as mixed but worth watching for their impact on the commercial health insurance marketplace as well as public plans designs in Medicare, Medicaid, and ACA Exchange offerings.

What is a public health insurance option?

The classic definition of a public health insurance option is a publicly funded, government-run insurance plan that competes directly with private health insurance coverage. [xix]The common goal of those who seek to create public health insurance options is to primarily lower premiums and the underlying health care costs which drive them. These plans are also looked upon as a way to promote health equity by reducing disparities through improved network adequacy, engaging diverse voices, providing subsidies to those in need, and expanding access to safety net and rural providers. [xx]

Broader Understanding of Public Option Model

Recently, the term "public option" has been interpreted more broadly by policymakers and others to encompass a variety of models that include:

- *Fully Public Plan* – This model envisions the establishment of a newly created publicly insurance plan that competes directly with private health insurance coverage.
- *Public Plan Buy-In* - Under this model, individuals could opt to buy into existing public programs such as Medicare, Medicaid, or a federal or state employee health plan. For example, the ability to buy into the Federal Employee Health Benefits program. [xxi]
- *Public-Private Program* – This third model, is viewed as a joint public-private partnership where the government requires or encourages private entities, such as private health plans, to offer additional and a more highly regulated plan or plans for which the private entities bear the financial risk.

History offers a cautionary lesson

Vermont offers a cautionary lesson for policymakers who espouse a single-payor fully public plan. In 2010, its then governor laid out a bill for the Green Mountain Care which was passed by the state legislature. In effect, the state sought to replace the private health insurance system with a newly created publicly operated health care system. Four years later, after concluding the financial costs to the state were too great for the potential coverage provided, the efforts to launch the program were abandoned. [xxii]

Current state public option efforts

Current state public option underway in Washington, Colorado, and Nevada (and being closely watched by other states) are taking a different approach focusing on public-private program initiatives. In other words, privately funded plans are established according to state law and subject to certain heightened requirements compared to other plans for items such as cost containment, network adequacy, and care quality. These plans will be offered on the ACA marketplaces and designed to qualify for federal subsidies. [xxiii]

Right now, the results have been mixed. In its first operation, the Washington State plan was complicated by higher-than-expected premiums and limited availability.[xxiv]Subsequent legislation has sought to alert these deficiencies.[xxv] And some commentators contend that lower costs can only be attained by cutting provider fees which could present additional hurdles.

[xxvi]Moving forward these state public option initiatives are likely to change and evolve to meet different needs and marketplace conditions.

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[xix] Georgetown University Center for Health Insurance Reforms, Public Option 101: Understanding Public Health Insurance Options, available at https://publicoption.chir.georgetown.edu/public-option-101/

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25 Government Programs: Medicare

Learning Objectives

After completing this lesson, you will be able to:

- describe the Medicare program, including its component parts and the options available to beneficiaries
- tell how the Medicare Advantage program has developed
- identify the different types of Medicare Advantage plans
- describe Medigap policies
- discuss Medicare responses to the COVID-19 public health emergency

Government Programs and Healthcare Benefits

The federal government is a payor and purchaser of healthcare benefits. It provides health benefits directly or through grants, and it operates programs that serve populations such as the elderly and disabled (Medicare), low-income people (Medicaid), federal employees (FEHB), and active and retired members of the uniformed services and their dependents (TRICARE). The federal government also plays an important role in healthcare by maintaining standards for Medicare healthcare providers, federally qualified HMOs, and health plans for federal employees, as well as quality standards for hospitals, clinical laboratories, and many other healthcare entities. Most federal healthcare functions are under the Department of Health and Human Services (HHS), which includes the **Centers for Medicare and Medicaid Services (CMS)**.

This lesson examines the Medicare program, with special attention to the Medicare Advantage program, through which individuals can opt to receive Medicare coverage from a private-sector health plan. It also takes a look at Medicare supplement insurance, also known as Medigap.

Medicare: An Overview

Medicare is a federal program that was established under Title XVIII of the Social Security Act of 1965 as part of President Lyndon Johnson's Great Society Program. It is social insurance that provides benefits for hospital care, medical services, and other healthcare expenses. It is available to persons 65 or older; people under 65 with severe, long-term disabilities; and persons with end-stage renal disease (ESRD) and those suffering from ALS.

Medicare is an entitlement program—for individuals who meet the qualifications, benefits are a right. Medicare provides extensive coverage, but it does not cover all health-related expenses, and beneficiaries must pay significant deductibles, copayments, and coinsurance. Therefore, individuals may want to supplement Medicare with private-sector insurance (discussed later).

Four Components of Medicare

Medicare has four key components referred to as Parts A, B, C, and D:

- Medicare originally had two components: **Part A** (hospital coverage) and **Part B** (medical coverage). Parts A and B together are referred to as "**Original Medicare**" or "traditional Medicare." Original Medicare is traditional fee-for-service coverage.

- In 1997, **Part C** was added. This is the **Medicare Advantage (MA)** program, which gives beneficiaries the option of obtaining Part A and Part B coverage (and some other benefits) through a Medicare-approved private-sector health plan. Most MA plans are managed care plans.

- In 2006, **Part D** (prescription drug coverage) was added. Medicare beneficiaries choose whether to participate in Part D, and those who do participate pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector prescription drug plans (PDPs) and by many Medicare Advantage plans.

A majority of Medicare beneficiaries receive coverage though Original Medicare, but over 26 million (about 42 percent) choose Medicare Advantage (2021). [i]

A majority of beneficiaries are also enrolled in Part D, either through a standalone prescription drug plan (PDP) or an MA plan that includes prescription drug coverage, typically referred to as MA-PD. .

Medicare Part A Coverage

Medicare Part A includes benefits for the following (based on 2022 figures):

- **Inpatient Hospital Care-**There is a large deductible ($1,556) per benefit period (usually a hospital stay), large daily copayments ($389) after 60 days, and a limit of 90 days per benefit period (except for 60 lifetime reserve days, for which there is a daily copayment of $778).[ii]

- **Skilled Nursing Facility Care-**following hospitalization. Skilled care must be medically necessary for recovery from an acute illness or injury, and other conditions must be met. There is a limit of 100 days per benefit period and large daily copayments ($194.50) after day 20.[iii]

- **Home Health Care-**following hospitalization or nursing facility care. Intermittent skilled care must be medically necessary for recovery from an acute illness or injury, and other conditions must be met. There is no cost-sharing for home health care but beneficiaries are responsible for 20 percent of the Medicare-approved amount for durable medical equipment such as a hospital-type bed or wheelchair.

- **Hospice Care-**provided to terminally ill persons. Only small copayment and coinsurance amounts for a few items are charged.

Click here for a chart of Part A – Hospital Insurance costs.

2022 Medicare Amounts – Part A Hospital Insurance [iv]

Cost For:	You Pay:
Part A Deductible for Each Benefit Period	$1,556
Hospital Inpatient Stay for Each Benefit Period	$0 for days 1-60 $389 a day for days 61-90 $778 a day for days 91-150 (lifetime reserve days) All costs for all days after 150
Skilled Nursing Facility Stay	$0 for days 1-20 $194.50 a day for days 21-100 All costs for all days after 100
Home Health Care	$0 for home health care services 20 percent of the Medicare-approved amount for durable medical equipment
Hospice Care	$0 for hospice care You may need to pay a copayment of no more than $5 for each prescription drug and other similar products for pain relief and symptom control while you are at home. You may need to pay 5 percent of the Medicare-approved amount for inpatient respite care. Medicare does not cover room and board when you get hospice care in your home or another facility where you live (like a nursing home).

<u>Medicare Part A Eligibility and Premiums</u>

Part A is provided without charge to U.S. citizens and certain resident aliens who are 65 or older and receiving or eligible for Social Security or Railroad Retirement Board (RRB) retirement benefits, as well as most persons participating in retirement programs for federal, state, or local government employees instead of Social Security. Other people 65 or older may enroll in Part A, but they must pay a premium. This premium stood at $499 [2022] a month for those with less than 30 Social Security work quarters and $274 for individuals or their spouses with 30 to 39 work quarters. As a general rule, those who paid into the Medicare system while they were working by means of FICA payroll deductions for at least a

minimal amount of time (or whose spouses did so) do not pay a premium, while those who did not must pay.

Medicare Part A is also available to disabled persons under 65 who meet certain criteria. They must qualify for Social Security (SS) or RRB disability benefits, which means that their disability must be total—that is, so severe that they are unable to engage in any substantially gainful work. The disability must be long-term—they must have received SS or RRB disability benefits for at least 24 months. Because of these restrictive conditions, many disabled persons do not qualify.

Individuals of any age who suffer permanent kidney failure (end-stage renal disease, or ESRD) or amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease) are also eligible. [vvi]To qualify on the basis of a disability, ESRD, or ALS, a person (or his or her spouse) must have paid into the Medicare system for at least minimal amount of time while working. Those who have not done so may not enroll by paying a premium, as can those 65 or older.

Finally, the Affordable Care Act amended the Social Security law so as to extend Medicare eligibility to people who have developed certain health conditions as a result of living in an area where they were exposed to environmental health hazards.[vii viii]

Medicare Part A Funding

Medicare Part A is funded primarily by payroll taxes on working people and their employers. Currently, employees and employers each pay 7.65 percent of wages in FICA taxes, of which 6.2 percent is for Social Security and 1.45 percent is for Medicare. While Social Security taxes are levied only on wages up to $147,000 (2022) per year, Medicare taxes apply to all wages, even those above this level. A self-employed person pays both the employer and the employee portion, for a total of 15.3 percent. [ix]

The Affordable Care Act (ACA) made two important changes to this system beginning in tax year 2013:

- **Tax increase on earned income-**Those with annual employment earnings above $200,000 (individual) or $250,000 (couple) pay a higher Medicare employment tax rate on their earnings above that level (2.35 percent instead of the usual 1.45 percent). In other words, high earners pay an additional 0.9 percent. The employer contribution (1.45 percent) is not increased. These thresholds are not adjusted for inflation, so over time more people will be liable for this increased rate. Individuals subject to this additional Medicare tax file Form 8959 along with their annual 1040 tax return. [x]

Additional information on the Social Security wage base:

Social Security Wage Base

The Social Security Old-Age, Survivors, and Disability Insurance (OASDI) program limits the amount of earnings subject to taxation for a given year. These are the earning used in calculating an individual's Social Security benefits. These figures are sometimes referred to as the taxable maximum or Social Security wage base. The amounts generally tend to rise from year to year based on changes in the

national average wage index but did remain flat during the Great Recession. Here are the contribution and benefit bases from recent years:

Year	Amount
2012	$110,100
2013	$113,700
2014	$117,000
2015	$118,500
2016	$118,500
2017	$127, 200
2018	$128,400
2019	$132,900
2020	$137,700
2021	$142,800
2022	$147,000

It is important to remember that earnings above the Social Security wage based are taxed at an unlimited basis for the Medicare Hospital Insurance (HI) program at 1.45 percent for employers and most employees. High earners may be subject to a 0.9 additional tax. [xi]

- **Tax on unearned income-** There is a 3.8 percent Medicare surtax on unearned income (investment income such as interest, dividends, and capital gains) of high-worth individuals, estates, and trusts. For individuals this tax applies to net investment income or to modified adjusted gross income (MAGI) in excess of $200,000 (individual) or $250,000 (couples), whichever is less. [xii]

Medicare Part B Coverage

Medicare Part B covers a wide array of services and supplies, including physician and surgeon services, services provided by some other healthcare practitioners, outpatient medical and surgical services, emergency room and ambulance services, laboratory services, therapy, mental healthcare, durable

medical equipment, and others. The Affordable Care Act (ACA) added several preventive care services to Part B coverage, including annual wellness visits, various disease screenings, personalized disease prevention plans, cardiac rehabilitation programs (including exercise, education, and counseling), an EKG, and others.

