Stanford MEDICINE

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INTRO TO HEALTHCARE STUDY GUIDE

MODULE 4 - INTERMEDIARIES, HEALTH INSURANCE PLANS, AND HEALTH CARE FINANCING

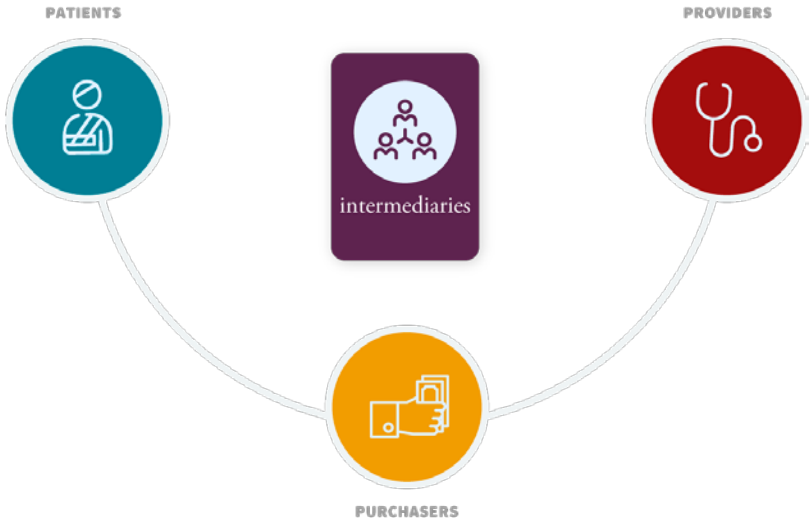
LEARNING GOALS

- Describe the main tools that intermediaries/insurers use to influence health care utilization, costs, and quality
- Describe stereotypical plan designs, including HMOs, PPOs, and "traditional" insurance models
- Identify the main sources of health coverage in the U.S., including private insurance plans and major government plans Medicare and Medicaid

INTERMEDIARIES OVERVIEW

Intermediaries are called plans, payers, and insurers. They are essential to the functioning of the healthcare system. Provide mechanisms for risk pooling, taking on risk from individuals in the population. Handle many payments to providers, and defining coverage rules that influence the ways patients can use care.

- Public intermediaries: Intermediaries run by, or under the auspices, of a government
- Private intermediaries: Intermediaries that operate as private businesses



Intermediaries face three different groups:

1. **Providers**: Intermediaries have to work out arrangements with health care providers to provide structure for taking care of patients covered by the intermediary and getting paid when they do so.
2. **Patients**: Intermediaries have to work out the terms under which they will cover health care, which often ends up influencing things like what services patients can get and how easy it is to get them.
3. **Purchasers:** The people who pay for coverage from them, their customers or buyers

The ways intermediaries work with providers and patients will influence the satisfaction people have with their products.

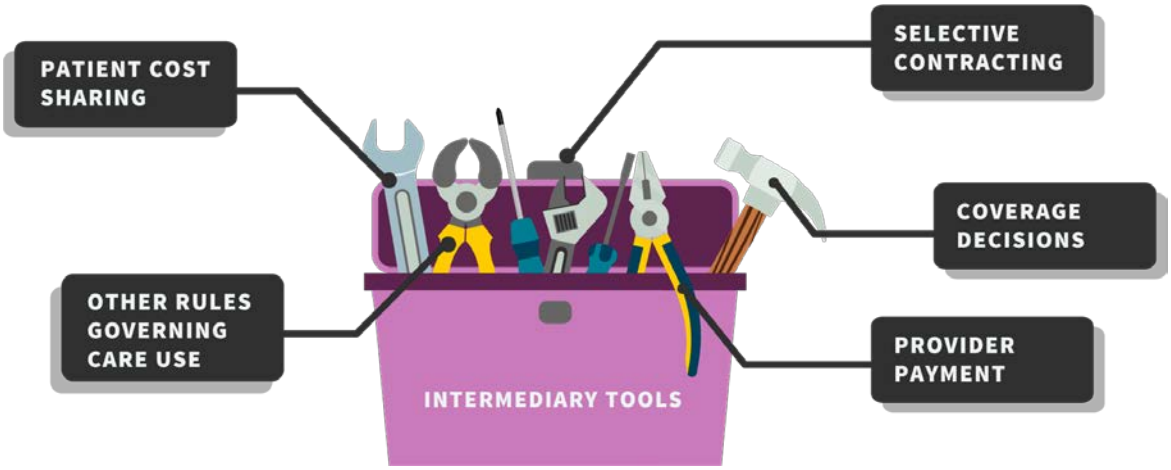
The ways intermediaries work with providers and patients also influences the amount of money they have to ask for.