With a few limited exceptions, Original Medicare does not pay benefits for dental care and dentures, vision care and eyeglasses, hearing exams and hearing aids, foot care and orthopedic shoes, chiropractic services, healthcare delivered outside the United States, and some other health-related services and products. In the past, Medicare coverage of preventive care was fairly limited, but it has been expanded in recent years. As a result, although there are still a few screenings and diagnostic tests that are not covered, this is no longer a major coverage gap.

Medicare Part B, as will be discussed shortly, is a benefit that is actively elected by most enrollees and entails the payment of monthly premiums. For most Part B services and products beneficiaries must pay an annual deductible and 20 percent coinsurance. The ACA eliminated this cost-sharing for most (but not all) preventive care. Under both Part A and Part B, beneficiaries must pay for the first three pints of blood (if it is not donated by a blood bank, as is usually the case).

Part B Eligibility and Premiums

All U.S. citizens (and certain resident aliens) 65 or older have the option of receiving Medicare Part B. Persons with disabilities, ESRD, or ALS who are eligible for Medicare Part A are also eligible for Part B. Because Part B covers important healthcare services not covered by Part A, many of those enrolled in Part A choose Part B as well.

All Part B enrollees pay a monthly premium. Most people—those with annual income at or below $91,000 (individual) or $182,000 (couple)—pay the standard premium, while those with greater income pay higher amounts based on their income. In 2022, the standard Part B premium is $170.10. Those with higher incomes pay up to $578.30 per month.

More information on Medicare Part B costs:

Cost Item	Amount (2022 figures)
Part B Deductible	$233 per year
Part B Coinsurance	After a beneficiary's deductible is met, they typically pay 20 percent of the Medicare-approved amount for most doctor services, outpatient therapy, and durable medical equipment.
Part B Standard Premium	The standard Part B premium is $170.10. Some people who receive Social Security pay less. Those with higher income pay more.

Part B and Higher Income Levels

Since 2007, Medicare beneficiaries with higher income levels have paid higher Part B monthly premiums. If a beneficiary's modified adjusted gross income is above a certain amount, they pay an Income Related Monthly Adjustment Amount **(IRMAA)**. Medicare uses the modified adjusted income **(MAGI)** reported on an individual's (or couple if filing jointly) 1040 tax return from 2 years prior (the most recent tax return information provided to Social Security by the IRS). Those subject to IRMAA are notified of their status by the Social Security Administration (SSA) along with information as to how to appeal the determination. [xiii] [xiv]

Definition of Modified Adjusted Gross Income (MAGI) .[xv]

Modified Adjusted Gross Income **(MAGI)** is the sum of a Medicare beneficiary's adjusted gross income (AGI) per their 1040 Income Tax Return plus tax-exempt interest.

Example: Wilbur is a single individual who has comfortably retired and is over age 65. Wilbur's income is as follows:

Pension(s)	$60,000
Social Security	30, 600 (tax amount)
Rental Income	12,000
Taxable Interest	1,400
AGI	$104,000
Tax-exempt Interest	$ 1,000
MAGI	$105,000

More information on Medicare Part B premiums for those with higher incomes:

Part B Premium(s) in 2022 based on income (MAGI) shown on 2020 return [xvi]

Individual Income Tax Return Filers	**Joint Tax Return Filers**	**Premium**
$91,000 or less	$182,000 or less	$170.10
Above $91,000 up to $114,000	Above $182,000 up to $228,000	$238.10

Above $114,000 up to $142,000	Above $228,000 up to $284,000	$340.20
Above $142,000 up to $170,000	Above $284,000 up to $340,000	$442.30
Above $170,000 and less than $500,000	Above $340,000 up to $750,000	$544.30
Equal to or above $500,000	Equal to or above $750,000	$578.30

Married Filing Separate Retuns	**Premium**
$91,000 or less	$170.10
Above $91,000 and less than $409,000	$544.30
Equal to or above $409,000	$578.30

[xvii]

Part A and Part B Enrollment

People who receive Social Security (SS) or RRB retirement benefits are automatically enrolled in Medicare Part A when they turn 65. Disabled persons are automatically enrolled after they have received SS or RRB disability benefits for 24 months. Both of these groups are also enrolled in Part B unless they indicate that they want to opt out. Others eligible for Medicare (such as those who are 65 or older but still working and not receiving Social Security) must sign up for Part A and Part B if they want it.

Those who must pay for Medicare Part A can enroll during an initial enrollment period (three months before and after they turn 65) or later during a **general open enrollment period** (every year from January 1 through March 31). Persons who have employer-sponsored health insurance can enroll at any time while they are still covered by the employer plan and up to eight months after this coverage ends. People who opt out of Medicare Part B when they first become eligible may enroll later during a general enrollment period, and those with employer-sponsored coverage have until eight months after that coverage ends. [xviii]

Late Enrollment

There are premium penalties for late enrollment into Medicare. The rules differ for Part A and Part B.

Part A – Most individuals are eligible, due to their work histories, for premium-free Part A but some are not. If an individual must pay for Part A and fails to enroll when first eligible their monthly premiums increase up to 10 percent more for twice the number of years they waited to enroll. [xix]

Example:

Marie becomes eligible for Medicare at age 65, but because she never paid into the Medicare system, she will have to pay Part A premiums. Marie waits 2 years – until she is 67 to enroll. She will have to pay a higher premium for 4 years.

Part B – Late enrollees into Medicare Part B have to a premium penalty up to 10 percent for each 12-month period that the person waits to enroll. This penalty applies for as long as the late enrollee has Part B coverage. (As we will discuss later lifetime penalty rules also apply for late enrollment into Part D Prescription Drug Coverage).

In addition, an individual may have to wait until the General Enrollment Period (from January 1 to March 31) to enroll. In such situations, Part B coverage will not begin until July 1 of that year. [xx] [xxi]

Example:

Jane's Initial Enrollment Period ended September 30, 2017 Jane waited to sign up for Part B until the General Enrollment Period in March 2020. Jane's premium penalty is 20 percent. While she waited a total of 30 months to sign up, this included only 2 full 12-month periods. Jane has to pay this penalty for as long as she maintains Part B coverage.

<u>Medicare Part C (Medicare Advantage)</u>

Medicare Advantage (Medicare Part C) is an alternative to original Medicare. Those entitled to Medicare can choose to receive coverage through Original Medicare, or (in most areas of the country) they have the option of instead participating in a Medicare Advantage (MA) plan. MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private fee-for-service (PFFS) plans, and others.

Medicare Advantage plans are Medicare-approved private-sector health insurance plans. The Medicare program pays an MA plan a fixed amount each month for each person it serves, and the plan provides Medicare coverage. An MA plan must provide all Part A and Part B coverage. Many MA plans provide additional benefits, such as coverage of Medicare cost-sharing payments, and some provide coverage that goes beyond original Medicare such as dental care, hearing aids, and eyeglasses. Finally, many Medicare Advantage plans offer Medicare Part D prescription drug benefits (usually at an additional cost). [xxii]

MA Premiums and Enrollment

Enrollees pay their MA plan a monthly premium that covers the Medicare Part B premium and pays for any benefits in addition to Medicare Part A and B that the plan provides. MA participants also pay copayments and sometimes deductibles and coinsurance for some services. The extent of coverage beyond Original Medicare, premium rates, and cost-sharing payments vary from plan to plan.

To enroll in a Medicare Advantage plan, a person must be enrolled in or eligible for Medicare Part A and enrolled in Part B and live in the area covered by the MA plan. A person can enroll in an MA plan when they first become eligible for Medicare (three months before and after they turn 65 or three months before and after their 24th month of disability). There are also enrollment periods each year during which a person can switch from Original Medicare to an MA plan, or from an MA plan to Original Medicare, or from one MA plan to another. This open enrollment period runs from October 15th to December 7th of each year. [xxiii]

Medicare Part D

Medicare Part D provides outpatient prescription drug coverage. Persons eligible for Medicare choose whether to participate in Part D, and those who do pay an additional monthly premium. Part D benefits are provided by Medicare-approved private-sector **prescription drug plans (PDPs)**. A Medicare beneficiary enrolls in the PDP of their choice, receive benefits from that PDP, and pay their Part D premium directly to the PDP. Many Medicare Advantage plans also offer Part D benefits (usually at an additional cost). These plans are referred to as MA-PD plans.

PDPs

Medicare beneficiaries usually have many PDPs to choose from, and PDPs vary in the benefit packages they offer. But all plans must provide a minimal level of benefits, and Medicare also specifies certain drugs that all PDPs must cover. The benefits and cost-sharing of a PDP are typically structured as follows:

- **Annual Deductible-**Enrollees typically pay an annual deductible, but this may vary, and not all PDPs have a deductible.

- **Copayments and/or Coinsurance-** Coinsurance percentages are often 25 or 33 percent. Copayment amounts vary widely from plan to plan.

- **Coverage Gap-** Once the total amount both the beneficiary and the PDP have paid for drugs reaches a certain level (the initial coverage limit), there is a coverage gap, during which the beneficiary previously plaid all cost and this gap was referred to as the *donut hole*. The ACA included provisions gradually closing this gap. Today, the enrollee plays 25 percent of prescription drug costs for generic drugs and 25 percent of undiscounted costs for brand name drugs.

- **Catastrophic Coverage-** If the amount the beneficiary has paid for drugs reaches a certain level (the out-of-pocket limit), catastrophic coverage is triggered, and the coverage gap (donut hole) ends. From this point until the end of the year, the beneficiary pays only small copayment or coinsurance amounts. [xxiv]

Standard and Non-Standard Part D Benefit Coverage

A PDP plans must cover at least the standard benefit prescribed by CMS or meet the requirements for *alternative benefits.* Part D plans structure that are not standard but are instead actuarially equivalent are know as "alternative" coverage. Some Part D plans may also offer enhanced coverage for additional monthly premium. Some coverage enhancements may include coverage of excluded drugs or lower coinsurance amounts.

Standard Part D Benefits (2023 Plan Year)

To provide you with a better sense of how Part D works let us consider the standard benefit for the 2023 plan year. It requires the beneficiary to pay:

- A $505 deductible
- 25 percent of prescription drug costs during the initial coverage phase – that is, between the deductible and the initial coverage limit of $4,660 or the actuarial equivalent to an average expected coinsurance of no more that 25 percent of actual costs during the initial coverage phase.
- 25 percent of the cost of generic drugs and 25 percent of the undiscounted costs of brand name drugs during the "Coverage Gap" phase.
- Once beneficiary out-of-pocket costs (including 70 percent drug manufacturer discounts) reach a total of $7400 the beneficiary is through the "Coverage Gap" and reaches catastrophic coverage. Simply put, at this level a beneficiary either pays either a co-pay of $4.25 for generic drugs or $10.35 for brand name drugs or a coinsurance amount of 5 percent, whichever is greater.

Part D Example (Standard Benefits)

Mr. James is enrolled in a PDP with no monthly premium and a standard benefit structure (described above). He takes a prescription drug with a total cost of $6,000 annually. Mr. James pays $1878.75 for his drugs ($6,000 [total drug costs] - $505 [deductible] = $5495 X.25 [initial coverage cost sharing percentage] = $1, 373.75 + $505 [deductible] =$1,878.75.

Help for Individuals with Limited Income & Limited Resources

If an individual has limited income and resources, they may qualify for a low-income subsidy to cover all or part of the Part D plan premium and cost-sharing.

Part D Enrollment

A person can enroll in Part D when they first become eligible for Medicare or later, during an annual enrollment period (October 15th – December 7th of each year, with coverage beginning January 1st). However, for those who enroll after they first become eligible there is generally a late enrollment

penalty—they pay a higher premium for as long as they are enrolled in Medicare Part D. There is an exception for those who have employer-sponsored drug coverage—they may wait to enroll, and there is no penalty as long as they enroll no later than 63 days after losing their employer coverage.

Further information on the Part D late enrollment penalty:

The cost of the Part D late enrollment penalty depends on how long an individual went without Part D or creditable drug coverage. Medicare calculates the penalty by multiplying 1 percent of the "national base beneficiary premium" times the number of full uncovered months the individual did not have Part D or creditable coverage. The amount is rounded to the next 10 cents and added to the late enrollee's Part D premium. The national base beneficiary premium may increase each year, so that the late enrollee's penalty amount increases each year.

Example: Henry Initial Enrollment Period for Part D ended on May 31, 2014. He goes without drug coverage until he health starts to fail and takes advantage of the open enrollment period of 2017. His drug coverage becomes effective January 1, 2017. He has gone 31 months without Part D or creditable drug coverage (June 2014 –December 2016). Henry's penalty is 31 percent. The national base beneficiary premium in 2017 was $35.63. Henry had to pay a penalty of $11.10 per month in addition to his Part D premium.

.31 (31% penalty) x $35.63 = $11.05 rounded to nearest .10 cents = $11.10

History of Medicare Managed Care

The History of Medicare Managed Care: Introduction

Medicare beneficiaries pose unique challenges for Medicare health plans, which take on the financial risk for the provision of services under fixed payments received from the federal government. Medicare beneficiaries have a higher incidence of both acute illness and chronic illness than does the general population, and they are more likely to become disabled and require long periods of rehabilitation. At the same time, health plans have a much greater ability than fee-for-service insurance to effectively manage the delivery of multiple or complex medical services and contain costs through emphasis on preventive care services, utilization management, and coordinated care through network providers. The federal government seeks to bring these attributes to Medicare by encouraging private-sector options. The following section presents as short history of these efforts.

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982

The **Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982** introduced managed care into Medicare. Under TEFRA, health plans entered into contracts with Medicare to provide Part A and/or Part B benefits on either a cost basis or a risk basis. Organizations with cost contracts received monthly payments from the federal government based on estimates of the reasonable cost of delivering covered services, which could be adjusted to reflect actual costs. Cost plans accepted no risk and allowed beneficiaries to use doctors and hospitals outside the plan networks. Enrollees were required to pay a large portion of their healthcare expenses through premiums and deductibles. Health plans could contract on a cost basis for

both Medicare Part A and Part B coverage or for Part B services only. Health plans that offered Part A and B were referred to as reasonable cost contracts or cost contracts. Health plans that offered only Part B coverage were classified as healthcare prepayment plans (HCPPs).

Medicare Risk Contracts

Health plans that participated in Medicare risk contracts received a specified geographically based capitation payment from CMS each month for each plan member, regardless of the amount or cost of services the member actually received. The health plans were at risk for delivering the contracted-for level of services at these fixed rates. Medicare risk contracts were attractive to beneficiaries because they typically offered preventive care and other benefits beyond the traditional Medicare Part A and Part B services for the same or only slightly higher premiums. For services to be covered, however, they needed to be obtained from the Medicare risk plan's network of providers and were subject to other utilization controls.

The Balanced Budget Act (BBA) of 1997

The **Balanced Budget Act (BBA) of 1997** again restructured the Medicare program, absorbing the TEFRA Medicare risk contracts into the new **Medicare+Choice** program. Medicare plans that complied with CMS requirements were automatically transitioned into Medicare+Choice. Cost contracts were initially to be phased out by December 31, 2002, but subsequent legislation extended their operation first by two more years and then indefinitely under certain conditions set out by the Medicare Modernization Act of 2003.

The BBA expanded the number of delivery options for Medicare services and also established operational requirements for plans participating in Medicare+Choice. These requirements have a direct impact on the types of administrative and healthcare services that Medicare health plans offer and the steps that health plans must take to maintain the quality of those services, and they were carried over to the next Medicare program restructuring.

The Medicare Modernization Act (MMA) of 2003

The **Medicare Prescription Drug, Improvement, and Modernization Act of 2003** (commonly called the *Medicare Modernization Act*, or **MMA**) renamed the Medicare+Choice program Medicare Advantage. The **Medicare Advantage (MA)** program was largely based on the Medicare+Choice program in terms of program operations, benefits, and quality of care initiatives, but it expanded the existing private health plan product options available to Medicare beneficiaries. Coordinated care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs), as well as private fee-for-service plans, were the options made available under Medicare Advantage. The MMA expanded the types of options to include regional PPOs.

Local MA Plans

In addition to regional MA-PPOs, there are the following categories of local MA plans:

- **Coordinated Care Plans (CCPs)-** include health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs).

- **Private Fee-For-Service (PFFS) plans-** PFFS plans are similar but not the same as Original Medicare. The plan determines how much it will pay doctors, and other healthcare providers and how much enrollees must pay. An enrollee can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms and agrees to treat him or her. Not all providers will agree to the plan's terms and provide treatment. If the PFFS has a network, an enrollee can see any of the network providers who have agreed to always treat plan members. Prescription drugs may or may not be covered in the PFFS plan. If the PPS does not offer drug coverage, enrollees can join a Part D Prescription Drug Plan. [xxv]

- **Medicare Medical Savings Account (MMSA) plans-** MMSA plans work like health savings accounts (HSAs), discussed in an earlier lesson. Participants are covered by a qualified high-deductible health plan (HDHP) and can withdraw money from a tax-advantaged account into which the plan makes an annual deposit. Participants must pay for their care out of their own pockets until they have satisfied the deductible, after which the plan pays. They can use money from their account to pay out-of-pocket costs, but the amount deposited each year is usually less than the deductible, so they generally have to pay at least some costs out of their own funds. MMSA plans do not include drug coverage, but participants can enroll in a PDP.

- **Special Needs Plans (SNPs)-** SNPs serve special populations, such as Medicare/Medicaid dual-eligibles, those with certain chronic and debilitating diseases (such as diabetes or HIV/AIDS), or nursing home residents. They operate like an HMO—they have a network, and care must normally be obtained from network providers. Members must have a primary care physician or a care coordinator and must have a referral to see a specialist. All SNPs provide drug coverage.

<u>The Affordable Care Act (ACA) of 2010</u>

The **Affordable Care Act (ACA)** included provisions designed to reduce government expenditures on Medicare and make Medicare Advantage (MA) plans operate more efficiently. Prior to the passage of the ACA, some industry experts observed that the Federal government paid MA plans more than traditional Medicare for providing similar services. The additional funds allowed MA plans to attract members by offering benefits not included under traditional Medicare, such as gym memberships. The ACA made major changes to the government payment formula to MA plans in three ways:

- **New Benchmark Payment System**–Before the ACA, the MA benchmark payment for any given county was based on the previous year's benchmark for that county increased by the per capita growth rate in Medicare. Under the ACA, benchmark payments are no longer based on the previous year's costs, but are set as a percentage of per capita traditional fee-for-service spending.

- **Bonus Payments**–In contrast to the less generous benchmarks, the ACA provided a new bonus payment system for qualifying plans based on "quality ratings." These bonus payments are based on a five-star scale and determined by the Centers for Medicare and Medicaid Services

(CMS). A plan must use this money first to reduce costs, then to add prevention and wellness coverage, and if any money remains, to add coverage of such items as vision and dental care.

- **Updated Rebate Policy**–Prior to the ACA, if a plan bid below the benchmark payment set by CMS, it received a rebate. Under that pre-ACA system, 75 percent of the difference between what the plan bid and the CMS set benchmark was given to the plan as a rebate and the Medicare program retained 25 percent as savings. The ACA changed this first by reducing the rebate amount to 70 percent and then taking into account a plan's quality score. Only plans receiving the highest scores receive the full 70 percent rebate. Those with the lower scores receive less.

In addition, the ACA required MA plans to maintain a medical loss ratio of at least 85 percent beginning in 2014.

ACA Goals

Overall the ACA changes to MA were designed to reduce spending and better align the costs of MA with the cost of traditional Medicare. The concern at the time of the ACA's passage was that this would result in higher premiums, fewer benefits, reduced enrollments and a withdrawal from the marketplace by MA. And while plans have changed their designs in response to the ACA, MA plan enrollment has in fact increased since the law's passage.

Recent Legislation Impacting Medicare

In this section, we will discuss the impact of three relatively recent laws on Medicare:

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
- 21st Century Cures Act of 2016
- Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2018

We will also examine flexibilities in Medicare coverage brought about by legislative and regulatory responses to the COVID-19 pandemic and the ensuring public health emergency (PHE).

MACRA

The **Medicare Access and CHIP Reauthorization Act (MACRA) of 2015** aims to keep physicians and other healthcare professionals from leaving Medicare (thereby reducing beneficiaries' access to care) by changing how they are compensated. MACRA repealed the Sustainable Growth Rate (SGR) formula, which had linked annual increases in provider payments to earlier spending and growth in the gross domestic product (GDP). Many providers felt this approach resulted in insufficient compensation, and they threatened to stop serving Medicare beneficiaries. For years, Congress responded with a series of short-term "doc fixes" – laws that temporarily overrode the SGR system to raise provider payments for a limited time. MACRA represents a permanent solution to this problem.

Provider Payments

Equally important, MACRA seeks to move Medicare away from fee-for-service to a value-based system – one that rewards providers not for the quantity of services they deliver but for the quality of their care. The law called for the implementation of the Quality Payment Program starting in 2017, under which physicians and other healthcare professionals who serve Medicare beneficiaries had participate in one of two payment systems:

- Merit-Based Incentive System (MIPS) – Under MIPS a provider's compensation could be increased for good performance on a variety of quality measures or in some instances decreased for poor performance.
- Alternative Payment Model (APM) - MIPS can be thought of as the basic program and the Alternative Payment Model (APM) as the advanced alternative. APM entails more risk for providers – it offers higher rewards for good performance but also greater penalties for poor performance.

Small providers and those with few Medicare patients qualify for exemptions.

Medicare Cards

MACRA required the removal of Social Security numbers (SSN) from all Medicare cards and issuance of new cards to then current enrollees. In an age of hacking and identity theft, this action was mandated to better protect individuals' health and financial information as well as information on Medicare payments to providers. [xxvi]

21st Century Cures Act

The **21st Century Cures Act (Cures Act)** aimed to:

- Accelerate research into preventing and curing serious illnesses
- Speed drug and medical device development
- Address the opioid abuse crisis
- Improve the delivery of mental health services
- Improve the use of information technology within healthcare

The Cures Act also modified the rules regarding Medicare Advantage (MA) disenrollment by eliminating the MA Disenrollment Period (MADP). Instead, the Cures Act established, beginning in 2019, a new open enrollment period (OEP) held from January 1 to March 31 of each year. The OEP allows MA enrollees to make a one-time election during the first 3 months of the calendar year to switch MA plans or to disenroll from a MA plan to Original Medicare. In addition, its provisions afford newly MA eligible individuals who enroll in a MA plan, the opportunity to also make a one-time election to change MA plans or drop MA coverage and obtain Original Medicare. [xxvii xxviii]

CHRONIC Care Act

The **CHRONIC Care Act** became law in February 2018 as part of the Bipartisan Budget Act. Among other things, the law sought to accomplish the following in regard to Medicare:

Increased Flexibility for MA Plans–The Act provided Medicare Advantage (MA) plans with increased flexibility to provide coverage of non-medical benefits. Examples of these non-medical benefits include bathroom grab bars to prevent falls and wheelchair ramps to improve mobility of the chronically ill.

Telemedicine-The Act encouraged increased use of telemedicine (providing healthcare remotely through electronic means) for members of MA plans.

Dual-Eligible Special Needs Plans–The Act provided for better coordination between Medicare and Medicaid for individuals enrolled in MA special needs plans (SPNs) for those eligible for both programs – dual-eligible(s).