Intermediaries are trying to figure out ways to work with patients and providers that both maintain those relationships and keep people happy with the care they can provide or get, and the terms under which they get it, and keep costs under control.

Broader forces that affect intermediaries:

- High and rising health care costs
- The need to provide high quality health care
- The need to enable access to care

INTERMEDIARY APPROACHES TO INFLUENCING HEALTH CARE UTILIZATION AND SPENDING



Intermediaries have a variety of tools they can use to influence health care use and spending.

Tool 1: The management of provider availability and networks. The key question is working out which providers the intermediary is going to work with.

In some places, large intermediaries or other government entities already exert influence on the provider space. Large public intermediaries in those places may find it natural to work with all or nearly all providers.

In the US, there is relatively little intermediary or government-led guidance. Providers are free to set themselves up where they want.

Terminology

- **Network or provider panel:** The set of providers organized by an intermediary to care for enrolled patients
- **Selective contracting:** Intermediaries selecting some but not all available providers to be included in their network

Some possible criteria for choosing providers:

- Quality
- Efficiency
- Payments required
- Location

Along with identifying a network, the plan sets the rules they will make for their members with respect to the choices of providers. Some intermediaries choose to be what we call "closed panel". **Closed panel** means a requirement that enrollees see providers in the panel, or else the intermediary won't contribute to the costs of care.

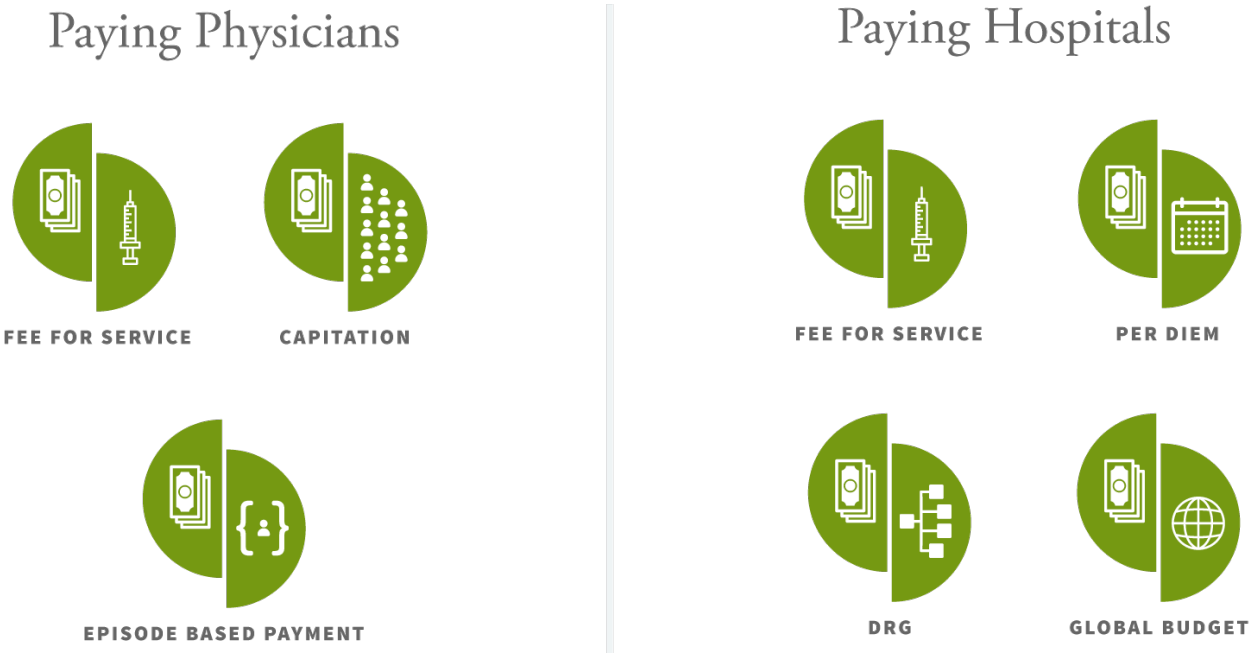
On the other side, a plan could go **open panel**. Here, the intermediary allows its members to go to pretty much any provider that they want to out there.