Responses to COVID-19 Public Health Emergency

The COVID-19 pandemic created a public health emergency (PHE) that necessitated increased flexibility in how medical services were delivered particularly in the area of telehealth.[xxix] In March of 2020, Medicare began paying for telehealth services by physicians and other practitioners to patients located anywhere in the country including in offices, hospitals, and patient's home. Not only did CMS expand the types of services that could be furnished by telehealth, it also indicated it would pay for these services at the same rate as if delivered in-person. [xxx]

Consolidated Appropriations Act of 2022

The telehealth flexibilities brought about by the pandemic are regarded as temporary and scheduled to end once the public emergency (PHE) is officially declared to have ended. CMS lacks the authority on its own to extend them thus requiring Congressional action. As of this writing, the PHE could officially end as early as April 2022. To avoid a "telehealth cliff" the Consolidated Appropriations Act of 2022 (March 2022), extended telehealth flexibilities for Medicare patients by 151 days after the official end of the public health emergency (PHE). This basically gives Congress five additional months to review data from CMS and other sources regarding the use of telehealth and to enact permanent policy changes.

Summary of telehealth flexibilities under the Consolidated Act:

There are three telehealth flexibilities brought about the Consolidated Appropriations Act of 2022 of(Act) which you should be aware:
(1)Telehealth Provided at Home – Before the PHE Medicare coverage was restricted to services delivered to patients located at hospitals and other provider facilities – not the patient's home. The PHE flexibilities allowed providers to receive Medicare payments for delivering telehealth services to patients at home. The Act continues this for 151 days past the end of the PHE.
(2)Practitioner List Expanded – Prior to the COVID-19, only physicians, nurse practitioners, physician assistants, and other specified providers could deliver Medicare covered telehealth

the Act, the list of telehealth practitioners will continue to be expanded to include physical therapists, occupational therapists, speech pathologists and others for a 151 day period past the end of the PHE. **(3)Mental Health Services via Telehealth –** The requirement for an in-person visit within six months of the first telehealth service is delayed until the 152nd day after the PHE ends. [xxxi]

Medicare Supplement Insurance (Medigap)

Medicare Supplement Insurance: Overview

As we have seen, although Original Medicare provides extensive coverage, it does not pay all healthcare expenses. It has substantial deductibles, copayments, and coinsurance, and it does not cover dental care and dentures, vision care and eyeglasses, hearing aids, and a number of other health-related services and products.

To fill some of these gaps, those enrolled in Original Medicare may purchase **Medicare supplement insurance** (commonly called **Medigap policies**). Because Medicare Advantage plans offer more comprehensive coverage, MA enrollees do not need (and are not permitted to purchase) Medigap policies.

A Medigap policy is a state-approved, private-sector individual insurance policy that provides reimbursement for expenses not covered by Original Medicare. Medigap policies primarily cover cost-sharing payments Medicare beneficiaries must make. Some policies also provide benefits for a few healthcare expenses not covered by Medicare, such as emergency care received outside the U.S. Medigap policies do not cover dental, vision, or hearing care, nor do newly issued policies cover prescription drug coverage.

Information about the history of Medigap:

When Medigap policies were first introduced, a wide variety of products were offered, resulting in a great deal of consumer confusion. In response to this problem, in 1990 the National Association of Insurance Commissioners (NAIC) developed a model for the standardization of Medigap policies. This model established **10 standard Medigap plans** and required insurers to offer only those plans.

The 10 standard Medigap plans developed in 1990 by the NAIC were designated A through J. Plan A was, and still is designated as the "core" plan. In general, the higher the letter the more comprehensive the benefits. Today, there are still 10 standardized Medigap plans but they are no longer A through J. Over the years due to NAIC rules and various legislation, some "letters" have been dropped while others added. Today, the 10 standardized plans are A, B, C, D, F, G, K, L, M, and N.

Standard Medigap Plans

Medigap policies are subject to extensive government regulation. A limited number of standard Medigap plans, each with a certain combination of benefits, have been established, and insurers are required to offer only these plans. In addition, all insurers must use the same standardized format, language, and definitions in describing the benefits of the plans. This standardization is intended to make it easier for consumers to compare plans and premiums. Since insurers offer the same standard plans, they compete on the basis of price and customer service. (This system applies in all states except Massachusetts, Minnesota, and Wisconsin, which have their own regulations.) Changes have been made to this system over the years. These changes included removal of prescription drug coverage from the benefits offered by newly issued policies following the passage of the Medicare Modernization Act and the introduction of Medicare Part D. Major revisions to the program went into effect June 1, 2010 that included the retirement of some policies as well as the addition of new policy types. Additional changes were included in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, which will be discussed later.

Medigap Chart showing the standard Medigap plans that can be currently sold:

AHM 250 Lesson 25 – Medigap Chart

Medigap Plans

Plans available to all beneficiaries									Plans available only to beneficiaries eligible before 2020	
Medigap Benefits	A	B	D	G[5]	K[4]	L[4]	M	N	C	F[1]
Part A Coinsurance and Hospital Benefits	X[2]	X	X	X	X	X	X	X	X	X
Part B Coinsurance or Copayment	X	X	X	X	50%	75%	X	X[3]	X	X
Blood (First 3 pints)	X	X	X	X	50%	75%	X	X	X	X
Part A Hospice Care Coinsurance/ Copayment	X	X	X	X	50%	75%	X	X	X	X
Skilled Nursing Facility Care Coinsurance			X	X	50%	75%	X	X	X	X

1. Plan F also offers a high-deductible plan that is only available to individuals eligible for Medicare before January 1, 2020. In 2022, a policyholder pays $2,490 before the Medigap policy pays anything.
2."X" indicates that coverage is 100% of the Medicare allowable amount. A percentage number indicates the proportion of the Medicare allowable amount covered.
3. Plan N has a copayment of up to $20 for physician office visits and up to $50 for emergency room visits (waived in certain circumstances).
4. Plans K and L pay 100% after out-of-pocket limit is reached. In 2022 the out-of-pocket limits for Plan K and Plan L are $6,620 and $3,310, respectively.
5. There is a high deductible version of Plan G. The deductible for 2022 is $2,490.

Medigap Plans

All Medigap plans must provide at least a basic benefit package. This includes Part A daily hospital copayments, up to 365 days of hospital coverage per lifetime after Medicare hospital benefits are exhausted, hospice copayments or coinsurance, and the first three pints of blood each year. These plans also currently cover Part B coinsurance or copayments. Since the establishment of Medicare Part D in 2006, new Medigap policies may not include prescription drug benefits, but some policies sold before then do.

Currently, Plans C and F are the only two Medigap plans that cover the part B deductible. MACRA provided that beginning in January 1, 2020, a Medigap policy may not be sold or issued to a *newly eligible* Medicare beneficiary that provides coverage of the Part B deductible. This means that individuals who were born on December 31, 1954 (turning 65 on December 31, 2019) are the last to be able to purchase plans covering the Part B deductible ($233 in 2022). Those born after that date will fall into the *newly eligible* category.[xxxii]

Moving forward, this is likely to mean a bifurcation of the Medigap marketplace. Coverage of the Part B deductible will go away for that portion of the senior population considered *newly eligible*. However, Part C and F plans covering the Part B deductible will remain available for those who became eligible for Medicare prior to January 1, 2020. Why is this important? Because, it is possible that some members of *previously eligible* may choose to first purchase or switch Medigap plans in post-2020 years.

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26 Government Programs: Medicaid, CHIP, FEHB, TRICARE, and Workers' Compensation

Objectives

After completing this lesson, you will be able to:

- describe the main federal health coverage programs for low-income people (Medicaid and CHIP)
- explain the role of health plans in Medicaid and CHIP
- describe the Federal Employees Health Benefits (FEHB) Program and the TRICARE program for the uniformed services and explain the role of health plans in them
- describe state-mandated workers' compensation coverage and the role of health plans in it

Major Government Health Programs

In the preceding lesson, we discussed a federal program, Medicare, that provides health benefits to seniors and some disabled persons. In this lesson, we will look at the other major government health benefit programs.

- **Medicaid** - a federal-state program that pays for healthcare for low-income people who meet certain criteria. Traditionally most recipients have been children, pregnant women, and elderly and disabled persons. The Affordable Care Act (ACA), as we will discuss later, offers states the opportunity to expand covered populations to include single able-bodied adults without children.
- **Children's Health Insurance Program (CHIP)** - a federal-state program. It provides health coverage for children whose families are not poor enough to qualify for Medicaid but too poor to buy private-sector health insurance.
- **Federal Employees Health Benefits (FEHB)** Program- as an employer, the federal government sponsors health coverage for its employees and their dependents.
- **TRICARE** – a health plan of the Department of Defense fir members of the uniformed services, retirees, and their dependents.
- **Workers' Compensation Laws** - states require employers to purchase or provide coverage that pays employees benefits for healthcare costs and lost earnings if they suffer a work-related injury or illness.

Medicaid

Medicaid is a government program that pays for healthcare received by some poor people. Medicaid is a major component of the nation's healthcare financing system. In 2021, it served more than 75 million people and spent approximately $603 billion.[i] [ii]

Medicaid is a federal-state program. The federal government establishes broad guidelines for its operation, but each state administers its own program and determines, within these guidelines, eligibility criteria; the type, amount, and duration of services its program pays for; and rates of payment for services. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state. The benefits provided in one state may not be provided in another. State Medicaid programs may change from year to year in response to changing needs or emerging problems.

The federal government pays a percentage of each state's Medicaid expenditures, and the state covers the rest. As a general rule, the federal percentage is higher for poor states and lower for rich states, but it is at least 50 percent.

Medicaid Eligibility: Mandatory Categories

Medicaid is for the poor, but not all poor people are eligible. Some people are considered **categorically needy**, that is, they qualify for Medicaid because they fall into certain categories. The federal government has established a number of **mandatory categories**—all state Medicaid programs must provide benefits to people in these categories in order to receive federal funding. The most important mandatory categories include:[iii]

- children ages six through eighteen whose family income is at or below the federal poverty level (FPL) and children under six whose family's income is at or below 133 percent of the FPL
- pregnant women with family income at or below 133 percent of the FPL
- elderly and disabled persons with very little or no income who qualify for Supplemental Security Income (SSI) payments
- a few parents and other family members (such as grandparents) who take care of children younger than 18, have extremely low income, and meet certain restrictive conditions

Medicaid Eligibility: Optional Categories

There are also **optional categories**—states may provide Medicaid coverage to members of these categories but are not required to do so. These groups include individuals receiving home and community-based services and children in foster care who are not otherwise eligible.

The Affordable Care Act of 2010 (ACA) created the opportunity for states to expand Medicaid coverage to low-income able-bodied individuals without children under age 65. The ACA, as enacted, provides coverage for those with incomes at or below 133 percent of the FPL (138 percent with allowable adjustments under the ACA calculation of modified adjusted gross income - MAGI).[iv] The intention of those crafting the legislation was that all states would be required to expand coverage. However, due to a Supreme Court decision, states have the option to expand or not expand coverage.

Learn more about why states have a choice in whether or not to expand Medicaid coverage:

Medicaid Expansion, the Supreme Court, and State Options

Following the passage of the Affordable Care Act (ACA) in 2010, the law was challenged on constitutional grounds with two provisions at issue:

(1) Coverage Mandate -The requirement that individuals maintain health coverage (with some exceptions) also referred to as the individual mandate

(2) Medicaid expansion - Challengers, which included many states such as Florida, feared that state failure to expand Medicaid could result in the loss of all federal Medicaid funding – not just extra dollars promised under the ACA to cover the cost of expansion.

The Supreme Court on June 28, 2012 issued its decision in *National Federation of Independent Business (NFIB) vs. Sebelius,* 567 US 519.

The Court upheld the individual mandate and rendered a complex opinion regarding the ACA's Medicaid expansion provisions. A majority of the Court found the provision to extend coverage to those with incomes below 133 percent of the FPL to be unconstitutionally coercive of states. However, a majority consisting of a different mix of Supreme Court Justices found that this issue was fully remedied by limiting the authority of the Secretary of Health and Human Services regarding enforcement of this provision. This left the Medicaid expansion provision intact in the law.