In between sometimes you we might say a plan has a **semi-open** or a **semi-closed panel**, where they set up a network, and then incentivize enrollees to go to providers in the network with maybe favorable cost-sharing, but maybe the plan would still pay something and help cover the cost if patients went out of the network.

Tool 2: Provider Payment Methods and Levels. Intermediaries are engaged in defining the structures governing payments to providers, as a tool they can use to influence care use and costs.

Depending on the context, this can be more or less a one-sided conversation. When intermediaries have a lot of power, say they are a large government intermediary, they may get a lot of control over the structure. On the other hand, sometimes the dynamic is more of a real negotiation – when both intermediaries and providers have some power, there can be more meaningful negotiations.

The structure of payment arrangements can have a couple of dimensions.



The first dimension - Form of the payment:

- For paying practices of physicians and other professionals, you have choices like fee for service, capitation, sometimes episode payments.
- For hospitals, the fee for service, per diem, DRG, global budgets are all methods that you'll see out there.

The second dimension - The level of payment.

- Fee for service, DRGs, any method, can be more or less costly if you set the fee schedule or the DRG payment amounts higher or lower
- One interesting interaction is between selective contracting and payment negotiations. Sometimes you will see selective contracting used to enhance a plan's bargaining ability with providers

Tool 3: Patient cost sharing. Intermediaries often use patient cost-sharing to influence care use and costs.

Cost sharing / Out-of-pocket payment: Money paid by patients to providers when they receive care.

Cost sharing structure:

- Deductible: an amount that a patient has to pay out of her own pocket before an intermediary will start contributing to the cost of the care.
- Copayments: a payment that a patient must make every time that they see a provider.
- Coinsurance: a percentage of the bill that the patient is responsible for when a provider is used.

Deductibles, copayments, coinsurance can come in a variety of combinations.

Variations in cost sharing:

- Across different types of services
- By level of spending (related to "out of pocket limit" or "out of pocket maximum")
- By network status of the provider
- By tier

The hope can be that by giving patients some incentives, they will steer themselves to more efficient, more thought-through choices about the care they really need and is worth it for them to get.

Tool 4: Utilization Review, Gatekeepers, and Other Methods of Directly Influencing Care. A set of tools to directly control or manage utilization.