Result: The practical effect of the Supreme Court's decision makes the ACA's Medicaid expansion optional for the states because, if states do not implement the expansion, states lose only ACA Medicaid expansion funds.[v]

Medicaid Eligibility: Financial Eligibility: MAGI

In order to be eligible for Medicaid, individuals must satisfy both financial and non-financial eligibility tests.

The ACA sought to simply change a myriad of prior financial eligibility rules emanating from Medicaid's origins as a form of welfare and subsequent changes. The ACA established a new methodology for determining income eligibility for Medicaid, which is based on **Modified Adjusted Gross Income (MAGI)**. MAGI, as you may recall from our lesson on the ACA, is used to determine financial eligibility for Medicaid, the Children's Health Insurance Program (CHIP), and the premium tax credit available through the health insurance marketplace(s).

MAGI is the basis for determining Medicaid eligibility for most children, pregnant women, parents, and single able-bodied adults. It considers taxable income with some adjustments as well as tax filing relationships to determine financial eligibility for Medicaid.

Some individuals are exempt from the MAGI-based income counting rules. This group includes those whose eligibility for Medicaid is based on blindness, disability, or advanced age (65 and older). For this group, Medicaid eligibility is generally determined using income methodologies of the supplemental security income (SSI) program administered by the Social Security Administration.

When is 133% really 138% under the ACA:

The Affordable Care Act (ACA) as written cites 133 percent of the federal poverty level (FPL) as the percentage point for Medicaid eligibility expansion. However, the ACA also adds a 5-percentage point adjustment to the FPL effectively making its financial eligibility criteria 138 percent.[vi vii viii]

Other groups do not require a financial eligibility test for Medicaid coverage. These include children for whom an adoption assistance agreement is in effect under the Social Security Act, and young adults who are former foster care recipients.[ix]

Medicaid Eligibility: Non-Financial Eligibility

Individuals must also meet certain non-financial criteria to be eligible for Medicaid. The list of these non-financial eligibility rules includes the following:

- **Residency** – Medicaid beneficiaries must, as a general rule, reside in the state where they are receiving benefits.
- **Citizenship** – Medicaid beneficiaries must either be citizens of the United States or lawful permanent residents of the United States.

In addition, some eligibility groups are limited by age, pregnancy, or parenting status.

Medicaid Eligibility: Medically Needy

Some states also extend Medicaid eligibility to the **medically needy**—those who do not qualify as members of one of the categories but who have depleted their income and assets to pay for healthcare or long-term care. These states allow non-poor individuals to **spend down**—that is, they can qualify for Medicaid benefits by spending their money on care until their income and assets are reduced to very low levels established by the state. Many middle-income people faced with the enormous costs of an indefinite period of nursing home care or home healthcare spend down until they have almost nothing left, at which point Medicaid begins covering costs.

Coverage of Services

The healthcare and long-term care services covered by Medicaid vary somewhat from state to state, but in all states, they are extensive. The federal government requires all state programs to provide benefits for what are termed **mandatory benefits**. These include:[x]

- inpatient and outpatient hospital services
- physician services

- laboratory and X-ray services
- nursing facility services
- home healthcare for persons who are **nursing home eligible** (those who, according to criteria established by Medicaid, would need nursing home care if they did not receive home care)
- various other services

Many states also provide other benefits that are termed **optional benefits**. These benefits include dental services, optometrist services and eyeglasses, and prosthetic devices. Optional benefits also include prescription drugs which are now covered by all states.[xi]

Medicaid recipients may be charged small deductibles and copayments for some services. Only a few states charge premiums, and the amounts are very small.

Long-Term Care

In the area of long-term care, all states are required to pay for nursing home care and home healthcare for the nursing home eligible. And although federal guidelines do not require it, some states also pay benefits for home and community-based long-term care services for certain other Medicaid recipients. Finally, some states pay for long-term care services received in an assisted living residence.[xii]

Medicare and Medicaid Overlap

Some elderly people with very limited assets and incomes are **dual-eligibles**—they receive benefits from both Medicare and Medicaid. If a service is covered by both programs, Medicare pays. Medicaid pays for services not covered by Medicare but covered by Medicaid (such as nursing facility care beyond Medicare's 100-day limit, eyeglasses, and hearing aids). Medicaid also pays for Medicare premiums and deductibles, coinsurance, and copayments for certain very poor Medicare beneficiaries.[xiii] [xiv]

Children's Health Insurance Program (CHIP)

The **Children's Health Insurance Program (CHIP)** is a federal-state program that pays for healthcare for children from families not poor enough to qualify for Medicaid but too poor to afford private-sector health coverage. As with Medicaid, the federal government sets broad guidelines, and within those guidelines each state administers its own program, establishes eligibility rules, and provides coverage. Also like Medicaid, CHIP is jointly funded by the federal government and the states, but the federal government pays a higher percentage of costs than for Medicaid.

More information about CHIP federal funding levels:

CHIP is funded jointly by the federal government and states through a formula based the Medicaid Federal Medical Assistance Percentage (FMAP). As an incentive for states to expand their coverage programs for children, Congress created an "enhanced" federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate. For example, if a state has a 50 percent match rate for Medicaid, the state is likely to have a 65 percent match rate for CHIP.[xv]

While nowhere near as large as Medicare or Medicaid, CHIP provides coverage to large numbers of children who otherwise would have been uninsured. There are roughly 9.6 million children currently enrolled in CHIP.[xvi]

CHIP Eligibility

Eligible for CHIP are children who:

- are 18 (up to a youngster's 19th birthday) or younger
- are not covered by health insurance
- are ineligible for Medicaid
- have family income below a certain level

States set their own income eligibility limits for CHIP. However, full federal funding is provided only for children with family income at or below 300 percent of the federal poverty level (FPL). A state may provide coverage to children with higher family income, but federal funding is lower. Most states have income limits from 200 to 300 percent of the FPL, but a few have limits above or below this range.

States have the option of offering CHIP coverage to pregnant women without health insurance, and several do through CHIP, while many other states provide health coverage to pregnant women through Medicaid beyond the 133 percent (138 percent as adjusted) federal poverty level (FPL) set forth in the ACA.[xvii]

CHIP Coverage

A state's CHIP can be part of its Medicaid program, a separate program, or both. Under a Medicaid expansion, a state must provide CHIP eligibles the same coverage it provides other Medicaid recipients. In creating a coverage package under a separate CHIP, a state may choose from these three options:

- **Benchmark coverage-**The state provides the same coverage as the standard Blue Cross/Blue Shield plan preferred provider service plan offered to federal employees, the health plan offered to state employees, or the health maintenance organization (HMO) with the largest number of non-Medicaid enrollees in the state.[xviii]
- **Benchmark-equivalent coverage-**The state provides basic coverage (physicians' surgical and medical services, inpatient and outpatient hospital care, well-baby/well-child care including immunizations, and laboratory and x-ray services). The state also provides coverage for additional services (prescription drugs, vision and hearing care) that is at least 75 percent of the actuarial equivalent of the benchmark plan.[xix]
- **Secretary-approved coverage-**The state proposes an alternative plan and receives approval from the Secretary of HHS.[xx] [xxi]

CHIP Costs

CHIP coverage includes many benefits for free including "well-child" doctor and dental visits. There can be deductibles and copayments for other services and some states charge a monthly premium for CHIP

coverage. The costs depend in great part on decisions made at the state level. Costs however, are capped. There are strict limits for families with incomes at or below 150 percent of the FPL, and for all families the total amount of premiums and cost-sharing cannot exceed 5 percent of family income.[xxii] [xxiii]

CHIP Funding

The Children's Health Insurance Program (CHIP) is ***not*** an entitlement program, unlike Medicaid. Just because a child qualifies for the program does not mean he or she will be enrolled. For example, if a state's CHIP program runs out of money, a child who otherwise qualifies could be turned away. CHIP is dependent in great part on Congressional reauthorization of federal block funding.

CHIP was enacted in 1997 with funding authorized for a decade. Subsequently, Congress reauthorized CHIP funding several times for shorter periods (e.g. two-year extension in 2007). In 2017, tense budget negotiations put the program's ability to provide services at risk. Questions arose as to how long states could continue to run their programs without federal support. Fortunately, Congress on January 22, 2018 passed a six-year extension of CHIP funding from fiscal year 2018 through fiscal year 2023 as part of a broader continuing resolution to fund the federal government. Several weeks later in February 2018, Congress provided an additional four years of funding for CHIP as part of broader bipartisan budget agreement. Funding for CHIP has as result been reauthorized through fiscal year 2027.[xxiv]

The Growth of Medicaid Managed Care

In the early years of Medicaid, most states made healthcare available to recipients exclusively through fee-for-service arrangements with participating medical providers. But as the program and the number of recipients grew, states began using managed care to control and predict costs and provide access to healthcare in areas where Medicaid providers were limited. States also hoped to reduce reliance on emergency rooms as a source of primary care.

However, the shift to managed care was initially slowed by federal rules that allowed enrollment in health plans only on a voluntary basis (with the agreement of the recipient).

Waivers

A state could require individuals to participate in managed care, but only by obtaining a waiver (an exemption from federal guidelines) from the federal Centers for Medicare and Medicaid Services (CMS). Two waivers were used for this purpose: The 1915(b) waiver allowed states to require enrollment in managed care and to mandate managed care in only parts of the state (waiving the rule that the same coverage must be provided statewide). The 1115 waiver provided for even more flexibility in state Medicaid programs' benefit packages and service delivery models and allowed states to require managed care statewide.

These waivers enabled states to increase the use of managed care, and large numbers of Medicaid recipients were enrolled in health plans. But the process of obtaining a waiver is burdensome and lengthy, often taking a year or more, and renewal is required every five years.

The Balanced Budget Act of 1997

The **Balanced Budget Act (BBA) of 1997** addressed this problem by allowing states, without a waiver, to mandate managed care for all Medicaid enrollees except Medicare-Medicaid dual eligibles (elderly and disabled persons), Native Americans, and certain children with special needs. Under the BBA, a state need only obtain approval of a state plan amendment (SPA), which can take as little as 30 days.

The BBA resulted in substantial growth in Medicaid managed care. In the last two decades, the proportion of Medicaid recipients has grown from a small percentage to a large majority. Today, over 70 percent of Medicaid recipients are enrolled in a managed care plan. Today, Medicaid recipients may have the option or enrolling in a managed care or not. Or a state, with CMS approval, can require participation in managed care for some or all health care services (with the excepted groups noted). A state may make participation optional for some and mandatory for others (as those in a rural area)

The Growth of Medicaid Managed Care [xxv] [xxvi]

Year	Number of Recipients in Managed Care	Percentage of All Recipients
1983	750,000	3%
1994	7.8 million	23%
2019	53.7 million	69%[xxvii]

Types of Medicaid Managed Care Arrangements

There are currently three major managed care arrangements used by Medicaid:

- Managed Care Organization (MCO)
- Prepaid Health Plan (PHP)
- Primary Care Case Management

  (PCCM)

Managed Care Organization (MCO)

A **Medicaid Managed Care Organization (MCO)** is a private-sector health plan that contracts with a state Medicaid agency to provide health care to enrollees. Plans must meet standards related to the services covered, the adequacy of the provider network, access to care, claims and appeals, and other matters.

MCOs provide comprehensive coverage (in contrast to prepaid health plans, which cover only limited services). An MCO may use subcontractors to deliver some services. Certain services (such as prescription drugs or behavioral health care) may or may not be covered by an MCO. (The state may provide them to enrollees through a separate arrangement).

Example:

Example: Green Glen Health Plan contracts with a state Medicaid agency to provide comprehensive coverage to Medicaid enrollees. Green Glen delivers most services through its own network of providers. It subcontracts with another company to provide prescription drug coverage. And it does not offer behavioral health care – the state arranges with another organization to provide this to enrollees.

Capitation

An MCO is paid by the state by **capitation** – that is, it receives a per-member-per-month (PMPM) premium (a flat amount per month for each enrollee it serves). In exchange, the plan must provide all the services the enrollees need (of the type of services stipulated by the contract). This means the MCO takes on **financial risk** – it will receive the same amount regardless of the actual costs it incurs in providing covered services.

Example:

Example: ABC Health Plan contracts with a state Medicaid agency to provide comprehensive coverage to a group of Medicaid enrollees. Some months the enrollees need numerous health care services, other months they need few. ABC receives the same amount from the state per enrollee every month. If this is not enough to cover ABC's costs, ABC must take a loss, if it is more, ABC realizes a gain.

Prepaid Health Plan (PHP)

A **Prepaid Health Plan (PHP)**, like an MCO, is a private-sector health plan that contracts with a state Medicaid agency. And like an MCO, it is usually paid by capitation and so assumes financial risk. But unlike MCOs, which provide comprehensive coverage, PHPs cover only a limited set of services (and are sometimes called **limited benefit plans**).

There are two types of PHPs:

- **Prepaid Inpatient Health Plans (PIHPs) -** provide only inpatient hospital or institutional services, such as hospitalization for surgery or inpatient behavioral health care.
- **Prepaid Ambulatory Health Plans (PAHPs) -** provide certain outpatient services, which may include: dental care, behavioral health care and substance abuse treatment, nonemergency medical transportation, disease management, and/or vision care for adults.[xxviii]

Primary Care Case Management (PCCM)

Primary Care Case Management (PCCM) is a long-standing Medicaid model.[xxix] Each enrollee participating in a PCCM program has a primary care provider (PCP), selected by the enrollee or assigned to him or her. The PCP may be a single physician, a medical practice, or (more recently) a physician's

assistant. The state Medicaid agency contracts with the PCP to provide, coordinate, and monitor primary and preventive care for the enrollee, and the PCP services as the enrollee's "medical home."[xxx]

The PCP is paid a set monthly fee for managing and coordinating an enrollee's care. But for the medical services the PCP provides, he or she is paid on a fee-for-service basis. So under PCCM, providers do not take on substantial financial risk.[xxxi]

Example:

Example: Franklin is a physician serving as a PCP under a Medicaid PCCM program. He receives a flat monthly fee for each enrollee for managing his or her primary and preventive care. But if Franklin provides any medical service beyond care management, he is paid a fee for each service.

Innovative Medicaid Managed Care Arrangements

Now, let's turn our attention to some innovative care delivery models used by Medicaid and health plans contracting with Medicaid (as well as by Medicare and other payors). These models include:

- Patient-Centered Medical Homes (PCMH)
- Medical Health Homes (HH)
- Accountable Care Organizations (ACOs)

Patient-Centered Medical Home (PCMH)

A **Patient-Centered Medical Home (PCMH)** is designed to control costs and improve the quality of care delivered through the better coordination of medical services. It typically includes these six elements:

- **A personal provider** – A lead physician heads a team that is collectively responsible for the patient care.
- **A holistic approach –** The provider is responsible for the whole person during all stages of life.
- **Coordinated care –** The care provided is coordinated or in some cases provided through an integrated system.
- **Quality and safety emphasis –** The PCMH model emphasizes the importance of providing quality care while also stressing safety.
- **Enhanced access –** The model strives to provide patients with enhanced access to care through all systems.
- **Value of services –** The model considers the value of the services provided, rather than simply rewarding the quantity of services as under fee-for-service.[xxxii]

Providers participating in a Medicaid PCMH receive a capitation payment, either from the state Medicaid agency or from an MCO contracting with Medicaid.

Medical Health Home (HH)

The **Medical Health Home Model (HH)** (included in the Affordable Care Act (ACA)) is similar to and builds on the patient-centered medical home (PCMH).[xxxiii] The difference is that the HH targets those

with multiple chronic conditions, such as individuals suffering from both diabetes and heart disease. A state Medicaid program may have several HH programs for different populations.

The HH model aims to coordinate services for such patients, from primary through acute care, and it includes both clinical and non-clinical support (such as behavioral health care and social services).

Accountable Care Organization (ACO)

An **Accountable Care Organization (ACO)**, as you may recall from an earlier lesson, is a group of providers or other health care entity that agrees to deliver health care to a certain population and take on some financial risk. ACOs vary but generally they include both primary care and specialty providers and at least one hospital.

ACO compensation is based on a benchmark – a projected amount that it will cost the ACO to provide services to the population. If the ACO is able to deliver care for less than that amount, savings are realized, and the ACO and the payor share these savings. On the other hand, if it costs the ACO more than the benchmark to deliver care, the ACO may have to bear part of the loss. Some ACOs share both savings and losses; others share only savings. The ACO model is used by Medicaid, Medicare, and private-sector health plans. [xxxiv]

Managed Medicaid for the Elderly and Disabled

The elderly and disabled are only a small percentage of the Medicaid care population. This reflects the fact that they represent only about a quarter of the overall Medicaid population (most recipients are women and children).[xxxv]

But while the elderly and disabled are only a minority of Medicaid recipients, because of their greater needs they account for almost two-thirds of expenditures.[xxxvi]

States seek to rein in spending for these categories and in doing so they increasingly look to managed care to provide services. Providers and organizations (such as MCOs) contract with a state Medicaid agency to deliver various long-term services and supports (LTSS) to Medicaid recipients. The contracting organizations often take on financial risk. Some programs provide only certain services, such as adult day care, others offer a wide range of LTSS. In recent years the focus has shifted from institutional care to home and community- based services.

Additional information on Medicaid and long-term care can be found in other course(s) within the AHIP Insurance Education curriculum.

Federal Employees Health Benefits (FEHB) Program

The **Federal Employees Health Benefits (FEHB) Program** provides health coverage for full-time employees of the United States government, qualified retirees, and their spouses, dependents, and survivors. Established in 1960, the FEHB Program is largest employer-sponsored health benefits program in the United States, providing health care benefits to approximately 8.2 million people. [xxxvii] FEHB is

operated by the federal Office of Personnel Management (OPM). Each year, under the aegis of OPM, a large number of insurance companies and employee associations (including labor unions) offer health plans through FEHB.

Federal employees can select from health plans offering a variety of coverage types, benefit packages, and premiums amounts. In recent years, more than 250 plans have participated in the FEHB Program, although the number available to each employee varies depending on where he or she lives. (While some plans operate nationally, others are regional.) Plans include:

- traditional fee-for-service insurance policies
- PPOs
- HMOs
- HMOs with a point-of-service (POS) feature
- high-deductible health plans (HDHPs) with health savings accounts (HSAs)

FEHB Coverage Level and Standards

While benefit packages vary significantly, all FEHB plans must provide a minimal level of coverage that includes hospital care, surgical care, in-patient and out-patient care, obstetrical care, mental health and substance abuse care, and prescription drugs. All plans must also meet FEHB standards related to access to care, benefit design, and patient safety. Premiums vary according to plan type and benefit package. The federal government pays a portion (usually 72 or 75 percent), and the employee pays the rest. Generally, depending on the plan selected, enrollees also pay part of the cost for any service received in the form of deductibles, copays, and co-insurance.

When a person is hired by the federal government, they choose a plan from those available in their locality. A plan may not refuse to enroll them based on preexisting conditions, other health factors, age, or similar factors, and it may not impose a waiting period before coverage begins. Each year, there is an open enrollment period (typically running from mid-November to mid- December) during which federal workers can evaluate their benefits, provider networks, and change plans if they wish.[xxxviii]

TRICARE

TRICARE is the U.S. Department of Defense healthcare plan, serving members of the military and other uniformed services of the U.S. government, retirees, and their spouses and dependents. TRICARE uses a worldwide system of military hospitals and clinics as its main healthcare delivery system, but this is augmented by a network of civilian providers and facilities. TRICARE provides coverage to approximately 9.6 million people.[xxxix]

Congress funds TRICARE through the annual Department of Defense appropriation, and it can make changes to TRICARE benefits. The Assistant Secretary of Defense for Health Affairs (ASD/HA) and the TRICARE Management Authority (TMA) translate the annual appropriation and changes into policy. Contracted third-party administrators (two regional U.S. contractors and one international contractor)

execute the policies to serve beneficiaries. The contractors also develop and maintain the network of civilian providers and facilities.[xl]

TRICARE Eligibility

To qualify for TRICARE, a person must be associated with one of the seven **uniformed services** of the U.S. government: the four branches of the military (the Army, the Navy, the Air Force, and the Marine Corps) plus the Coast Guard, the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA), and the Commissioned Corps of the Public Health Service. Those eligible include the following:

- active duty members of the services and activated members of the National Guard and the Reserves
- retirees of the services (honorably discharged after 20 or more years of service)
- their spouses and dependent children

Service members honorably discharged after less than 20 years are not eligible for TRICARE, but they can receive care through the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

TRICARE Coverage

TRICARE covers a broad range of healthcare services from both military and civilian providers. Participants choose from numerous plans based on their needs; the major options are summarized:

- **TRICARE Prime**—a traditional gatekeeper HMO with a point-of-service (POS) option. The beneficiary's primary care provider (called a "primary care manager") must work in a military facility or be a network provider. TRICARE Prime is required for active duty service members and activated reservists; it is an option for beneficiaries living in a "Prime Service Area" who are not eligible for Medicare.
- **TRICARE Select** – a fee-for-service plan with a preferred provider network. There is an annual deductible and copays (or coinsurance) for covered services. Plan members may also receive services from non-network providers but they are likely to face higher out-of-pocket costs. Beneficiaries do not need a referral from a primary care provider before seeing a specialist but may need prior authorization. Non-active duty service members may enroll.
- **TRICARE Reserve Select**—a premium-based health plan for certain members of the Reserves and their families who are not eligible for FEHB.
- **TRICARE for Life**—Medicare wrap-around coverage for individuals enrolled in Medicare Parts A and B.
- **TRICARE Young Adult** – is a plan that qualified adult children can purchase after eligibility for "regular" TRICARE ends at age 21 (or 23 if enrolled in college). Young adults may participate if

they are an unmarried, adult child of an eligible member of TRICARE, and at least 21 but not yet 26 years old. [xli] [xlii]

- **TRICARE Dental Program**—a voluntary traditional, premium-based dental insurance plan. It is free-of-charge for active duty service members and activated reservists.

- **TRICARE Pharmacy Program**—tiered formulary prescription drug coverage provided through military facilities, network and non-network retail pharmacies, and mail-order pharmacies.

- **US Family Health Plan**—a version of TRICARE Prime. Beneficiaries do not receive care from military facilities, TRICARE network providers, or Medicare providers, but rather one of the six former Public Health Service healthcare providers.

TRICARE is always the payor of last resort. When a dependent or military retiree has health insurance from an employer or some other coverage, TRICARE pays benefits on the remaining balance only after the other insurance has paid.

TRICARE Premiums

Active duty service members and activated reservists do not pay a premium for TRICARE, although they may be charged copayments for some benefits (such as prescription drugs). Most other TRICARE beneficiaries pay premiums. Premiums vary based on a person's status (retiree or dependent) and the benefit package they choose, and they range from nominal amounts to rates typical of the private-sector market. Retirees generally pay fairly low premiums.

TRICARE Health Plan Features

TRICARE has adopted health plan features such as referrals, authorization systems, and case management. In some locations military treatment facility (MTF) staff conduct medical management activities, while in others private-sector health plans are contracted to perform them. TRICARE medical management programs include preventive care, utilization management, disease management, case management, and care coordination. TRICARE has undertaken a variety of quality initiatives using performance measures, and it seeks appropriate accreditation for facilities. All health plan contractors are required to follow TRICARE quality management and utilization management procedures.

The Effects of War

Armed conflict has important effects on TRICARE:

- Active duty physicians, nurses, and other medical providers are routinely deployed overseas. Since their military facility positions are then vacant, network providers are more heavily relied on to maintain the same access to care.

- When reservists are called to active service, they and their families are added as TRICARE beneficiaries before, during, and for a period after deployment.