1. Gatekeeper requirement. This refers to a requirement that patients must select or be assigned to a particular primary care physician, and then have to then see that physician as their first point of contact for any medical issue if the plan is to cover. Before they go see a specialist, for example, or get testing, they need to see and get a referral from the primary care doctor.
2. Utilization review. A general term that refers to plan efforts to monitor the utilization of patients and try to be involved in guiding decisions about care use. It is often said to come in 3 main types.
    a. One is pre-authorization, or "prior review." This is a requirement that, for certain services, the plan must approve of use before the service is delivered if the plan is going to cover it. Or they might do other things like maybe require the patient to try some less expensive therapy first before they go for the more expensive one. A plan

could target pre-approval requirements at services where they were worried about the overuse of expensive but low-value things.

b. The second version is a concurrent review. Plans monitoring care as it's being given and attempting to influence care. This is most often done for hospital stays whereby the insurance will contact the hospital if they think the patient is staying to long and the doctor/admin must justify why the patient is still there.
c. The third area is a retrospective review. Happen also after the care is completed. Plans may take a look at the care that was delivered and may review that for appropriateness.

There are other things that can happen in the space of plans trying to influence care. They might monitor providers by collecting data on their use of certain services, or their quality scores, or other things, and then provide feedback to the providers that might influence the utilization of care. Working with patients, they might send reminders and other information to patients to try to influence the utilization of care.

Tool 5: Coverage Decisions. Influence care use and costs by limiting the services the plan will cover.

It is common for plans to seek to cover a pretty broad range of services, generally trying to cover services that are "medically necessary." That is, services that medical professionals would commonly say are warranted or indicated for the patient. Some may not elect to cover everything out there.

Example criteria for coverage decisions:

- Efficacy
- Cost or cost-effectiveness

One area where questions about this coverage decisions come up a lot lately is around new drugs, where there can be some high priced new treatments that raise interesting cost-effectiveness questions.

Tool Overview: Combinations and Tradeoffs.

Intermediaries are expected to be good at:

- Determining specific goals
- Determining the providers and people they work with
- Determining how to deal and compete with other intermediaries
- Designing their approach to meet their goals

- Mixing and matching existing tools and sometimes making new ones
- Adapting over time

Intermediaries can vary in different ways:

- Use different combinations of the tools
- Use the tools to greater or lesser extent

COMMON HEALTH PLAN DESIGNS

1. **Traditional insurance or traditional indemnity insurance.** This stereotypically involves minimal use of the tools.
    - Open panel
    - Fee-for-service
    - No gatekeepers
    - Limited use of utilization review
    - Often higher patient cost sharing.
2. **HMO.** HMO stands for health maintenance organization. It was meant to convey that these were health plans particularly focused on prevention and maintenance of health, perhaps distinguished from other traditional insurers that are focused on treating people once they got sick and less on keeping them healthy.
    - HMOs are in many ways the opposite of traditional indemnity insurance.
    - Defined network and closed panel
    - Stronger provider payment incentives
    - Gatekeep and utilization review common
    - Often less patient cost sharing
3. **PPO.** Stands for preferred provider organization. In-between traditional indemnity and HMOs.
    - Semi-open/semi-closed panel
    - Moderate provider payment incentives
    - Gatekeeper uncommon
    - Some patient cost sharing

"Managed care" is defined as plan designs where the intermediary exerts some efforts to manage the care of its enrollees through the use of the intermediary tools. HMOs and PPOs would be examples of managed care plans.

These are two illustrations of more recent developments in plan design:

1. High deductible plan.
    - Common structure: Similar to a PPO, but with higher deductible.
    - Has lower insurance premiums
2. Narrow network plan.
    - Common structure: Similar to an HMO or PPO, but with a smaller, more selected provider network.

DIFFERENT INTERMEDIARIES OFFERING HEALTH CARE COVERAGE

We commonly separate private insurers from public intermediaries.

Many countries use a combination of intermediaries, multiple public plans, multiple private plans, public and private plans, to suit their needs depending on histories, norms, and expectations of their populations, and a range of other factors.

Be clear that this is different from plan design, plan type. Some private insurance companies actually offer multiple choices of specific plans, each acting in different ways. Some public intermediaries do this too.

PRIVATE INSURANCE COMPANIES

Private insurance companies. These are the most common source of insurance for people under age 65 in the US. There are many different insurance companies that sell private insurance. Some of them are big essentially national in scope and many are smaller often more regional. They are subject to some oversight by government authorities.

Private insurance companies in the US offer a variety of different products- HMOs, PPOs, high deductible health plans, and many others, as they see opportunities to sell them.

The common thing in this market is for health insurance plans to cover a broad range of doctors, hospitals, testing, prescription drugs, and other services. And there are some types of services that are normally excluded, like long term care, optometric (eye care), dental care. You would buy separate coverage that specifically covers those items.

Private insurance in the U.S. is either bought by an individual or provided by an employer. The individual market is set up in each state. There may be subsidies to low-income people from the government. Note every employer offers coverage to their workers, and some people are self-employed, or not working, and don't get insurance from their employer. Thus, some people get private insurance by themselves, which is called, the "individual market." There are marketplaces that have been set up in each state, in which insurance is sold directly to individuals. One important feature of the individual market is that the government provides subsidies to some people with lower incomes to help them buy coverage.

MEDICARE

Medicare:

- Large public intermediary
- Covers people over age 65
- Covers the permanently disabled
- People with end-stage renal disease
- Largely financed through taxes, with some premiums from enrollees

Medicare is run by a government organization called the Center for Medicare and Medicaid Services (CMS).

Different structures and options:

1. Traditional Medicare (Part A and B)
    - Traditional indemnity coverage
    - Open panel
    - Little utilization review
    - No gatekeepers
    - Pays doctors using a fee schedule, and hospitals using a DRG system
    - High cost sharing

2. Medicare Advantage (Part C)
    - Medicare contracts with private insurance companies to take Medicare enrollees
    - A strong focus on just the Medicare market
    - Plans offered are often HMO or PPO plan types
3. Medicare Part D
    - Coverage for prescription drugs
    - Purchased as an add-on to traditional Medicare
    - Often incorporated into Medicare Advantage plans

Medicare Supplement or Medigap: Supplemental insurance obtained by enrollees in traditional Medicare, to cover cost sharing or other things not covered by Medicare.

Medicare over time has been innovative in key areas, trying to achieve like acting as a pioneer in the creation of fee schedules and DRGs, and more recently encouraging the development of ACO models. At the same time, it has sometimes faced criticism for allowing too much choice and an outdated traditional insurance model in Parts A and B. But at the same time, they have been building Medicare Advantage, which brings in newer plan designs.

Medicare also offers good examples of interactions between private and public intermediaries. Overall, a lot we can see and learn from thinking about Medicare.

MEDICAID

Medicaid:

- Large public intermediary
- Covers lower income populations
- Overseen by both federal and state governments
- Largely financed by tax revenue

Medicaid offered in two main forms:

1. **Traditional Medicaid.** Original offering; generally traditional indemnity-style coverage
2. **Medicaid Managed Care.** More commonly found; HMOs or other managed care plans for Medicaid recipients

An important challenge with Medicaid over the years has been limited funding, and as a result, limited pay for the providers who take care of Medicaid patients, which has sometimes been a criticism and a political challenge for Medicaid.

Another challenge for Medicaid is that the limits for eligibility vary from one state to another. A result is that its ability to meet its goal of covering low income populations is met to differing degrees in different places, which can raise concerns.

Medicaid's greatest issues appear to stem from the challenges of raising sufficient funds for public programs in complex fiscal and political environments, particularly when the public program serves a subpart of the population that may face limitations in its political power.

LESSONS FOR AI AND DATA

Intermediaries' functions:

- Trying to figure out which tools to use and how to use them well
- Determine which providers to contract with
- Determine which providers in their network to drop
- Provide feedback to design payment approaches
- Determine complex medical care enrollees
- Determine which requests for pre-authorization should be approved
- Determine which hospital stays by their numbers are too long
- How to optimally set cost sharing
- Find most likely customers and market to them
- Process loads of bills for medical care claims
- Determine which claims to pay and which not
- Determine which, if any, have errors
- Determine which be fraud and which not