- Significant care, both physical and emotional, is needed for those injured in war. The full impact of post-traumatic stress disorder (PTSD) is only now starting to be recognized.

- The effect on families should not be ignored either—being separated from a family member in harm's way for a prolonged period takes a severe mental and physical toll on spouses and children, increasing their need for medical services.

Workers' Compensation

Workers' compensation is a state-mandated insurance program that provides benefits to cover healthcare costs and lost earnings for employees who suffer a work-related injury or illness.[xliii]

Every state has a workers' compensation law and all states - except Texas- require employers to provide workers' compensation benefits.[xliv]

Most employers meet this requirement by purchasing workers' compensation insurance from an insurer. But some larger employers obtain permission from the state to self-insure or purchase high-deductible policies under which the employer retains much of the risk. Self-insured employers often hire a third-party administrator to manage their program.

Workers' Compensation vs. Group Health Insurance

Workers' compensation provides the same types of medical benefits as regular group health insurance, but there are some significant differences:

- Workers' compensation benefits are paid only if an injury or illness is work-related.

- Workers' compensation laws prohibit deductibles and copayments, and they do not specify an annual or lifetime dollar maximum on medical benefits.

- While group health plans typically limit coverage to employees who meet eligibility requirements (for instance, excluding part-time workers), workers' compensation laws in nearly every state mandate coverage for all employees.

- In many states, employers are prohibited from limiting provider choice.

While in general group health plans provide benefits whether an injury or illness is work-related or non-work-related, an injury or illness that is covered by workers' compensation is typically excluded from health plan coverage. But health plans differ greatly in the extent to which they enforce this provision. Many plans make little or no effort to determine if a medical bill should have been covered by workers' compensation, while a few are quite aggressive. If there is evidence the condition is occupational, plans often pay a submitted bill but then seek reimbursement from a workers' compensation insurer.

Disability Income Benefits

In addition to medical benefits, workers' compensation also provides disability income benefits, which replace most (typically two-thirds) of the earnings an employee loses while they are unable to work because of a work-related injury or illness.[xlv]

These DI benefits, known as **workers' compensation indemnity benefits**, account for about half of all workers' compensation expenses, with medical benefits making up the other half. All states provide for temporary DI benefits during a recovery period, and in all there is some form of benefits for permanent disabilities, although the nature of these permanent benefits varies greatly by state.

Workers' compensation is a "no fault" system. It is not required that an employer be at fault for an employee to be eligible for benefits—if an employee suffers from an illness or injury arising out of their employment, they are eligible. However, under state laws, workers' compensation is an employee's **exclusive remedy**—if an employer is at fault, the employee receives workers' compensation, but they cannot obtain damages in a civil lawsuit against the employer.

Managed Care: Workers' Compensation

While the frequency of claims has been trending down in recent years due in part to greater emphasis on workplace safety, there has been concern about the rising costs of workers' compensation medical costs. In response to this, employers and insurers have applied managed care principles to workers' compensation, including case management, selective networks, and utilization review. More recently, there have efforts to introduce value-based models into workers' compensation.[xlvi] [xlvii] [xlviii]

Controlling Workers' Compensation Medical Cost

In general, the same approaches that help control health insurance costs also work in workers' compensation. Recent workers' compensation medical cost results have confirmed this, although concerns of medical cost information remain.[xlix]

A potential problem arises in states that (as mentioned previously) prohibit employers from limiting an employee's choice of providers. But in these states, many employers find that if they suggest a provider, employees will usually give her a try and continue with her if they are satisfied with the care and service they receive.[l]

To help employers and health plans comply with state laws designed to ensure quality care, accreditation standards have been developed for workers' compensation PPOs and workers' compensation utilization review organizations (UROs) by the American Accreditation HealthCare Commission/URAC.

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27 Ethics and Health Equity

Learning Objectives

After completing this lesson, you should be able to:

- name and define the five main ethical principles for health plans.
- describe the ways health plans can implement these principles, including codes of conduct and task forces.
- discuss some of the ethical concerns that arise with health plan providers.
- discuss some of the ethical concerns that arise in health coverage sales.
- explain what is meant by health equity and ways of seeking its achievement.

Ethics & Ethical Principles for Health Plans

What Are Ethics?

Ethics are the principles and values that guide the actions of an individual or an organization when faced with questions of right and wrong.

Ethics are not the same as laws, although both reflect the values of a community. Laws are enforceable in our court system, but ethics are not; some actions may be legal but not necessarily ethical.[1]

Expectations for Health Plans

We expect businesses not only to adhere to applicable laws but also to be ethical—to "do the right thing" as they conduct their activities. And the expectation of ethical behavior is especially high for organizations and individuals involved in health care or health care benefits. Patients generally believe that those in the health care system will act in their (the patients') best interest.

Ethical questions arise under any health care system, but the nature of health plans creates particular issues. Health plans have multiple goals—accessibility, cost-effectiveness, and quality of care—and this creates the potential for a variety of ethical dilemmas, both for the health plan and for health care providers.

Five Ethical Principles for Health Plans

The five principles listed are widely accepted as important foundations of ethics in health care and are applied to the activities of health plans.

None of the principles is absolute; each is qualified by the others. Additionally, principles must always be considered and weighted in the context of the particular decision.

- **Autonomy.** Health plans and their providers must respect the right of plan members to make decisions about the course of their lives.

- **Non-maleficence** (not doing harm). Health plans and their providers must not do harm to their members.

Ethical Principles for Health Plans (Continued)

- **Beneficence** (doing good). Health plans and their providers must promote the good of both individual plan members and the members as a group.

- **Justice and equity.** Health plans and their providers should allocate resources in a way that fairly distributes benefits and burdens among members.

- **Truth-telling and promise-keeping.** Health plans and their providers must present information honestly and honor commitments.[2]

Virtue

These principles are important criteria in ethical decision-making and underpin statements of rights, duties, and obligations. But there are other ethical concepts that merit consideration, the most important of which is **virtue**.

Virtues are traits of character generated by community and tradition that dispose individuals to act honorably. Virtues are those values that, when endorsed by an individual, create (in the words of Aristotle) "a habitual disposition to act well."

A health plan can behave virtuously not only toward its members, but also toward the community at large. It can adopt corporate policies that encourage health care professionals to provide uncompensated care, it can respond to community needs in time of crisis (such as a natural disaster), and it can offer community outreach programs.

Caring

A considered balance of ethical principles and virtues can promote better ethical decision-making than grounding decisions on either alone.

In the same way that it is the foundation of all positive human relationships, virtuous behavior is inherent in the caring aspect of health care. An emphasis on caring is both unique and ethically imperative in the delivery of health care.[3]

Striking a Balance

As mentioned previously, the multiple objectives of health plans may create ethical issues.

Health plans strive to keep treatment costs down, for the benefit of each patient and also of the plan membership as a whole. The goal is not only that the individual will receive appropriate, quality care but also that the entire membership will have affordable premiums and can be offered additional benefits. In other words, health plans are not exclusively focused on the treatment needs of individual patients but also are attentive to the needs of the group.

In this way, ethical issues for health plans can be different than for health care providers, particularly individual providers, who tend to look at each individual patient in isolation.[4]

Implementing Ethical Principles in a Health Plan

Promoting an Ethical Corporate Culture

Health plans can promote and support an ethical organizational environment in a number of ways:

- Encouraging honest, effective, and open communication between the plan, potential members, providers, members, and members' families.
- Adopting and honoring statements of rights and responsibilities for members, providers, and the plan.
- Educating members about how the system works.
- Educating employees, providers, and members about ethical issues and the mechanisms that the plan has available for understanding and responding to those issues.

Promoting Ethics (Continued)

- Having policies and procedures in place to provide guidance to providers and members confronted with ethical issues, and involving providers and members in developing and implementing these policies and procedures.
- Developing and maintaining a culture where ethical considerations are integrated into decision-making at all levels.
- Ensuring that organizations with which the plan contracts have policies, procedures, and practices that are compatible with those of the plan.
- Developing formalized methods for managing ethical conflicts.

The Ethics Task Force

Some health plans establish a special committee, task force, or advisory group to consider ethical issues. Others may use bioethics consultants or network with other organizations that have expertise in this area.

An ethics task force typically includes a broad cross-section of those working for or interacting with the health plan: plan staff, network physicians, consumers, purchasers, brokers, and external health system and ethical leaders.

Roles and Functions of Ethical Task Force

The role and functions of an ethics task force are generally understood to be to:

- Provide a forum for the discussion of ethical issues
- Promote ethics education in the organization
- Generate and review policy statements related to ethics
- Provide case consultation to providers, patients, and their families facing ethical questions or conflicts

An Example

Example

> *The ethics advisory group of ABC Health Plan discusses whether ABC should pay benefits for an erectile dysfunction drug. Some members of the group feel that such drugs, although approved by the FDA, are a lifestyle choice and that the costs should be borne by individual members. Other members think such drugs should be covered because they restore a basic bodily function. After discussion, the group recommends that limited benefits be paid for such drugs.*

This example shows how a task force's ethical analysis and discussion can make a meaningful contribution to tough decision-making about allocating plan resources. This approach makes such decisions deliberative and transparent and includes a wide range of stakeholders.

Corporate Codes of Conduct and Ethics

Health plans also use corporate codes of conduct and ethics to help guide the behavior of employees, contractors, and others who interact with the plan and its members.

These go by different names, such as Standards of Conduct and Ethical Behavior, Codes of Ethics and Principles of Conduct, or Principles of Business Ethics.

Their purpose is to instill the importance of acting with integrity in the conduct of business and the delivery of services.

Elements of Codes of Conduct

A code of conduct and ethics may include directives and commitments in these areas:

- **Integrity**—making honest commitments and honoring them; recognizing and addressing conflicts of interest.
- **Accountability**—for complying with application laws, regulations, and contractual obligations, on the part of both the organization and individuals.

- **Fair competition**—seeking competitive advantage only through legal and ethical business practices.

Example of an unfair practice. *To sell coverage to large employer, a representative of a health plan makes a gift to a charity designated by an officer of the employer.*

Elements of Codes of Conduct (Continued)

- **Information**—appropriately safeguarding the privacy and security of personal information.
- **Stewardship**—protecting company assets (including intellectual property, reputation, and goodwill) from misuse, improper disclosure, or destruction.
- **Corporate citizenship**—acting in a socially responsible way (for instance, contributing to nonprofit organizations in the plan's community).
- **Workplace equality**—promoting equal opportunity in employment and preventing workplace harassment.

Health Care Providers

Health Care Providers

Health plans also have an obligation to take steps to ensure that the health care providers employed or contracted by them behave ethically.

Physicians and other health care practitioners have traditionally taken an oath of commitment to serve humanity through their profession. Typically derived from the ancient Hippocratic Oath, these oaths are viewed as a statement of medical ethics and further reinforce the provider's responsibility to place the patient's health above other considerations.[5]

Support for Provider Ethics

Health care providers are supported in their efforts to act ethically by institutions of their professions. Medical schools, nursing schools, and other professional schools provide training in health care ethics.

The American Medical Association (AMA) includes ethics groups that focus on ways to improve patient care and the health of the public by examining and promoting physician professionalism. The AMA produces a Code of Medical Ethics.

Other professional organizations have their own ethics groups and codes of conduct.

Hospitals

Most hospitals are required to have an ethics committee, and many have expanded such committees to more comprehensive programs addressing both clinical and organizational issues.

Traditionally, ethics committees draw members from diverse backgrounds, including clinicians (physicians and nurses) from different areas of practice, social workers, and community representatives.

The Functions of the Hospital Ethics Committee

The committee is charged with supporting three primary functions:

- Providing consultation in clinical ethics—often to resolve conflicts or answer questions
- Developing and revising policies pertaining to clinical ethics and hospital procedures such as advance directives, informed consent, and organ procurement
- Facilitating education on issues dealing with clinical ethics.

The Goals of the Committee

The underlying goals of ethics committee are to promote:

- Patients' rights
- Shared decision-making between patients and their physicians (or other health care providers)
- Fair policies and procedures that maximize the likelihood of achieving positive, patient-centered outcomes

An Issue: Step Therapy

Many health plans, in an effort to hold down costs and premiums, require **step therapy** for some expensive drugs. This means that a member must usually try a lower-cost alternative drug first; if that drug does not work, the plan will authorize benefits for the higher-cost drug.

Step therapy raises ethical questions about the appropriate balance between cost-control (which benefits all plan members) and the ability of physicians to prescribe the drug they think most likely to be effective in a case.

Examples

> ***Example.*** *Winston suffers from hypertension. His health plan will not cover Drug A until he tries Drug B, a generic equivalent. Research has shown that B is just as effective and safe as A, and it is considerably cheaper, allowing the plan to control costs and hold down premiums for all members. This is an ethical use of step therapy.*
>
> ***Example.*** *Juan has high cholesterol. Research shows that, for many people, Drug A is as safe and effective as Drug B. But for others, it is not, and delay in the use of Drug B can result in poor health outcomes. Requiring the use of Drug A first before benefits are paid for Drug B is ethically questionable.*

An Issue: Predictive Analytics

Predictive analytics uses "big data" and algorithms to forecast future events. In health care, very large amounts of data from numerous medical records can be used to generate recommendations for treatment in certain kinds of cases.

The question arises, however: How much leeway will be given to physicians to ignore the default recommendations produced by predictive analysis for populations and take a different approach in an individual case?

An Example

> ***Example.*** *A predictive analytic program recommends that a person in Marie's circumstances immediately undergo surgery. However, Marie's doctor believes that, in her case, this could induce stress levels that could result in an adverse health event.*

Health care experts generally believe that a physician should have the ability to override the default recommendations of a predictive analytic system.

Other Concerns with Predictive Analytics

Another question: Does the system allow for patient preferences?

> ***Example.*** *In David's case, the default recommendation is radical surgery for prostate cancer. If David prefers a less invasive approach, will his choice be accommodated?*

Yet another issue relates to the source of the data.

> ***Example.*** *A recommendation is generated based on data is drawn from a limited population rather than a wide variety of patients. To what extent should this recommendation be relied on?*[6]

Ethics and Health Coverage Sales

Ethics and the Sales Force

Health plan organizations sometimes sell their products through agents and brokers and pay them sales commissions. In some cases, the question can arise: Is the salesperson trying to meet the needs of their client, or are they just trying to earn the biggest commission they can?

Examples

> ***Example.*** *Agent Jones sells Medicare Supplement policies from several companies. He meets with Ruth, but instead of finding out about her needs and preferences and recommending the product that best meets them, he persuades her to buy the policy that pays him the highest commission. This is unethical behavior.*

> ***Example.*** *Agent Chan sells Medicare Advantage plans offered by several companies. He meets with Clara and undertakes detailed fact-finding to determine which plan would be best for her. He finds out that she suffers from diabetes and recommends that she enroll in a special needs plan that focuses on care for this condition, even though he would earn more by selling other plans. He has behaved ethically.*

Unethical and Illegal Practices

Some sales practices are not only unethical, they are also usually illegal and could costs an agent or broker their license. Some examples:

> ***Example.*** *Agent Gary tells Audrey that a Medicare Advantage plan he is selling provides certain benefits that it does not. This is* ***misrepresentation****.*

> ***Example.*** *Agent Kelli knows that Joe is a smoker. This will make his health insurance premium higher, making him less likely to buy the policy. So she tells him to say on the application that he does not use tobacco. This is* ***application fraud****.*

> ***Example.*** *Agent Bruce tells consumers that their current coverage is inadequate. In fact, he knows that it meets their needs and the new coverage he is offering is no better. He does this so that he can sell more policies and earn more commissions. When an agent does this with his own clients, it is called* ***churning****. When he targets new prospects, it is* ***twisting****.*

Good Intentions

Sometimes agents, in trying to help their clients, cross ethical and legal lines.

> ***Example.*** *Agent George has been talking to Ken about buying a policy. Finally, Ken decides that he wants the policy and would like the application to be submitted immediately. But he is out of the country and cannot sign it. So George signs it for him.*

> ***Example.*** *Another of George's clients, Lois, has signed her application, but she inadvertently failed to sign or initial in two places. Rather than bother her again, George signs for her.*

Such actions can constitute forgery. They can put the agent and the company they represent in a precarious legal position should the client later bring legal action.[7]

Additional Thoughts

Good Ethics Is Good Business

Today the health plan industry is moving from a business-to-business model to a focus on individual consumers. This makes it increasingly important for health plans and their employees, providers, and salespeople to establish and maintain trust with both current members and prospective enrollees.

Trust takes time to establish, but it can be lost very quickly through unethical behavior. Ethical missteps are difficult to hide, particularly in the age of social media. Failure to acknowledge and rectify wrongdoing as soon as possible can ruin reputations and directly affect a business's bottom line.

Examples

> ***Example.*** *A company sought to develop a new, more efficient blood-testing technology. Later it was revealed that the company had faked blood tests in order to claim promising results and attract investment capital. Result: Loss of business, major staff layoffs, loss of personal wealth and loss of freedom due to criminal conviction.*[8]

Example. *The manufacturer of a lifesaving allergy-reaction injector raised the price from $100 to over $600 in just five years, even though there was no substantial increase in the cost of producing or distributing the device. Public reaction resulted in congressional hearings, a lawsuit for racketeering, and plummeting sales. The company did not consider the welfare of consumers as well as its own profits, and it paid a price.*[9]

Questions to Ask in Ethically Challenging Situations

There may be times when you are unsure of what action to pursue. Your company's code of conduct and ethics may not provide answers. When this occurs, ask yourself these questions:

- Would the action be legal? Would it be ethical?
- What are the possible outcomes of the action?
- What person or entity might be helped or harmed by the action?
- If there are several possible actions, which is likely to do the least harm or the most good?
- Would you be comfortable if the action were published in the press or on the Internet? Shared on social media? If you had to testify about it in a legal proceeding? How would you or your family feel if the action were made public? Would you be embarrassed? Would you be proud?

Ethics: Recap

All businesses must operate ethically, but for those involved in health care the expectations are especially high.

A health plan must uphold five main ethical principles: It must respect the autonomy of its members, avoid doing harm (non-maleficence), try to do good (beneficence), share benefits and burdens equitably among those it serves, and tell the truth and keep its commitments.

A health plan can promote and support ethics in many ways, including establishing an ethics task force and publishing a code of conduct.

Plans must take steps to ensure ethical behavior not only by its employees but also the providers that serve its members and the agents and brokers who sell its products.

A plan's policies regarding benefits—such as requirements for step therapy and the use of recommendations produced by predictive analytics—must balance the need to hold down premiums for all plan members and the obligation to provide the best care to each individual member.

Health Equity

What does health equity mean?

Health equity means the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual

orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes. [10]

Health equality versus health equity

Health equality is not the same as health equity. Health equality means everyone receives the same standard of care. Health equity, on the other hand, means people receive individualized care to bring them to the same level of health. [11]

Example:

ABC Health Clinic offers free checkups every morning. Individuals within the community who must work during the morning cannot take advantage of this service While the clinic offers checkups to everyone on the same terms, those who work during morning hours cannot take advantage of this service. This is an example of health equality. Achieving health equity would involve the clinic offering alternative times during the day or evening, so that community members could access the checkup service at a time that fits their schedule(s).

How can health equity be achieved?

Achieving health equity requires focused and ongoing efforts to address avoidable inequalities, historical and contemporary injustices and racism, and health care disparities. This will often involve giving special attention to the needs of those at greatest risk of poor health based on their sociodemographic and socioeconomic conditions versus treating everyone the same.

Impact of social determinants of health

The social determinants of health are the socioeconomic conditions in which people live, learn, work, play and age. They include the financial, social, familial, and educational aspects of a person's life as well as the physical environment in which the person lives. Social determinants of health can have a positive or negative influence on person's health and their ability to live healthy lives by impacting their ability to make health choices and access to quality health care.

Social determinants that can negatively impact a person's health include inadequate access to nutritious food, lack of affordable housing, lack of convenient and efficient transportation options. They can also include limited opportunities for quality education and meaningful employments as well as limited Internet access. In turn, poorer socioeconomic conditions lead to health inequities in the form of worse health outcomes, higher health care costs, and greater health disparities for communities.

Importance of data in achieving health equity

One approach used by health plans to achieve health equity and alleviating disparities is the collection and use of data. [12]Gathering data can allow a health plan to identify disparities within their own systems and take steps to address them.

Example:

A health plan gathered and analyzed data on their enrollees. The plan found that asthma patients within a community were driving many miles to access care at a hospital even though most lived within one mile of a clinic. Their solution was to partner with a local federally qualified health center to create a community-based program to treat asthma. [13]

In addition to health plans gathering data for internal use, recommendations for the use of data include sharing the data with employer-customers and the medical community to created value- based payments programs aimed at improving health equity. [14]

Role of Medicare in Promoting Health Equity

Medicare Advantage plans, thanks to a broadened definition of supplemental benefits by the Centers for Medicare and Medicaid (CMS), are now able to provide coverage for a variety of non-medical benefits that include products and services that address social determinants of health and thus promote health equity.

Examples of these supplemental benefits include in-home support services, transportation to and from health care appointments, transportation for non-medical needs, and home delivery of essential supplies including prescription drugs and groceries.

Role of Medicaid in Promoting Health Equity

Medicaid, as you will recall from a earlier lesson, is a joint federal-state program and is uniquely positioned to advance health equity. It is the gateway to essential health care for many populations that face significant health disparities, including low-income adults, pregnant women, children, elderly adults, and people with disabilities.

How Medicaid Managed Care Promotes Health Equity

States use two principal delivery systems in their Medicaid programs:

- Fee-for-Service (FFS) – This model provides services and then bills the state Medicaid agency. The FFS model is primarily designed to simply pay for medical products and services without a focus on improving health outcomes for quality.
- Medicaid Managed Care – Under this model, the state contracts with managed care organizations (MCOs) to organize provider networks, coordinate and manage care, and pay providers. When states use a Medicaid MCO model, they can include health outcome and quality improvement goals with financial incentives and hold MCOs accountable for meeting those goals – thus, promoting health equity.
  In 2021, 40 states, the District of Columbia and Puerto Rico relied on the MCO model to serve some or all of their Medicaid enrollees. [15] Nationally, nearly two-thirds of Medicaid enrollees are served by Medicaid MCOs. [16]

Medicaid MCOs: Overcoming Barriers to Better Health

Medicaid MCOs seek to address the socioeconomic barriers to better health in many ways including:

- Conducting outreach and screening members' socioeconomic needs and offering access and/or referrals to services to address them.
- Using data analytics to better identify and act on disparities in underserved communities and populations.
- Building community resource directories to speed access to locally available resources.
- Designing programs to address identified health-related social needs, such a providing medically tailored meals, transportation to medical appointments, and housing-related services.
- And, coordinating care and services for individual patients. [17]

Bottom Line Benefits of Health Equity

Eliminating disparities in health care promotes healthier, more productive, and more resilient communities and workplaces and ultimately helps to reduce overall costs. To summarize health equity as part of the ethical equation is good business.

Appendix

The Hippocratic Oath – A Modern Version

I swear to fulfill, to the best of my ability and judgment, this covenant:

- I will respect the hard-won scientific gains of those physicians in whose steps I walk and gladly share such knowledge as is mine with those who are to follow.

- I will apply, for the benefit of the sick, all measures that are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

- I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

- I will not be ashamed to say, "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

- I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

- I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

- I will prevent disease whenever I can, for prevention is preferable to cure.

- I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling, and may I long experience the joy of healing those who seek my help.

Written in 1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University and used in many medical schools today [18]

Notes

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